

had not taken medication for their symptoms on more than one occasion.

The validity of these exclusions warrants further consideration. It is acknowledged that the exclusion of those whose depressive disorder is associated with alcohol and/or drugs, or with concomitant physical illness and injury, is consistent with DSM-IV guidelines, but we agree with Paykel (2002) that the DSM-IV 'assigns separate unjustified categories of medical and substance-induced mood disorders'. At the very least the exclusion of persons with such comorbidity, which is common in clinical practice, would result in an appreciable underestimate of depression. In this regard it is of interest that the CIDI even excludes pregnancy as a 'physical condition that can cause symptoms', although it is reassuring that the probe guidelines acknowledge that 'pregnancy is not a physical illness'!

The exclusion of those who considered their symptoms to be trivial risks the omission of those who tend to deny the significance of their symptomatology and who have poor mental health literacy. Indeed, there are data that have demonstrated that the mental health literacy of those in the community who have major depression is no more conducive to identifying depression and recommending its treatment than it is in those without depression (Goldney *et al*, 2001). Therefore, the exclusion of those who believe their symptoms are trivial is not necessarily supported by existing evidence.

Exclusion of those who sought treatment but who had not taken medication more than once is also liable to underestimate the prevalence of depression. Poor mental health literacy and the presence of side-effects which may militate against medication use are but two reasons why those with major depression would be excluded by this criterion.

Each of these exclusion criteria is open to interpretation and we doubt whether many researchers, let alone the average clinician, would be aware of this potential for the CIDI to underestimate the prevalence of depression. Weich & Araya noted correctly that prevalence surveys were designed to provide data for local health planners, but Vicente *et al* observed that planners may well distrust studies when there are marked differences in results.

We have expressed concern about the use of CIDI-derived prevalence figures for depression in Australia, as they could

underestimate by at least half both the financial burden on the community and potential service requirements (Goldney *et al*, 2004). It is probable that these exclusion criteria explain the majority of the difference in the results of the two Chilean studies. We trust that health planners in Chile and elsewhere are aware of the potential for underestimation of depression in studies using the CIDI.

#### Declaration of interest

R.D.G. has received honoraria, been on advisory boards, and has received grants from Bristol-Myers Squibb, Janssen-Cilag, Lundbeck, Organon, Pfizer Australia, Sanofi Synthelabo and Wyeth Australia. G.H. received financial support from Pfizer Australia, Bristol-Myers Squibb Australia and Wyeth Australia.

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#### Compulsory community treatment and admission rates

We fully agree with Kiskey *et al* (2004) that the patients receiving compulsory community treatment are often relatively young, male, single, Black or from a minority ethnic group, unemployed and with a history of schizophrenia, drug use, previous admissions and forensic contact. They

obviously are more severely unwell and more liable to be readmitted than are those who are treated without compulsory treatment orders (CTOs). Therefore, it would have been more appropriate to compare the patients on CTOs with individuals whose applications for CTOs were not granted by the family courts (as in New Zealand), or who were discharged by the Mental Health Review Boards (as in Australia).

In our experience, a patient's non-adherence with treatment is a common reason for the psychiatrist to consider compulsory treatment in the community. In this respect, the clinical experience of psychiatrists in New Zealand has been satisfactory as 69.2% reported that CTOs were a useful tool for promoting community treatment for people with mental illnesses (Currier, 1997). On the other hand, there is a paucity of conclusive findings and qualitative research into the experience of patients, carers and professionals regarding compulsory community treatment, with respect to how it may impact upon civil liberties and, in particular, future engagement with mental health services (Moncrieff & Smyth, 1999), which is of concern.

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**Author's reply:** As Robinson & Mahmood point out the crucial issue in our paper is the comparability of those patients who were on community treatment orders (CTOs) and those who were not. Although we controlled for sociodemographic variables, clinical features, case complexity and psychiatric history, we fully acknowledged in our paper that there may have been additional factors that we could not control for in the analysis. These might include social disability, aggression not resulting in a forensic history, medication