Although the statement agreed by our Society refers to papers on schizophrenia, the principles apply more generally to all publications in psychiatric journals. Perhaps it is time that responsible journals institute sensitive systems for evaluating papers submitted to them whenever such papers are concerned with questions of race so that their overall worth in the context of the realities of the society that we live in at present may be assessed.

SUMAN FERNANDO

Chase Farm Hospital
Enfield, Middlesex

References

BALLANTYNE, A. (1988) Young blacks vulnerable to schizophrenia. *The Guardian*, 31 October, p. 6.

HARRISON, G. *et al* (1988) A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychological Medicine*, **18**, 643–657.

JENSEN, A. R. (1969) How much can we boost IQ and scholastic achievement? *Harvard Educational Review*, **39**, 1–123.

KEVLES, D. J. (1986) *In the Name of Eugenics*. Harmondsworth: Penguin.

DEAR SIRS

This letter is a timely reminder of the need for caution and sensitivity in researching psychiatric disorders and ethnic groups. The author rightly points to the way in which biomedical scientists themselves participated in the construction of Nazi racial policy (Proctor, 1988), and to the outrageous statements on race which have been made by psychiatrists. Research into different patterns of illness in ethnic groupings *could* be undertaken for sinister reasons, and their findings may certainly be misconstrued by the general public.

However, it is unsatisfactory to accept that schizophrenia is diagnosed to a disproportionate extent among black people, while effectively calling upon journal editors to censor publication of attempts to discover why this might be the case. If we are to be deprived of research findings which can be analysed, replicated and challenged, what are the alternatives? It seems that we must rely upon assertions made by various pressure groups and upon anecdotal media reports about the scale of 'misdiagnosis' of black people.

When considering variations in rates of any illness it is, of course, important to consider differences in service utilisation and the social geography of patients included in studies (Harrison *et al*, in press). However, if differences persist after taking such factors into account, then it is in the nature of scientific enquiry to consider all possible explanations. Personally, I believe that genetic factors are relatively unimportant in relation to the higher rates of psychoses in Afro-Caribbeans. But my personal views, and for that matter those of anybody else interested in commenting upon these issues, must be subject to scientific scrutiny.

There is widespread concern that our psychiatric services should be sensitive to the needs of ethnic groups. However, it is surely naive to think that we can make sensible plans for development of services and treatments without at least attempting to measure symptoms in a standardised way and to relate treatment outcome to diagnostic profile. Services based upon vague impressions and good intentions simply will not do.

It is important to emphasise that many conditions (e.g. neural tube defects and Down's Syndrome) have substantially *lower* rates in Afro-Caribbeans. Because of the stigma attached to mental illness, findings of higher rates of schizophrenia and related psychoses call for considerable care in their interpretation.

However, to attempt to censor the findings of scientific enquiry or restrict the consideration of all possible explanations is unacceptable. It places us on an even more dangerous course which, interestingly, also has its precedents in the Nazi era.

GLYNN HARRISON

Department of Psychiatry
University of Nottingham Medical School
Nottingham

References

HARRISON, G., HOLTON, A., NEILSON, D., OWENS, D., BOOT, D. & COOPER, J. Severe mental disorder in Afro-Caribbean patients: some social, demographic and service factors. *Psychological Medicine* (in press).

PROCTOR, R. N. (1988) *Racial Hygiene: Medicine under the Nazis*. Harvard University Press.

Towards a working definition of the long-term mentally ill

DEAR SIRS

We appeal to your correspondents for examples of the above.

The Community Mental Health Centre movement pioneered in the USA is accused of having neglected the needs of long-term mentally ill (LTMI) people and of having drifted towards the care of patients more immediately responsive to treatment. Attempting to learn from this lesson, the mental health team operating from this office in Battersea (DEW) was established with a brief to give priority to LTMI patients. Over the past three years we have established a case-management style of working, an outline of which is given below. This way of dealing with patients is expensive as compared with traditional out-patient care or CPN care, because of the requirement for regular multidisciplinary review and because of the time consumed in preventing drop-out. We wish to reserve it for LTMI patients while continuing to treat acute or minor disorders in the cheaper, traditional out-patient setting. To divide our work in this way, we need a working definition of the LTMI patient. The literature offers little that is adaptable to our use. Bachrach (1988) proposes the admirable principle that definitions of the LTMI should include three parameters: diagnosis, duration and disability. Most research criteria are too exclusive for use in a service setting. We are working with the following definition which we offer here for comment.

DEW definition of LTMI patients 1988

Any one of the following specifies inclusion in the LTMI category:

(a) two or more years continuous contact with psychiatric services – including out-patients
(b) depot medication prescribed
(c) ICD diagnosis 295.X or 297.X
(d) three or more in-patient admissions in past two years
(e) three or more day-patient episodes in past two years
(f) DSM-III "Highest level of adaptive functioning in past year" rating 5 or more.

Having allocated a patient to this category, we specify the following minimum intervention for his keyworker:

DEW case management checklist for LTMI patients (1988)

(a) He cannot be allowed to drop out of follow-up.
(b) We perceive him as a patient needing regular review in a multidisciplinary discussion. (Specifically, out-patient care by one person or CPN care by one person is unlikely to afford him the best that this district can offer.) He therefore must be regularly reviewed in community team meetings.
(c) We foresee major problems of poor motivation in attempting to provide him with community support. For this reason assertive outreach, including personal help with attending appointments or events, is appropriate.
(d) Subject to his consent, one member of the team must make a home visit. (Home visits are the norm for patients with psychoses but some of the very disabled neurotic LTMI patients are longstanding out-patients and have not, in the past, been seen at home.)
(e) If he moves into the intensive care of another agency we must maintain contact, at least at three month intervals.
(f) If he refuses both our service and social services intervention, we will jointly attempt some follow-up via families, neighbours or friends, at least at three month intervals.

DEW is using the LTMI definition and the case-management checklist in a service context. We have neither the rigorous intake criteria of a research project nor the three year time scale of many demonstration projects. Consequently, we use the definition in a rough and ready manner. Over the passage of years some patients change unexpectedly. A few whom we have designated LTMI have made surprising recoveries and achieved discharge. A few others have eluded our most strenuous efforts to maintain three monthly contact. Nevertheless, we find the definition a serviceable tool for our purposes and should welcome a debate in your columns about its refinement.

ELIZABETH K. MCLEAN
JUDITH A. LEIBOWITZ
Doddington Edward Wilson Community Mental Health Team
311 Battersea Park Road
London SW11 4LU

Reference

BACHRACH, L. L. (1988) Defining chronic mental illness: a concept paper. *Hospital and Community Psychiatry*, **39**, 383–388.

MIND Special Reports

DEAR SIRS

It must appear churlish for an author to write to your journal to complain about a favourable review of his work by a learned professor of psychiatry (*Psychiatric Bulletin*, November 1988). However, in his positive review of the MIND Special Report *ECT Pros: Cons and Consequences*, Professor Brandon chose to cast slurs unsupported by reason or argument against other unspecified Special Reports in the MIND series. For his information there are four other Special Reports: *Minor Tranquillisers: Hard Facts Hard Choices*, *Anti-depressants: First Choice or Last Resort*, *Major Tranquillisers: The Price of Tranquillity*, and *Lithium Therapy: Questions of Balance*.

MIND Special Reports are based on close readings of the relevant literature, advice from eminent academics and practitioners in the field and on the experiences and views of the people who receive the treatments in question. I strongly suspect that Professor Brandon has not read the Special Reports which he dismisses so lightly. I challenge him to do so in order that I may learn from his reasoned