of the fact that studies of terrorism have consistently found that a greater number of lone-actor incidents in Europe and the USA are perpetrated by right-wing extremists or white supremacists[13,14] and that it is lone actors embracing far-right ideologies that pose a greater threat in Europe than Islamist ones, causing 48% of terrorism-related fatalities.[15] It is unclear to us whether opponents of the Prevent strategy in healthcare would have similar qualms about using Prevent mechanisms with, for instance, a future potential Breivik. We can all deplore, with Summerfield,[1] the way that poor – and possibly illegal – British and US foreign policy decisions in Afghanistan and Iraq have had unintended consequences; but we cannot put the clock back. We may not like the way societal changes impinge on our professional duties, but this does not mean we are entitled to turn our back on them.

Jonathan Hurlow, consultant forensic psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK, email: jonathon.hurlow@nhs.net, **Simon Wilson**, consultant and honorary senior lecturer in forensic psychiatry, Barnet, Enfield and Haringey Mental Health NHS Trust and UCL Department of Security and Crime Science, London, UK and **David V. James** MA, MBBS, FRCPsych, consultant forensic psychiatrist, Theseus LLP, London, UK.

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Author's reply: I cannot accept that the Prevent programme is of a piece with everyday psychiatric practice concerning safeguarding and confidentiality. Prevent is about spying and intelligence-gathering and this cannot be ducked.

Hurlow *et al* are wrong: historically there has been very little relationship between diagnosable mental illness and terroristic acts, which are almost always committed on political grounds. Indeed, most of the terroristic violence in the world is committed by states, not by private individuals. And although it is true that violent radicalised individuals may be from, say, the neo-Nazi right, no one imagines that Prevent was intended to capture anyone other than Muslims. Prevent is part of a wider effort, deeply self-serving, to objectify Muslim culture and religion as carrying explanations for terrorism, so obscuring what damage Western powers have wrought in the Middle East.[1]

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Derek Summerfield consultant psychiatrist, South London and Maudsley NHS Foundation Trust, London, and honorary senior lecturer, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK, email: derek.summerfield@slam.nhs.uk

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Secure services for patients should be needs based and locally available

Dye *et al*'s[1] timely editorial on 'locked rehabilitation' highlights the need for a closer working relationship between local and specialist commissioners in order to achieve appropriate, least-restrictive local care provision. It also raises the question whether the emergence of locked rehabilitation units is caused by a reduction in open hospital or community-based rehabilitation facilities, combined with a difficulty in accessing low secure units.

In our experience, the pathway into locked rehabilitation is usually via acute in-patient facilities where treatment focus is on stabilisation of mental state and early discharge. In the absence of appropriate open or community-based rehabilitation facilities available locally within the National Health Service (NHS), patients requiring longer periods of rehabilitation are referred for locked rehabilitation in the private sector, usually out of area. A significant minority of these patients have a history of violence, including serious physical assault and fire-setting, but have neither been charged nor convicted.

Regardless of current or future risks, 'gatekeeping assessment' to low secure care on behalf of NHS England relies on the non-clinical requirement that the person has either serious offence charges pending or has been convicted of an offence. This becomes a barrier to accessing appropriate local secure care because in some areas police are reluctant to charge patients with long-term psychotic problems, as it may be clear that eventually they will receive a psychiatric