becoming lost in services where emergency cover is provided solely by general practitioners or consultants in a de-centralised fashion.

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Training schemes

DEAR SIRS

The comparison of 'on-call' experience by P. Donnelly & K. Rice (*Psychiatric Bulletin*, May 1989, **13**, 237–239) makes interesting reading. Trainees and trainers need to take note of the wide variation in experience available to trainees in the United Kingdom. Variation exists as a result of services developing to meet the needs of the indigent population in the catchment area. In the College (1985) document 'Statement on Approval of Training Schemes for General Professional Training for the MRCPsych' it is significant that emphasis is placed on 'the efforts made to include all available types of local experience into a training scheme'. The College (1981) has recognised the need for any guidelines to permit individual training schemes the flexibility to offer a variety of experiences all acceptable for general psychiatric training.

The Nottingham Psychiatric Rotational Training Scheme, I hope, is not alone in offering trainees the opportunity of experience in a peripheral district general hospital based psychiatric unit. I have recently completed six months in general psychiatry in Mansfield about 15 miles from Nottingham. Most trainees spend at least six months in Mansfield. As there are more consultant posts outside teaching hospitals it follows that eventually most trainees will end up in peripheral psychiatric units at the level of consultant. It seems obvious that early experience at the periphery will prove of lasting value to all trainees.

Trainees in Nottingham and Mansfield are designated the consultant's nominated deputy for the Mental Health Act. I agree with Donnelly & Rice and consider it invaluable to have responsibility of using the Act. It appears a desirable feature for all rotations and possible with perhaps only minor modifications in existing working practices.

It is essential that prospective trainees are aware of the wide variation of experience and training available even on training schemes which fulfil the criteria for approval by the Royal College of Psychiatrists. This is an issue of concern to the Collegiate Trainees' Committee of which I am a member. We intend to produce a document which will provide prospective trainees with guidelines to assist them in selecting training schemes suitable to their own needs.

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The plight of the Special Hospitals

DEAR SIRS

'Special Hospital Bashing' is a popular sport among journalists and TV reporters, as recently witnessed by the Cook Report documentary on Park Lane Hospital, broadcast on 22 May 1989. I recall ITV's documentary on Rampton Hospital – 'The Secret Hospital' – in May 1979. On that occasion strong criticism was levelled at Rampton Hospital, as a harsh, abusive, custodial institution, which offered its patients little progressive therapy. On this occasion the Cook Report concentrated solely on a particular danger inherent in treating dangerous psychiatric patients; namely, that following treatment, discharge of patients will occur, mistakes will surely eventually be made, and thus disasters of serious re-offending be occasioned, however rare one hopes such incidents might be. Balanced precariously as they are between the need to protect the public from dangerous psychiatric patients and the expectation that they will attempt to 'cure' the same, it is hardly surprising that the Special Hospitals make such inviting targets for journalists.

It is instructive to compare the plight of the Special Hospitals with that of the prisons. Paraphrased in brief terms, the Annual Report of the work of the prison services states that the primary function of the Prison Service is to keep prisoners in custody, with appropriate security, for the duration of their sentences. The rehabilitation of prisoners, or any equivalent, is not mentioned in the Prison Board's Policy

Statement. When a prisoner, having completed his sentence, re-offends, public outcry and apportioning of blame often tend to be relatively muted, in comparison with the furore which may follow re-offending by a Special Hospital patient. The rationale employed by society appears to be that once an individual has served the punishment imposed for his crime, then it is correct that he should return to society and if he re-offends agains, the fault lies with him alone. When we hear of recividism rates for prisoners in the order of 80%, this rationale is indeed fortunate for the prison authorities.

The expectation made upon the Special Hospitals is considerably more complex than, as with prisons, merely acting as a vehicle for punishment and containment. Offences must be understood in terms of mental disorders present, and patients maintained in adequate security until such time as these disorders are ameliorated. Not surprisingly such terms of reference result, not infrequently, in longer periods of detention for offenders than would have been occasioned by a prison sentence.

It would appear to me that the Department of Health, as Managers of the Special Hospitals, have a duty to clearly state the purposes and functions of these institutions and bring the recividism statistics of Special Hospital patients into the open, instead of continuing to function, as perceived by the media, behind a 'veil of secrecy'.

Such action might result in more enlightened discussion over the complex problems that the Special Hospitals pose, and perhaps even tempt reporters into making more balanced documentaries than that portrayed in the recent Cook Report. It might also avoid the distasteful scapegoating of Special Hospital Medical Directors, as happened in this particular documentary.

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Psychiatry and the private sector

DEAR SIRS

I fear that Dr Turner is looking only at the negative side of psychiatry in the private sector (*Psychiatric Bulletin*, May 1989, **13**, 249). There is a good deal that the NHS could learn from the independent sector especially in the climate of the Government White Paper, *Working for Patients*. For example it is possible to treat NHS and private patients in the same surroundings. Between March 1987 and October 1988, 66 of Camberwell's most severely ill patients were admitted to The Priory Hospital. Most of them were on Sections of the Mental Health Act (2,3,4 and 136).

The diagnostic categories were as follows:

ICD-9	*Diagnosis*	*Camberwell Health Authority (NHS)*	*Priory Hospital (Private)*
295	Schizophrenia	60%	16%
296	Affective psychoses	29%	28%
300	Neurotic disorders	5%	16%
303 304	Alcohol and Drug dependence	6%	29%
	Other	0%	11%

As expected, there was a higher proportion of schizophrenic patients in the Camberwell sample and more neurosis, alcohol and substance abuse among the private patients. The scarcity of resources for the in-patient treatment of alcohol problems in the NHS has been the subject of a recent televison programme. The percentage of affective disorders was, however, remarkably similar.

The mean durations of stay of both groups were almost identical: Camberwell patients 24 days; private patients 23 days. The Camberwell patients were treated in the same intensive care setting as the private patients. There are no locked doors and there is not a seclusion room. Only one of the Camberwell patients absconded. There were no suicides. It was apparent that those needing a locked facility for forensic reasons were not appropriate. The one patient who did abscond, did so in his pyjamas. When asked where he was going by a fellow passenger on the bus, he replied "To a pyjama party of course". Another patient, who was on a section of the Mental Health Act, was asked by a Mental Health Act Commissioner "Do you mind being in this hospital?" To which he replied "What? You must think I'm mad!"

The NHS no longer has a monopoly of administrative or innovative ideas. It has been demonstrated that the private sector can also be an appropriate place for registrars and nurses from the NHS to be trained. (*Psychiatric Bulletin*, April 1989, **13**, 199). If the White Paper does nothing else, I hope it will reduce the barriers between the NHS and the independent sector. The Royal College of Psychiatrists appears to recognise this, since there is a representative from the private sector on the College committee discussing the Government White Paper.

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Treatment for patients unable to consent

DEAR SIRS

I wonder how many of my colleagues are aware of the implications of the recent decision of the five Law