mental handicap; biological and ethical considerations; additional handicaps; diagnostic challenges; and psychiatric illness in mentally handicapped people. This teaching, which included time for discussion, ensured an adequate baseline of knowledge. *Small group work:* this involved the discussion of videos illustrating various lifestyles and biographies of handicapped people. Topics here included bereavement and loss; sexuality; risk taking; the sickness model; and medication and its abuse. There was also an experiential game illustrating some of the challenges and dilemmas in the planning of services in the long-stay sector. *Activity workshops:* these were enthusiastically received and involved a behavioural approach to skill building and treatment of behaviour disorders; the role of the physiotherapist for mentally handicapped people; and non-verbal communication systems with special reference to MAKATON. *Research papers and personal viewpoints:* presentations here included 'Long-acting phenothiazines in mental handicap practice' and 'The viewpoint of the Community Mental Handicap Team'.

Participants were asked to evaluate the course and an analysis of their comments yielded a positive response. There was a unanimous request for a feedback meeting some months after the course to be held in a Mental Handicap Service where the skills that had been learned could be seen in practice.

The value of such a course can only be measured by a change in awareness of the medical needs and of the roles of others in the lives of mentally handicapped people, and by an improvement to the medical service wherever mentally handicapped people might be. My impression was that the course will make a significant contribution towards that end and the model might be adopted by others who are committed to raise the standard of primary care through a better understanding of the needs and vulnerabilities of this patient group.

Saskatchewan Secure Unit

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The British approach to administrative problems is often to accumulate more and more evidence for changes which are obsolete before enaction. Such a fate seems likely to happen to plans for the management of the psychiatrically disturbed offender following several reports.[1,2,3] It was interesting, therefore, this summer to work as a locum consultant in a Saskatchewan forensic psychiatric hospital.

The Regional Psychiatric Centre (Prairies) located in Saskatoon, is a secure hospital accepting referrals from the prisons, the courts and correctional centres exclusively. The Centre was opened in 1978 and is one of three similar units in Canada, set up following a Committee of investigation into the management of the forensic psychiatric patient.

The building is a polyhedron with central courtyard. Neatly tended lawns and bedding flowers surprise; the entrance is as formal as the adjacent prairie is informal. Access is gained to the five locked patient areas by means of the perimeter corridor. Doors are opened centrally and are under constant video surveillance. Once inside the patient areas, access to day rooms is permitted by security staff, the doors being under remote control.

Patient facilities, in line with American standards, included the constant availability of coffee and direct access to a music room on the ward. A well-equipped gymnasium was also available in the hospital, together with a good library. Furniture, although modern and functional, was spartan. There was little or no evidence of vandalism and graffitti were a minimal problem. The hospital had space for approximately 100 beds.

The hospital has several functions. The first provides for a two to three-week period of assessment by psychiatric, psychological, nursing and security staff. This period culminates in a Case Conference. The patient is invited to attend part of the proceedings and conclusions regarding disposal are discussed with him during the conference, after he has had an opportunity to put his point of view.

In addition to assessment, there are units for the treatment of sexual offenders, chronic psychotics and severe personality disordered individuals, as well as a therapeutic community orientated towards the more intact individual, generally also with personality difficulties. Treatment is within a group setting and involves the combination of interpretative and directive approaches.

Sexual offenders in Canada, as in the UK, are generally subject to abuse and assault from other prisoners. A secure psychiatric unit is able to afford protection as well as treatment since, in such an institution, many other inmates have been rejected by the general prison population for a variety of reasons.

The hospital also has an isolation unit in which particularly disturbed individuals can be nursed in single locked rooms whilst under constant 24-hour surveillance. Individuals were generally kept in such circumstances for, at most, a few days. This was a remarkable achievement when one considers that commonly such individuals were referred because they could not function or could not be managed within the penitentiary system, generally because of self-destructive or aggressive behaviour, deemed to be related to

psychiatric disturbance.

In addition to psychologically orientated treatments, chemotherapy was used extensively with, in particular, the psychotic patient population. An interesting feature here was patients' greater awareness of potential side effects of medication, compared with a UK population. As a result patients were more questioning of their drug prescription and consent to treat with drugs generally meant informed consent. No patients were treated involuntarily with medication unless their illness was of sufficient severity and danger to themselves or others to merit the application of a formal treatment and detention order. There was, however, amongst the staff a lack of enthusiasm for the use of electroplexy, perhaps emanating from the patient's own perceptions of the nature of this treatment. I found my own 'pro ECT' approach for the severe psychotic depressive considered by nurses and psychologists something of an anachronism.

The most unique feature of this hospital was the total separation of therapeutic and security roles. Security was the responsibility entirely of security personnel. Nurses were not involved to any great extent in issues of security, except that they obviously had to nurse individuals who were incarcerated. Electrically operated doors freed staff from carrying large bunches of keys. I am sure this both improved the atmosphere and removed an obvious goad to assaults on staff.

The benefits in terms of nurses' perception of their role were quite obvious. In general, a calm and reasoned therapeutic milieu prevailed. This persisted during my stay despite an unpleasant attempt at sexual assault of a nurse by a patient. Indeed, it was noticeable that some of the security staff began adopting therapeutic alliances with the patients. Nursing reports on patients tended to be authoritative and most nurses demonstrated a willingness for independence and assumption of responsibility. I felt this was helped by the informal trousersuit uniforms worn by nurses, in stark contrast with the over-formalized hierarchical costume of some British nurses.

Perhaps because of the hospital's initial terms of reference as a centre for handling psychopathy, there seemed to be a marked enthusiasm for the treatment of personality disorders. One became extremely conscious of the rather defensive British conception of individuals with personality dysfunction, in which assessment often seems to culminate in a negative statement about the prospects for therapy being effective. Of course, it is difficult to appraise the success of policy in the RPC since clearly offenders are motivated towards demonstrating improvement whilst involuntarily incarcerated by society. At the very least, some extremely difficult and dangerous people were not merely contained but managed and even cared for during sizable periods of their sentence.

On the negative side, it was distressing to see deteriorated psychotic people referred by the penal system when clearly there had been opportunity for more vigourous treatment within the prisons. In the UK it is felt that a number of psychotic people remain in the prison system who could best be managed elsewhere.[4] Such individuals' inevitable isolation in these institutions often seemed to facilitate deterioration. A closer liaison with psychiatrists involved in other forensic settings might have helped but, of course, in Canada. this means overcoming large distances.

I suspect also that many of the non-therapeutic staff members in penal settings saw psychosis as merely an extreme example of deviant personality. Thus madness would seem a bizarre expression of badness. Of course, our society has a marked degree of ambivalence to this dichotomy,[5] dramatically demonstrated by the treatment of psychiatric evidence in the so-called 'Ripper' and 'Nielson' cases. I believe psychiatrists could help by adopting a more medical model approach, making a distinction between, for example, schizophrenia and personality disorders on illness terms. This, of course, is not to deny the implications of social and personal factors unrelated to any presumed biological dysfunction.

I felt also that psychologists tended to rely too much on psychometric assessment, indulging in the Trans-Atlantic enthusiasm for the Minnesota Multiphasic Personality Inventory (MMPI). I understand that Canadian parole boards have now come to expect this type of approach, but perhaps a personal interview with the aim of providing a behavioural analysis might have been more productive since this would lead to obvious therapeutic manoeuvres.

Such a hospital could be effective in the United Kingdom. It certainly would be easier to attract staff to smaller purpose-built units located within centres of population as Butler recognized.[1] For nurses, there would be the added attraction of freedom from security obligations. For many patients the opportunity to work with a therapeutic contract gives an appropriate route for demonstrating change to society and parole boards. This must inevitably prevent despair, particularly amongst those likely to spend long periods deprived of their liberty.

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