the Townsend score based on the 1991 census as a measure of deprivation, and the number of people with limiting longstanding illness was taken from the 1991 census. We compared the relation found with the relation between deprivation and mortality in 0-64 year olds for the years 1982-91.

Whereas linear regression suggested that only 21% of the variation among wards in standardised mortality ratios in 0-64 year olds could be explained by deprivation, it suggested that deprivation explained 66% of the variation among wards in standardised limiting longstanding illness in 0-64 year olds. Also, the difference in standardised longstanding illness between the most and least deprived fourths of wards was larger than the difference in standardised mortality (table).

Relation between deprivation and standardised mortality ratio and standardised longstanding illness ratio in 0-64 year olds

	Standardised mortality ratio	Standardised longstanding illness ratio
Most deprived fourth	108	128
Second fourth	86	92
Third fourth	87	85
Least deprived fourth	83	80

The relation between deprivation and longstanding illness in Worcester and District Health Authority seems to be much stronger than that between deprivation and premature mortality. If this is true in other areas it would be sensible to use standardised longstanding illness ratios instead of standardised mortality ratios in the formula for resource allocation.

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Gradient between north and south remains

EDITOR,—It is surprising that Margaret Eames and colleagues occasionally mentioned, but did not incorporate in their abstract or their section on the "implications for the *Health of the Nation*," the overall geographical finding that premature mortality increases steeply from the south to the north of England.¹ The differences in regional mortality have been fairly constant for at least the past 30 years^{2,3} and the search for reasons for and solutions to the north-south divide is surely one of the greatest challenges to medical and public health research. The omission was particularly disappointing in view of the new finding of the paper that variations in deprivation account for some, but not all, regional variations in premature mortality (and hence the north-south gradient). The paper implies the need to target not only improvements in health care but also improvements in social and material circumstances in the north more than the south, but these implications were omitted.

Two additional points arise from the paper. Firstly, the authors seem to have attributed to individual people an overall average characteristic of an area (the ecological fallacy). Thus the authors state: "Although, intuitively, increasing affluence may not be expected to have a continual effect on mortality, this was not seen in the dataset." However, the measures of affluence (or, rather, its inverse, deprivation) are composed of percentages—for example, the percentage unemployment—in a given area and therefore a continuous relation would be expected. The authors thus seem to imagine, wrongly, that in electoral wards (which are highly heterogeneous with respect to deprivation

of individual people) the deprivation measures used in some sense describe the deprivation of all the residents.

Secondly, the attempt to show that the prevalence of smoking explains north-south variation in mortality from diseases related to smoking was inadequate and should have been omitted. If two regions have values at opposite extremes and the 12 others show little variation this cannot support, even crudely, a hypothesis about general north-south variation.

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Supervised discharge of mentally ill people

EDITOR,—We endorse Robert Buglass's comments¹ concerning recommendations for the care of mentally ill people in the community.² In particular, we share his concern that, in its present form, supervised discharge may not be an advance on current guardianship arrangements.

We recently conducted a postal survey to determine the attitudes of consultant general psychiatrists working with adults in the Oxford region towards the proposed new legal powers (supervised discharge, extended leave of absence, and guardianship). Part of the questionnaire was adapted from a survey into attitudes towards community supervision orders.³ After five weeks there had been a 71% (37/52) response rate.

Supervised discharge—Thirty four of the 37 respondents stated that they would be prepared to use the new legislation regarding supervised discharge, though 19 of them had reservations. Respondents were offered eight possible reasons that might make them reluctant to use supervised discharge. Three aspects caused concern: supervised discharge would generate an increased workload, for which resources are not available (25/37); there is no sanction on the patient if he or she does not comply (24/37); and supervised discharge would be used instead of properly resourced community care (20/37). Several respondents commented that the legislation would not be appropriate for patients lacking insight (for example, those who did not see the need to take regular medication to keep them well).

Extended leave of absence—Thirty one respondents were prepared to use an extension of leave of absence from six months to one year, but 12 respondents did not think that this would be a useful option. Reservations were expressed about the coercive nature of the legislation and the possibility that it might be abused. Several respondents commented that if it was necessary to keep a bed available for the patient on leave the proposal would be impractical. Again respondents stated that this option could not replace adequately resourced community care programmes.

Guardianship—The reasons for the unpopularity of current guardianship arrangements are unclear. We offered seven possible reasons for not using it. Three presented problems for practitioners: there is no way of enforcing provisions if the patient is unwilling (33/37); guardianship arrangements do not ensure that patients receive the care they need (25/37); and it is difficult to gain access to the patient if he or she is unwilling (25/37).

We acknowledge the difficulties that the Department of Health faces in drafting new legislation; the differing views held both between and within interested parties must be taken into account. In addition, treatment of patients in the community without their consent may contravene the European Convention on Human Rights and has therefore been rejected as an option.

In conclusion, supervised discharge increases the responsibility on mental health workers to ensure assertive follow up of seriously mentally ill people who find it hard to accept the treatment they need. This may help identify patients earlier in a relapse. There is a risk, however, that the public and other groups will assume that supervised discharge offers new powers to keep people well in the community. In fact there are no new powers, and these patients still have to deteriorate and then be readmitted compulsorily before they can receive the treatment they need.

We thank the consultants for completing the questionnaires.

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Bed sharing and smoking in the sudden infant death syndrome

EDITOR,—R Scragg and colleagues report that if a Maori mother smokes and shares her infant's bed the infant's risk of dying of the sudden infant death syndrome is increased.¹ Their suggestion that bed sharing increases the risk of the syndrome even in the absence of maternal smoking, however, needs to be considered with caution. In the authors' previous report the relative risk associated with bed sharing in Maoris was 1.4, and this was after allowance for potentially confounding variables, including maternal smoking.²

Studies in several countries have reported ethnic differences in mortality from the sudden infant death syndrome, and the lower incidence of the syndrome among Asians compared with other groups in Britain has recently been recognised.³ Our survey of 374 mothers (172 Asian, 202 white) attending our antenatal clinic in west Birmingham showed pronounced differences in the infant care practices of the two groups despite similarities in social class and housing.⁴ We found that 162 (94%) Asian infants slept in their parents' bedroom in the first year compared with 123 (61%) white infants ($p < 0.0001$), and three times as many Asian infants as white infants slept in the parental bed (62 (36%) v 22 (11%)).⁴ A random sample of 156 mothers (72 Asian, 84 white) from this population showed that 30 (36%) white mothers smoked compared with two (2.8%) Asian mothers.

Thus white mothers are more likely to smoke but much less likely to share their infant's bed. Nevertheless, white infants have twice the mortality from the sudden infant death syndrome of Asian infants.³ Our observations therefore do not support Scragg and colleagues' hypothesis that bed sharing (even in the absence of maternal smoking) increases the risk of the syndrome. Moreover, Scragg and colleagues failed to find a positive relation between paternal smoking and the risk of the sudden infant death syndrome. Gantley *et al* showed, however, that Bangladeshi men in Britain smoke much more than other Asian men, yet their infants have a similar (equally low) mortality