Correspondence

The needs of remand *v.* sentenced prisoners

In their paper, Kosky & Hoyle[1] use a postal questionnaire to consider the provision of secondary mental healthcare in prisons. They conclude that 'there is generally no correlation between input and prison capacity, although there was some evidence of correlation in the high secure . . . estate'.

Their introduction states: 'The ONS [Office for National Statistics] data do try to quantify the range of morbidity across remand, convicted and female populations but do not consider security categorisation or age range.' The high prevalence of mental disorder in prisons has been well documented, with higher levels of mental ill health established among particular groups such as women, older prisoners and juveniles.[2] Perhaps more important is the absence of discussion in this paper of the higher morbidity among remand as compared with sentenced prisoners, a difference highlighted by Singleton *et al*.[3] Indeed, the Royal College of Psychiatrists in their 2007 report[4] provided specific guidelines on psychiatric input to prisons. They acknowledged the method by which they came to the suggested norms was a guide, but crucially they differentiated between not only security categorisation, but also local remand *v.* dispersal prisons.[4] It is also worth noting that most prisons hold prisoners of a lower category, and the majority of prisoners in category A establishments are not actually category A prisoners.

Given known differences in levels of morbidity between remand and sentenced prisoners, it is surprising Kosky & Hoyle have chosen not to use this information in their results, particularly as these data were readily available (in terms of remand *v.* dispersal prisons). In our view, this information is essential when considering any future secondary mental healthcare planning. However, it would be even more useful if this included the proportion of remand *v.* convicted prisoners in establishments as well as the prison turnover. The paper perhaps only highlights what we already know anecdotally, that secondary healthcare in prisons varies and this variation may be arbitrary.

1 Kosky N, Hoyle C. Secondary mental healthcare in prisons in England and Wales: results of a postal questionnaire. *Psychiatrist* 2011; **35**: 445–8.

2 Fazel S, Baillargeon J. The health of prisoners. *Lancet* 2011; **377**: 956–65.

3 Singleton N, Meltzer H, Gatwood R, Coid J, Deasy D. *Psychiatric Morbidity among Prisoners in England and Wales*. HMSO, 1998.

4 Royal College of Psychiatrists. *Prison Psychiatry: Adult Prisons in England and Wales* (College Report CR141). Royal College of Psychiatrists, 2007.

Oriana Chao, Consultant Forensic Psychiatrist, North London Forensic Service, London, UK, email: oriana.chao@nhs.net, **Faisal Mudathikundan**, Associate Specialist in Forensic Psychiatry, North London Forensic Service, South London and Maudsley NHS Foundation Trust.

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Authors' response: We are delighted that Drs Chao & Mudathikundan have taken the trouble to read our paper so carefully. Our personal experience is that getting any consistent information, rather than being easy as is suggested, on anything to do with the prison estate is actually quite difficult. Finding out whether a given establishment had an inreach team was something of a hurdle. Finding out how many remand compared with sentenced prisoners each institution really holds is even more problematic. We recognise the greater morbidity in the remand population – there are of course many variables, including this one, that could be looked at in a study of this nature, but in the absence of research funding simple studies are all that will be carried out. Our view when we set out was there had been little rational planning in mental health service provision in prisons – we feel that Dr Chao & Mudathikundan's final line, 'The paper perhaps only highlights what we already know anecdotally' vindicates us in having carried this work out – after all, is that not important? We certainly have no pretensions to anything greater. Unless the haphazard nature of service provision is highlighted, no one will do anything about it.

Nick Kosky MBBS FRCPsych, Associate Medical Director and Consultant Psychiatrist, Prison Mental Health Inreach Team, Dorset Healthcare University NHS Foundation Trust; **Clifford Hoyle** Offender Mental Health Development Manager, Offender Health South West, Bristol.

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Those who forget history . . .

Fear *et al*[1] describe the Fair Horizons model of service organisation. It should be noted that this model has yet to be tested or indeed actually implemented. It is unfortunate that the authors do not refer to the need for evaluation after this model is put into operation. I am sure we all look forward to reading a report of an independent evaluation in due course.

Those who forget history are doomed to repeat it. I remember being at a meeting at the Royal College of Psychiatrists on the day the Department of Health confirmed that old age psychiatry would be recognised as a specialty separate from general psychiatry. Old age psychiatry arose because age-blind generic services neglected the particular needs of older patients – and because late-onset illness is or may be clinically different. Discrimination is bad but specialisation is good.

1 Fear C, Scheepers M, Ansell M, Richards R, Winterbottom P. 'Fair Horizons': a person-centred, non-discriminatory model of mental healthcare delivery. *Psychiatrist* 2012; **36**: 25–30.

Adam Moliver, consultant psychiatrist, [2]gether National Health Service Foundation Trust, Cheltenham, Gloucestershire, UK, email: admoliver@btinternet.com

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Authors' response: It is always good to hear from an old friend and Dr Moliver does well to emphasise Dr Tyrer's point[1] that a considered evaluation of any new service is essential to its development. We are already engaged in commissioning this process.