Correspondence

A 21st century truism

Phillip McGarry previously highlighted benefits of maintaining medical impartiality in an era of political dissent,[1] but this striving for neutrality seems vulnerable to coming unstuck when it comes to analysis of putative relationships between mental illness and terrorism. In his response to the piece by Hurlow *et al*[2] he sets up and then demolishes a straw man.

Of course, he is entirely correct that those who are members of terrorist groups are generally psychologically stable. This is a consistent finding in the literature. After all, as observed by Lord Alderdice in his analysis of the 30-year campaign of terrorism in Northern Ireland, 'individuals with psychosis [. . .] are excluded by terrorist organizations since they create a high risk' and those with 'personality disorder [. . .] often become impossible for their organizations to handle'.[3] But the same is not the case with lone actors, where a high prevalence of mental illness is found. And, within the UK, this has been the finding of those whose research background is the civil strife in Northern Ireland,[4] to which McGarry wishes us to turn our attention.

One might question whether any lone actor can truly be called a terrorist, as most exhibit a mixture of mental disorder and social grievance, wrapped in a political flag. Indeed, the overlap between so-called lone actor terrorists, lone actor school/university killers, lone actor workplace shooters, lone actor assassins and lone actor spree killers is sufficiently large to suggest that they all be considered as parts of one phenomenon: grievance-fuelled violence.

The role of mental illness in lone actor political assassinations – a companion phenomenon to that of lone actor terrorism – has been understood for centuries, if not millennia.[5] It has also been subject to systematic study since the 19th century with the work of Laschi and Lombroso[6] and, in particular, the 80-case study by Régis.[7] In this second decade of this millennium it is beginning to seem reasonable to ask if the trend of repeating the truism that most people with mental illness are not violent is tipping the balance towards a culture within psychiatry that does not assist in the task of preventing violence from occurring where we can, both for the sake of the patient and their potential victims.

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1 McGarry P. The fortunes of the legal and medical professions during the 'Troubles' – presentation to The Northern Ireland Medicolegal Society – October 14 2014. *Ulster Med J* 2015; **84**: 119–23.

2 Hurlow J, Wilson S, James D. Protesting loudly about Prevent is popular but is it informed and sensible? *BJPsych Bull* 2016; **40**: 162–3.

3 Alderdice J. The individual, the group and the psychology of terrorism. *International Review of Psychiatry* 2007; **19**: 201–9.

4 Gill P. *Lone-Actor Terrorists: A Behavioural Analysis*. Routledge, 2015.

5 James DV. Another helping of 'Intellectual Hash': commentary on 'Assassins of Rulers' (MacDonald, 1912). *Journal of Threat Assessment and Management* 2015; **1**: 228–40.

6 Laschi M, Lombroso C. Le délit politique. In *Actes du Premier Congrès International d'Anthropologie Criminelle, Rome 1885* (pp. 379–89). Bocca Frères, 1886.

7 Régis E. Les régicides dans l'histoire et dans le présent. Maloine, 1890.

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Alternatives to acute in-patient care: safety and efficacy

Hunt *et al*[1] discuss implications of recent findings regarding high rates of suicide in patients under crisis resolution home treatment. Their obvious conclusion points towards improving safety in this setting. There is, however, in my opinion, another important consequence – reconsidering other evidence-based models that provide treatment as an alternative for in-patient admission at times of acute mental health crisis. The NHS Plan policy mandate appears to have been too one-sided in favouring one model of care over other evidence-based services.

The acute day hospital (ADH) model – somewhat out of fashion, partially because most services provide step-down day care rather than acute crisis care – is an interesting alternative model worth considering because of its established safety track record and hence its relevance to this debate. In contrast to the home treatment team model, the ADH ('virtual community ward') provides individuals who experience an acute mental health crisis with an intensive group therapy programme including psychological therapies and social activities, as well as multidisciplinary daily monitoring of their mental state and associated risks.

According to a Cochrane review, 25–40% of all voluntary patients can be treated in an ADH with significant cost reductions,[2] and the treatment is associated with higher patient satisfaction and better efficacy in reducing psychopathology.[3] Most importantly, suicide incident rates were reported as being low.[4] Furthermore, unpublished data from the East London ADH indicate an average length of stay close to that of in-patient wards.

There appears to be renewed interest in alternative models for in-patient care in the context of financial constraints, and it might be worth comparing the various models directly in terms of their clinical efficacy and cost-effectiveness.

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1 Hunt IM, Appleby L, Kapur N. Suicide under crisis resolution home treatment – a key setting for patient safety. *BJPsych Bull* 2016; **40**: 172–4.

2 Marshall M, Crowther R, Almaraz-Serrano A, Creed F, Sledge W, Kluiter H, et al. Day hospital versus admission for acute psychiatric disorders. *Cochrane Database Syst Rev* 2003; **1**: CD004026.

3 Priebe S, Jones G, McCabe R, Briscoe J, Wright D, Sleed M, et al. Effectiveness and costs of acute day hospital treatment compared with conventional in-patient care. *Br J Psychiatry* 2006; **188**: 243–9.

4 Jones G, Gavrilovic J, McCabe R, Becktas C, Priebe S. Treating suicidal patients in an acute psychiatric day hospital: a challenge to assumptions about risk and overnight care. *J Ment Health* 2008 **17**: 375–87.

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Scottish provisions for vulnerable witnesses

Cooper and Grace discussed the special measures for vulnerable witnesses in England and Wales[1]. We hope to provide the context of these provisions in Scotland.

In Scottish legislation an individual may be deemed vulnerable when giving evidence if they are under 18 or have a mental disorder which may affect the quality of this evidence. Under the Victims and Witnesses (Scotland) Act 2014 'standard special measures' are given for vulnerable witnesses. In contrast to England and Wales, these measures also apply to those who are accused. The following measures are included in the Criminal Procedure (Scotland) Act 1995 (3) (Section 271H).

'Taking of evidence by a commissioner': an individual appointed by the courts takes the evidence.

'Use of a live television link': the witness gives evidence from somewhere outside the courtroom by means of a live television link, not necessarily within the court building.

'Use of a screen': the accused is physically concealed from the witness, although the court ensures that the accused can watch and hear the witness giving evidence.

'Use of a supporter': supporters can be selected by witnesses or on their behalf. Their role is to support witnesses while the witnesses give evidence. If they also have to give evidence, they must do so before acting as supporters.

'Giving evidence in chief in the form of a prior statement': a statement by the witness is lodged in evidence without the witness having to speak in court.

If it is felt that these measures are necessary, a Vulnerable Witness Application must be lodged by those who are citing the witness. This application includes which measures are being requested and the views of the witness, including any carer if possible. The court has the final decision on which measures are most appropriate.

In contrast to England and Wales legislation, the Vulnerable Witnesses (Scotland) Act 2004 put an end to the competence test for witnesses. Competency is set out in England and Wales legislation under the Youth Justice and Criminal Evidence Act 1999. The advantage of removing this test is that it allows the judge or jury to determine the witness's reliability, rather than a test which did not necessarily ensure the truthfulness of their evidence. This ensures that vulnerable people have the opportunity to be heard.

It is important that practitioners working with vulnerable witnesses who may be appearing in the Scottish courts are aware of these procedures, as their input could drastically change a witness's experience of the court. Psychiatrists are in a position to advise on optimum conditions to aid a patient's mental state, and in so doing not only ensure a fair legal process, but also a legal process that is as stress-free as possible.

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1 Cooper P, Grace J. Vulnerable patients going to court: a psychiatrist's guide to special measures. *BJPsych Bull* 2016; **40**: 220–2.

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Voting and mentally disordered offenders: a Scottish (and post-Brexit) supplementary

Rees and Reed advocate expanding the electoral franchise to convicted mentally disordered offenders,[1] referring to a judgment of the European Court of Human Rights. The current prime minister has spoken in favour of withdrawing from the jurisdiction of the Court[2] – a possibility in the era of Brexit – so their suggestion is unlikely to come to pass. However, they also provide a helpful summary of which mentally disordered offenders have the right to vote. We would like to reply with a summary of the situation in Scotland, which was notably omitted from their editorial.

The Representation of the People Act 1983 was amended in 2000 and has specific provisions for Scotland. Patients detained on civil provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 are eligible to vote by virtue of the amended 1983 Act, as are those subject to guardianship orders under the Adults with Incapacity (Scotland) Act 2000. Remand prisoners and civil prisoners are also eligible to vote.

Those at the pre-trial stage in Scotland may be detained in hospital on Assessment Orders or Treatment Orders. As untried persons, they can vote. By virtue of Section 3A(3) of the amended 1983 Act, those subject to one of the various psychiatric disposals are ineligible to vote. These are a Compulsion Order, which authorises hospital treatment, or a Hospital Direction, which authorises hospital treatment and return to prison when well enough, or a Compulsion Order and Restriction Order, which involves special restrictions. Those found unfit for trial and subject to a temporary Compulsion Order cannot vote, and neither can those admitted from prison on a Transfer for Treatment Direction.

That is all similar to England. However, in Scotland, patients can be subject to a unique form of community-based criminal detention without a precise English analogue. This is a Compulsion Order without a provision under Section 57A(2)(8)(a) to authorise detention in hospital. Such patients are ineligible to vote by a strict reading of the amended 1983 Act, which was probably not written with such a scenario in mind. Conditionally discharged restricted patients, living in the community, are also ineligible.

Even if the current position in Scotland is clear, the future is less clear. The Scotland Act 2016 has expanded the legislative remit of the Scottish Parliament with respect to electoral law, and the voting age for local and Holyrood elections has been lowered to 16, giving different franchises for elections to Holyrood and to Westminster.

So Holyrood could now legislate to expand the franchise for Scottish elections. However, there may be little appetite for Rees and Reed's recommendations, since the Scottish Parliament did not allow prisoners to vote in the 2014 independence referendum – a decision upheld in the Court of Session and the Supreme Court of the United Kingdom.[3]

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1 Rees G, Reed J. Patients or prisoners? Time to reconsider the voting rights of mentally disordered offenders. *BJPsych Bull* 2016; **40**: 169–72.

2 Asthana A, Mason R. UK must leave European convention on human rights, says Theresa May. *The Guardian,* 2016; 25 April (https://www.theguardian.com/politics/2016/apr/25/uk-must-leave-european-convention-on-human-rights-theresa-may-eu-referendum).

3 Moohan and another *v* Lord Advocate [2014] UKSC 67 (https://www.supremecourt.uk/decided-cases/docs/UKSC_2014_0183_Judgment.pdf).

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Liaison psychiatry: a brief history

Aitken *et al* suggest that it was the bringing together of the alienists (asylum doctors) and academics that 'enabled' liaison psychiatry to be recognised as a subspecialty by the newly founded Royal College of Psychiatrists.[1] However, I would argue that change in the practice of psychiatry prior to that date was much more determined by the *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*[2] that led to the 1957 Mental Health Act. Foremost among its recommendations were:

(1) to place mental illness and mental deficiency on the same footing as other illnesses or disabilities
(2) to abolish special designation of psychiatric hospitals
(3) to expand community services.

Subsequently, W. S. Maclay gave an academic address to the 1st Canadian Mental Hospitals Institute entitled *Experiments in Mental Hospital Organisation*, in which he outlined the likely future progression of these recommendations based on developments in the Manchester region. As early as 1948 the medical administrative staff of the Manchester Regional Hospital Board had begun to address how best to serve the care of psychiatric patients. It was agreed that psychiatric care should be as far as possible analogous to that of all healthcare – community facilities together with primary medical services, and secondary medical provision within local general hospitals. Psychiatric units of 100 to 200 beds were developed within district general hospitals (DGHs) and a consultant psychiatrist and support staff appointed to each unit from 1954.

Initially, there was little or no support from the large hospitals or academic psychiatric departments of the region. However, the regional clinical research committee requested a review of such units in 1960. This was carried out by Dr Stanley Smith, the superintendent of a large mental hospital. It is worth quoting the final paragraph of his 'Review of Psychiatric Units Associated with General Hospitals in the Area of the Manchester Regional Hospital Board':

> 'In my view they (these units) may well be the most significant social development in British psychiatry today'.

The existing DGHs of the Manchester region were based on the needs of individual communities ('ecologies'). They were built physically and conceptually from the provision made available by central and regional health services, local government and the community and charitable resources of each area. 'Liaison' was implicit to successful provision of overarching healthcare in such facilities.

Services continued to evolve in the DGH psychiatric unit in which I had my longest experience – and which served 200 000 people. These included in-patient beds for people with acute illness, those with chronic illness and elderly patients. A number of beds on the general wards were assigned to psychiatry; they were used for investigation of mental illness and for drug withdrawal. Additionally, beds were held on medical wards for the direct admission of patients who had attempted suicide by drug overdose – these were seen by consultant psychiatrists and social workers before discharge. The average duration of stay of all in-patients was 3 to 4 weeks throughout those 30 years.

Progress in modes of psychiatric treatment was readily acknowledged by the hospital management. The advent of behaviour therapy led to the establishment of a clinical psychology department in 1966 – probably the first of its kind in a DGH. Psychiatric social workers were attached to each consultant team. The laboratory biochemical facilities were extended to allow monitoring of drug therapy and substance misuse.

Before the formal role of community psychiatric nurse was established, nurses from the hospital used to visit patients in their homes if this was felt appropriate. Readily available links to psychiatric assessment were made with the police, the large local Salvation Army hostel and local organisations that dealt with homelessness. A drug team was jointly established with the local authority. An industrial unit served those with work maladjustment. An Alcoholics Anonymous group held its meeting within the hospital. There was a well-recognised postgraduate teaching centre within the DGH which organised regular seminars that included psychiatric topics.

Consultant numbers grew from one to four, enabling a duty consultant to cover intra-hospital consultations and out-of-hours emergency calls from whatever source, in addition to requests from primary care and community organisations. All waiting list referrals were seen within 4 weeks. All the intervention categories that Aitken *et al* describe were part and parcel of the service.

Guthrie *et al* commented that one of the most difficult aspects of any provision is that of measuring outcomes.[3] The DGH model aimed to give 'comprehensive' healthcare to a district, defined as the smallest population for which such healthcare could be satisfactorily planned, organised and provided. This required the greatest possible co-ordination between health services and the local authority, particularly social services. The majority of districts were expected to serve a population of less than 250 000.

Owing to the closed population and ready liaison with groups and individuals, outcomes could easily be measured. Follow-up clinics, re-referrals and community responses, together with statutory and non-statutory data collection, ensured awareness of changing needs. The importance of early clinical intervention and continuity of care became apparent and data were used to sustain appropriate staffing, bed numbers and budgeting in the DGH.

Lastly, it is my personal view that the Mental Health Act 1983 and the establishment of mental health trusts have hugely emphasised the dichotomy between mental and physical healthcare. I believe that liaison – intimate communication – with both the individual and his or her 'ecosystem' is necessary to all good quality care and cannot be prescribed. It is not particular to psychiatric practice; it is the hallmark of good doctoring in all specialties.

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1 Aitken P, Lloyd G, Mayou R, Bass C, Sharpe M. A history of liaison psychiatry in the UK. *BJPsych Bull* 2016; **40**: 199–203.

2 HM Government. *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* 1954–1957 (Cmnd 169). HMSO, 1957.

3 Guthrie E, McMeekin A, Thomasson R, Khan S, Makin S, Shaw B, et al. Opening the 'black box': liaison psychiatry services and what they actually do. *BJPsych Bull* 2016; **40**: 175–80.

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Psychiatrists' use of psychological formulation

In a qualitative study[1] Mohtashemi *et al* have helpfully explored the use of psychological formulation by adult psychiatrists. They describe how this is limited in extent and discuss the implications of these findings from the perspective of clinical psychologists. We would like to offer some additional observations from a different perspective, that of psychiatrists with a particular interest in the use of formulation in everyday psychiatric practice.

It is perhaps worth mentioning that the term 'formulation' continues to be used in different ways, as it has been for at least 30 years.[2,3] Sometimes it denotes a summing up of a case and its management, sometimes an interpretation of *why* a problem is occurring.

We suggest that many psychiatrists do not share the view that the core tasks of psychiatry should be diagnosis and medication. This is not the position of the Royal College of Psychiatrists,[4] and in our personal experience colleagues are frequently seeking to practise in a way which is genuinely biopsychosocial. Unfortunately, it is common for psychiatrists to report that pressures of time and the expectations of services and patients lead to diagnosis and medication dominating more than they would wish. When many psychiatrists are trying to practise holistically, we believe that the term 'medical model' as used in the paper is misleading and that the term 'biological model' perhaps more aptly describes the views which Mohtashemi *et al* see as conflicting with clinical psychologists' perspectives. There is a similar issue in the paper's use of the term 'psychiatric formulation', which seems again to imply something that would not include psychological elements. We strongly believe that, when well conducted, formulation by psychiatrists should always consider psychological elements and that in practice conflict between psychiatrists' and psychologists' views may be less frequent than the paper appears to imply.

While we agree with the authors that team formulation with clinical psychologists is valuable, we think that over-emphasising its importance risks overlooking other ways in which formulation may be helpful. Recently, for example, increasing attention has been given to the potential of a dialogical approach, as in the open dialogue model. For clinicians seeing patients who may not go on to be supported by a multidisciplinary team, a relevant skill will be that of conducting initial assessments in such a way that consultation includes thinking collaboratively with the patient about what may be contributing to their problems and, in doing so, giving due respect to psychological and social as well as biological factors, and to the patient's perspective.

We agree that team formulation with clinical psychologists may be helpful in supporting psychiatrists to make more use of psychological formulation and we welcome the suggestion for some overlap in the training of psychologists and psychiatrists. However, we think that if psychiatrists are to make optimal use of psychological formulation, we need to do more than increase contact with clinical psychologists. Most importantly, progress is likely to be limited without attention to the systemic barriers that make it hard even for the most highly motivated psychiatrists to give adequate emphasis to psychological formulation. We believe that training should address psychiatrists' particular needs – such as being able to combine understanding of both psychosocial and biological elements – and should recognise the drawbacks of an excessive focus on biological explanations. Having a genuine belief in the value of psychological formulation is likely in itself to have a significant impact on how much it is used. We think that there is scope for making better use of existing training opportunities – such as the Balint groups available in all trusts that train psychiatrists – and for making better use of the requirements for higher specialist training to include ongoing training in psychotherapeutic skills. We believe that greater emphasis on formulation skills in workplace-based assessments and examinations might make a significant difference. Beyond training, consultant Balint groups and other arrangements that support reflective practice are likely to also support development of formulation skills. Medical psychotherapists and other psychiatrists with specialist training in working psychologically are likely to be well placed to contribute to training and support for colleagues, as well as to team formulation.

The study by Mohtashemi *et al* seems part of a surge of interest in formulation and how it might be used more effectively. The interest has been shared by psychiatrists; the Royal College of Psychiatrists' Medical Psychotherapy Faculty and General Psychiatry Faculty executives have recently agreed good practice guidelines for the use of formulation in general psychiatric practice, and these are likely to be adopted shortly as formal College guidance (details available from the authors on request). An information leaflet for patients based on the same guidance is also being developed. An initiative aiming to enhance training in formulation across disciplines has recently been set up by Health Education England, and the multi-agency working group includes representatives of both the British Psychological Society and the Royal College of Psychiatrists.

Declaration of interest

A.S., on behalf of the Medical Psychotherapy Faculty Executive Committee, was the lead author of *Using Formulation in General Psychiatric Care: Good Practice* (Occasional Paper OP103, Royal College of Psychiatrists, 2017).

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1 Mohtashemi, R, Stevens J, Jackson PG, Weatherhead S. Psychiatrists' understanding and use of psychological formulation: a qualitative exploration. *BJPsych Bull* 2016; **40**: 212–6.

2 Hollyman JA, Hemsi L. What do psychiatrists understand by formulation? A survey of clinicians in a group of hospitals in London. *Psychiatr Bull* 1983; **7**: 140–3.

3 Hollyman JA, Hemsi L. What do the examiners understand by formulation? A survey of the members of the College's board of examiners. *Psychiatr Bull* 1983; **7**: 165–6.

4 Royal College of Psychiatrists (2014). *When Patients Should Be Seen by a Psychiatrist (CR184)*. Available at http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr184.aspx

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A 21st century truism

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