patients who will not utilise such facilities and also of those who may wish to utilise them.

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Australian depression

SIR: It does seem better to be treated for depression in Australia (Lee & Murray, *Journal*, July 1989, **155**, 123–124). In our cohort there were 22 patients who presented with depression but in whom the final diagnosis made on the index episode was either schizophrenia, schizoaffective disorder, or organic psychosis. They were not included in any further follow-up studies. It is fortunate that we made the correct diagnosis at the beginning of the study.

We agree that we misinterpreted the first paragraph on p. 746 of Lee & Murray (1988). To be strictly comparable, we should have excluded our nine unnatural deaths from the bottom line of the first part of our Table IV. When we do so, the pattern of clinical criteria outcome for the remaining Sydney patients is more favourable, but the comparison with the Maudsley patients ($\chi^2 = 2.35$, d.f. = 2, NS) remains non-significant. The second part of the table remains unaltered, and on the Lee–Murray criteria the Sydney patients did do better. Thus the conclusions drawn from Table IV (Kiloh *et al*, 1988) remain unchanged: being admitted to hospital in 1970 for depressive illness was, even in Australia, an event of serious import.

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Obstetric liaison

SIR: We were most impressed with the description given by Appleby *et al* (*Journal*, April 1989, **154**, 510–515) of the establishment of an obstetric liaison clinic. However, while appreciating that the main focus of their work was the identification of those women at risk for post-natal depression, we were nevertheless disappointed that they did not take a broader view in their discussion of further directions for the service, particularly in relation to substance misuse.

The catchment area served by their unit has a high prevalence of illicit drug users. Following the development of a Community Drug Team (CDT), we have witnessed an increase in the number of women presenting for treatment, with 38% of our total patient population being women, one-third of whom were caring for one or more children. This contrasts with a quarter of our patient population being women in previously published reports from our unit, and with the national figures from the Home Office Addicts Index (1989), in which 29% of new addicts in 1988 were female.

In the past two years, we have seen 20 pregnant women addicted to opiates in a cohort of 372 addicts who have been resident in the CDT catchment area (population 213 000). This indicates an annual incidence rate for pregnant opiate addicts of at least 4.0 per 100 000 catchment population, or 3.0 per 1000 births.

During this same period, we have witnessed the rapid spread of HIV through the drug-using population. The advent of HIV has increased the necessity to draw this high-risk population into contact with services. The ante-natal clinic, labour ward, and post-natal ward are areas where drug users are already being seen, although often without identification (or with late identification) of their drug problems. Staff in these services should make more of the opportunities for earlier identification and intervention.

There is now a pressing need for closer links between drug services and obstetrics services in an effort to limit the vertical spread of HIV and to provide appropriate support and help. The psychiatrist in the obstetric unit will be a vital link in this