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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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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