their Voluntary Service Coordinator as part of their regular induction process. This will enable their VSC to educate them with regard to the potential use of volunteers in their hospital and/or District.

Training in the use of volunteers and relationship with them should be a part of all postgraduate programmes in psychiatry, psychiatric nursing and psychiatric social work. Since all members of the team are involved, this could well be an element in mixed disciplinary training programmes (themselves a logical way of teaching inter-disciplinary collaboration).

The basic sciences underlying much of this work include group psychology, sociology and family dynamics. At advanced level, psychologists, medical sociologists and psychotherapists all have contributions to make to training in family psychiatry, organizational psychiatry, community psychiatry and preventive psychiatry. These topics should henceforth be given greater prominence in the training of psychiatrists than they have in the past.

In the end the aim must be to produce a psychiatrist who can adopt a balance between the full range of psychiatric approaches. He should be not only a specialized diagnostician and therapist but an 'enabler'. He should be ready to listen, to encourage, to respect the expertise of his fellow team members and to share management with them in a non-authoritarian manner. He must also be willing to take final responsibility for the management of difficult situations.

The members of the Working Party included Drs Alexis Brook, Rudolf Freudenberg, Josephine Lomax-Simpson, Colin Parkes (Chairman), Anthony Ryle, Dennis Scott, David Wallbridge (psychiatrists), a general practitioner, community physician, nursing officer, three social workers, a chaplain and representatives of educational psychology and voluntary work.

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CORRESPONDENCE

REGIONAL MEDIUM SECURITY UNITS: SOLUTION OR DISASTER?

Dear Sir,

For the last decade I have earned my living as a forensic psychiatrist and recently I have been deeply concerned that our profession is being persuaded to participate in an idea that will bring us public ridicule, and perhaps even scandal. I refer to the establishment of medium security units. Public ridicule, I believe, may ensue because psychiatrists will be inefficient (and dangerous) jailers. Our failures will be exposed in open court. Scandal may also result because, unless the Government are prepared to spend millions of pounds, the quality of life in these units may leave a great deal to be desired. In fact, if they are small, cramped and lack adequate facilities, then they will compare unfavourably with the Special Hospitals.

I believe the concept of these units springs from the embarrassment that was engendered by the large number of patients crowded into the old buildings of Broadmoor, with the consequent lack of privacy and space for personal possessions. The idea seems to be that these units will cater for a large number of Broadmoor patients, either acting as brief staging posts on the return to the community, or as treatment units for a longer period under conditions of lesser security. Secondly, I believe the intention is to deflect as many mentally disordered offenders away from the Remand Centres and the prisons. The feeling is that the secure units will produce better medical reports and there is less chance of the ill offender being missed.

https://doi.org/10.1192/S0140078900002236 Published online by Cambridge University Press

There was no Broadmoor consultant or prison medical officer on the Butler Committee. If there had been, perhaps it could have been explained that when a Broadmoor consultant considers his patient is fit to leave, that means he is fit for the community or an open ward. Sending him to a locked ward of a hospital is primarily for the treatment of the nursing staff. Furthermore, the Broadmoor patient is used to a wide range of facilities both social and occupational. He is also used to a good deal of outdoor space within the security perimeter. He would much resent being placed in a more confined hospital situation whilst he remains under an indefinite order and the discharge date is still uncertain.

On page 172 of the Butler Report there is an arrangement suggested whereby if the Defendant's demeanour in the witness box should give rise to anxiety, then on the oral evidence of a Police Surgeon or GP, the court may despatch him to the local psychiatric unit. The report adds, most considerately, that the hospital consultant need not attend the court.

There seems to be a failure to appreciate the daily routine work of a busy Remand Centre. Large numbers of people arrive; some of them will certainly be mentally ill, but many others are eccentric and have odd personalities. Certainly, their demeanours may well be peculiar in the witness box—this is not an indication for them to be immediately admitted to the local hospital. How many young females of psychopathic tendency will soon learn the ropes and manipulate their way into the local hospital? Who will record their injuries, list their property and search them for drugs or hidden razor blades? Will the local psychiatric hospital really want to deal with the meths. drinker who has been living rough and who has committed theft and is going to have the DTs? I think not. It seems to me that if the consultant were to appear in court, after such a system was initiated, his comments would be unrepeatable.

However, let us assume such a unit is built for between 50 and 100 patients—this is the number suggested by the Glancy Report. If we envisage some of the patients staying at least a year, we must inquire what recreational facilities will be provided for them. Will there be a wide range of workshops and social activities? If not, will the patients be bored and those of psychopathic propensities seek excitement (as they are prone to do) in attempting to escape; or will it be decided that those unfortunate people who have a personality disorder and a mental illness will not be considered suitable candidates for these units?

Assuming a remanded patient escapes and cannot be produced in court, the court will understandably be displeased. What if the psychiatrist forgot to make inquiries regarding the patient's aggressive fantasies, and the patient escapes and there is a very serious incident in the local community? The hostility will be enormous because, presumably at the Public Inquiry stage, all the usual reassurances about security and type of patient will have been given. In these circumstances the morale of the nursing staff will be affected—after all, they live in the community too. Everyone with practical experience of the complexities of treating patients in secure conditions knows that once the morale of the nursing staff becomes too low the unit ceases to be therapeutically effective.

If there are incidents and the local community become hostile, the doctor running the unit will have to exercise increasing caution over the selection of patients. By this time, however, the unit will have cost a huge amount of taxpayers' money and must be seen to continue to function. The difficult patients who might have been helped will return to the local Remand Centre.

At this stage further difficulties will ensue. When the remanded prisoner appears in court and the prison doctor states he feels the prisoner could benefit from psychiatric treatment, the solicitor or barrister will pursue this course with enthusiasm, as being in the best interests of his client. In court will be the doctor from the Regional secure unit, the doctor from the open psychiatric hospital and the prison doctor. If the Regional secure unit has run into difficulties and the consultant in charge is playing safe, there will be a great deal of unseemly wrangling in open court about the disposal of the patient. Such a situation could become almost routine and do grave harm to relationships between psychiatrists in the forensic field. The press would have a field day.

If these units fail, what is to be done? The prison hospital is merely a sick bay, but is an excellent place for the assessment of patients and for the treatment of the acutely psychotic patient who may be violent. The prison doctor armed with his D.P.M. and, one hopes, his Membership should be able to cope and get the patient sufficiently better so that he can then be transferred to an open psychiatric hospital to continue treatment. The prison hospital can do no more than this. It has no facilities for further treatment of psychotic patients beyond the acute stage of illness.

Assuming the patient makes a degree of recovery in the prison hospital in the course of his first few weeks there, the prison doctor will then make an assessment as to what kind of unit the patient should proceed to, i.e. whether he should go to an open-door specialist forensics unit or an ordinary pychiatric

https://doi.org/10.1192/S0140078900002236 Published online by Cambridge University Press

hospital. The prisoner's solicitor may also get a second opinion at this stage. The prison medical officer will invite the appropriate consultant to see the prisoner and if there is any disagreement will call a meeting involving the doctors, the nursing staff and the probation service. What the doctors and nurses at open door hospitals require is support and back-up. Nursing staff can work miracles of therapy when given difficult patients, providing they know that if the situation becomes too tense or dangerous the patient will be removed to a greater degree of security. So it may well be that the prisoner receives a sentence and the court is told that he will be transferred to the local hospital under the provisions of Section 72 when he is well enough; he can be withdrawn to prison immediately should he cease to cooperate. Or a Probation Order may be made with a condition of psychiatric treatment and the Probation Officer agreeing to bring breach proceedings if the hospital decides that the patient should return to court (and perhaps prison) for reappraisal. It may be that a bed in a Special Hospital could be sought—vacancies would be available as the consultants from the Special Hospitals would have transferred a proportion of their patients to open forensic psychiatric units on the understanding that they would be prepared to accept them back immediately within a few hours should this be necessary. Very violent incidents in the open-door hospitals would be resolved by the arrival of the police and the patient being sent to the local Remand Centre via the court. The situation would be re-assessed and he then might be returned to the open-door situation, welcomed, it is to be hoped, by the nursing staff who would feel that they had been adequately supported in a crisis.

To some extent what I have described already happens. The missing links are the specialized open forensic units and an adequate number of psychiatrists who wish to make a career in the prison service. Recently, however, an open forensic unit has been opened at Knowle Hospital, and perhaps if it becomes apparent that Regional security units will not be the order of the day more psychiatrists will feel that they can pursue a worthwhile and fascinating career within the Prison Service.

In the November issue of *The Bulletin*, Dr Paul Bowden stated (p 15) that the forensic developments envisaged by Glancy and Butler were 'obviously unacceptable to the majority of psychiatrists'. If this is the case, perhaps it is time the majority of psychiatrists stood up to be counted.

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IS IT CRICKET?

Dear Sir,

It was very useful to read of Ezra the Scribe's experiences with the Multi-Disciplinary Cricket Management Committee (*Bulletin*, Nov. 1977, p 12) as we have for some time been trying to arrange a match in this area with the local Social Services Department. We have, of course, had the usual problems common to all areas, in that some of our fielders are not only in the pay of the captain of the opposite team, but seem unsure as to who should be telling them whereabouts in the field they should be standing.

There have been other difficulties, such as on whose ground the match should take place, whose set of rules we should be playing to and even about the composition of the two teams. Some of the less important players on each side have wondered why in fact we do not dispense with the match altogether and try to form a joint team, but the problem then would be where would we find any opposition? The only other team so far suggested is a team of psychiatric patients, but some leading members of both teams show a marked dislike of having any contact with mentally ill people, so this does not seem possible, at least for the time being.

Like Ezra, we have had advice from a lot of people about this, including the principal clinical psychologist who, also like the Scribe's, had no knowledge of cricket, but felt that she could give a great deal of well-meaning but irrelevant advice. She has, however, now given up the struggle and has gone away to advise a University cricket team. There has also been a problem with the captain of the other side who seems to require a large number of other people to communicate his instructions to the members of his team, in fact so much so that the number of his side has been increased from 11 to 311 to cope with this. This does not worry us too much as it appears that despite this very large team the number actually batting and bowling is less than it was before. It also seems that the local Community Cricketer (Social Services Liaison) became rather upset because he felt that his role in making the arrangements had not been fully recognized, but this perhaps does not matter as nobody, including himself, ever really knew which side he was on. All of these problems, together with the theoretical question of what would happen if a cricket social worker and a cricket community nurse found themselves fielding in the same place, caused so much difficulty and disagreement that I am afraid the whole matter had to be considered by the Joint Cricket Planning Team, none of the members of which actually play cricket, but it is said that one

https://doi.org/10.1192/S0140078900002236 Published online by Cambridge University Press