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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.

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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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that in no branch of science had there been greater progress during the last generation than in the knowledge of the brain and the central nervous system. That wonderful web of delicate fibre and cells was being gradually unravelled and day by day a command was being obtained over the brain which was unknown when the Lunacy Acts were introduced. Though medical science had reduced other diseases, lunacy, if anything, was on the increase, and the main fault was in the present state of the lunacy laws which, if they did not hinder, certainly did not facilitate the application of science to the disease, especially in its early stages, in which it was most likely to be amenable to treatment. He proceeded to show the necessity for changes in the present methods of notification and certification and strongly supported Sir John Tuke's demand for a complete inquiry. Dr. R. Farquharson, who followed, dwelt upon the superiority of the Scotch method of managing what are often described as "border cases" and declared that there ought to be special hospitals or special wards and special pathological institutions. In fact, there was a general recognition by the medical Members of the House that the time had come when insanity should be regarded as a disease like other diseases and that it should be investigated and treated by ordinary clinical methods. The Attorney-General, in rising to maintain on the part of the Government that everything is for the best in this best of all possible worlds, "was not satisfied" that there was any proof of increase of insanity. He has, however, presented a Bill, which was read for the first time on Wednesday afternoon, having for its object the amendment of the Lunacy Acts. His somewhat unscientific attitude in his speech makes of his practical action a pleasant surprise.

REFERENCE

Lancet, 21 May 1904, 1438–1439.

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Corrigenda

Pathological Child Psychiatry and Medicalization of Childhood (book review). *BJP*, **184**, 282. The book reviewer's name should read Louise Theodosiou.

Cognitive therapy for command hallucinations: randomised controlled trial. *BJP*, **184**, 312–320. The last sentence under the subheading 'Reduction in compliance' (p. 318) should read: Perhaps more importantly, the risk factors for compliance in the CTCH group had reduced markedly, particularly the perceived power of the voice, its omniscience and controllability, and the need to appease it (14% of the CTCH group were appeasing or complying *v.* 53% of the TAU group).

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