gerous than their more psychiatrically normal peers. Other less dramatic but important effects of mental illness may indirectly have contributed even more. For example, inability to give a permanent address is known to be a factor in determining custodial remand,[4] and, as expected, those with active psychiatric symptoms in general ($\chi^2=30{\cdot}66$, df=1, $p<0{\cdot}0001$) and with a diagnosis of schizophrenia in particular ($\chi^2=54{\cdot}57$, df=1, $p<0{\cdot}0001$) were more likely to be of no fixed abode than the healthier men.

There is no evidence that the mentally ill in this series were particularly vulnerable to being detained on charges that were subsequently not upheld in court. If anything the reverse was true. This tendency to a higher incidence of conviction among the mentally ill, however, cannot necessarily be accepted at face value. Once charged they may be less able than their normal peers to defend themselves in court. The substantial incidence of acquittals, which was higher among the mentally normal men on serious charges, is disturbing. Most were imprisoned for weeks and some for as long as 18 months and yet were found not to be guilty of any offence.

Our findings must dispel any notion that custodial remands for the assessment of the mentally ill do much to help them into subsequent treatment. In the accompanying paper we noted that a conservative estimate of all those with active symptoms of psychiatric illness on admission to the prison was 246 men (9% of new admissions).[1] In some additional men psychiatric disorders were diagnosed, although their disorders were apparently quiescent, and a further 257 men (9·4%) were addicted to drugs or alcohol. Of the 246 actively ill men, only 78—less than a third—received hospital orders. Within the whole sample a further 175 men received treatment or supervision orders of some kind, but many of these were neurotic, psychotic without symptoms, or men who did not show any formal psychiatric disorder. Interestingly, in the present series the main overt factor that distinguished those who were ordered to receive treatment from those who were not was the presence of complicating factors such as substance abuse or additional diagnoses that militated against treatment. There is a popular view that criminals are rejected for treatment because of their violence, but this was not borne out by our study. For example, there was no difference between those schizophrenic men who were accepted for treatment and those who were not in terms of the nature of their current offence. If anything a history of violence improved their chances of receiving a hospital order.

Bowden studied the outcome of recommendations for treatment in an earlier sample of men remanded to the same prison for medical reports.[5 6] Only 14% were recommended for treatment, although 94% of these were accepted.[5] He evaluated the progress of those who were accepted 14 months later.[6] He concluded that those with improved mental states represented only 5% of those initially remanded to Brixton prison. Just over one third of those who received treatment, however, showed definite improvement and a further 26% showed some improvement in mental state, although their social behaviour remained impaired or offensive. Only slightly more than one third failed to show any benefit from treatment, and no account could be taken of the receiving psychiatrist's commitment to the patient, which is not always of the fullest for offender patients. Whether any of those who were not referred for treatment might have benefited had they been so remains speculative. Certainly only a few of those who have psychiatric disorders receive treatment after custodial remands; most are not even offered the chance of treatment. According to Bowden, nearly two thirds of those mentally abnormal criminals who do get the chance of treatment are likely to show some improvement.[5 6] The new Mental Health Act of 1983 rules that in future psychiatrists must consider the chances not only of curing patients but also of preventing their deterioration. This is an important time to consider whether psychiatry offers enough to offenders with psychiatric disorders.

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References

1 Taylor PJ, Gunn J. Violence and psychosis. I. Risk of violence among psychotic men. *Br Med J* 1984;**288**:1945-9.

2 Banks C, Brody S, Fairhead S. *A survey of the south east prison population.* London: HMSO, 1978. (Home Office Research Bulletin No 5.)

3 Gunn J, Robertson G, Dell S, Way C. *Psychiatric aspects of imprisonment.* New York: Academic Press, 1978.

4 Gibbens TCN, Soothill KL, Pope PJ. *Medical remands in the criminal court.* London: Oxford University Press, 1977. (Maudsley monograph No 25.)

5 Bowden P. Men remanded into custody for medical reports: the selection for treatment. *Br J Psychiatry* 1978;**133**:320-31.

6 Bowden P. Men remanded into custody for medical reports: the outcome of the treatment recommendation. *Br J Psychiatry* 1978;**133**:332-8.

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ONE HUNDRED YEARS AGO The Vestry of Camberwell have gleefully passed a special vote of thanks to their health-officer, Dr. Bristowe, for a report in which he trenchantly attacks the model by-laws recently issued by the Local Government Board with respect to houses let in lodgings. We shall not follow Dr. Bristowe through his various criticisms on the by-laws; but there is one point in his remarks that appears to merit special attention, and that is the apportionment of duties between the different persons concerned in tenement-houses. If there be one point more than another which the recent discussions on the subject have brought out, it is that houses inhabited by a number of families need some one corresponding to the French *concierge* to keep order and be responsible for the cleanliness of the premises. The by-laws should impose upon this person, and not upon each lodger, the responsibility of performing the duties prescribed in the regulations. How, for instance, is the sanitary authority to enforce on each individual lodger the requirement that he shall cause every window of every sleeping-apartment to be kept fully open for two hours every day; or that he shall cause the room of every floor let to him to be thoroughly swept at least once in every day, and thoroughly washed at least once in every week? As Dr. Bristowe observes, "it is at least as desirable that he should wash himself from head to foot every day, and that his clothing should be frequently changed and cleansed"; but for these desiderata no provision has been made (nor could be expected) in the by-laws. Practically speaking, it is almost impossible that a sanitary authority can exercise any real power over lodgers, except through the people who take them as lodgers; and it appears very unwise to relax the hold on the letters of lodgings by throwing (as the model by-laws do) duties on lodgers which it is the duty of the letter of lodgings to perform, and many of which it is in his own interests that, backed up by the sanitary authority, he should himself enforce. (*British Medical Journal* 1884;i:624.)

Correction

Resolution after radiotherapy of severe pulmonary damage due to paraquat poisoning

Errors occurred in the paper by Dr D B Webb and others (28 April, p 1259). (1) In the second line of the abstract and the eighth line of the case report 5 g paraquat should have been about 3 g. (2) In the third line of the abstract 3·4 kPa should have been 4·6 kPa. (3) In the third line of the case report alkaline dithionate should have been alkaline dithionite. (4) In the seventh line of the case report 80 mg/l should have been 80 μg/l. (5) In the fourth line of the third paragraph of the case report γ rays labelled with cobalt-60 should have been γ rays produced from a cobalt-60 source. (6) In the second and third lines of the discussion intracellular nicotinamide adenine dinucleotide phosphate should have been reduced intracellular nicotinamide adenine dinucleotide phosphate.