circumference is a simple tool to exclude insulin resistance and to identify those at greatest risk (therefore those who would benefit most from lifestyle adjustments).

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Contributors: All authors contributed to the study design. KH and B-ML did all the clinical examinations. L-GP built and managed the database where all data were stored. ET, PA, and HW were responsible for the statistical analysis of the data. HW wrote the first draft of the manuscript. All authors contributed to the final version of the manuscript. HW is the guarantor for the study.

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Mental disorders in prison populations aged 15-21: national register study of two cohorts in Finland

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Juvenile delinquency is linked to psychiatric morbidity.^{1 w1-w9} We were interested in temporal changes in psychiatric morbidity in offenders. Criminal policy in many Western countries emphasises the need for alternative methods of punishment for adolescent prisoners.² In Finland, successful policy to diminish the number of adolescents in prisons has been internationally recognised.³ We studied the changes in psychiatric hospitalisations in Finnish prisoners aged 15 to 21 to see whether a selection process occurs as the number of young prisoners decreases.

Participants, methods, and results

We linked the unique personal identification numbers of all prisoners aged 15 to 21 years from 1984-5 and 1994-5 to the Finnish healthcare register, which includes data of all hospitalisations in Finland. We retrieved occurrences of depression, psychosis, personality disorder, and substance dependence, and we analysed temporal changes. The observation period for the first cohort was 1980-9 and for the second 1990-9. We compared hospitalisations with those of a control group, matched for sex, age, and place of birth, derived from the population register. The full method is on bmj.com.

The earlier cohort from 1984-5 comprised 656 prisoners (719, with 63 (8.8%) missing identification numbers), and the later cohort included 370 prisoners (377, with 7 (1.9%) missing identification numbers). This temporal decrease shows the effect of the policy to reduce the number of young prisoners. The cohorts did not differ in terms of sex (Fisher's exact test, $P=0.19$); in the earlier cohort there were 18 (0.03%) women, in the later 5 (0.01%).

The number of inmates with at least one hospital treatment for any mental disorder increased significantly (odds ratio 1.8, 95% confidence interval 1.3 to

What is already known on this topic

Prisoners are more likely to have serious mental disorders than the general population, and efforts have been made to reduce the number of young prisoners

What this study adds

More mentally ill young people end up in prison as the prison population diminishes

2.3, age adjusted) over time compared with the general population, in which we detected no increase in hospitalisations for mental disorders (1.0, 0.7 to 1.4; table). The increase in treatment for psychosis was significant between the two cohorts (2.7, 1.4 to 5.1, age adjusted) and it was significant for substance dependence (3.0, 2.0 to 4.6, age adjusted). In the control groups the changes in prevalence of these disorders were not significant (1.6, 0.7 to 3.5 and 0.9, 0.3 to 3.0).

The absolute number of prisoners who had had inpatient treatment for psychosis or substance dependence increased from the earlier to the later cohort. The odds of being hospitalised for schizophrenia in the earlier prisoner group were fourfold greater (3.9, 1.6 to 9.4) than in the control group but were eightfold greater (8.0, 2.7 to 23.5) in the later cohort.

Comment

Relatively more mentally ill people end up in prisons as the prison population diminishes. Hospitalisations

P+ The full method and references w1-w9 are on bmj.com

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Young prisoners and controls with psychiatric hospital treatments, Finland, 1984-5 and 1994-5

	Cohort 1984-5, follow-up 1980-9			Cohort 1994-5, follow-up 1990-9		
	No (%)		Odds ratio (95% CI)	No (%)		Odds ratio (95% CI)
	Prisoners (n=656)	Controls (n=2528)		Prisoners (n=370)	Controls (n=1444)	
Mental disorder						
Psychosis	17 (2.6)	22 (0.9%)	3.03 (1.60 to 5.74)	24 (6.5)	8 (0.6)	12.45 (5.55 to 27.95)
Depression	23 (3.5)	21 (0.8%)	4.34 (2.39 to 7.89)	13 (3.5)	9 (0.6)	5.81 (2.46 to 13.69)
Personality disorder	110 (16.8)	25 (1.0%)	20.17 (12.94 to 31.45)	63 (17.0)	11 (0.8)	26.73 (13.93 to 51.32)
Substance dependence	39 (5.9)	8 (0.3%)	19.91 (9.26 to 42.82)	59 (15.4)	5 (0.3)	54.60 (21.74 to 137.16)
Any mental disorder	217 (33.1)	112 (4.4%)	10.66 (8.31 to 13.69)	172 (46.5)	64 (4.4)	18.73 (13.56 to 25.89)

of young prisoners for mental disorders increased during the 10 year period separating the two study cohorts. We did not detect a similar increase in the matched general population sample. Young prisoners had considerably more inpatient treatments for mental disorders than did the controls. The most alarming finding is the increase of psychoses in the more recent group. This cannot be explained by changes in the population morbidity, as the number of hospitalisations for psychotic disorders in the general population control group decreased, as seen before.⁴

Our findings reflect the failure of healthcare systems and emphasise the necessity for early screening of mental disorders in delinquents.

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In praise of half doing a job

To many of us, "half doing" something is quite unthinkable. We are programmed by our upbringing and medical training to believe that if a job's worth doing it must be done properly. In the real world, however, life's not quite like that. In general practice we often have to cut corners because we simply don't have time to do a full examination on every patient.

To diverge slightly, I was once told that many people with messy desks are actually very tidy. This apparent paradox arises from the fact that they prefer to live with the mess if they haven't time to do a thorough job tidying up. They feel uncomfortable just putting papers into piles, so they put off the job until there is time to file everything in its proper place.

Perhaps it's a bit like that in general practice. I suspect one or two of us don't even attempt to do a particular examination (funduscopy, for example) because we haven't the time (or the skills) to do it properly.

I returned to general practice two years ago after a career in medical journalism. One of the perks of coming back via the (excellent) "returner scheme" is to be invited to higher professional training meetings for the next two years. A couple of months ago, I attended a talk by an specialist registrar in neurosurgery entitled "So you think you've got a brain tumour." The food and company were great, but I confess to being somewhat disappointed with the talk. I had hoped to receive pearls of wisdom on how to distinguish between "benign" and serious headaches; what I learnt was that basically you can't.

But I did take home one message: always examine the fundi in any patient presenting with a headache.

Nothing particularly novel about that, you might think. However, our young speaker did add one extra dimension—he gave us permission to "half do" the job. With the pragmatism of a surgeon, he stressed that the important issue was to check out the optic disc. It was not necessary for us to agonise over the state of the retina or retinal vessels through a small undilated pupil.

So, my guilt assuaged, I now look at the optic discs of every patient who presents with a headache. Imagine my surprise last week when I couldn't find any sort of edge on either disc of an 18 year old presenting with a three week history of headache. Yes, this obese young woman, who was taking antibiotics for her acne, had bilateral papilloedema.

My patient is now doing well with treatment for her benign intracranial hypertension. And, guess what? My formerly messy desk is now clear—except for three large piles of paper waiting to be filed.

Jill Graham *general practitioner, London* (jjrgraham@aol.com)

We welcome articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on <http://submit.bmj.com>. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.