prevalence of past psychiatric history quoted is 33%, again very similar to that of Topp (38%) and Backett (39%) (1987). These rates are no higher than have been found among general hospital patients admitted after episodes of non-fatal deliberate self-harm, the majority of whom are socially deprived and distressed rather than mentally ill. They are lower than those found among people who kill themselves outside prison, the majority of whom may be mentally ill. In this respect the sentenced prisoners described by Gunn *et al* (1978) are not an adequate control group, since half of Dr Dooley's sample were on remand or unsentenced.

Common sense might suggest that people who kill themselves in prison do so *because* they are in prison. The data tend to support that view, since suicide has been such a persistent risk of imprisonment across the years and is not overwhelmingly associated with mental illness. Again, surely the explanation for an increase in prison suicides in the summer months is that it is during those long hot days that loss of liberty becomes hardest to bear?

Such an interpretation leads to the conclusion that it is institutional reforms which are needed if the suicide rate in prison is to be reduced, and two spring readily to mind. Firstly, fewer people should be held in prison on remand. The proportion of non-sentenced prisoners in Topp's cohort was 37%; in Dr Dooley's it was 47%. Among the 68 people who killed themselves in prison in 1987 and 1988, 74% were on remand (*Hansard*, 1989). These figures confirm that remand prisons are unsuitable places in which to assess and respond to the psychological and social needs of vulnerable and distressed people (Howard League, 1986, 1989). Secondly, we should make far less use of custodial sentencing for non-violent crimes (Blom-Cooper, 1988). Half of Dr Dooley's sample killed themselves while imprisoned for crimes against property. We no longer hang people for murder; it is a great irony that they should hang themselves while in prison for lesser offences. Conditions in British prisons are a national scandal: they are overcrowded, disorganised and insanitary. If they were emptied of trivial offenders it would be for the general good. It would also increase the opportunities for a reformed prison medical service to respond to the needs of the long-term prisoner whose suicidal despair is (as Dooley points out) so often tragically unidentified under the present system.

In the 1890s the authorities responded to the problem of suicide in prison by putting up safety netting between landings. In the 1990s, should they respond by redesigning cells so that desperate prisoners cannot garrotte themselves on their bars? We must do better than that. The suicide rate in prisons raises important ethical questions about our social and penal policies. Psychiatrists (both individually and through the College) should press for reforms in the prison system with a vigour equal to that which they show in proposing reforms in the practice of forensic psychiatry in other countries. To do less is simply hypocritical.

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Outcome in unipolar affective disorder after stereotactic tractotomy

SIR: The report by Lovett *et al* (*Journal*, October 1989, **155**, 547–550) confirms our finding that a better outcome, especially in unipolar affective disorder, can be achieved by simpler surgical techniques such as bimedial frontal leucotomy (Hussain *et al*, 1988).

In our series, there were 15 cases of unipolar affective disorder. Of the 13 who had a non-stereotactic operation, 11 had a good outcome at follow-up, and of these, eight achieved a complete recovery. Neither of the two stereotactic cases however, had a good outcome. Our study was similar to Dr Lovett's in, for instance, the long histories of depressive disturbances in mood (either recurrent or continuous), the resistance to all forms of treatment available, and the assessment approach. However, the length of follow-up was longer in our study – a mean length of 108 months, compared with 69. It would seem that the stereotactic tractotomy lesion in the lower medial quadrant of the frontal lobe is unable to give a better result than the simpler modified bimedial approach, which not only produces a lesion in the lower medial quadrant but also severs the connection from the frontal lobe to the cingulate gyrus – the fronto-limbic northern pathway (Kelly, 1976).

There has thus been support for this finding and for providing this simpler form of surgery, which can be done at a regional level (Snaith, 1989).

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SIR: In their recent paper, Lovett *et al* (*Journal*, October 1989, **155**, 547–550) repeat the advice from a previous paper (Lovett & Shaw, 1987) that stereotactic tractotomy may give a poorer outcome in patients with organic cerebral changes. They again quote a bipolar case (no. 4) from their 1987 series as showing a particularly poor course after, and possibly before, the woman's second operation in 1981. This was associated with embolic cerebral damage.

Unknown to the authors, this woman, two-and-a-half years after her second operation, showed an almost complete resolution of affective symptoms that allowed her eventually to be transferred from long-stay to out-patient care. For the last five-and-a-half years she has suffered from neither mania nor depression, and her only psychotropics are diazepam (5 mg) in the morning and temazepam (20 mg) at night. If anything, her organic cerebral changes came on after the extension operation, since a preoperative Emergency Medical Information scan was reported as normal. Since that time she has experienced several cerebral infarctions in both frontal areas from emboli due to mitral valve disease, but has recovered well from the resulting brief hemiplegia and dysphasia.

She walks normally, although her speech can become muddled when she is under pressure, and very occasionally she is a little 'high' and 'interfering' for some hours at a time.

I have no doubt that this woman would never have been discharged nor have been free of affective illness without tractotomy. The recovery two-and-a-half years after the operation may seem late, but it may possibly have been delayed by the stroke eighteen months after operation, or alternatively the stroke may have represented a further and curative extension of the limited surgery to her frontal tracts.

Certainly, it would seem too early to regard cerebral changes as an absolute contraindication to psychosurgery.

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Forensic aspects of mental handicap

SIR: Turk's annotation on the forensic aspects of mental handicap (*Journal*, November 1989, **155**, 591–594) is timely in bringing this issue to prominence. However, I feel that he omits to mention an important cause of distortion in the available figures relating to mental handicap and criminal offences, namely the great reluctance of the police to prosecute people with a mental handicap. As a result, the available figures on any relationship which may exist between crime and mental handicap are not a true reflection of the situation. For example, over the last six months I have seen six individuals each of whom have committed what would normally be regarded as criminal offences, including assault, theft, destruction of property, sexual offences, and various minor nuisance offences. None of these people were prosecuted by the police although they were, in three cases, brought into our hospital by the police. It is of course debatable how far prosecuting an individual with a mental handicap serves any useful purpose, and this is not a plea for the wholesale prosecution and imprisonment of all mentally handicapped offenders. However, until we can collect more accurate figures about offences committed by people with mental handicap, it is misleading to use existing figures on convicted persons as an indication of the presence or absence of relationships between intellectual retardation and criminal behaviour.

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Asian patients and the HAD scale

SIR: I was puzzled by the letter from Chaturvedi (*Journal*, January 1990, **156**, 133) as it appears he has failed to grasp the content of my article (*Journal*,

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