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EDITORIAL

Defeating depression

Some years ago, the Royal College of Psychiatrists conducted a campaign aimed at increasing the recognition and effective treatment of depression. The battle continues.

Physicians and others working in geriatric medicine are in the front line of this battle because of the high prevalence of depressive illness in the old people they see. Prevalence is particularly high in acute medical wards [1, 2] and among old people with chronic physical illness and disability in the community [3]. Despite some evidence that depression in people with physical illness responds to pharmacological treatment [4] and that depression is linked to poorer prognosis and increased consumption of health service resources in medically ill patients [5], detection rates are low and effective treatment is relatively rare [6]. The basic facts about the prevalence and treatment response of depressive disorders in older people have been known for some time. Antidepressants work as well as many treatments in medicine, yet they are under-used. Psychological treatments of proved efficacy are even less well used in the older age group. Simple methods of detection have been available for years.

Scales for detecting depression

A number of scales are available to assist in the detection of depression [7–12] but they are not applied systematically, even in high-risk populations where they are likely to be particularly useful. The developers of a brief observer-rated screening scale reported in this issue of *Age and Ageing* [13] believe that such a scale may be used more routinely because it does not involve asking questions and makes systematic the recording of observations that nurses often make. The scale has potential.

What obstacles might prevent the new scale from producing change?

There may still be some prejudice. Old people are perhaps expected to be miserable and, if their mental pain occurs in the context of physical illness and/or social deprivation, it may be regarded as secondary and not worthy of medical treatment. This would be analogous to not providing analgesia for physical pains on the grounds that we understood the underlying cause! Treating the underlying physical illness and helping to alleviate social deprivation cannot be ignored; but neither should we ignore the mental pain of depression.

Another reason for under-treatment may be lack of personal experience and commitment. The slow onset of action of antidepressants in older people [14] prevents many hospital doctors from seeing the transforming effects that these treatments can have. When we talk about evidence in medicine, we usually refer to the systematic knowledge gained from research but we should also be aware of the personal knowledge that comes from experience. I have seen many lives changed, often markedly, for the better as the result of antidepressant treatment; but how many physicians, in busy modern practice, have time to see the benefits of starting such treatments? The same arguments can be applied to psychological therapies, but these are even less likely to be part of the everyday experience of the physician. Alongside personal experience of the benefits of detecting and treating depression, goes a personal commitment to do the best each of us can for each individual patient. Again, rapid turnover and lack of continuity of care in contemporary hospital practice may reduce the opportunities for good practice.

Medical training puts a higher value on the detection and treatment of physical illness than on the detection and treatment of mental disorder. The doctors who spend most time with inpatients are often relatively junior and studying for exams, in which the emphasis is more on body than mind. The pressure that nurses work under and the increasing use of 'bank' and agency staff may make them less likely to provide continuity, and they too may tend to view physical care as of higher value than emotional care. When patients are 'sleeping out' and the pressure is always to keep length of inpatient stay to a minimum, depression may be missed or seen as an unwelcome complication to be ignored if possible.

How can we overcome these obstacles?

We need continually to recognize and deal with prejudice. Medical and nursing education must emphasize the importance of mental disorders and their interdependence with physical illness. Training and supervision in delivering evidence-based psychological therapies should be more widely available. Perhaps the content of exams needs to be reviewed. Exposure to a few successful cases of recognition and treatment of depression in ill old people is needed both to overcome medical and nursing prejudices and to build up the necessary personal positive experiences to change practice. Between one-quarter and a half of older acute inpatients will suffer from depression. Do you know which patients under your care have depressive disorder?

A commitment from every physician reading this editorial to identify patients with untreated depression, treat them and monitor response would produce an

important change in outcomes. A commitment to work systematically with nurses to ensure that all patients are assessed for depressed mood and that depression, when detected, is adequately treated could continually transform the outcome of inpatient care for many patients. It might also incidentally improve physical prognosis and reduce readmission rates for physical disorder. The systematic use of one of the self-rating scales or the observer-rated scale reported in this issue could be a foundation for such a change.

Initiatives like clinical governance and managed care give all of us the opportunity to put the detection and management of depressive disorders in patients with physical illness on the map. A systematic rating of mood with appropriate action when depressed mood was found could become part of every medical admission (or outpatient consultation) for older adults. Old age psychiatry services can help with these systematic changes as well as dealing with severe, hard-to-diagnose or complicated cases. Emerging liaison old age psychiatry services may be able to help more directly in programmes to detect and manage depression in medical inpatients.

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