

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.

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#### 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 psy-

choses 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.

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#### *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