

Aboriginal communities find themselves in. He, I suspect, rightly asserts that the mental health problems facing Australian Aborigines cannot be understood and worked within, without "reflecting the broader political and social issues". He also notes the positive strengths of Aboriginal people such as strong family ties and the communities increasing confidence and self-empowerment.

Given Dr Laugharne's admirable respect for context and sensitivity to cultural issues why, I must ask, has he appeared to replicate the very mistake he rightly criticised earlier well-meaning non-Aboriginal workers for making. For example, he noted how the view among those who sought the welfare of Aboriginal Australians was that "assimilation of Aboriginal people into the dominant White population was the only way forward", and that such attitudes persisted up to the early 1970s. He recognises that such attitudes marginalise and belittle the Aborigines' own culture and way of life. This is of course the attitude of the colonialist.

Yet, in his own attitude towards understanding mental health problems in Aborigines, Dr Laugharne makes no mention of the Aborigines' own beliefs and practices around mental health issues. Instead he is clear that those in his practice including himself have attempted to use "our Western model psychiatry" and in that respect he states that "I have tried to focus my energies primarily on the diagnoses and treatment of psychiatric disorders".

Surely Dr Laugharne should be aware that he is acting in the same manner as the colonialists he earlier criticised. Western psychiatry has developed through its own historical and cultural context a way of describing mental health problems and subsequently dealing with them. It is as subjective as any other belief system. To impose it on another community who are likely to have their own historical and cultural context within which they have developed their own subjective belief system concerning mental health issues and have to deal with them, has the same effect. It marginalises and belittles the value of the communities' own knowledge on this subject. Dr Laugharne should focus his energies on learning more about Aboriginal communities' own beliefs and practices around mental health issues and help them feel empowered to use this for their benefit.

SAMI TIMIMI *Consultant Child and Adolescent Psychiatrist, Child and Family Consultation Service, 250-252 Katherine Road, Forest Gate, London E7 8PN*

Author's reply

Sir: In response to Dr Timimi's comments I must firstly emphasise that I was recruited into a post within a community-controlled Aboriginal medical service which had been created under the initiative of that service. My managers were Aboriginal and frequent discussions with them made it clear to me that they wanted the best health care for their community through the best of Western medicine alongside traditional practices. My skills are in 'Western psychiatry' and this is what my Aboriginal managers and colleagues wanted from me. Furthermore, I cannot agree with Dr Timimi that Western psychiatry is merely a subjective belief system. I consider it to have a degree of scientific validity which makes it a useful discipline across cultures.

In regard to traditional approaches to healing, these were encouraged in line with the philosophy of my organisation. On several occasions families sought out traditional healers and we supported these approaches. Funds were available to facilitate this.

As I indicated in my article, other initiatives are vital to address the broader mental health issues. These include political change and specific initiatives from within the Aboriginal community such as projects I have worked alongside which are successfully addressing alcohol-related problems within the community.

It is a great challenge for today's Aboriginal communities to integrate traditional lifestyles with those of European Australia in ways which are meaningful and acceptable for them. When Aboriginal Elders choose to employ Western mental health professionals to use their skills within their communities it would smack of cultural arrogance to instead direct them to be more 'Aboriginal' in their solutions. To do so would, in my view, indicate a gross misunderstanding of the current situation.

JONATHAN LAUGHARNE, *Consultant Psychiatrist and Director of Psychiatry, Coffs Harbour Base Hospital, Coffs Harbour, NSW, 2450 Australia*

Prescriptions, licences and evidence: A reply

Sir: Mr Panting, from the Medical Protection Society, has replied to an article by myself and Professor Nutt (1998) on Off-Licence Prescribing (*Psychiatric Bulletin*, March 1999, **23**, 182) He has stated that we have reported that "the Defence Unions would not support the prescriber prescribing off-licence in the event that things went wrong". This selective quote is in danger of being misleading. In our original article it is quite clear that we believe this to be a popularly held

perception of what the Defence Unions would and would not do. At no point do we suggest that we believe that this is what the Defence Unions would or would not do. But we do indicate our dismay at responses we have had from the Defence Unions hitherto.

Mr Panting's rephrasing of the standard Defence Union response comes somewhat closer to being helpful in our opinion. He states that "broadly speaking, provided there is supportive expert opinion, then the claim will be defensible, irrespective of the wording of the drug licence". We realise that on the one hand that the whole field of medicine may be driven to an extraordinary extent by fashions and fads that have little evidence base and against this background the job of a Defence Union may be particularly difficult. We were drawing attention, however, to the hazards of relying on a supposed evidence base that underpins product licensing as a defence against members or insurers finding themselves in difficult situations. It might, perhaps, be too much to ask Defence Unions to provide an ideal response to enquiries, which would be that they are in the business of supporting physicians to do all they can for their patients.

Reference

HEALY, D. & NUTT, D. (1998) Prescriptions, licences and evidence. *Psychiatric Bulletin*, **22**, 680-684.

DAVID HEALY, *Director, North Wales Department of Psychological Medicine, University of Wales College of Medicine, Hergest Unit, Ysbyty Gwynedd, Bangor, Gwynedd LL57 2PW*

Standards of statistical presentation in the *Psychiatric Bulletin*

Sir: We were interested to read Brown's description of substance misuse habits and staff perception of them in a chronic psychosis sample (*Psychiatric Bulletin*, October 1998, **23**, 595-597), particularly the main finding that staff had a significant tendency to overestimate the rate of substance use.

We were, however, concerned about the standard of presentation of statistical findings in this paper on a number of accounts which we would like the authors to address.

In Table 3, showing the logistic regression results it was unacceptable that no correlations were presented either in the table or in the text and that the results were only presented as odds ratios. In particular it is regrettable that the odds ratio for 'living independently' as a risk factor for substance misuse was stated to be: 1.54 with

95% confidence limits of 1.01-1.32, an obvious error, we hope typographical in origin.

We are left confused about the direction of the effect which the authors describe as being one of the main findings of the study - that is, the contribution of the risk factor 'younger age' to substance misuse in this group. Whereas Table 3 describes the logistic regression data as showing younger age as a factor suggesting marginally, but non-significantly reduced risk of substance misuse (odds ratio of 0.97 with 95% confidence limits of 0.95-0.98, exhibiting a similar error to that above), the text states that the regression results are in the opposite direction, though does not detail them.

While a minor point compared to the above, we regret that in Table 2 contrasting patient reports and staff perceptions of substance misuse by χ^2 analysis, the *P* values are stated, but actual values of χ^2 are absent from both the table and text.

It appears that this paper illustrates some fairly basic errors of statistical presentation and it seems regrettable that they were not spotted pre-publication as part of the review process.

ALAN D. OGILVIE, *Consultant Psychiatrist and Clinical Scientist, and SUBHARSRI SIRCAR, Senior House Officer in Psychiatry, Department of Psychiatry, University of Cambridge, Addenbrooke's Hospital, Hills Road, Cambridge CB2 2QQ*

Sir: I am grateful to Drs Ogilvie and Sircar for allowing me the opportunity to correct the statistical errors in this paper.

Substance misuse was correlated with younger age and with living independently. The odds ratio for independent living as a factor for substance misuse was 1.32 (95% CI 1.01-1.54). The first error was a misguided attempt to clarify the data presented in the table, the second typographical. In both cases *mea culpa*. As to the form in which logistic regression results were presented, this was as requested by the *Psychiatric Bulletin*.

STEVE BROWN, *Eastern Locality Mental Health Team, Hawthorn Lodge, Moorgreen Hospital, Botley Road, West End, Southampton SO30 3JB*

Additional clinical load as a cause of stress

Sir: I read with interest the article by Guthrie *et al* on Sources of stress, psychological distress and burn-out in psychiatrists (*Psychiatric Bulletin*, April 1999, **23**, 207-212). I was amazed to find no mention of additional clinical load being a cause of stress and burn-out. Such work is