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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Crime and psychopathology

SIR,—In the 1970s 34% of people in English prisons were found to have psychopathology severe enough to justify psychiatric treatment[1] and a similar figure was found in Scotland (R S Bluglass, personal communication). Last year Taylor and Gunn examined people on remand at Brixton prison on charges of violent offences and found an over-representation of sufferers from schizophrenia, exceeding epidemiological expectations by 22·5 times.[2] This novel situation had not been seen in earlier surveys: previously the ratio of schizophrenic patients charged with or convicted of violent crimes corresponded to the proportion of sufferers in the population—3 to 4 per 1000 at any particular time.[3]

These studies, conducted at particular points of time, do not portray the dynamics of the changing population in the prisons, but one can infer that the severity of psychopathology in prison is rising and therefore the proportion with important psychopathology is probably also rising.

The prison population continues to increase inexorably, with 14 new prisons planned. Meanwhile the numbers of long stay patients in psychiatric hospitals continue to fall, as efforts to discharge patients to community provisions succeed, and 30 psychiatric hospitals are planned to close in the near future. The first graph shows the decline in the number of patients in long stay psychiatric hospital beds since 1950, using figures supplied by the DHSS, which includes the peak in 1954. The same graph also shows the prison population, the figures being supplied by the Home Office.

The recent figures for the number of patients in hospital are not available, but one can convert the bed availability figure since, over four years when both bed availability and patient numbers were available, the bed occupancy rate was 91·4%. Using this conversion factor we have regressed the inpatient psychiatric population against the prison population and found a highly significant correlation ($r=0·94$; $p<0·001$) (fig 2). The most recent figure for the prison population is 47 600, showing a sharp increase over 1984, but the psychiatric inpatient population is not known, so the final point on the graph is indicated by a question mark (and excluded from the calculation of the correlation coefficient). The intercept of the linear regression suggests an ultimate prison population of 66 599.

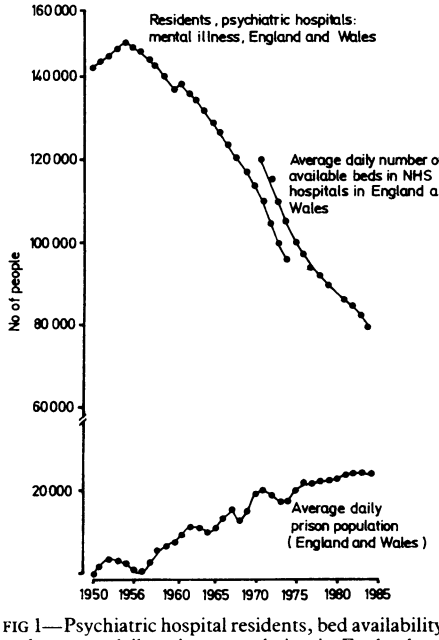

FIG 1—Psychiatric hospital residents, bed availability, and average daily prison population in England and Wales since 1950.

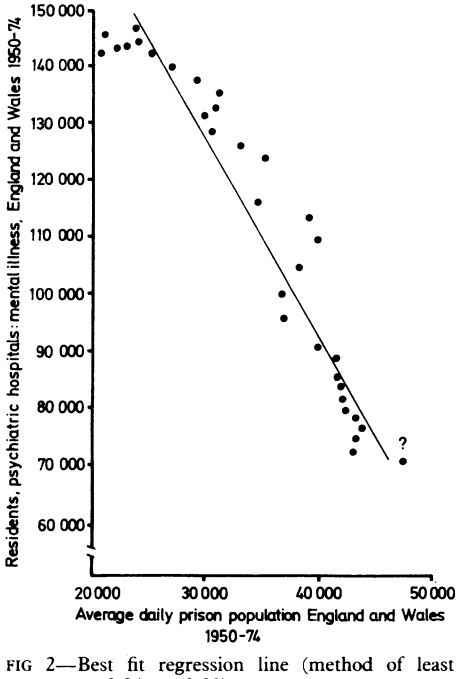

FIG 2—Best fit regression line (method of least squares; $r=0·94$; $p<0·01$).

In the 1930s Lionel Penrose found the same inverse correlation between numbers of psychiatric beds and the prison population of European countries, and Dr John Kilgour has mentioned his fears of a decrease in one leading to an increase in