use preferable to the National Assistance Act (1948), and to 'persuasion' or even deception that undoubtably does occur in this difficult clinical situation.

However, it was not the intention for the assessment and treatment sections of the MHA to be used to facilitate residential care for patients with dementia, and controversy over the use of section 47 of the National Assistance Act (1948) and guardianship orders indicates that none of the available legislation adequately provides for this group. The recent Royal College of Psychiatrists' proposals for a community supervision order and the Department of Health's response (supporting greater use of guardianship orders, extended leave of absence on a section 3 and a new form of supervised discharge) is concerned primarily with ensuring the continuing psychiatric treatment of patients with recurrent psychotic illness following discharge from hospital (Bluglass, 1993). None of these proposals addresses the need of demented patients which is usually 24-hour social care rather than psychiatric treatment. One option would be a new 'care order' which would enable demented patients to be looked after more satisfactorily while still providing protection of civil liberties, but we suggest that it would be preferable for the role of the existing guardianship order to be extended and made more explicit. We believe this would lead to a greater consensus over the application of legal powers to this very needy and extremely vulnerable group of patients.

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Antidepressant prescribing among referrals to a community mental health unit in New Zealand

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This study involved a case-note review of referrals to community psychiatric services in a university town in New Zealand. About one third of all 163 patients referred were taking antidepressants for depression; of these one third were taking therapeutic doses, with the remainder taking inadequate doses. This tends to confirm the findings of other studies that have identified problems relating to GP prescribing of antidepressants.

In the UK, increased interest in depression in the setting of general practice has led to the recent Defeat Depression campaign.

As long ago as 1973, the correct prescribing of antidepressants by general practitioners (GPs) was questioned with inadequate doses being one of the main problems. Johnson (1973) recommended that more active supervision of treatment was needed by GPs and a

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high frequency of consultation was desirable. Recent recommendations suggest a dose of 125–150 mg daily of tricyclics (Paykel *et al*, 1992). Indeed, in some hospital patients, or outpatients under specialised care, it may be necessary to increase this to 300 mg daily for up to six weeks (Quitkin, 1985).

For many years in New Zealand, access to primary health carea has involved a consultation fee set by the GPs. For adults in full-time employment this is around $30 NZ. People on social welfare usually receive a subsidy and pay about half this. Prescription charges also vary depending upon income, $15 NZ an item being the standard charge.

This study began while I was working as a registrar in community mental health in Hamilton, a university town in the North Island of New Zealand. The Psychiatric Services are sectorised. Unlike the GP services, patients are not charged for appointments. The area covered was Hamilton East, this has a population of approximately 100,000 with a roughly equal split between urban and rural populations. The area has a higher than average Maori population (18% Maori single origin or Maori descent) and a younger age composition than the national average. It has a strong agricultural and service industry base (Waikato Area Health Board, 1991).

The aim of the study was to look at GP referrals to Hamilton East with a diagnosis of depression (DSM-III) who were receiving antidepressants and determine whether dosage and treatment were adequate.

The study

A retrospective review of referral requests and case-notes was undertaken.

All GP referrals between June and December (inclusive) 1992 were identified using referral request letters and case-notes. Where necessary, a follow-up call to GPs was made. A number of patients did not attend for assessment, and a number of referrals were redirected at the referral stage. In a number of cases, patients were on a higher dose of antidepressants than stated in the referral request when assessed by the community mental health team; where this was so the higher dose was recorded. The issue of compliance was not addressed, as information regarding this was scanty.

Findings

There were 163 referrals; of these 55 satisfied DSM-III criteria for depression and were said to be taking antidepressants. Of these 55, 36 (65%) were women with an age range of 19–60, (35%) were men with an age range of 25–56.

Of the 55 patients on antidepressants, 48 (87%) were said to be taking tricyclics, the remaining seven were taking fluoxetine (3) and moclobemide (4) at therapeutic doses. Of the 48 patients taking tricyclics, 16 were on 100 mg daily or more with 11 of these 16 taking 150 mg or more. The remainder were taking less than 100 mg, including 22 taking 50 mg or less. Thirty-seven per cent of patients on tricyclics were prescribed dothiepin, 19% amitriptyline and 19% amoxapine and the remainder were on different tricyclics.

Comments

These results tend to confirm that inadequate doses of antidepressants are prescribed by GPs in a large proportion of patients referred to a community mental health service in New Zealand.

It is possible that, for a number of patients, the financial burden of visiting their GPs regularly leads to a low consultation rate. This is clearly of concern, as not only will the drug defaulting rate be higher (Johnson, 1973) but other important treatment options, including psychological treatments and social interventions, may be neglected (Scott & Freeman, 1992). Further research is needed to address these issues and to look at length of treatment and drug compliance in the primary care setting in New Zealand.

It may be that psychiatrists and drug representatives should play a more active role in the education of primary care GPs in an attempt to improve their antidepressant prescribing practice.

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