Because of the increased risk of developing metachronous tumours in the contralateral breast the treatment of that breast has posed a dilemma. A few surgeons have advocated prophylactic mastectomy, either routinely^{45 46} or selectively, for those women regarded as being at increased risk,⁷ but most surgeons have advocated a conservative policy because of the psychosocial morbidity of mastectomy and the small percentage of women who develop a metachronous tumour.^{4 14 16 24} These patients should be followed up regularly on a long term basis, and mammography should be done annually on the remaining breast. Women with lobular carcinoma should undergo biopsy of the contralateral breast. Those with only in situ change should be followed up. Patients presenting with synchronous primary breast cancers should be offered mastectomy, axillary clearance, and breast reconstruction. Cuzik and Baum have shown a significant reduction of metachronous tumours in patients receiving tamoxifen for two years,⁴⁷ but the role of adjuvant treatment, particularly the long term use of tamoxifen, needs further evaluation.

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Managing flying phobia

The extent of the fear of flying is difficult to gauge. Epidemiological surveys show that a 10th of adults report intense fear,¹ but as flying is an unusual event for most people how much travelling is curtailed is far from clear. Some concern about air travel may be normal as many air crew who apparently experience no difficulties in carrying out their duties admit to worry about flying.² The decision to seek treatment for flying phobia is probably a product of factors other than anxiety, such as a change of occupation that requires overseas work or pressure from family members to agree to more adventurous holidays. The basis for the fear is also variable: although the commonest worries concern crashing and fear of being enclosed within the restricted confines of an aircraft, others with flying phobias mainly fear heights and loss of control.^{3 4}

Variability in the nature and importance of a fear of flying makes conclusions on the comparative efficacy of different treatments speculative. Minor tranquillisers have been recommended,⁵ and many passengers probably prepare themselves by using alcohol or psychoactive drugs without any medical help. More systematic investigations have been carried out on psychological treatments. Flying phobia responds poorly to analytical psychotherapy in most cases,^{6 7} but greater success has been claimed for techniques of behaviour therapy such as systematic desensitisation and exposure. Although treatment with imagined or filmed stimuli confers some benefits,^{3 8} current approaches emphasise the importance of exposure to real flight.⁹ A recent investigation from the University of Nottingham of a three session training course illustrates this technique.⁴ The first session provided information about both flying phobia and the technical aspects of flying procedures and safety. The second session took place at an airport, where participants checked in and boarded a flight but did not take off. In the third session 38 out of 41 participants agreed to undertake a real flight. Participants were supported by the course organisers throughout the procedure and were advised about coping at different stages. The results showed significant reductions in anxiety about most aspects of flying in the people who completed the course compared with that in a control group from the waiting list. Twenty three of the 38 treated participants took at least one flight over the next three

years, but no group was available for comparison at this stage. Real life treatments are more expensive and difficult to organise than office based procedures, but the cost effectiveness of such brief courses may be high.

Because more people are flying—overseas flights by British residents rose from 5.9 million in 1971 to 16.5 million in 1986¹⁰—the demand for treatment of flying phobia is certain to increase. General practitioners faced with patients wanting treatment for flying phobia should refer them to clinical psychologists, who are likely to be familiar with the strategies of behavioural management. As a flight will probably be taken during treatment the patient (or his or her employer) should expect some expense. Nevertheless, this may be a small price to pay for relief from a problem that may cause such inconvenience. In some parts of Britain private treatment may be obtained through the medical officers of the major airlines.

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Mentally disordered prisoners: reports but no improvements

Since the beginning of the century reports on prisons have conveyed concern for the number of mentally disordered people in prison.¹⁻⁵ The proportion of such inmates appears steadily to increase, confirming a favourite aphorism (more or less correctly attributed to Penrose⁶) that the use of prisons and mental hospitals varies inversely. Thus with the decline of the mental hospital and the enthusiastic promotion of community care more mentally abnormal offenders are likely to find their way into custody.

Coid reviewed eleven studies that attempted to measure the prevalence of psychiatric morbidity in prison populations over this century.⁷ None had found psychotic illness to be higher in prison than in the general population, but they generally reported more neurotic symptoms, mostly secondary to imprisonment itself, and a higher prevalence of mentally handicapped and epileptic prisoners. Information from the Home Office on the numbers of mentally disordered prisoners in English prisons is based on inadequate estimates, and its evidence to the House of Commons Social Services Committee⁸ minimised the problem, although it conceded that "a number of mentally abnormal offenders will . . . slip through the net." Many others, including those representing

the prison reform organisations, considered that there was a much more serious problem.⁹ There is an urgent need for research to obtain an accurate and up to date assessment of the psychiatric morbidity in the prison population, and this is to be carried out by the Institute of Psychiatry.

Many solutions have been offered over the years on how to manage the mentally disordered in prison. They have included the establishment of the psychiatric prison at Grendon in 1964, the creation of consultant posts in forensic psychiatry jointly between the National Health Service and the Home Office from 1966, and starting the regional secure unit programme in 1974. Despite these and other initiatives the problem will not go away. The Social Services Committee report of 1986 made many recommendations pertinent to the issue,¹⁰ and, although 48 of the 58 recommendations were accepted in principle by the government, little change is evident. The secure unit programme has been the most determined initiative intended to relieve the prisons, and now virtually every NHS region has a service in operation. Despite this Coid (p 1779) reports that one in five mentally abnormal men remanded to Winchester prison in 1979-83 was rejected for treatment by the responsible NHS psychiatrist; those from the Oxford region (which had no supporting secure unit or forensic psychiatrist) fared worse than those from the Wessex region (p 1783). Clearly much remains to be done on this front.

More recently, at the end of last year, a report prepared by a working group of Home Office and DHSS officials was quietly issued seven months after its completion.¹¹ The group was established by Home Office and DHSS ministers a few days before the Social Services Committee report was published. Its aim was to minimise the numbers of mentally disordered prisoners and to facilitate their management and treatment while in custody and afterwards. The members of the group were all civil servants, and it did not take any evidence or carry out any investigations so that it had to rely on the limited information available from censuses of "mentally disturbed" prisoners carried out by prison medical officers.

The group produced 16 recommendations, many of them seeking to improve procedures in the communications between prisons and hospitals. Curiously it made no reference to the concurrent recommendations of the Social Services Committee nor did it consider the wealth of important information that was given to that inquiry in evidence. Most of the group's suggestions are unlikely to make much difference to present problems. It is encouraging, however, that the DHSS recognises the need to continue to develop comprehensive secure provision, particularly for those with chronic mental illness and mental impairment who are not appropriate for regional secure units. But there is little or no reference in the report to the responsibilities of psychiatric hospitals and psychiatrists or to the role of the special hospitals.

The need to obtain accurate data and to improve and upgrade both prisons and prison medical facilities remains urgent. Little has changed since the *BMJ* published a series of articles on prisons in 1984¹²: the fundamental causes of all the difficulties remain and will continue to do so until the Home Office and DHSS attack the problems with real determination.

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