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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 under-resourced 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.

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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.

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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