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Psychiatry and ethnic groups

SIR: In their paper on police admissions to a psychiatric hospital, Dunn & Fahy (*Journal,* March 1990, **156,** 373–378) report that for both black and white patients, "treatment does not appear to be independent of diagnosis". We recently completed a survey (Lloyd & Moodley, 1990) in the Bethlem and Maudsley Hospitals of 138 catchment-area in-patients, comparing white patients of British origin with black patients of Caribbean origin, and found important differences as well as similarities in the treatment received by these two ethnic groups in terms of types, routes, and frequency of administration of psychotropic medication, diagnosis, detention under the mental health act, and episodes of violent behaviour, self-harm and absconding. Some of these differences were dependent on diagnosis, others were not.

Black patients of both sexes were more likely to receive a clinical diagnosis of schizophrenia (Yates' $\chi^2 = 3.91$). Black patients with a diagnosis of schizophrenia were more likely to be compulsorily detained than their white counterparts matched for age and sex (Fishers exact test $P < 0.05$). Black patients with a diagnosis of schizophrenia were more likely to have been involved in a violent incident during the index admission (Fishers exact test $P < 0.05$) whereas white patients were more likely to have been involved in an episode of self-harm.

Without matching for diagnosis, significantly more black than white patients received antipsychotic drugs (Yates' $\chi^2 = 6.351$, $P < 0.05$) and depot antipsychotic preparations ($\chi^2 = 8.96$, $P < 0.01$). When matching for diagnosis, age and sex, black patients with a diagnosis of schizophrenia were no more likely to receive antipsychotic medication either orally or by depot injection than their white counterparts.

The dosages of differing antipsychotic drugs given by various routes and frequencies were converted to their equivalents in daily milligrams of oral chlorpromazine using conversion factors derived from a number of sources (Lloyd & Moodley, 1990). Without matching for diagnosis, black patients received higher oral and depot dose equivalents than their white age, sex-matched counterparts ($P > |Z| = 0.04$). These differences disappeared when patients were matched for diagnosis.

White patients who had been involved in a violent incident or were detained under the mental health act received significantly higher doses of antipsychotic medication than informal white patients who had not been involved in a violent incident ($P > |Z| = 0.0080$). This was not the case for black patients who received similar doses of medication whether formal or informal, violent or not.

This suggests that black in-patients were more likely to receive antipsychotic medication, especially depots, because they were more likely to have a diagnosis of schizophrenia. The accuracy of those diagnoses is of central importance. Even if the diagnoses are correct, black patients with a diagnosis of schizophrenia were more likely to be detained under the mental health act than their white counterparts, and to have been involved in a violent incident. It could be argued that this reflects higher levels of disturbance among the black group. Alternatively this could be due to the predominantly white staff's perception of the dangerousness of the black in-patient group. One prevalent myth we discovered while conducting this study was that many of the black schizophrenics in the hospital were "big, dangerous and chronically psychotic". In fact, there were no statistically significant differences between the two ethnic groups for age, height, weight, length of stay, number of previous admissions or length of illness from first presentation. Speculatively, it may be that myths of this sort contribute to differential access to the services and to black patients receiving more coercive means of treatment.

KEITH LLOYD
Department of Psychological Medicine
Kings College Hospital
London SE5

PARIMALA MOODLEY
Maudsley Hospital
London SE5

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HLA-DR2-frequencies in affective disorders

SIR: Rieman *et al* (*Journal,* February 1988, **152,** 296) reported on HLA-DR2-frequencies in patients with endogenous depression (bipolar and unipolar type). Seven of 11 patients studied (64%) were DR2-positive compared with a population rate of about 16% (Albert *et al*, 1984).

Serologically-detectable HLA-DR-specifities arise from genetic variation at the $DR\beta_1$-locus coding for the β-chain of the DR-antigens. Since $DR\beta_1$-cDNAs have been cloned (Long *et al*, 1983) and can be used