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Correspondence

Restriction orders

DEAR SIRS

Graham Robertson's interesting and provocative article on restricted hospital orders (*Psychiatric Bulletin*, January 1989, **13**, 4–11) provides an excellent historical account and much useful information, but it has one major omission: any mention of Regional Secure Units (RSUs).

His graph (Fig. 1, p. 7) shows a steady decline in restricted patients admitted to local hospitals from 1973–1977, then a gradual rise, accelerating in 1981. The first interim RSUs opened in 1976 in Liverpool and Manchester, and by 1981 permanent RSUs were being completed. This is likely to account for the increase from around 30 to around 60 admissions per year, extrapolating from the graph. This was at a time when Special Hospital Restriction Orders were declining, so it is no longer true that the "open door policy ... of local hospitals" made "the notion of secure containment a nonsense".

A restriction order makes relatively little difference to a patient's life within a Special Hospital, but usually has a considerable effect on his freedom in local hospitals, including in an RSU. This is because the Responsible Medical Officer (RMO) normally only has power to grant parole (freedom to leave the unit without staff escorts) within the grounds of the hospital. Leave to go outside the grounds, to work, or to move to a hostel or other accommodation in the community has to be obtained from the Home Secretary – or a Tribunal.

Except for a brief period when an unusually restrictive Minister was responsible for these decisions, co-operation between C3 Division of the Home Office and consultant forensic psychiatrists has normally been good. I have valued the opportunities to discuss the progress of these potentially dangerous patients with the staff of C3, and to share with them the responsibility for difficult decisions, which potentially puts the public at risk. During the Mellor era I persuaded the Courts to make unrestricted hospital orders on three patients who had committed homicide, and while there were no disasters, I found that even with the support of my multidisciplinary team I felt rather exposed in deciding when to allow freedom outside the hospital and when to discharge them, and in managing them as out-patients without the benefits of the conditional discharge provisions.

Dr Robertson may be correct in arguing that the restriction order is an illogical compromise. However, it seems reasonable that Courts should not have the power to order the detention of a patient in hospital who has not committed an imprisonable offence, and in my opinion the restriction order is a successful British compromise. It does restrict doctors as well as patients, but for RSU forensic psychiatrists, who have sufficient restriction order patients to develop a regular working relationship with C3 Division, the frustrations and delays are minor compared with the benefits of shared responsibility for decisions, independent assessments of difficult cases where mistakes can be lethal, and invaluable continuing care with control during the patient's aftercare – the only community treatment order we have at present.

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DEAR SIRS

I am grateful to Dr Campbell for pointing out a major omission in my article on the Restricted Hospital Order, namely the lack of any reference to the possible role and effect of Regional Secure Units. These units have indeed provided valuable new local facilities for secure containment. However, this does not invalidate my contention that open door policies make secure containment a nonsense – the units referred to are locked.

Having worked at C3 for a time, I share Dr Campbell's high opinion of the staff in this Home Office Division. I was extremely impressed by their obvious concern for the needs of both patients and responsible medical officers. I would also accept his description of the restriction order as being "a successful British compromise".

In my paper, I argue that courts should have the power to send but not to sentence to hospital and I cannot accept the point he makes regarding imprisonable offences.

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Psychosurgery, the Mental Health Act Commission and the Law

DEAR SIRS

The Mental Health Act (MHA) Commission has recently been challenged in the High Court by a patient for the first time and the decision of the Commissioners to refuse treatment by the subcutaneous implantation of goserelin was reversed (Dyer, *British*

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