any psychiatric admission and one would assume that the 7 patients who presented with psychotic symptoms would have been admitted to a psychiatric unit. Finally, we know interdisciplinary liaison appears to carry many advantages but it has both clinical and resource implications,[3] more so in the current climate where availability of funds is limited. We would be interested to know how the authors dealt with it.

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Authors' reply

We would like to thank Dr Mushtaq and Dr Helal for their letter, and welcome the opportunity to clarify the points they have raised. With regard to the study design, since 2002, data on emergency presentations have been prospectively collected at the time of presentation and recorded on a secure database within the hospital network. Access to this information is regulated, and in 2008 we sought and received ethical approval to access and analyse these data retrospectively for the purpose of this study. No data other than those recorded at the time of presentation were included in the study.

During the study period there were no direct admissions from the emergency department to specialist child and adolescent psychiatric in-patient units. This finding most likely reflects the significant lack of capacity within such units as discussed in the paper. Of the subset from 2006 for which data on onward referral were collected ($n = 278$), 20 were referred onwards for in-patient psychiatric assessment. Presenting complaints for those referred were self-harm, suicidal ideation and psychosis.

We agree on the many benefits of interdisciplinary liaison and acknowledge the clinical and resource implications. Indeed, the need to review the efficacy and value for money of services we deliver was a significant factor in our decision to conduct this study. We have presented the findings to all the involved service providers, to encourage awareness of the demand and the rationale for ongoing service provision. Although a cost–benefit analysis was outside our study design, possible cost savings attributable to the model of service provision have been considered in the study discussion. Finally, within a national context in Ireland, improving child and adolescent mental health and reducing suicide are both key performance indicators for our health services, thereby supporting the ongoing provision of services.

We would like to acknowledge the study of Hillen & Szaniecki, and that this study also addresses many aspects of the service model and demand for out-of-hours services. This paper's publication coincided with the timing of our original submission, and the lead author apologises that this study was not located at the time of revision of the paper.

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Are some subspecialties better with foundation doctors?

Welch *at al*'s[1] qualitative exploration and findings on the views of foundation trainees on psychiatry placements were interesting and hopefully will contribute towards creating posts that are valuable to trainees. The transition from medical school to the ward environment is a challenging one[2] and early impressions can influence trainees a great deal in their choice of careers.[3]

The conclusions of Welch *et al*'s paper are not as favourable as the outcomes described by Boyle *et al*.[4] There could be several reasons for this: larger numbers of respondents, trainees' individual preferences, life choices and career plans. Perhaps another reason was the subspecialty in Boyle *et al*'s report – old age psychiatry. The large amount of physical and mental health comorbidity in this patient group gives trainees the opportunity to contribute to the management of physical health (which they are more familiar with) as well as learn about assessment and treatment in psychiatry. If Welch *et al* had broken down feedback from trainees by subspecialty, this might have helped clarify whether some subspecialties lend themselves better to foundation year programmes and the unique challenges they pose in terms of trainee needs.

Welch and colleagues report on the importance of maintaining links with the acute hospital and sense of isolation trainees experience away from their peers. Liaison psychiatry services are uniquely placed to bridge this gap and working within liaison psychiatry teams based in the acute hospital gets around these problems. Trainees would not need to travel to attend mandatory teaching sessions or medical grand rounds. Liaison psychiatry is also a good training experience to those trainees who do not opt for psychiatry as a career but would still have to assess and manage patients with mental health problems in their chosen specialty. Liaison teams, too, benefit from having foundation trainees attached to them. Not only are their medical skills and knowledge of medical terminology of value to multidisciplinary team members, but their informal contacts with peers on medical wards often clarify the covert reasons underlying referrals and lead to successful consultations.

It is also our experience that news of positive training placement by foundation trainees gets around the hospital, and we often get requests for psychiatry taster days or weeks by

trainees who have not been allocated a psychiatry job. We have found that acute hospital clinicians value the training provided by liaison psychiatry teams to trainee doctors.[5] Liaison psychiatrists are thus uniquely placed to take on foundation year trainees and be the gateway to psychiatry for an increasing number of trainees.

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Minority report on violence risk assessment

The cover of the July 2011 issue of *The Psychiatrist* featured the unshaven face of a young man staring impassively back at the reader, with the caption 'Psychiatric Report', in what was an unmistakable parody of the publicity posters for Steven Spielberg's science-fiction neo-noir classic, *Minority Report*. The cover referred to two articles within about psychiatric report writing. We see similarities between the central idea of the film and those psychiatric reports that claim to estimate the risk of future violence.

Based on a short story by Philip K. Dick, *Minority Report* took us to Washington DC in 2054, a world where homicides can be prevented. A special police department, the Pre-Crime Unit, apprehends people before they commit a murder, based on the reports of three psychic 'pre-cogs'. Once identified by the pre-cogs, criminals-to-be are apprehended and permanently placed into a state of suspended animation. The story follows the plight of John Anderton, played by Tom Cruise, who discovers that he is about to be arrested for a murder he is sure he will never commit. The movie works because we empathise with Anderton as he realises the injustice of convicting people who have yet to commit a crime and struggles against both the particular error in prediction and sinister political opportunism based on fear of crime.

The Mental Health Act demands the detention of a person with a mental disorder if 'he ought to be so detained in the interests of his own health or safety or *with a view to the protection of other persons* [emphasis mine]' (Part II, Section 2 (2b)). Unfortunately, current psychiatric risk assessment, on which decisions to protect the public might be made, compare very poorly with the powers of the fictional pre-cogs.

In the most optimal circumstances, using the best instruments, a sensitivity and specificity of 80% might just be achieved.[1] If Pre-Crime had used risk assessment with this predictive power in the years before 2054, about 200 murders would still have occurred, 800 would have been prevented and 20 000 citizens of Washington DC (2% of the population) would have been needlessly frozen. In the film, Pre-Crime is eventually shut down, because even a single false positive is unacceptable to the Washingtonians of the future. Back in the real world, the Mental Health Act continues to demand that doctors make judgements about detention for the protection of others.

The false positive rate is a major problem with violence risk assessment in psychiatry and for mental health legislation that requires judgements about future harm. False positives waste resources, and lead to needless and unfair detention and excessive treatment.[2] True negatives can also be a problem if mental health law does not allow the treatment of those who cannot consent to it by virtue of incapacity, but who are not judged a threat to themselves or others.[3]

Moreover, there is no evidence that the application of risk assessment can offer adequate protection to the public.[4] Risk assessment, as it is currently practised in psychiatry, is so flawed that it should not be used as the basis for clinical decision-making or coercive treatment. Instead, treatment decisions should be made as they are in the rest of medicine, after discussing the risks and benefits of treatment with the patient or, in the case of those who lack capacity, be made in the patient's best interests, after discussion with a proxy decision maker.

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Adult attention-deficit hyperactivity disorder – a very much real diagnosis

Moncrieff & Timimi[1] have challenged whether adult attention-deficit hyperactivity disorder (ADHD) exists as a discrete condition. They suggest that it is merely the medicalisiation of ordinary human difficulties and that the diagnosis is being pushed by pharmaceutical companies who then make a tidy