Appleby, L., Shaw, J. & Amos, T. (1997) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. *British Journal of Psychiatry*, **170**, 101–102.

___, ___, Sherratt, J., *et al* (2001) *Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.

Department of Health (2002) *National Suicide Prevention Strategy for England*. London: Department of Health.

Gairin, L., House, A. & Owens, D. (2003) Attendance at the accident and emergency department in the year before suicide: retrospective study. *British Journal of Psychiatry*, **183**, 28–33.

L. Appleby, N. Kapur, J. Shaw, J. Robinson Centre for Suicide Prevention, University of Manchester, 7th Floor, Williamson Building, Oxford Road, Manchester M13 9PL, UK
E-mail: Louis.Appleby@man.ac.uk

Authors' reply: We think that Appleby and colleagues have misunderstood what we are saying. Of course we are aware of the methods of case ascertainment used by the National Confidential Inquiry. Our main point is exactly that made by Appleby and colleagues – that the Inquiry is not set up in a way that enables it to identify suicides following attendances at accident and emergency departments. This is because specialist mental health services in the UK do not provide comprehensive monitoring of self-harm attendances, even of those referred for a specialist opinion, and yet the Inquiry does not seek evidence directly from accident and emergency departments about attendances following self-harm.

Self-harm is closely linked to suicide, and yet self-harm services are in a disorganised and underresourced state nationally. We see this as a challenge both to national policy makers and to local service providers. The National Suicide Prevention Strategy does indeed refer to self-harm. However, we find its recommendations couched in such general terms that it is unclear how real change will come about in services hard-pressed for staff or funding.

As a first step mental health trusts should be required to provide comprehensive self-harm services to accident and emergency departments, and acute hospitals and mental health services should collaborate to monitor all attendances that follow self-harm. This action would improve local service provision for a neglected and high-risk group, at the same time as solving the National Confidential Inquiry's monitoring problem.

We disagree with the National Director for Mental Health that the evidence is not strong enough to support such a policy; it is at least as good as the evidence for the wholesale introduction of standardised risk assessment in mental health services. If further evidence is needed, then we are not sure that a study restricted to 'mental health patients' (and therefore presumably excluding the very people we are discussing) is the answer. It would, however, be a relatively simple matter to attempt to replicate our findings in a multi-centre prospective monitoring study at those other centres that run accurate accident-and-emergency-based clinical databases.

D. Owens, A. House Academic Unit of Psychiatry and Behavioural Sciences, University of Leeds, 15 Hyde Terrace, Leeds LS2 9LT, UK

I. Gairin Yorkshire Centre for Forensic Psychiatry, Wakefield, UK

What is early intervention?

Drs Pelosi and Birchwood (2003) have provided some stimulating thoughts about the implementation of early intervention for psychosis. Perhaps one of the underlying difficulties that may lead to the dichotomy of views expressed by the two authors is a confusion about what constitutes 'early intervention'. Pelosi rightly identified both the lack of evidence and theoretical restriction in clinical usefulness based on the epidemiology of schizophrenia and the sensitivity and specificity of screening for the disease. It seems reasonable to question the widespread and costly implementation of a service based on such shaky evidence.

However, there is a sharp contrast between the concept of early intervention as a service aimed at secondary prevention, with treatment in prodromal phases of schizophrenia, and the way in which it is defined in the UK Government's *Mental Health Policy Implementation Guide* (Department of Health, 2001). Here, it is clear that the service should primarily be focused on interventions in people who have already developed psychotic symptoms, with various broad-ranging strategies to ensure early identification and referral and good links with employment and education institutions ensuring a high-quality and holistic service.

None of this is rocket science and the argument that it could be provided by existing community mental health teams might seem attractive were it not for the failure over many years of existing teams to truly address these issues. Experience from other areas of health care, such as cancer services, suggests that specialisation often leads to improvements in quality of services and the same might be expected within the context of early intervention for psychosis.

Early intervention provides an opportunity for significant improvements in the way in which young people with devastating illnesses are managed, and it is essential that psychiatrists lend the full weight of their experience and expertise to ensuring the success of these teams.

Department of Health (2001) *Mental Health Policy Implementation Guide*. London: Department of Health.

Pelosi, A./Birchwood, M. (2003) Is early intervention for psychosis a waste of valuable resources? *British Journal of Psychiatry*, **182**, 196–198.

A. Owen St Michael's Hospital, St Michael's Road, Warwick CV34 5QW, UK

Psychiatric services for ethnic minority groups: a third way?

The publication of the debate on separate psychiatric services for ethnic minorities (Bhui/Sashidharan, 2003) highlights the unmet needs of some of these people. Their progress on the pathway to mental health care has suffered through poor recognition of mental illness because of issues related to language, idioms of distress and other cultural factors. Bhui rightly points out that the majority of ethnic minority services are run by the voluntary sector and are outside the National Health Service (NHS). Their limitations include: limited involvement of NHS psychiatrists; targeting of only certain ethnic groups; restriction to small geographical areas; and short-term funding. The statutory sector has mainly catered only for those groups with severe mental disorders, sometimes involving law and order issues but not addressing the needs of the majority who have less severe mental disorders. This may mean that depressive illness, which goes undetected and untreated, leads to considerable suffering.

In planning culturally competent services, the notion of a specific service for each cultural group is unrealistic. In areas where 25% of the population are ethnic minority groups speaking up to a hundred languages, creating services for individual ethnic groups seems unattainable. There is another problem in that specific services for ethnic minority groups raise fears of

https://doi.org/10.1192/bjp.183.6.562-a Published online by Cambridge University Press

'ghettoisation' and further marginalisation of those already marginalised.

With Professor Sashidharan's dislike for words such as 'separate', 'different' and 'them', one gets the impression that he wants a 'melting pot' approach to address inequalities in service provision. Whatever perspective we may have, ethnic groups have their own identity and specific needs; thus, a 'mosaic'-like approach, with better awareness of individual needs in a broader perspective is required.

Caution is needed regarding reference to cultural matters. Sometimes, everything is attributed to ethnicity or culture, while at other times the existence of cultural impact is completely denied. Concentrating on cultural differences may lead to important diagnostic signs being missed. Cultural sensitivity is not a fixation on culture and it should not be a synonym for unexplained variance.

On the basis of our own experiences in Manchester and Toronto, we propose a third approach – founded on Professor Kirmayer's 'cultural consultation model' (Kirmayer *et al*, 2003) – as an interim option. This in some respects lies midway between the opposite poles of the debate. This model proposes the operation of a specialised multi-disciplinary team that brings together clinical experience with cultural knowledge and linguistic skills essential to working with patients from diverse cultural backgrounds. A team built on the cultural consultation model aims to give advice to other clinicians rather than take on patients for continuing care. The latter will be reserved for cases where there are difficulties in understanding, diagnosing and treating patients where cultural factors may be important. The assessment will usually involve two or three interviews with the patient and his or her family, which should result in a clear cultural formulation, diagnosis and treatment plan. The members of this team will be a resource for clinicians in primary care, social services, mental health and other related disciplines. They will also be involved in the training of interpreters, culture link workers and members of the mainstream and existing community services.

Until 'they' become 'us' we have to find a way forward that is both financially and logistically viable and that allows mainstream services to provide a culturally sensitive approach to all groups rather than a service to a minority of those in need.

Bhui, K./Sashidharan, S. P. (2003) Should there be separate psychiatric services for ethnic minority groups? *British Journal of Psychiatry*, **182**, 10–12.

Kirmayer, L. J., Grolean, D., Guzder, J., *et al* (2003) Cultural consultation: a model of mental health service for multicultural societies. *Canadian Journal of Psychiatry*, **48**, 145–153.

W. Waheed, N. Husain, F. Creed Department of Psychological Medicine, Rawnsley Building, Oxford Road, Manchester M13 9QL, UK

Author's reply: Waheed and colleagues raise some important dilemmas in the debate on specialist services for ethnic minorities. We already have specialist services for many cultural groups in the voluntary sector and statutory sector. I agree that within the statutory sector, there would be insufficient funds to equip a large number of new specialist services in all parts of the country for all subcultural groups. Yet, we currently rely on just such an underfunded solution within the voluntary sector to plug gaps in psychiatric service provision. Specialist services may continue to exist in response to unmet need rather than by design.

There are some problems with the cultural consultation model. First, this solution is not novel, and was established in Bradford some two decades ago, only to be brought to an end due, I believe, to lack of funds for such a specialist service! The approach can be successful, but not because of the structure it imposes. Improvements in the quality of care will not be achieved by simply restructuring the services, as entrenched attitudes and skills deficits will simply be transferred into new services. All practitioners should have the necessary skills, knowledge and attitudes for a modern multiculturally capable service. Who will be qualified to lead such a service, and what are the capabilities necessary for workers in such a service? Moodley (2002) addressed these issues for psychiatrists following development work by the Transcultural Special Interest Group within the Royal College of Psychiatrists.

Irrespective of the service model, any service can respond to the needs of Black and minority groups only if the workforce is skilled and continues to acquire new knowledge and skills to work with new migrants. Motivating the workforce to acquire skills is essential, but current workloads, rapid changes in services and waves of new policy deter the acquisition of new skills and the development of innovative paradigms for service delivery. Until these issues are addressed, we rely heavily on specialist services that have managed to attract and motivate staff to be creative and tailor packages of care. A specific problem of the consultation model is that specialists are expected to be the fount of all wisdom on cultural issues, absolving the rest of the workforce from these responsibilities (Bhui *et al*, 2001). Furthermore, no single consultant can ever claim to be an expert on all cultures of the world. However, a consultant can reasonably be expected to communicate general principles, aptitude and methods in order to discover more about mental distress in the context of unfamiliar cultures using, for example, ethnographic approaches. Yet, those seeking advice from such a service must be able to change their practice. Business efficiency can work against improving the cultural capability of services and warrants more attention by purchasers and providers (see Bhui, 2002). Irrespective of the service model, organisational cultural capability, a motivated workforce and optimal learning conditions will diminish the need for specialist services, but not in the foreseeable future. In the meantime we can learn from these specialist services, but their existence is inevitable and necessary if the cultural capability of the NHS workforce does not improve.

Declaration of interest

K.B. is Secretary to the Transcultural Special Interest Group of the Royal College of Psychiatrists, and Director of the MSc programme in transcultural mental healthcare at Queen Mary, University of London.

Bhui, K. (2002) *Racism and Mental Health*. London: Jessica Kingsley.

___, Bhugra, D. & McKenzie, K. (2001) *Specialist Services for Minority Ethnic Groups?* Maudsley Discussion paper No. 8. London: Institute of Psychiatry.

Moodley, P. (2002) Building a culturally capable workforce – an educational approach to delivering equitable mental health services. *Psychiatric Bulletin*, **26**, 63–65.

K. Bhui Barts and London Medical School, Department of Psychiatry, Queen Mary, University of London, 327 Mile End Road, London E1 4NS, UK

Neuroimaging psychopathy: lessons from Lombroso

Blair (2003) outlined a neurobiological basis for psychopathy. The orbitofrontal cortex has also been implicated in psychopathy by other authors (Dolan, 1999). A

https://doi.org/10.1192/bjp.183.6.562-a Published online by Cambridge University Press