dopamine transporter, and neuroimaging findings of altered brain structures including frontal lobe and striatum.

Castellanos *et al* (2002), for example, report the altered neuroanatomy of ADHD, with the brains of those who have never been medicated being more abnormal than those of children who have received stimulants.

Dr Double extends the debate to the question of the use of medication. A large controlled trial (MTA Collaborative Group, 1999) has shown significant advantages of medication over psychological therapy (although I believe that psychological treatment still has an important place). I should therefore like to emphasise that there are dangers in being too reluctant to diagnose and treat ADHD. Children then often receive more destructive labels. Treatment can restore normal function, so it seems to me unacceptable to withhold its benefits from individual children for the sake of a preference for a different form of society.

Declaration of interest

E.T. has an honorary National Health Service contract, and lectures at conferences receiving sponsorship from pharmaceutical companies.

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Castellanos, F. X., Lee, P. P., Sharp, W., *et al* (2002) Developmental trajectories of brain volume abnormalities in children and adolescents with attention-deficit/hyperactivity disorder. *Journal of the American Medical Association*, **288**, 1740–1748.

DiMaio, S., Grizenko, N. & Joober, R. (2003) Dopamine genes and attention-deficit hyperactivity disorder: a review. *Journal of Psychiatry and Neuroscience*, **28**, 27–38.

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Commissioning conundrum for custodial care

Simon Wilson presents an editorial (2004) that questions the traditional role of the prison hospital wing. I have also questioned this over the years (Gannon, 2002). However, a factual inaccuracy in his introduction flaws his conclusion.

The Health Secretary for England announced that there would be a transfer of responsibility whereby the NHS *in England* would become responsible for *commissioning* health care in prisons from April 2003. It is very different to announce 'commissioning', as distinct from 'provision' – as Dr Wilson claims. It is, I fear, less of a take-over than a make-over by the Department of Health. Primary care trusts can commission provision from a range of providers – including the current prison provider. The governor will continue to maintain control over the 'cells' in the hospital wing.

Once the reader understands the distinction between commissioning and providing, it provokes thought about the appropriate allocation of health care spending. Why spend the commissioning money twice, on the same citizen, in two different places? Why construct a parallel health care system?

Choosing to highlight capital investment on prisoners may be a public relations disaster. The general public is easily swayed by popular media headlines. Health care spending on special-care baby cots is more palatable than making the prison experience more decent for citizens.

There are hundreds of people in the secure hospitals who have been assessed as no longer requiring that level of security. Capital investment is required urgently at the lower end of the security scale – it is an illusion that more high security is required – thus creating remand beds (not cells) made directly available to courts. This is the only way to seek equivalence. Our mentally ill citizens should not be in prisons at all – we should argue for nothing less.

Eroding this principle, however well intended, just sanitises society's tolerance of this essential injustice. It is all too collusive to believe that we are somehow caring more appropriately if we allow an expansion of common law – lest it just become common lore.

Gannon, S. (2002) A reflective view. In *Prison Nursing* (eds A. E. Norman & A. Parrish), pp. 178–189. Oxford: Blackwell Science.

Wilson, S. (2004) The principle of equivalence and the future of mental health care in prisons. *British Journal of Psychiatry*, **184**, 5–7.

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Author's reply: I am pleased that my editorial has encouraged some discussion about how best to care for the mentally ill in prisons. Mr Gannon is right to point out that it is commissioning rather than providing that has moved to the primary care trusts. The reason for commissioning twice is perhaps to do with geography – people do not necessarily remain in the borough that is responsible for commissioning their health care. Prisoners are not as free to move around as other citizens and one can hardly expect a Leeds general practitioner to attend to her patient in Brixton prison, or vice versa. Otherwise, Mr Gannon and I appear to be in broad agreement – the status quo is unacceptable, and that is why I argued against any expansion of medical treatment under common law (*contra* Mr Gannon's assertion, and *contra* an earlier paper of mine (Wilson & Forrester, 2002)). I advocated an extension of the Mental Health Act 1983 to prisons precisely because that would include openness, accountability and scrutiny in a way that more use of the common law would not. I think that it is the current system that is collusive and dishonest: the championing of equivalence (a noble idea) enables us to feel better about the reality of a failing system of hospital transfers for mentally ill prisoners. I do not, however, share Mr Gannon's optimism that more secure beds (at whatever level of security) are the solution, and it seems to me that history is on my side. At the moment we cannot even make provision within the National Health Service for the most severely mentally ill prisoners, let alone Mr Gannon's suggestion that there should be no mentally ill citizens in prison at all. I wonder whether that includes adjustment disorders, mild depression, treated schizophrenia, substance dependence and personality disorder? Peter Scott, a predecessor of mine at HMP Brixton, suggested that the nature of the walls (prison or hospital) were an irrelevant distraction as the people inside were the same in both types of institution and the treatment needed was broadly similar (Scott, 1970). I have a great deal of sympathy with this view.

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Scott, P. D. (1970) Punishment or treatment: prison or hospital? *BMJ*, **2**, 167–169.

Wilson, S. & Forrester, A. (2002) Too little, too late? The treatment of mentally incapacitated prisoners. *Journal of Forensic Psychiatry*, **13**, 1–8.

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Integrated in-patient adolescent services

Gowers & Cotgrove (2003) correctly draw attention to the scarcity of emergency access to in-patient care for adolescents. It is therefore disappointing that they have reported the evidence from Snowfields Adolescent Unit (Corrigall & Mitchell, 2002) – the first unit in the UK to offer an all-beds, 24-hour, 7-day-a-week emergency admission service – in such a misleading way. Gowers & Cotgrove claim that the paper describes a service focused principally on responding to emergencies, but neglecting other aspects of a comprehensive Tier 4 service. This is not true. The service was designed from the outset to be comprehensive, inclusive and adapted to local needs. An emergency admission service was a necessary response to need, not an end in itself, and has not been provided at the expense of other aspects of care. Evidence in the paper demonstrating the comprehensiveness of the service includes the broad range of diagnoses covered, the wide distribution in length of stay, the high rate of admissions with learning disabilities and, most tellingly of all, the very low rate of referral on to other forms of Tier 4 adolescent service. In fact, since publication, the need to seek alternative in-patient provisions has dropped even further. In the past 3 years, out of 189 discharges, only one case has been transferred on to another type of in-patient care as a result of Snowfields being unable to meet the patient's needs – and that individual went to a specialist adult service (the National Psychosis Unit), not a Tier 4 adolescent service.

The Snowfields approach has now been generalised to other settings, with similar principles having been successfully incorporated into new adolescent services such as the Coborn Unit in East London.

Gowers & Cotgrove call for the establishment of specialist units to complement existing services as an answer to the need for more emergency access, but a failure to rethink existing provision would be a mistake. The Snowfields and Coborn Units have shown that it is perfectly possible to provide an integrated and comprehensive adolescent in-patient service that includes emergency access.

Corrigall, R. & Mitchell, B. (2002) Service innovations: rethinking in-patient provision for adolescents. A report from a new service. *Psychiatric Bulletin*, **26**, 388–392.

Gowers, S. G. & Cotgrove, A. J. (2003) The future of in-patient child and adolescent mental health services. *British Journal of Psychiatry*, **183**, 479–480.

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A new name for the *Journal*?

Do our patients have loves, hates, hopes, fears, passions, fantasies, beliefs, hobbies, sports? A steady reader of the *Journal* would have no hint that they ever had. Consequently, if the new Editor wonders what improvements he might contribute, I suggest a more suitable name, the *British Mausoleum of Psychiatry*, unless there be changes in the *Journal* far more radical than in name.

Dr Williams (2004) urges him to bring back the case report instead of monotonously publishing academic research, the gains that offers to clinical practice being 'doubtful', he says. Doubtful is the wrong word – the research is in volumes; the gains in practice are few and seldom visible. Meanwhile, a statistical analysis of 20 different ways of scratching one's bum is more likely to be published in the *Journal* than an interesting case report.

Certainly bring back case reports, but also bring back the human being centre stage – the patients; families; psychiatrists; nurses; art, movement, group, and other psychological therapists; the whole therapeutic community, and people's lives. After all, why not? What else is the day-to-day practice of psychiatry about?

Williams, D. D. R. (2004) In defence of the case report (letter). *British Journal of Psychiatry*, **184**, 84.

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One hundred years ago

The amendment of the lunacy acts

Sir John Batty Tuke availed himself of the vote for the maintenance of the Lunacy Commission for England and Wales in order to lay before the House of Commons the extreme inadequacy of this Commission as at present constituted and to ask for some inquiry into the subject. He pointed out that there are only three medical commissioners to supervise the treatment of 114,000 lunatics, so that, while in Scotland there is one such commissioner to every 3622, in England the proportion is one to 38,000, and he maintained that a Commission so undermanned must necessarily work in a wooden fashion, unsympathetically and without elasticity. The numerical inadequacy of which he complained was, he said, growing worse and worse, for there had been no enlargement of the Commission since its establishment in 1845, while the number of the insane had increased nearly five-fold and while a great change had come over the conception of insanity. The insane person was no longer regarded as a psychological curiosity but as a pathological subject. The nation was doing its best to stamp out tuberculosis and cancer but it was not doing its best in respect to a disease which attacked three persons out of every 1000 and which, if not arrested, consigned its victims to a living death. Sir John Tuke was well supported by other medical Members of the House, and especially by Sir Michael Foster, who declared

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