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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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.

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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.

https://doi.org/10.1192/bjp.184.5.454 Published online by Cambridge University Press