# Correspondence

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## Prejudice against providers of psychiatric services for Black people

**Sir:** The impression that many young Black people have a particularly negative experience of psychiatric in-patient care is confirmed by the recent study of Parkman *et al* (1997). This may well reflect the cumulative alienating effect of repeated in-patient admissions, particularly as Black people are more likely than Whites to be admitted formally under the Mental Health Act (Koffman *et al*, 1997). Koffman *et al* also confirm that Black people with a diagnosis of schizophrenia are over-represented in psychiatric units across London, and suggest in explanation that Black people may show more conspicuous disturbed behaviour and avoid or have less access to primary mental health care than Whites. The greater socio-economic deprivation experienced by Black people may also partly account for their disproportionate use of psychiatric beds.

However, individual Black patients are no more likely than Whites to be heavy users of psychiatric beds, as shown by the comparable proportion of Black and White patients who had been admitted two or more times in the preceding 12 months. This suggests that Black and White people are managed similarly by psychiatric services, and that the excess of Black people in psychiatric units is a true reflection of their need for care.

In drawing conclusions from their findings, Koffman *et al* (1997) seem therefore to place unwarranted emphasis on "the potential for discriminatory practices" and "racism" in psychiatric services, although they do acknowledge that the impact of social disadvantage on the mental health of minority ethnic groups is "beyond the scope of the NHS to influence". Disaffected and alienated Black people with serious mental illnesses are already likely to be difficult to engage in help and treatment without fuelling the prejudice that psychiatric services are racist. It may be relevant that Koffman *et al* (1997) represent, or are themselves commissioners, of mental health services. Rather than casting aspersions on those of us who are working against difficult odds to provide reasonable quality services to Black people with serious mental illnesses, commissioners might devote more time and energy to the vexed question of how scant resources for mental health care may be procured, and more effectively and fairly deployed according to need (e.g. Smith *et al*, 1996).

**Koffman, J., Fulop, N. J., Pashley, D., et al (1997)** Ethnicity and use of acute psychiatric beds: one-day survey in North and South Thames Regions. *British Journal of Psychiatry*, **171**, 238–241.

**Parkman, S., Davies, S., Leese, M., et al (1997)** Ethnic differences in satisfaction with mental health services among representative people with psychosis in South London: PRiSM Study 4. *British Journal of Psychiatry*, **171**, 260–264.

**Smith, P., Sheldon, T. A. & Martin, S. (1996)** An index of need for psychiatric services based on in-patient utilisation. *British Journal of Psychiatry*, **169**, 308–316.

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## Psychological debriefing for victims of acute burn trauma

**Sir:** Our main observation is that the study by Bisson *et al* (1997) may unfairly influence clinicians not to practise psychological debriefing (PD).

We are concerned by Bisson *et al*'s misinterpretation of the work they cite. PD has never claimed to eradicate symptoms but rather to manage them. PD techniques were not designed to be 'one off' or 'stand alone' but intended to be part of the Critical Incident Stress Management (CISM) procedure including pre-incident training, stress inoculation, defusing, demobilisation, debriefing and follow-up. PD itself was designed as a group process.

There is no mention of the total period over which the study was conducted, how many different debriefers were involved or whether or not the PD was carried out in the privacy of a side ward or in the open, shared ward environment. PD and non-PD groups cannot be realistically compared because of differences in severity of burns, exposure to previous trauma and involvement in accidents together with others as these factors introduce unacceptable bias. The PD group was obviously more 'distressed' at the outset. PD should always include previous traumatic experiences and discussion of reactions to them. It is not feasible to conduct a full PD in 30 minutes: two hours would be regarded as the bare minimum. We are not surprised that this study has found that PD may have detrimental effects under these circumstances.

In Bisson *et al*'s study there is no information as to whether the patients were pain-free or analgesia-free at the time of PD. Were the same nurses involved in both PD and painful procedures such as changing dressings, debridement, etc? If so, was their neutrality as debriefers not compromised? Was the actively intrusive burn treatment completed before PD was undertaken? If not, is it the case that the trauma was still in the process of evolution when the PD was attempted.

Our view is that PD can only be of benefit when survivors sense that their trauma is over and when they begin to feel safe again. Under the conditions described in this paper it is not surprising that burns victims were often further traumatised by detailed review of their trauma during the initial painful phase of treatment. Defusings are useful early interventions which avoid unnecessary reinforcement of traumatic memories. Sometimes several defusings may be required before PD is attempted. The phenomenon of increased symptomatology following PD is well-recognised and probably represents part of the natural process of adjustment.

**Bisson, J. I., Jenkins, P. L., Alexander, J. et al (1997)** Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, **171**, 78–81.

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