

population was 81 and the majority had coexisting physical disability, so that they were similar to those found in residential care. The main treatments proposed for the intervention arm were antidepressant medication (80 per cent), review of physical needs (96 per cent), social changes (70 per cent), counselling (60 per cent), and work with family (34 per cent).

A randomised controlled trial of a psychiatrist acting as 'case worker' for depressed people in residential homes in the London Borough of Camden was less successful'. Although the intervention group improved compared to the control group, this did not reach statistical significance. A similar range of interventions to that proposed in the Lewisham study was deemed

Key points

- Elderly people with depression should respond to treatment with antidepressant medication, ideally combined with attention to current physical health status
- Psychological and social factors should also be assessed and addressed in their role as precipitators or maintaining factors for the depression
- For those meeting the criteria for major depression, the drug of choice is now a selective serotonin reuptake inhibitor (SSRI)
- There is no evidence that benzodiazepines or neuroleptic compounds are useful in treating a depressive illness
- The visiting general practitioner plays a key role in co-ordinating treatment of depression in residential care

necessary, but it proved difficult for a visiting psychiatrist to co-ordinate social and physical health interventions in the time available.

Pharmacological treatment

For those meeting the criteria for major depression (see Table 1), the drug of choice is now a selective serotonin reuptake inhibitor (SSRI). There are fewer side-effects and interact less often with other medications than the tricyclic antidepressant (TCA) group¹. However, the SSRIs may still take four to six weeks for a full improvement to be seen and, if a response does occur, then treatment should be continued for up to two years. Older people with resistant depression, or

those with suicidal ideation should be referred to secondary care, perhaps by means of an assessment by a community psychiatric nurse linked to the home.

There is no evidence that benzodiazepines or neuroleptic compounds are therapeutic for a depressive illness, indeed they can make the condition worse. Yet they remain the most commonly prescribed psychotropic compounds for residents of care homes.

Psychosocial interventions

All residents with depression and those with significant depressive symptoms that meet the criteria for major depression might benefit from appropriate social interventions. Common factors that should be addressed are:

● Bereavement

The loss of a loved one is a common experience in late life. This may be the spouse but, less evident to an outsider, depression may be caused by the impact of the death of a relative or old friend. Recovery from depression usually occurs after six months, but for some the grieving is protracted. In these cases, encouragement to talk about the lost person, to express feelings, and for these feelings to be accepted by a listener are important steps to recovery. Ideally, this listener should be a member of the care staff, but a community psychiatric nurse or specific bereavement counsellor could be called in.

● Adjustment to residential care

It is common for many residents to move into care because their infirmity makes community care impractical or when the principal carer can no longer cope because of illness or death. Many older people seem eventually to welcome residential care, but it is rare to do so at the outset. Adjustments to loss of home, to a familiar neighbourhood, to living with others and to dependence on care staff can all take time. This process can be helped if the staff recognise that such adjustment is a necessary process and that it may (at times) lead to an expression of depression or even hostility. Care staff should, again, encourage residents to talk about their losses and fears, understand the process and never judge adversely those who are having difficulties.

● Isolation and inactivity

Once in care, a subjective sense of loneliness and uselessness may preoccupy a resident. Engagement in