Anti-therapeutic community mental health law

Chief medical officer defends the Mental Health Bill

EDITOR,—Nigel Eastman's editorial seems deliberately to present the Mental Health (Patients in the Community) Bill in the most negative possible light.¹ I would like to redress the balance. Eastman says that the bill "attempts to substitute legal rules for resources." The increased resources devoted to the care of mentally ill people are a matter of record, and I will not repeat it here. But the assertion simply does not stand up. The purpose of aftercare under supervision is defined as being to ensure that the patient "receives the after-care services provided for him." You cannot have the supervision without the services—surely just the reciprocal principle that Eastman says the bill eschews.

Eastman misrepresents the importance of the power to convey a patient to a place "for medical treatment, occupation, education or training." The therapeutic relationship, which he rightly underlines, must remain crucial, but the power to convey a patient provides an important backstop when the patient temporarily withholds cooperation and may be placing himself or herself at risk. We do not believe that doctors and other professionals will want to abuse such a power, and its limited nature will itself tend to ensure that.

The exclusion of compulsory medication in the community reflects the view of the Royal College of Psychiatrists and others consulted by an internal review in 1993² and also the government's legal advice on the effect of the European Convention on Human Rights. This has confirmed that the bill's provisions are fully consistent with the convention. If a patient does not cooperate with the care plan the bill ensures that consideration will be given to his or her readmission to hospital under the existing act.

The voluntary principle remains the basis of care for the overwhelming majority of mentally ill people. Supervised discharge was put forward in the 10 point plan as one element in a comprehensive strategy.³ This also includes professional education, which Eastman favours, and Department of Health officials are working closely with the royal college on training in these areas.

Eastman says that radical revision of the Mental Health Act is needed. How long will that take, and what should be done meanwhile about those patients who risk being lost to care? Rather than ignore the bill, as Eastman urges, I think that most psychiatrists will prefer to keep an open mind and use the new powers for patients who they believe

can benefit from them as part of a comprehensive package of care.

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- 1 Eastman N. Anti-therapeutic community mental health law. *BMJ* 1995;310:1081-2. (29 April.)
- 2 Department of Health. *Legal powers on the care of mentally ill people in the community: report of the internal review*. London: DoH, 1993.
- 3 Department of Health. *The ten point plan*. London: DoH, 1993. (Press release H93/908.)

National Schizophrenia Fellowship is highly critical of government's proposals

EDITOR,—Nigel Eastman cites the National Schizophrenia Fellowship, representing carers, as the only relevant body not heavily critical of the government's Mental Health (Patients in the Community) Bill.¹ It is unfortunate that the fellowship is widely seen to support the bill when in fact it is highly critical of the proposals—in particular, that the bill targets one group of patients at the expense of others who are also severely mentally ill and need adequate aftercare and that no further money is to be provided except to pay for the extra mental health review tribunals, which will be the only means of appeal open to patients subject to "after-care under supervision."²

My brother has been treated for schizophrenia for the past 25 years, and I am in touch with many other patients and their families. I cannot see how the proposed legislation could help any professionals or their patients. As for relatives (commonly referred to as carers), under the 1983 Mental Health Act the "nearest relative" has legal powers to apply for, or prevent, a patient's admission to hospital as well as a legal power to discharge the patient from hospital. The proposed additions to the act deny the relative any legal power so that, in the community, a patient subject to aftercare under supervision would be totally under the control of the statutory authorities.

While agreeing with Eastman's opinion of the bill, I do not agree with him that the 1983 Mental Health Act is out of date and needs radical revision. It seems to me that the present act is being scapegoated to justify its widespread misuse. What is needed is respect for, and use of, the law as it stands.

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- 1 Eastman N. Anti-therapeutic community mental health law. *BMJ* 1995;310:1081-2. (29 April.)
- 2 Silberston D. Mental Health (Patients in the Community) Bill. *NSF Today* 1995 Apr:4.

Medical schools and racial discrimination

Comparison between medical schools is unjustified

EDITOR,—The issue of 25 February contains two papers^{1,2} (we were coauthors of one³) and an editorial⁴ on the disadvantage of medical school applicants from ethnic minorities. We are con-

cerned about some points in the paper by Aneez Esmail and colleagues.¹

Firstly, applicants from ethnic minorities have lower mean A level grades and a longer tail of lower grades.² The stratification used by the authors is therefore ineffective for the group with lower A level grades since the lower grades of applicants from ethnic minorities make them more likely to be rejected on that basis alone. The only interpretable data are those from the smaller subset of applicants with high A level scores.

Secondly, the authors calculate an odds ratio and 95% confidence interval for each medical school. Multiple significance testing with an unadjusted $P < 0.05$ level ensures ($P = 0.76$), however, that one or more of the 28 schools will have a confidence interval excluding unity. Testing for heterogeneity suggests significant differences between schools ($\chi^2 = 49.3$, 27 df, $P < 0.01$).⁴ Removal of the school with the most significant result and retesting until remaining schools are homogenous ($P > 0.05$) suggests that only five schools had odds ratios significantly different from 1, in four cases being less than unity (that is, applicants from ethnic minorities were more likely to be accepted). The authors' suggestion that "some medical schools could be accused of practising discriminatory policies" should perhaps acknowledge that positive discrimination is also illegal under the Race Relations Act 1976.

Thirdly, Esmail and colleagues' conclusions are based on acceptances, which are difficult to interpret since applicants apply to several schools but can be accepted only at one. The odds ratios are therefore not statistically independent, and their confidence intervals are too narrow by a factor of about two (since applicants make about four applications). Calculations with revised confidence intervals show no heterogeneity between schools ($\chi^2 = 12.31$, df=27, NS). Any significant differences would not have been interpretable since discrimination by schools is confounded with preference by applicants from ethnic minority groups for particular schools. We emphasise that this problem does not apply to our current or previous studies, which analysed offers rather than acceptances.⁵

To summarise, although we ourselves concluded that applicants from ethnic minorities are disadvantaged in applications to medical schools for several complex reasons, we are concerned that the league tables presented by Esmail and colleagues are open to severe methodological criticism. In the circumstances it is unjustified that comparisons were given between identified schools, which inevitably received substantial publicity in the popular press.

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- 1 Esmail A, Nelson P, Primarolo D, Toma T. Acceptance into medical school and racial discrimination. *BMJ* 1995;310: 501-2. (25 February.)
- 2 McManus IC, Richards P, Winder BC, Sproston KA, Styles V. Medical school applicants from ethnic minorities: identifying if and when they are disadvantaged. *BMJ* 1995;310:496-500. (25 February.)
- 3 McKenzie KJ. Racial discrimination in medicine. *BMJ* 1995; 310:478-9. (25 February.)
- 4 Rosenthal R. *Meta-analytic procedures for social research*. London: Sage, 1984.

Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.