plans were informed by a fidelity review. Teams targeted specific items from the CRT Fidelity Scale (a median of eight items per team) as the means by which to improve their service. Our trial demonstrated that a service improvement programme, informed by a CRT fidelity review and focused on improving model fidelity, was successful in reducing hospital admissions and CRT patients' readmissions to acute care. Wong and colleagues' suggestion that this could be achieved just as successfully without reference to model fidelity is an untested assertion.

Our exploration of the relationship between CRT Fidelity Scale scores and outcomes involved only 25 teams in the unusual context of a trial. Further research is desirable to establish the relationship between model fidelity and outcomes, and, in time ideally, to refine the CRT Fidelity Scale to include only items demonstrated to constitute critical components of the CRT model.

In the meantime, the CORE CRT Fidelity Scale may not provide a blueprint, but does offer a helpful guide for practitioners and service planners in what an effective, high-quality CRT service looks like. As such, it is recognised as a descriptor of best practice for CRTs in current NHS England policy guidance.[3]

1 Lloyd-Evans B, Bond G, Ruud T, Ivanecka A, Gray R, Osborn D, et al. Development of a measure of model fidelity for mental health crisis resolution teams. *BMC Psychiatry* 2016; **16**: 427.

2 Lloyd-Evans B, Osborn D, Marston L, Lamb D, Ambler G, Hunter R, et al. The CORE service improvement programme for mental health crisis resolution teams: results from a cluster-randomised trial. *Br J Psychiatry* 2019; doi: https://doi.org/10.1192/bjp.2019.21.

3 NHS England. *Crisis and Acute Care for Adults*. NHS England, no date (https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/)

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Challenges for the implementation of the Mental Health Care Act 2017

I was extremely delighted to read Duffy & Kelly's editorial drawing attention to the National Mental Health Survey of India 2015–2016 and India's Mental Health Care Act 2017.[1] The Indian government states that the new Mental Health Care Act will give access to mental healthcare to all sections of society. The government also intends to 'integrate mental health services into general healthcare'. As India has a large population of 1.3 billion people there might be certain difficulties in implementing the Act.

As we all are aware, there is a dearth of psychiatrists and mental health staff to cater for the needs of the large population. We also know that there are remedies and treatments available in Ayurveda and other traditional methods that are practised in India. I would like to ask the authors' view about how they would recommend the Indian government and the Indian Psychiatric Society addresses the needs of people with mental illness when there is a big treatment gap across the country. It will also be challenging to incorporate the Mental Health Care Act for remedies and management options provided by Ayurveda, yoga and naturopathy, Unani, siddha and homeopathy establishments in the coming days. What would be the authors' view about how India, with a diverse culture, can align its mental health services so that they are at par with higher-income economic countries.

1 Duffy RM, Kelly BD. The right to mental healthcare: India moves forward. *Br J Psychiatry* 2019; **214**:59–60.

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Authors' reply

The logistical challenges of meeting India's mental healthcare needs are substantial, but not insurmountable. Many Indian clinicians are highlighting potential paths forward; often utilising and building upon pre-existing resources. Trained lay counsellors,[1] and peer support workers[2] are two good examples of what is possible. Financial and infrastructural investment is also essential particularly to facilitate treatment within the community; half-way homes, sheltered accommodation and supported accommodation are an unmet need.

The incorporation of Ayurveda, yoga and naturopathy, Unani, siddha and homoeopathy into the Mental Healthcare Act presents a unique opportunity. The reality on the ground is that many individuals with mental illness attend practitioners of traditional medicine, who are often highly skilled.[3] The exclusion of traditional practitioners from the Act would have been unlikely to stop the use of such services; consequently, their inclusion facilitates their regulation and registration. It brings their establishments under the remit of the Mental Healthcare Act and provides individuals attending their services with the same patient-centred rights-based protections.

Section 106 of the Mental Healthcare Act prohibits mental health professional (including traditional practitioners) from recommending 'any medicine or treatment not authorised by the field of his profession'. This will hopefully prevent all healthcare providers from practising outside of their field of expertise. In meeting the high standards put forward in the Mental Healthcare Act traditional practitioners may need to increasingly collaborate with psychiatry and this presents all parties with opportunities to enhance their treatments and better serve their patients.

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2 Pathare S, Kalha J, Krishnamoorthy S. Peer support for mental illness in India: an underutilised resource. *Epidemiol Psychiatr Sci* 2018; **27**: 415–9.

3 Thirthalli J, Zhou L, Kumar K, Gao J, Vaid H, Liu H, et al. Traditional, complementary, and alternative medicine approaches to mental health care and psychological wellbeing in India and China. *Lancet Psychiatry* 2016; **3**: 660–72.

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Scapegoating mentally ill people

Thank you for publishing the interesting debate on the ethics of diagnosing psychiatric disorders in public figures.[1] Langford correctly draws attention to the inevitable stigmatisation of all those with mental illness which such public diagnoses would entail, but arguably a more pertinent issue here is that of scapegoating.

French intellectual Rene Girard (1923–2015) claimed that scapegoating, although eschewed by modern ethics, was an important adaptation in human evolution, inducing the unanimity of 'all against one', and thus strengthening group cohesion and curtailing internecine violence.[2] Applying this Girardian anthropology, I have recently proposed the archetypal scapegoat hypothesis[3] on the

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evolutionary origins of psychosis. This posits that psychosis emerged as an adaptation that provided early human groups with efficacious scapegoat victims, about whom unanimity was more likely. However, features of psychosis alone, as manifested in the 'patient', would have been insufficient for such an unanimity-inducing adaptation to function, as it would have been equally reliant on a corresponding tendency in the general population to both recognise the individual with psychosis in their midst, and to blame them for whatever adversity was at hand. I have thus argued that not only have we inherited a tendency to respond to crises by scapegoating, but we have also evolved a cognitive bias towards selectively scapegoating people who are mentally ill. In other words, our evolutionary origins make us prone to the fallacious conclusion that 'If something is wrong, the madman must be responsible'.

Gartner's analysis of the current state of US politics seems to be based on a similar fallacy; 'Something is wrong, therefore the man responsible must be mad'. Admittedly, his argument invokes narcissistic personality disorder rather than psychosis, but such diagnostic nuances are most likely lost on the general public. Ironically, Trump himself is probably one of the most high-profile contemporary exponents of the human propensity to scapegoat. However, labelling him as 'mad' merely reinforces, in the public mind, the myth of a strong link between mental illness and dangerousness.[4] As psychiatrists, I believe that one of our duties is to de-mythologise mental illness, rather than to invite people to succumb to their innate propensity to scapegoat it.

1 Gartner J, Langford A, O'Brien A. It is ethical to diagnose a public figure one has not personally examined. *Br J Psychiatry* 2018; **213**: 633–7.

2 Girard R, Oughourlian JM, Lefort G. *Things Hidden since the Foundation of the World*. Stanford University Press, 1987.

3 Riordan DV. Mimetic theory and the evolutionary paradox of schizophrenia: the archetypal scapegoat hypothesis. *Med Hypotheses* 2017; **108**: 101–7.

4 Angermeyer MC, Matschinger H. Public beliefs about schizophrenia and depression: similarities and differences. *Soc Psychiatry Psychiatr Epidemiol* 2003; **38**: 526–34.

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Gartner is a clinical psychologist

On the face of it, it seems unnecessary to add to Langford's excellent response to Gartner's absurd thesis on Donald Trump's mental state.[1] But Langford makes one important mistake: Gartner does not 'expect the American people to thank him gratefully for his expert medical opinion', because Gartner is not a medical doctor and so cannot give a medical opinion. On the contrary, he is a clinical psychologist and does not claim to be a psychiatrist (personal communication, 9 November 2018).

This is highly pertinent to the debate for two reasons. First, it renders his demand upon the psychiatric profession to lower its ethical standards even more unreasonable. Second, it begs the question of why a psychiatrist was not invited to argue for this motion on a topic of ethics in psychiatry, in a psychiatric journal. If none could be found to argue for the motion, there is no debate to be had.

O'Brien, as chair of the debate, is quite incorrect in introducing Gartner as a 'US psychiatrist'.[1] I respectfully call upon the *Journal* to formally publish a correction.

1 Gartner J, Langford A, O'Brien A. It is ethical to diagnose a public figure one has not personally examined. *Br J Psychiatry* 2018; **213**: 633–7.

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Ethics of debating if it is ethical to diagnose public figures!

Is it ethical to have a debate on 'diagnosing a public figure who has not been personally examined?' This question came to mind on reading the 'In Debate' article published in the November issue of the *Journal*.[1] I find it is rather ironic that the debate by Gartner, Langford and O'Brien has diagnosed public figures by proxy. On the one hand, one may defend this debate in a scientific journal of repute as an academic or literary freedom – the right to free speech and to express views about anyone. However, in such a situation what happens to the privacy of the public figures discussed in the article and confidentiality regarding information about them, irrespective of the sources? Was any consent sought or taken from those who were quoted in this article? I find that the ethics of discussing public figures in the form of a debate is a proxy or deceptive discussion circumventing the Goldwater rule or principle. In order to make the debate ethical, the authors could have disguised or anonymised the names of the public figures. I wonder if one could take the same liberty of publishing a psychiatric assessment of the authors or other psychiatrists, without offending them? One could consider the views of the authors/debaters as a projection, displacement, suppression, repression, narcissism or any other psychoanalytic defence mechanism based on these authors' writing, publications and use of their twitter or other social media. One cannot rule out any psychic determinism in opinions and views. (Likewise, somebody can do the same for me!) The role of the *Journal* in this connection can also be questioned: the *Journal* permitted the discussion of public figures who had not been personally examined, in contravention of the Goldwater rule and principle, under the guise of an academic debate!

1 Gartner J, Langford A, O'Brien A. It is ethical to diagnose a public figure one has not personally examined. *Br J Psychiatry* 2018; **213**: 633–7.

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Editors' response

We are indebted to Dr Chaturvedi for raising concerns about the ethics of publishing a debate on the ethics of diagnosing public figures.[1] This question has entered public discourse in both national and international associations and the press, hence, it is relevant to air in the *Journal*.

The use of fictional characters would not work, as it is the role public figures occupy that is the basis of why some wish to raise concerns about their competence, precisely because of the office they hold or the power vested in their decisions. Mickey Mouse and Donald Duck as fictional characters would not raise so much concern, as they are not real. Using a pseudonym would also be disingenuous. For example, we could say, 'let's take a fictional character, JJ. Let's imagine he is the president of the United States, etc…'. It would not be easy to capture the consternation and concern of different audiences about the actual decisions made by the public figure, and the way it affects people's lives. JJ would not be on TV or in the press, nor be known by anyone. Such an approach would not be credible or progressive.

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