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The authors reply

We thank Knoop and colleagues for their comments and we are pleased that they also found high rates of chronic fatigue and related conditions in the Dutch military personnel who were deployed in a different conflict. Knoop and colleagues go on to state that it is insufficient to use conventional CBT for CFS intervention in military personnel; as our study was not an intervention study, this statement does not directly apply to our findings. We suggested a generic CBT model as a starting point but we agree it is important in the development and evaluation of an intervention, which is either completely novel or being applied to a new setting, that it takes account of illness-specific attributions, beliefs and behaviours. We would further add that these specific components should be explicit in any description of the intervention and analysable in a process evaluation (Clark, 2004). Whether a new intervention has to be designed for the psychological sequelae following every new deployment will present a challenge for researchers and for service providers trying to translate generic models to the specific setting.

Declaration of Interest

None.

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Letter to the Editor

Response to 'The social determinants of psychosis in migrant and ethnic minority populations: a public health tragedy'

Morgan & Hutchinson's (2009) timely review on the social determinants of psychosis in ethnic minority groups is the latest in a series of papers challenging the assertion that such high rates are related to 'institutional racism' in psychiatry (Singh & Burns, 2006; Murray & Fearon, 2007; Singh, 2007). A high rate of psychosis in immigrants is not a new finding, having been first reported in the 1930s by Odegaard and since then repeatedly replicated. Even some of the architects of the 'institutional racism' claim have started accepting that there is indeed a very high incidence of psychosis in ethnic minorities, calling it 'an epidemic' (McKenzie, 2007). The social aetiology of psychosis in migrants is also not novel. More than 20 years ago, a Canadian Task Force on Mental Health of Immigrants concluded that 'while moving from one country and culture to another inevitably entails stress, it does not necessarily threaten mental health. The mental health of immigrants and refugees becomes a concern primarily when additional risk factors combine with the stress of migration' (Canadian Task Force, 1988). In Britain, however, the ideological drive that places the cause of such higher incidence firmly but erroneously within psychiatric practice has led to years of neglect both of the unmet need of ethnic minorities and the political imperative needed to address the genesis of social disadvantage.

The authors also rightly point out that conflating issues around service use and access with population rates of the disorder has impeded the development of a single policy initiative aimed at reducing high rates of psychosis. However, problems of high rates and poor access are linked in as much as that the attribution of all ethnic differences to psychiatric racism has driven a wedge of mistrust between services and ethnic minority patients. Poor access to care is also related to socio-economic and cultural factors (Singh *et al*. 2007) and any strategy that deals with reducing high rates can not and should not stay divorced from actions to improve pathways into care.

Morgan & Hutchinson place the problem as occurring 'in society'. This is of course broadly correct. Deprivation in the Black Caribbean community in the UK is longstanding, stretching back to the immediate post-war period and even before. A House of

Commons Select Committee (Home Affairs Select Committee, 2007) set up to examine the causes of overrepresentation of Blacks within the criminal justice system in the UK commented that 'the first settlers in post-war Britain from the Caribbean were forced into ghettoes because of racial prejudice and restricted access to accommodation, resulting in them being stacked in deprived areas where schools were substandard, employment opportunities were minimal and long-term prospects to hold the family together were limited'. Understanding the historical roots of such disadvantage is necessary but not sufficient in offering solutions, since British society is unlikely to change suddenly or undo its past. A simplistic division of the world into oppressive society and victim minority groups risks engendering a paralysing sense of impotence and a sullen acceptance of the *status quo*. Averting the public health tragedy so eloquently described by Morgan & Hutchinson requires a concerted effort that engages minority communities in a way that the nature and magnitude of the problem is understood and accepted, mistrust between minority communities and mental health services addressed and equitable and appropriate services offered. Anything less would indeed be a tragedy.

Declaration of Interest

None.

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