non-psychiatric medical problem (Shapiro *et al*, 1984). Identification of this large population of untreated, but potentially treatable, group of depressed patients by primary care providers would help reduce the impact of this major health problem. Estimates of the failure rates of primary care physicians in the detection of depression range from 45% to 90% (Eisenberg, 1992).

In screening for depression in primary care and psychiatric settings, computers offer several advantages over both clinician-, and paper-and-pencil-administered tests. Computer-administered tests are more reliable, due to the standardisation of administration. Computers are not hurried, and do not forget to ask pertinent questions. Computers reduce, or free, clinicians' time, making them cost effective and time efficient. Errors due to scoring or data entry are eliminated, and results can be scored and presented to the physician immediately. In addition, patients may be more likely to disclose information of a sensitive nature, such as suicide, to a computer (Greist *et al*, 1974).

With the increased use of personal computers, computer-administered applications will become increasingly more common in both psychiatry and general medicine. The availability of valid and reliable computer-administered measures for the assessment of depression can be a valuable tool in assisting the primary care physician with the identification and treatment of this disabling disorder.

EISENBERG, L. (1992) Treating depression and anxiety in primary care: closing the gap between knowledge and practice. *New England Journal of Medicine*, **326**, 1080–1083.

GREIST, J. H., GUSTAFSON, D. H., STAUSS, F. F., *et al* (1974) Suicide risk prediction: a new approach. *Life Threatening Behavior*, **4**, 212–223.

HAMILTON, M. (1960) A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry*, **23**, 56–62.

KOBAK, K. A., REYNOLDS, W. M., ROSENFELD, R., *et al* (1990) Development and validation of a computer-administered version of the Hamilton Depression Rating Scale. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, **2**, 56–63.

SHAPIRO, S., SKINNER, E. A., KESSLER, L. G., *et al* (1984) Utilization of health and mental health services: three epidemiologic catchment area sites. *Archives of General Psychiatry*, **41**, 971–978.

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Community Treatment Order in Australia

SIR: The recent mauling by a lion of a young man in London with a chronic psychosis has quite rightly reopened the debate on the pros and cons of a Community Supervision (or Treatment) Order (CTO) as part of an amendment to the Mental Health Act.

Having recently returned (temporarily) from Victoria, Australia, where I worked for over two years in an increasingly community-orientated post near Melbourne, I would like to comment on the operation of their CTO which was introduced in the Victorian Mental Health Act (1986).

It soon became clear to me that the CTO was not used a great deal, but that most psychiatrists agreed that it had an important place in the community management of those patients with chronic psychoses who suffer from severe loss of volition and energy, lowered motivation, limited insight, and consequent poor cooperation with their treatment plans. The CTO is especially useful as a means of persuading patients to accept depot neuroleptics or some form of day care on a regular basis. It has very similar provisions to a Hospital Treatment Order, so that it is known from the outset by all concerned that if the patient is non-compliant he/she will be returned to hospital (revocation of the CTO) after receiving the written authority of the treating consultant.

There is, of course, an obvious potential for abuse, but interestingly this is not an issue that patients' rights groups have taken up with vigour. As with in-patients on Treatment Orders, there is the safeguard of automatic, regular review by the Mental Health Review Board (independent review tribunals). The latter's annual reports indicate very few instances of unjustified community 'detention'.

I would like to recommend close scrutiny of the Victorian CTO system in order to ascertain the extent to which it may be applicable and acceptable to the public and health professionals in Britain.

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Insight in psychosis

SIR: I read with interest the study by David *et al* (*Journal*, November 1992, **161**, 599–602) regarding measurement of insight in psychosis. While agreeing that concepts such as the relabelling of events as pathological, and the recognition of having a psychiatric or nervous illness are integral to the concept of

insight, I would doubt the wisdom of including compliance in any scale designed to measure insight. I was interested that such a high correlation between insight on the Present State Examination (PSE) scale and compliance was found. My experience of conducting a survey of patients' knowledge of medication on long-stay psychiatric wards suggested that there was little relationship between patients' willingness to comply with medication, and the degree of insight that they displayed as to their need for the medication or their having a psychiatric illness (McPherson *et al*, 1993).

This study, conducted on a long-stay population with mean age 63 years, showed an overall extremely poor awareness of medication and its actions, but a willingness to take medication, which did not correlate with the individual's own views as to whether they had a psychiatric illness or not.

As has previously been observed (McAvoy *et al*, 1989), many patients will comply with treatment while not regarding themselves as ill. This appears to be particularly so in hospitalised patients with chronic psychosis and therefore inclusion of compliance in a measure of insight will lead to erroneously elevated scores in these individuals.

While I would agree wholeheartedly with David *et al* that educating patients about their illness and treatment is a vital part of psychiatric practice and should never be neglected, I do not believe that compliance is, *per se*, an indicator of insight; increasing insight may lead to increased compliance, but compliance does not equate with insight.

McAvoy, J. P., Apperson, J. & Appelbaum, P. S. (1989) Insight in schizophrenia: its relationship to acute psychopathology. *Journal of Nervous and Mental Diseases*, **177**, 43–47.

McPherson, R., Double, D., Harrison, D., *et al* (1993) Long-term psychiatric patients' understanding of neuroleptic medication. *Hospital and Community Psychiatry*, **44**, 71–73.

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Down's syndrome, longevity, and Alzheimer's disease

Sir: In reply to my correspondence (*Journal*, November 1992, **161**, 722), Dr Harrison implies that there may be a differential association between the aetiological origin of Down's syndrome (trisomy, translocation, or mosaic form) and any resulting Alzheimer-type pathology; and "this could be tested by a combination of cytogenetics and subsequent neuropathological analysis" (*Journal*, February 1993, **162**, 276). Review of the literature already sheds light on such a provoking idea.

Many individuals with complete trisomy 21 (and therefore triplication of the APP gene) do not develop Alzheimer-type dementia (Wisniewski *et al*, 1985). Although the majority of pathological findings have been in proven cases of complete trisomy 21, cases of Alzheimer-type changes have been described in mosaic forms of Down's syndrome (Whalley, 1982; Sylvester, 1986; Rowe *et al*, 1989), and in individuals with 21/22 translocations (Sylvester, 1986). In such cases, overexpression of the APP gene is unlikely. The role of cytogenetics in the development of dementia in people with Down's syndrome, therefore, remains complex.

The establishment of a national case register of people with translocated and mosaic forms of Down's syndrome is recommended by the author. Subsequent access to a large sample population of the uncommon forms of Down's syndrome would prove invaluable in the future investigation of Alzheimer's disease, both in the general, and Down's syndrome population.

Rowe, I. F., Ridler, M. A. C. & Gibberd, F. B. (1989) Presenile dementia associated with mosaic trisomy 21 in a patient with a Down syndrome child. *Lancet*, *ii*, 229.

Sylvester, P. E. (1986) The anterior commissure in Down's syndrome. *Journal of Mental Deficiency Research*, **30**, 19–26.

Whalley, L. J. (1982) The dementia of Down's syndrome and its relevance to aetiological studies of Alzheimer's disease. *Annals of the New York Academy of Sciences*, **396**, 39–53.

Wisniewski, K. E., Wisniewski, H. M. & Wen, G. Y. (1985) Occurrence of neuropathological changes and dementia of Alzheimer's disease in Down's syndrome. *Annals of Neurology*, **17**, 278–282.

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Association of schizophrenia and Duchenne muscular dystrophy

Sir: We want to report a case of association of schizophrenia and Duchenne muscular dystrophy (DMD). DMD is a lethal, recessive, X-linked disease leading to a progressive muscle degeneration and wasting: 90% of the patients die before the age of 20 years (Emery, 1987). It is caused by mutations in the dystrophin gene, which codes for a protein localised in skeletal muscle and in the brain, located at Xp21 segment (Hoffman *et al*, 1988). The association of DMD and schizophrenia is apparently rare since we have found only two previous reports (Dubowitz & Crome, 1969; DeLisi & Crow, 1991).