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.

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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.

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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.

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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.

The need for a leap of faith is an unfortunate reality of services adapting to fast-changing business environments. Organisations that succeed place their trust in the analysis of experts to place them into a strong position to face new challenges. The pace of change is rarely sympathetic to the needs of more cautious individuals whose grasp of the issues and need to change may be equally acute but whose ability to make rapid intuitive shifts is limited by their need for security. The principles of Fair Horizons are unarguable, its service model addresses these, and we suggest that any service model demonstrating equal adherence to such principles will be sustainable in the future.

Dr Moliver is concerned about the fate of older people within age-blind services. Fair Horizons retains highly specialist services for those with dementia and other specialist needs. Many with less severe illness will be managed in primary care as proposed by the *National Dementia Strategy*. For those with functional illness, it is increasingly difficult to identify at what age people move to older people's services, given the advancing age and increasing health of the population. This has been an issue for many years and we would draw Dr Moliver's attention to the significant number of patients whose care continues in adult generic services into their seventh and eighth decades. Colleagues in older people's mental health recognise that such individuals continue to receive appropriate care within services for younger adults: Fair Horizons provides for joint working with older people's specialists if required.

Dr Tyrer makes the point that any service model works only if local clinicians commit to it. We have commitment from the majority of local colleagues from across professional groups. Nevertheless, there is work to do to ensure that all colleagues are fully supportive of the principles underpinning Fair Horizons.

1 Tyrer SP. An innovative service but will it work in practice? Commentary on . . . Fair Horizons. *Psychiatrist* 2012; **36**: 30–1.

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Recruitment in psychiatry: a complex and multifactorial problem

We read with interest the paper that explores the attitudes of those delivering undergraduate teaching in psychiatry as a factor in poor recruitment.[1] We appreciate that a positive attitude to teaching students is vital in the delivery of education and in creating appropriate role models, but we believe that these attitudes play a relatively minor role in this problem. The reasons for poor recruitment in psychiatry are multifactorial.

In recent years we have seen competition for psychiatry posts gradually decline.[2,3] One major factor that has contributed to this are the changes to visas for doctors trained outside the UK. International doctors have traditionally contributed significant numbers to British psychiatry, but current restrictions make it near impossible for international graduates to secure training positions.

Psychiatry as a specialty has always been considered somewhat separate from other hospital-based medical specialties, but we have to consider whether geographical and structural changes to mental health services are further reinforcing this idea and contributing to poor recruitment. We have come a long way from the asylum culture, but many psychiatric hospitals remain geographically separate from the main hospital, giving medical students the impression of psychiatry being a 'Cinderella branch' of medicine. Similarly, a streamlining of services has often led to a reduced presence of liaison psychiatry within main hospitals, giving an image of an isolated and understaffed specialty.

In years gone by, junior doctors enjoyed flexibility in training that allowed them to experience a wide variety of placements and specialties before choosing a career path. Changes to training have meant that doctors are now under pressure to choose a specialty early in their career, often without the luxury of having been able to explore all available options. As a result, the 'less obvious' options, such as psychiatry, may be overlooked. Early exposure to psychiatry through foundation year 1 posts has been suggested,[4] but caution should be exercised as we cannot underestimate the general medical experience and decision-making involved in an often community-based or 'off-site' placement such as are typical in psychiatry. It would not serve the specialty well to discourage potential applicants through asking too much of an inexperienced junior doctor.

This lack of exposure to the specialty may extend back to undergraduate training, where psychiatry is a comparatively small component of the syllabus and often not experienced until the later years of medical school. As a specialty that is often subject to outdated myths or jokes, the junior doctors and students who are relatively naive to the reality of psychiatry are at risk of adopting such untruths, which thus influence their opinions and, in turn, recruitment rates.

Exploring the factors affecting recruitment is complex. For this reason it is useful for studies such as that by Korszun *et al* to consider an individual factor. Much of the literature has concentrated on teaching and the opinions of medical students.[5] These writers believe that there is a need for further evidence on the opinions of foundation trainees, in particular whether the negative opinions suggested by studies such as this are widespread and affecting recruitment. A study to explore this factor has therefore been undertaken and we aim to release the results to add to the evidence to be used in tackling declining recruitment rates in the UK.

Psychiatry is one of the most exciting branches of medicine. Because of its very nature and complexity, innovation in psychiatry has been slow relative to other specialties. As a result, we now stand at the door of a major revolution in this branch of medicine. We are now where other medical specialties were half a century ago. We now know that one in four of us will suffer from a mental illness in our lifetime and with a vast amount of research ongoing, this remains a very exciting medical branch to be part of.

There is no doubt that we are guilty of underselling psychiatry. The time has come for us to excite the next generation of doctors and open their eyes to a fascinating specialty that will offer a challenging and fulfilling career. To