young as well as the old. They do not welcome new additions to their ever-expanding list of lifestyle limitations, or being labelled as excessive drinkers by their general practitioner if they choose to drink a pint of beer at night. A holistic approach might well conclude that in many instances an elderly person will be happier and even healthier (in the holistic sense) with a pint, or perhaps even two, than without them.

1 Royal College of Psychiatrists. Psychiatrists call for action to tackle substance misuse in older people (press release). Royal College of Psychiatrists 2011 (http://www.rcpsych.ac.uk/press/pressreleases2011/ourinvisibleaddicts.aspx).

2 Older Persons' Substance Misuse Working Group. *Our Invisible Addicts* (College Report CR165). Royal College of Psychiatrists, 2011 (http://www.rcpsych.ac.uk/files/pdfversion/CR165.pdf).

3 Hughes D. People over 65 should drink less, a report says. BBC News Health 2011; 22 June (http://www.bbc.co.uk/news/health-13863196).

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doi: 10.1192/pb.35.9.354a

The health status of prisoners is the real challenge

Exworthy *et al*[1] are to be commended for their attempt to go beyond the existing interpretation of the doctrine of equivalence of health service delivery in prison healthcare. This has driven improvements in prison healthcare for the past 10 years. However, they fail to identify the next challenge, that of achieving equal health status for prisoners and non-prisoners; this should be the doctrine that informs the strategy for service delivery for the next 10 years. Given the exceptionally high rates of mental and physical ill health in the prison population, not entirely explicable in terms of their sociodemographic profile, this will demand significantly greater investment than is currently the case. Per capita prison healthcare cost £2769 in 2007–2008, of which only £316 was for mental healthcare.[2] However, the advent of outcome-based payments for healthcare and for the management of offenders[3] allows for the relationship between health gain and criminological outcomes to be explored more rigorously.

The authors cite the UN *International Covenant on Economic, Social and Cultural Rights* as a guide to future prison health monitoring. This contains nothing to which anyone may object, but it is not specific to this very challenging area of healthcare. Exworthy *et al* largely neglect the advances in thinking by both the Department of Health[4] and Her Majesty's Inspectorate of Prisons,[5] which have led to much improved, relevant markers of activity, performance and outcome in routine review of contract delivery by prison health providers, as well as the role of the Care Quality Commission in assessing prison healthcare. In truth, they look out of step with commissioners and providers of healthcare who are already engaged in the detailed determination of local standards based on a grasp of local needs, for example those of young offenders, older prisoners and women.

Exworthy *et al* have, as might seem reasonable, a focus on mental health and the important issue of prison transfers. Such problems are relatively rare, although they need quicker resolution than is currently the case. However, they say nothing about primary care, including primary mental healthcare, which is poorly modelled. Nor do they comment on the treatment of drug and alcohol problems, difficulties that compound the management of serious mental illness but where there have been huge improvements in the past 10 years. Most of the prison health budget is devoted to these two areas. Prisoners have often had poor access to primary care and are highly likely to have drug and alcohol problems. The *de facto* 'polyclinic' nature of the prison environment is different from the external community, but this may be an advantage rather than a disadvantage for rapid healthcare delivery. Within a short period of time a prisoner can have a health check and be stable enough to reflect and plan for the future. For this to work, practitioners, including senior psychiatrists, will be required to operate in an integrated and multifaceted system of holistic care delivery where acute mental illness, for all its headline grabbing potential, is not the main issue.

Declaration of interest

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1 Exworthy T, Wilson S, Forrester A. Beyond equivalence: prisoners' right to health. *Psychiatrist* 2011; **35**: 201–2.

2 Brooker C, Duggan S, Fox C, Mills A, Parsonage M. *Short-Changed: Spending on Prison Mental Healthcare*. Sainsbury Centre for Mental Health, 2008.

3 Ministry of Justice. *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders*. TSO (The Stationery Office), 2010.

4 Department of Health, National Offender Management Service, Her Majesty's Prison Service. *Guidance Notes: Prison Health Performance and Quality Indicators*. Department of Health, 2008.

5 Her Majesty's Inspectorate of Prisons. *Expectations: Criteria for Assessing the Conditions in Prison and the Treatment of Prisoners*. HMIP, 2008.

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doi: 10.1192/pb.35.9.355

Personality disordered offenders – complex patients requiring more expertise

The ongoing debate on the management of personality disordered offenders has been further stimulated by the recently concluded Department of Health and National Offender Management Service joint consultation paper on the proposed personality disorder care pathway.[1]

The Labour government's flagship Dangerous and Severe Personality Disorder pilot programme is being scaled down at present to make way for national personality disorder services.[2] Approaching the conclusion of the Programme, clinicians are still looking at the most effective treatment regimes and politicians are still striving to ensure that the public protection element of treatment is not overlooked. Both parties are labouring to find the most effective way of managing this group of offenders who are considered to be 'difficult to treat', 'high risk' and 'carrying a high morbidity and stigma'.

Thus, we welcome and value the suggestion of early identification and provisions for a suitable care pathway for personality disordered offenders.[1] A standardised early identification system with clear pathways of treatment is likely

to reduce patient distress, risks to the public and long-term costs to the criminal justice and healthcare systems.

Nevertheless, we have concerns regarding the proposal that the diagnostic process and case formulation be undertaken wholly by offender managers along with forensic and clinical psychologists.[1] Although we value the important contribution from our colleagues in the ongoing management of this group of patients, it is more appropriate that the diagnosis should be carried out by medically qualified doctors, i.e. psychiatrists.

Those who have experience in forensic psychiatric settings appreciate that mentally ill offenders present with complex psychopathologies. The diagnosis and case formulation including management pathways require the corresponding level of experience, training and skill, particularly given the mandatory nature of this patient group's detention. A percentage of offenders who appear to present with functional mental disorders will in fact be presenting with endocrine, neurological, immunological or other related conditions. This requires medical training to identify. A 'diagnostic questionnaire' would be too simplistic, too inaccurate and would potentially lend itself to an underdiagnosis of personality disorder. In addition, if questionnaires and criteria for diagnosis are employed based on the face value, the error then would be an overdiagnosis of personality disorder. This would result in attaching a 'personality disorder' label to a selected group of patients. These patients are known to be stigmatised by society and at times excluded from prison treatment programmes, or worst still, marginalised by healthcare services. The presumptive diagnosis often significantly influences the latter stages of a patient's care pathway. This includes its direction (criminal justice or healthcare), sentencing, custody and the necessary level of health service input at each subsequent stage. A diagnosis achieved by a psychiatrist, whose training as a medical doctor requires years of experience, would surely be better than having significant numbers of patients being inaccurately categorised based on a form.

The skill of the medical doctor is in evaluating the patient as a whole, considering the symptoms and signs while utilising the appropriate diagnostic tools based on current evidence or guidelines. Having achieved a diagnosis, the real utility of a medical doctor is in treating the patient. Knowledge and experience in all medical conditions are therefore essential. This is important for a patient group with very serious psychiatric comorbidities such as psychosis, mood disorders and paraphilias.[3] It is accepted that at present treatment regimes for personality disorder are largely psychosocial in nature. However, correct treatment starts with correct diagnosis. In our experience, high psychiatric and physical comorbidities often necessitate the use of medication. Medical treatments for personality disorder and its manifestations (such as emotional lability and aggression) are increasingly being recommended as the evidence base supporting their efficacy expands.[4,5] The treatment of these symptoms is pertinent in contributing to the patient's risk reduction and hence future reoffending. The psychiatrist, apart from prescribing physical treatments and having a more holistic view, is able to discuss and refer the patient to other medical and surgical specialties if the need arises. The importance of such medical discussion and conference should not be underestimated, particularly if it relates to aetiology, as a missed or inaccurate diagnosis at the onset would result in repeated assessments conducted at various junctures and with added costs, longer waiting times and escalation of risks.

In our view, a thorough initial diagnosis and case formulation of personality disordered offenders by a psychiatrist is the crucial starting point. Providing the diagnostic expertise deserved by this complex patient group from the earliest stage ensures value for money for the taxpayer, a more accurate risk formulation and, most importantly, a fair and clinically based service for a very vulnerable and stigmatised group of people in our society.

1 Department of Health, Ministry of Justice. *Consultation on the Offender Personality Disorder Pathway Implementation Plan*. TSO (The Stationery Office) (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124489.pdf).

2 Duggan C. Dangerous and severe personality disorder. *Br J Psychiatry* 2011; **198**: 431–3.

3 Coid J. The co-morbidity of personality disorder and lifetime clinical syndromes in dangerous offenders. *J Forensic Psychiatry Psychol* 2003; **14**: 341–66.

4 Nose M, Cipriani A, Biancosino B, Grassi L, Barbui C. Efficacy of pharmacotherapy against core traits of borderline personality disorder: meta-analysis of randomized controlled trials. *Int Clin Psychopharmacology* 2006; **21**: 345–53.

5 Ingenhoven T, Lafay P, Rinne T, Passchier J, Duivenvoorden H. Effectiveness of pharmacotherapy for severe personality disorders: meta-analyses of randomized controlled trials. *J Clin Psychiatry* 2010; **71**: 14–25.

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doi: 10.1192/pb.35.9.355a

Prison GP services are reluctant to prescribe psychotropics

The significant frustration felt by those routinely working in the difficult and challenging environment of prison has rightly had the spotlight shone upon it.[1] In my experience, general practitioners (GPs) working in these settings are reluctant to prescribe psychotropic medications, often to the point of obstinacy.

The reasons put forward are mostly that: (a) the GPs themselves have no experience or confidence in prescribing these medications, and (b) there is a perception that this is solely the remit of in-reach mental health services. The second explanation has taken on absurd dimensions where prison GPs have refused to continue a prescription of a commonly used antidepressant, started by a GP in the community, without it being authorised by a psychiatrist!

I would like to see a similar study done comparing the continuity of prescribing of other chronic medications (i.e. antihypertensives or antihyperglycaemic agents) for newly received prisoners. I suspect that there would be significantly less discontinuity with these agents, as a GP would be rightly criticised for claiming that he or she would not continue with a patient's angiotensin-converting enzyme (ACE) inhibitor unless it was prescribed by a cardiologist! Indeed, a recent audit from the Offender Health Research Network[2] hinted that psychotropic medications were more likely to be omitted