

'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.

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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 health-care 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.

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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