

the domiciliary clinic was a failed patient contact when attending the home.

Of course, the elderly and general adult populations are not necessarily comparable. One of us (DL) subsequently piloted a similar domiciliary clinic for the 16–64 years age group specifically because the non-attendance rate for new referrals to the hospital clinic over the previous six months was 53%. For the following six months, new out-patient referrals who would have been seen in the hospital clinic were visited at home. The non-attendance rate fell to 15%.

It appears that visiting patients at home is another effective method of reducing non-attendance and has the advantage that the psychiatrist can directly observe the patient's home circumstances. From an efficiency point of view the limiting factor is time spent travelling to patients' homes and efficiency savings may not be realised where distances are large. The services described are inner city and adjacent districts of Liverpool that may be similar to the Sheffield service described by Rusius, who notes that the average distance between patients' home and hospital was only 3.7 miles. The average distance travelled in the elderly domiciliary clinic was 12.6 miles per clinic seeing an average 2.7 patients per clinic.

Experience indicates that patients like the domiciliary arrangements. Jones *et al* (1987) found that 72% of new general adult psychiatric referrals stated a preference for home visiting and only 12% for out-patients or general practice clinic. Eighty per cent felt assessors had gained a better idea of their difficulties because they were seen at home.

JONES, S. J., TURNER, R. J. & GRANT J. E. (1987) Assessing patients in their own homes. *Psychiatric Bulletin*, **11**, 117–119.

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Progress in defeating depression

Sir: I note that one of the tasks of the Defeat Depression campaign as described by Priest *et al* (*Psychiatric Bulletin*, August 1995, **19**, 491–495) is public education, and that 90% of their sample "thought that depressed patients should be offered counselling." It is not clear from the discussion that follows whether they regard this as evidence of ignorance or as a valid request for services for depressed people.

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Sir: The answer to Dr Kraemer's question is found in the consensus statement on which the Campaign is based (Paykel & Priest, 1992). Psychological (non-drug) treatments have an important place in the armamentarium of treatments that we propose for depression. Cognitive therapy in particular deserves attention.

We did not regard the attitude revealed in this answer as worrying. What did concern us, however, was that the majority of respondents regarded antidepressants as addicting. I am pleased to say that there has been a significant improvement in this answer in a more recent survey. Nevertheless, it is probably still the case that, where the patient and the doctor agree that a course of antidepressants is called for, the doctor should make it very clear to the patient that addiction is not a problem with antidepressants. Non-compliance is a serious hazard when medication is prescribed for depression, and many patients probably give up their antidepressant prematurely because they are afraid of becoming dependent on it.

PAYKEL, E. S. & PRIEST, R. G. (1992) Recognition and management of depression in general practice: consensus statement. *British Medical Journal*, **305**, 1198–1202.

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Sexism or pragmatism?

Sir: We read with interest the article by Hall and Deahl on the inadequacies of history taking by trainee psychiatrists in casualty (*Psychiatric Bulletin*, September 1995, **19**, 538–540). While we agree that efforts are merited to increase alcohol and substance abuse histories in all groups, we disagree that this discrepancy is likely to represent ageist or sexist attitudes. The OPCS survey (Goddard, 1991) of drinking habits in the late 1980s (quoted in part in Hall & Deahl's article), found that 23% of men and 8% of women exceeded sensible drinking levels (21 units for men and 14 units for women). Excess drinking showed a decline with increasing age in both sexes. Based on these figures, if a full alcohol history had been taken in all cases at least a further 5.3% of men and 3.4% of women would have been identified as exceeding sensible drinking levels. The recording of disorders more likely