

This was demonstrated when Saunders became the first case to make a full recovery from a diagnosis of Alzheimer's dementia.

In Fazel *et al*'s two related papers (2001a,b), significant levels of both psychiatric and physical morbidity are clearly evident that will surely have future service implications as the elderly prisoner population continues its inevitable rise. Prison services for elderly inmates have been slow to develop despite the Reed report (Department of Health & Home Office, 1992) that acknowledged the complex nature of elderly prisoners and demanded a 'holistic' approach in their management.

Yorston (1999) contemplates the future of old age forensic psychiatry as a sub-speciality akin to those of learning disabilities and child and adolescent psychiatry. As the number of elderly mentally disordered offenders presenting currently is small, but increasing, he suggests that a regional tertiary referral service for the most difficult or serious cases, with close links between the relevant forensic and old age services, might be preferable at this time.

An integrated approach between old age and forensic services using their different areas of expertise will make assessment and management of elderly offenders more comprehensive, as opposed to management by one team alone. This is in keeping with standards 2 (person-centred care) and 7 (mental health) of the National Service Framework for Older People (Department of Health, 2001), which emphasise the importance of an integrated approach to assessment and care-planning through liaison with specialist services for older people. Standard 2 also suggests that the National Health Service and local councils should ensure a flexible and integrated approach to service provision, regardless of professional or organisational boundaries.

To date, elderly offender research has almost exclusively been retrospective but the studies by Fazel and colleagues suggest that a substantial prospective study of

elderly offenders would not only be feasible but also desirable to improve our poor knowledge of this important group.

**Department of Health (2001)** *National Service Framework for Older People*. London: Stationery Office.

— & **Home Office (1992)** *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services. Final Summary Report (the Reed Report)*. Cm 2088. London: HMSO.

**Fazel, S., Hope, T., O'Donnell, I., et al (2001a)** Hidden psychiatric morbidity in elderly prisoners. *British Journal of Psychiatry*, **179**, 535–539.

—, —, —, et al (2001b) Health of elderly male prisoners: worse than the general population, worse than younger prisoners. *Age and Ageing*, **30**, 403–407.

**Yorston, G. (1999)** Aged and dangerous. Old age forensic psychiatry. *British Journal of Psychiatry*, **174**, 193–195.

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### The evolutionary psychology debate

I am very much honoured that a prominent scientific writer like Rose (2001) treats me with the same method as he and his circle have treated E. O. Wilson in their recent collection of essays (Rose & Rose, 2000). Being a mere practising psychiatrist, it puzzles me why it has become acceptable for the anti-sociobiology/evolutionary psychology movement to misquote their opposition, in either a patronising or an openly hostile way, attributing hidden agendas to those who dare to think about human behaviour and psychological functioning in an evolutionary context. Clearly, they feel that the end justifies the means, and that their version of the truth has to be defended at any cost.

Segerstråle (2000), in a detailed analysis of the sociobiology debate, compared the two camps of scientists to gardeners: one side representing the planters, and the other the weeders. It seems to me that both tasks are important in the development of

the perfect garden of science. Rose appears to be an overzealous weeder, who is afraid that the dangerous weed of evolutionary psychology will destroy his garden and tries to kill it at every opportunity. The effort is unlikely to succeed. However, I need to point out that in my previous letters concerning the evolutionary psychology debate (Ayton, 2000, 2001) there was nothing to imply 'some sort of conspiracy in psychiatry to ignore biology' (Rose, 2001). About 30–40% of all psychiatric references on the Medline database are biological studies, so there is no lack of biological studies and theories. However, what is lacking is a coherent theoretical framework; and evolutionary theory is largely ignored by psychiatric training or academia. It is untenable to state that only proximal causation is relevant to mental states or human behaviour. This was recognised by Darwin and beautifully demonstrated by Bowlby. Despite initial strong criticism, Bowlby's contribution to the understanding of the mother–infant relationship has become fundamental, and has wiped out earlier explanations.

If 'nothing in biology makes sense except in the light of evolution' (Rose, 2001), then surely, human beings and their behaviour cannot be excluded on scientific grounds.

**Ayton, A. (2000)** Implications of evolutionary theory for psychiatry (letter). *British Journal of Psychiatry*, **177**, 370.

— (2001) A defence of evolutionary psychology (letter). *British Journal of Psychiatry*, **179**, 267–268.

**Rose, H. & Rose, S. (eds) (2000)** *Alas Poor Darwin: Arguments Against Evolutionary Psychology*. London: Jonathan Cape.

**Rose, S. (2001)** Revisiting evolutionary psychology and psychiatry (letter). *British Journal of Psychiatry*, **179**, 558.

**Segerstråle, U. (2000)** *Defenders of the Truth. The Sociobiology Debate*. Oxford: Oxford University Press.

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