

Practical Management of
Depression in
Older People

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Getting the measure of depression in old age

John P. Wattis

Introduction

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Depression, impairment, disability, handicap and social factors

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Introduction

Depression is a disabling and sometimes fatal illness in old people. Those who suffer from it report that severe depression changes life completely. It affects behaviour, relationships, emotions, motivation, thinking, sleep and other somatic functions. The person who could mix well socially suddenly becomes isolated and reclusive. Everything is too much trouble. Personal appearance is neglected and the capacity for enjoyment is attenuated or disappears. Appetite is down, food is not enjoyed and weight is lost. Often sleep is disrupted and waking early in the morning may be compounded by diurnal variation of mood. Severe depression reduces motivation and slows mind and body. Often it distorts thinking and even memories, resulting in pre-occupation with negative themes such as poor physical health, guilt, self-reproach and unworthiness. Agitation sometimes complicates depression

and may paralyse the patient's capacity to make decisions or manifest itself in constant seeking for comfort and reassurance. Weepiness is more common in women than men but is often reported indirectly by friends, relatives and carers since the patient may feel she has to conceal her true feelings from strangers. Depression may be fatal indirectly through its interaction with physical illness or directly as a cause of suicide.

Suicide rates for men are higher than for women in a variety of cultural settings and in all age groups. Male suicide rates show two peaks: one in young adulthood and one in old age (Snowdon 1997). The rate in young men has been rising markedly in some cultures but in most settings the peak for old men remains higher. Young male rates in a recent study in the UK from an inner city environment have shown a young male suicide rate higher than that for older men (Neeleman *et al.* 1997).

Apart from its impact on individuals and their families, depression also has a major impact on the health and social services. Depression is associated with increased mortality (Murphy *et al.* 1988, Pulska *et al.* 1999) and depression is more common amongst elderly acute medical inpatients (Burn *et al.* 1993), among disabled isolated elders (Prince *et al.* 1997b) and in residential settings (Mann *et al.* 1984). It contributes to morbidity, mortality and increased usage of non-psychiatric medical services (Beekman *et al.* 1997). Depression may become more prevalent with increasing age, probably because of an association with disabling and handicapping physical conditions (Roberts *et al.* 1997). Perhaps partly because of this, it is much more likely to lead to the need for inpatient care. Factors which may contribute to the relatively high hospitalization rate for depression in old age may be summarized as follows:

- factors related to the severity of the depression – including problems in early diagnosis and treatment;
- suicide risk;
- living alone – 31% men and 58% women over 75 years live alone;
- loneliness;
- associated physical illness and disability; and
- association with cognitive impairment in some.

People with depression tend to be heavy consumers not only of inpatient psychiatric facilities but also of inpatient general hospital beds and, in the community of mental health, primary care and social services. No detailed analysis has been made of the economic impact of depression in old age. One comparative study found that dementia was the most expensive disorder per sufferer in terms of services used but that those with depression were also high users of health services. Despite presenting to health services (often 'in disguise!') most depression remains untreated. The most significant predictors of service cost in a multivariate analysis were living alone, being physically ill, depression, dementia and increasing age (Livingston *et al.* 1997). Depression stands out as a treatable but relatively untreated condition leading to high consumption of health resources.

In this chapter the prevalence of depression in old age and its associations with other diagnoses, disabilities, handicaps and social factors is considered.

Depressive disorder is essentially treatable but under-diagnosed and under-treated in many different settings (Baldwin 1988, Koenig *et al.* 1988, Murphy *et al.* 1988, Green *et al.* 1994, Snowdon *et al.* 1996) and its higher prevalence in particular groups makes people in those groups ideal candidates for early detection and intervention. We will also therefore briefly consider instruments used for screening, diagnosing and measuring outcome in depression.

Classification and definitions

The major international system for classifying diseases (ICD-10 – World Health Organization 1992) groups all mood disorders together under seven main categories as follows:

- F30 – manic episode;
- F31 – bipolar affective disorder (includes recurrent mania);
- F32 – depressive episode;
- F33 – recurrent depressive disorder;
- F34 – persistent mood disorder;
- F38 – other mood disorder; and
- F39 – unspecified mood disorder.

Each category is subdivided according to severity (mild, moderate or severe) and the presence or absence of psychotic symptoms. There are also coding provisions to record the presence or absence of 'somatic' symptoms (anhedonia, mood worse in the morning and early morning waking). This generates up to 30 different categories for depression, though in practice some are more common than others.

Unfortunately, the need for consistency in diagnosis can generate very complicated rules. For example a diagnosis of depressive episode rests on the following:

- (a) The syndrome must be present for at least *2 weeks*, there must be no history of mania and the depression must not be attributable to organic disease or psychoactive substances (the difficulty of this will become evident when we examine associations with physical illness in more detail).
- (b) At least *two* of the following three symptoms must be present:
 - (1) Depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and for almost every day, and largely uninfluenced by circumstances.
 - (2) Loss of interest or pleasure in activities that are normally pleasurable
 - (3) Decreased energy or increased fatigability
- (c) At least *four* of the following symptoms:
 - (1) Loss of confidence or self-esteem.
 - (2) Unreasonable self-reproach or excessive and inappropriate guilt.
 - (3) Recurrent thoughts of death or suicide; suicidal behaviour.

- (4) Complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation.
- (5) Change in psychomotor activity with agitation or retardation (either subjective or objective).
- (6) Sleep disturbance.
- (7) Change in appetite.

To be classified as moderate, at least *six* of the symptoms under section (c) must be present and to meet the criteria for severe depression all three from section (b) and at least *five* from section (c) (at least *eight symptoms from (b) and (c) in total*). *Depressive episodes* (F32), whether or not occurring in the context of *recurrent depressive disorder* (F33), are perhaps our main concern in this volume. However, *dysthymia* (F34.1) is also important. It describes people whose outlook is persistently depressed but whose depression is not sufficiently severe or acute in onset to be described as a depressive episode. Anxiety symptoms are often prominent. The relationship between dysthymia and depressive disorder is not exclusive. Dysthymia may follow or complicate a depressive episode and it is not always clear that they represent different conditions either in terms of causation or treatment.

Epidemiologists and others who research into the relationships between depression and other conditions in old age often must resort to less complicated definitions. The main diagnostic classifications (and the rating scales developed from them) have largely been developed in relation to younger adult patients and may not always be applicable to older adults (Weiss *et al.* 1986). In addition epidemiologists have to employ case-finding instruments which may be *mapped* on to diagnostic systems but may employ variable definitions of 'caseness'. *Pervasive depression* has been used as a term to define a level of caseness that defines depression of a type and severity likely to warrant medical or psychological intervention. Depression in epidemiological studies is diagnosed using instruments such as the Geriatric Mental State (GMS) (Copeland *et al.* 1976) examination or the Comprehensive Assessment and Replacement Evaluation (**Short-CARE**) (Gurland *et al.* 1984) schedule. Sometimes self-assessment measures such as the Geriatric Depression Scale (GDS) (Herrmann *et al.* 1996), the Brief Assessment Schedule for Depression in the Elderly-Cards (**BASDEC**) (Adshead *et al.* 1992) or the Hospital Anxiety and Depression (**HAD**) (Zigmond and Snaith 1983, Kenn *et al.* 1987, Wattis *et al.* 1994 a, b) scale are used. The correspondence between the categories produced by these latter scales and the more rigorous categories of the **ICD-10** (World Health Organization 1992) and the American Diagnostic and Statistical Manual (DSM-IV) (American Psychiatric Association 1994), is at times sketchy but even the simplest self-assessment scales like the HAD measure something that can properly be described as depression and that responds to treatment.

Prevalence of depression in older people

Here we need to distinguish carefully between overall prevalence and the prevalence of depression in subgroups who for one reason or another are

at higher risk of developing or continuing to suffer from depressed mood. For example, a large-scale epidemiological study using the GMS (Saunders *et al.* 1991) has shown that having *ever* been a heavy drinker (for a period of at least 5 years) increases the relative risk of depression in old age fourfold. These associations are often complicated and difficult to tease out. Overall, *pervasive depression* probably affects around 12 or 13% at any one time (past month 'point' prevalence) (Gurland 1976), but only about 2–3% older people have a depression that would meet the categoric criteria for *depressive episode*. There has long been conflict of opinion about whether depression is more or less common with increasing age. A recent study showed that prevalence of depression increased over the age of 80 years but that this was mostly associated with chronic health problems and functional impairment rather than a direct effect of ageing (Roberts *et al.* 1997) We will now examine the prevalence of depression in different settings, in different ethnic groups, the effect of depression upon mortality, and in association with different illnesses, social factors, disability and handicap.

Depression in different settings

In residential homes (Mann *et al.* 1984) and hospitals (Burn *et al.* 1993) depression is two or three times more common than in the community. An Italian study shows a very high prevalence of 20% 'major' depression, 4% dysthymic disorders and 13% 'atypical' depression in a geriatric day hospital where there was no distinct old age psychiatry service (Turrina *et al.* 1992). A UK study, using the GMS, of people in receipt of Home Care services found the prevalence of depression to be 26%, half of it severe and often not recognized (Banerjee 1993). A follow-up study of older medical inpatients showed that, when physical illness was controlled for, those who were depressed before discharge saw physicians more frequently, were more often hospitalized and more often needed nursing home care than controls without depression (Koenig and Kuchibhatla 1999).

Depression, culture and ethnicity

There have been few studies of the symptomatology, prevalence or outcome of depression by race. One relatively large-scale study suggests there is at least little difference in symptomatology between African-Americans and non-African-Americans (Blazer *et al.* 1998). A European study using the same case-finding methods in a number of different countries found a wide variation in prevalence from 9% in Iceland to 24% in Munich. The difference was even marked between two UK cities, London (17%) and Liverpool (10%) (Copeland *et al.* 1999). Explanations for these differences are only speculative at present.

Depression and mortality

Overall, point prevalence of depressed mood (mostly DSM-III dysthymia) did not predict mortality amongst the elderly in the community when other factors such as high age, gender, smoking, disability, somatic illnesses and number of medications taken was controlled for (Pulska *et al.* 1997). However, depression persisting over 5 years was associated with increased mortality (Pulska *et al.* 1999). Also, given the associations between heart disease and cancer and depression discussed later, there remains a question as to how logical it is to control for physical illness which is itself associated with disability and depression. Another, hospital study, reported later (Herrmann *et al.* 1998) does show an association between depressed mood (measured dimensionally using the HAD) and increased mortality.

Depression and physical illness

One carefully controlled large-scale ($n = 1286$) study with a 4-year follow up has recently shown that older people who report depressive symptoms are at higher risk of subsequent physical decline in simple tests of motor function (odds ratio 1.55; 95% CI 1.02–2.34) (Penninx *et al.* 1998b). For medical inpatients ($n = 454$), high depression scores on the HAD were associated with mortality at 22 months (multivariate odds ratio 1.9; 95% CI 1.2–3.1, $p < 0.01$) (Herrmann *et al.* 1998). Another study of outcome for depressed hospitalized patients with physical disability showed that, on average 47 weeks after discharge, generally depression and disability varied together (Koenig and George 1998), furnishing further evidence of the strong links between depression and disability in old people that will be explored further later. An interesting ethnic difference emerged in this study in that black people tended to have a better outcome for mood regardless of whether or not physical disability improved.

In a Finnish community study, coronary heart disease, physical disability, and widowhood or divorce were associated with self-reported depression in men. In women the association was between history of clinical depression, physical disability and the use of angiotensin-converting enzyme inhibitors and current depression (Ahto *et al.* 1997). A prospective hospital-based study in the USA of people having elective cardiac catheterization for coronary artery disease showed that at the time of catheterization self-reported physical function differed by the number of arteries stenosed, and observer-rated baseline anxiety and depression quartiles. Deterioration in physical function at 1 year was associated with baseline anxiety or depression but not with baseline artery status. Surgical or medical treatment seemed to neutralize the effect of coronary stenosis on physical function at 1 year but not the negative effect of baseline anxiety or depression (Sullivan *et al.* 1997).

Another large-scale study ($n = 4825$) has shown that, after controlling for

other known risk factors, depressed mood persisting over 6 years increased the hazard ratio for developing cancer to 1.88 (95% CI 1.13–3.14). This risk was consistent across most kinds of cancer and was not confined to cigarette smokers (Penninx *et al.* 1998a).

A thorough evaluation of 277 patients from 3 to 4 months after an ischaemic stroke (Pohjasvaara *et al.* 1998) found DSM-III-R major depression in 26% and minor depression in a further 14%. Major depression with no explanatory factor apart from stroke was present in 18%. Analysis showed that dependency in daily life was associated with an increased risk of depression (odds ratio [OR] 1.8; 95% CI 1.1–3.1) with an even greater association with major depression (OR 2.9 95% CI 1.6–5.5). Previous episodes of depression were also associated with a markedly increased risk of post-stroke depression. Another survey of stroke and hip fracture survivors living in private households found high levels (41%) of HAD depression or anxiety and of severe or very severe disability (57%). Not surprisingly there was a strong association between severe disability and anxiety ($p < 0.0005$ OR not given) and severe disability and depression ($p < 0.0001$). These authors also looked at the impact of social contact and found that there was a strong association between social contact and lower prevalence of anxiety ($p < 0.01$) or depression ($p < 0.0001$) (Bond *et al.* 1998). Caregivers also may become anxious or depressed following a stroke in the person they look after. Survivors of stroke and their relatives were asked at 6 months to complete the General Health Questionnaire (GHQ – a measure of emotional distress) and the HAD. Over half the carers were in the abnormal range on the GHQ. Caregivers were more likely to be depressed if the patients were severely dependent or emotionally distressed themselves ($p < 0.01$, OR not quoted) (Dennis *et al.* 1998).

A community survey of over 400 elderly people without dementia also found a general association between gait slowing, heart disease and chronic lung disease and self-reported depressive symptoms and poor life satisfaction. In all conditions except heart disease, the effect appeared to be mediated through disability (Broe *et al.* 1998).

Depression is common, though notoriously difficult to diagnose, in Parkinson's disorder (PD). Symptoms such as cognitive slowing (bradyphrenia) are hard to distinguish from psychomotor retardation. One study found major depression in 16.5% and dysthymia and other forms of depression in 25.7% of patients with PD. Low abilities in activities of daily living correlated with the diagnosis of depressive disorder and with high scores on the Hamilton Depression Rating Scale (an observer rating scale commonly used in trials of antidepressants) (Liu *et al.* 1997).

A review of depression in dementia estimated 17–30% of patients have depressive symptoms. Depression-related behavioural problems in patients with Alzheimer's dementia are distressing to caregivers. This is reflected by a prevalence of over 75% of depressed mood in those caring for patients with

both dementia and depression (Teri 1997). A study of over 1000 older people in a district of Stockholm, Sweden found a surprisingly high prevalence of dementia (28% by DSM-III-R criteria). More importantly for present purposes it found that the prevalence of major depression at around 12% was around three times higher than in the non-demented. Increased disability was associated with major depression in both demented and non-demented subjects (Forsell and Winblad 1998). A French incidence study in which 397 older people with subclinical cognitive impairment were followed up over 3 years found 11% developing dementia without depression and 5% dementia with depression. Those with dementia plus depression showed significantly greater decrements at 3 years in dressing, washing, use of the telephone and continence (Ritchie *et al.* 1998).

Depression, impairment, disability, handicap and social factors

Conditions such as depression produce impairments of function that result in a loss of ability (disability). The social response (or lack of response) to this can produce handicap. Depression is very common in selected groups of old people with a variety of disabling illnesses (and in those caring for them). Depression is often associated with increased disability and the direction of causality may be both ways. There are also hints in the studies cited above of a protective effect against depression through social contacts. This takes us back to the now classic study by Murphy on the social origins of depression in old age (Murphy 1982). She found an association between severe life events, major social difficulties, poor physical health and the onset of depression. Working class subjects had a higher incidence of depression and this was associated with both poorer health and greater social difficulties. Lack of a confiding relationship (associated with life-long personality traits) increased vulnerability to depression. A more recent large-scale study failed to support some of these findings but it clearly demonstrated a link between declining health, increasing disability and the onset of depression (Kennedy *et al.* 1990). Further clarification of the relationship between impairment, disability, handicap, depression and social factors is provided by the 'Gospel Oak' series of studies in London. The prevalence of short-CARE 'pervasive' depression in this relatively deprived area was 17%. Impairment, disability and particularly handicap were strongly associated with depression. The adjusted odds ratio for depression in the most handicapped quartile compared with the least was 24.2 (95% CI 8.8–66.6). Adjusting for handicap abolished or weakened most of the associations between depression and social support, income, older age, female gender and living alone (Prince *et al.* 1997b). When the overarching effect of handicap was put aside there was a moderate association between depression and the number of life events experienced over the previous year. Personal illness, bereavement and theft were reported as the most salient

events. There was a stronger relationship between the number of social support deficits and depression. Social support deficits also related to age, handicap, loneliness and the use of home care services. Loneliness was itself associated with depression (OR 12.4 (7.6–20)) (Prince *et al.* 1997a). A follow-up study a year later found that the 1 year onset rate for pervasive depression was 12% and the maintenance rate for those initially depressed was 63%. There was a high mortality rate among depressed people. Disablement, especially handicap, was the strongest predictor of onset of depression. Lack of contact with friends was a risk factor for onset of depression. For men marriage was protective; but for women it was a risk factor. Maintenance of existing depression was predicted by low levels of social support and social participation rather than by disablement (Prince *et al.* 1998).

Detecting depression and measuring outcome

In this section we will not be concerned with diagnostic interview schedules such as the GMS (Copeland *et al.* 1976), Short-CARE (Gurland *et al.* 1984) and others which are largely used in epidemiological research. Nor will we consider in depth observer rater scales such as the Montgomery Asberg Scale (Montgomery *et al.* 1978) and similar scales used largely to rate outcomes in drug trials. We will instead consider short scales that can be used, especially in high risk populations, to enhance the diagnosis of depression and the possibility of using such short scales for the systematic evaluation of outcome in routine clinical practice with depressed old people.

'Screening' for depression in older people

Screening is generally more effective in high risk populations. The geriatric depression scale (GDS) is most widely used for this purpose. It has been validated in a variety of settings, cultures and languages (Montorio and Izal 1996) and a number of short forms have been developed (Leshner and Berryhill 1994, Shah *et al.* 1997, Hoyle *et al.* 1999). The Brief Assessment Scale for Depression Card-sort (BASDEC) (Adshead *et al.* 1992, Loke *et al.* 1996) is a simple card-sort test which has been validated in an inpatient geriatric population. It has a potential advantage in that the questions are repeated in different languages on the reverse of the card but it has not been validated across cultures or different languages. The Even Briefer Assessment Scale for Depression (EBAS-DEP) (Allen *et al.* 1994) is a related scale. As even five questions from the GDS appear reasonably sensitive and specific at least in a setting with a high prevalence (46%) of depression (Hoyle *et al.* 1999), it may be that the value of these scales is as much in prompting clinicians always to ask about depression as in their intrinsic psychometric properties.