described: migrants were prescribed anxiolytic drugs more frequently while being less likely to be referred to psychotherapy (Charalabaki et al. 1995) and received neuroleptics more often (Lloyd & Moodley 1992).

We examined all charts of migrants admitted to the psychiatric clinic during 1993 and 1994 with respect to sociodemographic factors, diagnosis, and treatment factors. 263 admissions of migrants were recorded, which make up about 8% of all admissions. 58% were male, 42% female. The place of origin was Turkey in 19% of the cases, ex-Yugoslavia in 14%, 19% came from other West European countries, 16% from Eastern Europe, 14% from the Near East, 6% from the Far East, 5% from Africa and 6% from Latin- and North America. In 42% of the cases the diagnosis was a schizophrenic disorder, while only 11% received the diagnosis of a depressive disorder, 4% a bipolar disorder and 6% a diagnosis of a stress or adjustment disorder with depressed mood. The mental status on clinically relevant psychopathology showed that 32% of all admissions had psychotic symptoms, 29% had depressive symptoms, and 19% had psychotic and depressive symptoms.

With respect to psychopharmacological treatment, 49% received high-potency neuroleptics, while only 13% received antidepressants. While only 15% of the cases with psychotic symptoms did not receive high-potency neuroleptics, 77% of those with depressive symptoms did not receive antidepressants. Anxiolytics were used in 25% of the cases, mostly in combination with high-potency neuroleptics. Low-potency neuroleptics were prescribed in 49%' of the cases, also mostly together with high-potency neuroleptics.

There seems to be a tendency to diagnose a schizophrenic disorder when psychotic symptoms are present, while a depressive disorder seems to be underdiagnosed when correlated with the psychopathology. Correspondingly, the use of high-potency neuroleptics correlate with the presence of psychotic symptoms, while depressive symptoms seldomly lead to antidepressant use. As migrants are becoming more common in Europe, this study points to the necessity of becoming more familiar with transcultural aspects of psychopathology and optimizing the psychopharmacological treatment, especially antidepressant treatment.

WHY DO DOCTORS PRESCRIBE PSYCHOACTIVE DRUGS IN PRIMARY CARE? RESULTS OF AN INTERNATIONAL STUDY

S. Kisely [1], M. Linden [2], C. Bellantuono [3], G. Simon [4].
[1] *Department of Public Health, University of Manchester, UK;*
[2] *University Clinic, Free University of Berlin, Germany;*
[3] *Department of Medical Psychology, University of Verona, Italy;*
[4] *Centre for Health Studies, Group Health Cooperative, Seattle, USA*

Objective - To determine the factors associated with the use of psychoactive drugs by general practitioners.

Design - A multicentre cross-sectional design using a two-stage stratified sampling strategy.

Setting - Primary care facilities in 15 different countries.

Subjects - 1763 consecutive GP attenders aged between 16 and 65 years of age.

Main outcome measures - Antidepressant, anxiolytic, hypnotic and overall psychotropic drug prescription

Results - Diagnosis was only one determinant in the prescription of psychotropic medication. Although antidepressants tended to be used for depressive disorders, and anxiolytics for patients with anxiety, the differential diagnosis was otherwise not an important factor in prescribing behaviour. Older age and female sex were independently associated with prescription. Several other factors emerged when individual classes of medication were considered; these included the loss of a spouse and the absence of physical ill health in the case of antidepressants, and unemployment in the case of anxiolytics. The style of health service delivery was strongly associated with the pattern of psychoactive drug use. Antidepressants and anxiolytics were prescribed between two and three times more frequently in client centred clinics following a 'personal physician model' as opposed to non client centred settings where care was less personalised (odds ratios of 3.4 and 1.9 respectively). The reverse was true of hypnotics (odds ratio of 0.4)

Conclusions - Social factors are at least as important as clinical features in the prescription and choice of psychotropic medication even allowing for potential confounding factors. The appropriateness of some of these prescriptions may be questionable given the lack of association between their use and symptom severity. The growing cost of such medication suggests the importance of education and training to ensure that medication is appropriately targeted.

DIAGNOSIS AND TREATMENT OF PSYCHIATRIC DISORDERS IN PRIMARY HEALTH CARE

The ICD-10-PHC (Primary Health Care) Multicenter Field Trial in German Speaking Countries. *Silke Kleinschmidt, Angela Schürmann, Heidi Müssigbrodt, Horst Dilling*

Participants of the ICD-10-PHC Field Trial of the World Health Organisation in German speaking countries were asked to assess the new classification and to give information about their daily work. Although the data is biased by a certain selection of participants (e.g. interest in training sessions) the 93 general practitioners (37% female, 63% male) in 8 field trial centers showed a wide range in terms of age distribution, work experience and interest in psychological problems. The majority of participants thought that psychiatric diagnosis is of high importance in general practice (94%) but they felt quite insecure about their diagnostic abilities concerning psychiatric disorders (low degree of security 39.8%, moderate 52.7%). Only 14% of the GP's had any experience with the ICD-10 classification system. They achieved an interraterreliabilty of 0.8 (kappa) using the ICD-10-PHC for the diagnostic assessment of patients in video training sessions. The percentage of own patients suffering from psychiatric disorders was assessed as high (< 10%: 11%, < 20%: 27%, < 30% 23.7%, > 30%: 27%). The percentage of patients with e.g. depressions was even higher (> 30%: 37.6%). This could lead to the conclusion, that GP's are able to identifie specific syndroms but do not identifie them as psychiatric disorders. Another explanation would be that there is a high comorbidity of psychological problems in primary care. These and other data about e.g. rate of drug prescriptions, referrals to psychiatrists and social institutions will be shown.

DO GENERAL PRACTITIONERS DISCRIMINATE AGAINST PATIENTS WITH SCHIZOPHRENIA?

Stephen M. Lawrie. *Edinburgh University Department of Psychiatry, Edinburgh, EH10 5HF, Scotland*

Objective - To examine general practitioners' attitudes to patients with schizophrenia.

Method - A random sample of primary care physicians were alternately sent a case vignette of a patient with or without schizophrenia, in an otherwise identical clinical abstract, and asked to indicate their level of agreement with fifteen statements based on it. The median score on each statement was compared between the two groups of doctors with the two-tailed Wilcoxon Rank Sum test.

Results - Doctors responding to the vignette of the patient with schizophrenia were significantly less willing to have the patient on their practice list ($p = 0.0002$), more likely to refer them to a specialist ($p < 0.0001$) and more likely to think that they would be violent ($p = 0.002$); whereas there was no difference in the perception of how much time the patients would take up ($p = 0.4$).

https://doi.org/10.1016/0924-9338(96)88801-8 Published online by Cambridge University Press

Conclusions - This controlled trial of primary care physicians' attitudes towards patients with schizophrenia amounts to an empirical demonstration of medical discrimination against the sufferers of this and potentially of other long term psychiatric disorders. Psychiatrists and general practitioners should share care in the management of schizophrenia and try to overcome the prejudices against such patients in an attempt to improve their overall clinical care.

PSYCHIATRY IN TRINIDAD AND TOBAGO: A REVIEW

Rampersad Parasram. *St. Ann's Hospital Port-of-Spain, Trinidad West Indies*

Significant developments in psychiatry since 1950 are traced. Difficulties experienced in the transition from institutional care to community care, and changes in psychiatric morbidity patterns over this period are discussed. The new thrust in community care, as a consequence of recent health policy and reform is presented. It is concluded that the success of this new thrust is dependent on adequate resource allocation, intersectoral collaboration and reorientation of health services.

NR5. Depression and dementia in the elderly

Chairmen: M Prince, M Philpot

THE PROGNOSIS OF DEPRESSION IN OLD AGE: THE MELBOURNE STUDY

D. Ames, E. Chiu, K. Bennetts, N. Allen, T. Layton, K. Kingston, S. Harrigan, R. Yeatman, P. Ruth, L. Kramer. *University of Melbourne, Department of Psychiatry, Royal Park Hospital, Private Bag No 3, Parkville, Victoria 3052, Australia*

Controversy persists regarding the prognosis of depression in old age. Recent studies indicate that it is probably no worse than that of depression earlier in life. Many studies lack the statistical power to assess the impact of predictive variables on outcome and have excluded patients with non-major depressions about whom little is known. We aimed to assess over 200 patients aged 65 and above presenting to psychiatrists for treatment of depression. Patients had to be presenting to psychiatric services for treatment of a new depressive episode and had to meet one of DSM-III-R, ICD10, or AGECAT criteria for depression including depressive adjustment disorder and non-major depressions. They were interviewed with the Geriatric Mental Status Schedule and a range of other instruments. Follow-ups were conducted after 1 year and 3–4 years.

224 patients (mean age 75.1 ± 6.8, 64% female) were studied. 78 were inpatients in public psychiatric hospitals, 57 were inpatients in private psychiatric hospitals, 15 were inpatients in general hospital psychiatry units, 30 were liaison referrals in general and geriatric wards and 43 were outpatients or community referrals. 150 had DSM-III-R major depression but only 46 were experiencing their first episode; 13 more were bipolar. 177 met ICD10 criteria for a depressive episode and 16 for bipolar illness. There were 132 cases of AGECAT depressive psychosis and 64 of AGECAT depressive neurosis. 55% had suffered their first depression after the age of 60; this was a more common finding in the liaison group. Liaison patients had suffered more life events, while outpatients had milder depressions. A median of 4 weeks was spent in hospital. Private patients spent less time in hospital than public patients but were readmitted more often in the ensuing year.

At one year 25% of the sample had been continuously well and 7% had recovered after one or more relapses; 14% were depressive invalids, 16% were relapsed, 19% were continuously ill, 5% demented and 12% dead. Liaison patients and those with more physical illness were more likely to have bad outcomes, especially death. No other variable was a strong predictor of outcome. 3–4 year follow-up will soon be complete. So far 51% of those followed up are dead, 21% have been continuously well, 11% are depressive invalids, 3% are relapsed, 8% have been continuously ill and 5% are demented. Variables which may predict 3–4 year outcome will be fully analysed prior to the conference.

Late life depression treated by psychiatric services in Melbourne is most often recurrent, characterised by a fluctuating course with disabling residual depressive symptoms in the majority of subjects with a high death rate and a risk of dementia which does not seem to be much greater than that of the background population.

IS DEPRESSION TREATABLE IN A DISABLED ELDERLY POPULATION? A RANDOMISED CONTROLLED TRIAL

S.S. Banerjee, K. Shamash, A.J.D. Macdonald, A.H. Mann. *Section of Epidemiology and General Practice, The Institute of Psychiatry, London SE5; Section of Old Age Psychiatry, UMDS (Guy's Campus), London SE1*

Objective: To investigate the efficacy of psychogeriatric team intervention in treating depression in an elderly community-dwelling disabled population receiving Home Care.

Design: Randomised controlled trial with blind follow up six months after recruitment.

Setting: The community in Lewisham, South East London.

Subjects: 69 home care clients aged 65 or over with case level depression as defined by the GMS/AGECAT system. 33 were randomised to the Intervention Group (IG) and 36 to the Control Group (CG).

Interventions: Each member of the IG received an individual package of care formulated by the community psychogeriatric team which was implemented by a researcher working as a team member. The CG received normal GP care.

Main outcome measure: Recovery from depression (GMS/AGECAT case at recruitment to non-case at follow-up)

Results: Analysing the data on an intention to treat basis, 19 (58%) of the IG recovered compared with only 9 (25%) of the CG, a difference of 33% (95% CI 10 to 55). This powerful treatment effect persisted after controlling for possible confounders using logistic regression, with members of the IG nine times more likely to have recovered at follow-up compared with the CG (odds ratio 9.0; 95% CI 2.0 to 41.5).

Conclusions: Depression is treatable in the elderly Home Care population; therapeutic nihilism based on an assumed poor response to treatment in the socially-isolated, disabled elderly in the community is not justified.

THYROXINE AUGMENTATION OF FLUOXETINE TREATMENT FOR RESISTANT DEPRESSION IN THE ELDERLY: AN OPEN TRIAL

Yoram Barak, Daniel Stein, Joseph Levine, Aliza Ring, Jack Chadjez, Avner Elizur. *Abarbanel Mental Health Center, Bat Yam, Israel; Affiliated to the Sackler School of Medicine, Tel Aviv University, Israel*

Drug resistant depression is a confounding entity. More so in populations of elderly depressives where addition of lithium or

https://doi.org/10.1016/0924-9338(96)88801-8 Published online by Cambridge University Press