Correspondence

EDITED BY STANLEY ZAMMIT

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The endeavour to become international

We read with interest the inaugural editorial by Peter Tyrer (2003). We especially welcome his hope to continue the quest of his predecessor to make the *Journal* 'the leading international journal of general psychiatry'. Responding to his invitation for feedback, we offer the following comments and suggestions.

As suggested by Patel & Sumathipala (2001), evidence to influence mental health policies and practices at the international level will often have to come from research done both within and outside the cultural and health systems of Western Europe and America. In 1996 to 1998, of the articles published in the *Journal*, only 6.5% were from the 'rest of the world' (Patel & Sumathipala, 2001). Between 1991–1992 and 2001–2002, the regional distribution of contributions has remained largely the same (65–69% from the UK, 3–4% from Asia, Africa and South America) (Catapano & Castle, 2003). Obviously, the *Journal* has a long way to go in obtaining contributions from and with relevance to countries across the world. The negligible representation of members based in low- or middle-income countries on the Editorial Board (one among 69 members) (Saxena *et al*, 2003) is also incongruent, perhaps even incompatible with being truly international.

We suggest a few steps that might be taken by the *Journal* under the new Editor. First, more Editorial Board members should be recruited from low- and middle-income countries. It is likely that at least some suitable candidates from psychiatrists and researchers working in Asia, Africa and Latin America can be found if a serious search is made. Second, the *Journal* should use international relevance as a criterion in selection of articles for publication, in addition to the criterion of scientific excellence, which should remain uncompromised. Third, the *Journal* should be proactive in attracting and supporting submissions from low- and middle-income countries. This could include, for example, appointing regional Deputy Editors, launching special sections and themes (e.g. 'Psychiatry around the world', referred to by Wilkinson, 2003) and assistance with editing for authors whose first language is not English.

We believe that concrete steps like these will make the *Journal*'s aim of becoming truly international more easily achievable.

Catapano, L. A. & Castle, D. J. (2003) How international are psychiatry journals? *Lancet*, **361**, 2087.

Patel, V. & Sumathipala, A. (2001) International representation in psychiatric literature. Survey of six leading journals. *British Journal of Psychiatry*, **178**, 406–409.

Saxena, S., Levav, I., Maulik, P., *et al* (2003) How international are the editorial boards of leading psychiatric journals? *Lancet*, **361**, 609.

Tyrer, P. (2003) Entertaining eminence in the *British Journal of Psychiatry*. *British Journal of Psychiatry*, **183**, 1–2.

Wilkinson, G. (2003) How international are the editorial boards of leading psychiatry journals? *Lancet*, **361**, 1229.

S. Saxena, P. Sharan Mental Health: Evidence and Research, World Health Organization, CH-1211, Geneva, Switzerland. E-mail: saxenas@who.int

Editor's response: The points made by Drs Saxena and Sharan are well taken and, on behalf of the *Journal*, I have to plead *mea culpa* to the charge of Western parochialism. The *Journal* will take these criticisms on board and hope that readers will note a move in the direction suggested by Drs Saxena & Sharan shortly. As they say, the criterion of scientific excellence should remain uncompromised and this should remain the clearest of guides.

Peter Tyrer Editor, *British Journal of Psychiatry*, 17 Belgrave Square, London SWIX 8PG, UK. E-mail: bjp@rcpsych.ac.uk

Suicide and self-harm

What conclusions should we draw from the article by Gairin *et al* (2003) on attendance at the accident and emergency department in the year before suicide? That if you do not do your homework, you will make mistakes. Although they criticise the National Confidential Inquiry and make 18 references to it, they do not seem to know what it does.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness has been based in Manchester since 1996, covering only one of the years studied by Gairin *et al*. It was set up to identify all deaths by suicide of people who had been under the care of specialist mental health services in the previous 12 months (Appleby *et al*, 1997). Our remit (not to mention our funding) does not extend to emergency departments. Our method of case ascertainment (Appleby *et al*, 2001) is to obtain lists of suicides and undetermined deaths from the Office for National Statistics and to check these against records held by local mental health services. We then collect further information from each patient's consultant psychiatrist. Gairin *et al* seem to think that we rely on voluntary reporting by health districts.

The Inquiry has been notified of 35 000 suicides since 1996 and has collected detailed information on over 9000 people in contact with mental health services. Gairin *et al*'s assertion that we 'must record the occurrence of hospital attendances for self-harm' for all patients is a bold one, especially when it is based on five misclassified cases in one region. The issue is not whether self-harm is important, but the best way of collecting information about it in a national study. As a first step we are now carrying out a psychological autopsy study of 300 suicides by mental health patients, obtaining details of attendances in emergency departments and general practice, and interviewing the families of those who have died.

Gairin *et al* are also critical of policy makers for not recognising that self-harm is a key indicator of suicide risk. They must have missed the fact that the National Suicide Prevention Strategy for England includes a section on preventing suicide following self-harm (Department of Health, 2002).

Declaration of interest

The authors all work on the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

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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

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