

activities and social contacts should, therefore, be encouraged where possible, as both increase self-esteem and may prevent the onset of a more severe depressive state. Staff should assess the needs of each resident as an individual and use existing home and community resources to help. Volunteer visitors, outings, church attendance, and occupational activity should be mobilised, while continuing contact with family members must be facilitated.

### Attention to physical health

The Lewisham study discussed above suggested the relevance of assessment of physical disabilities to minimise handicap and, perhaps, prevent depression.

Interventions by care staff can be quite basic. For example, staff could make sure that hearing aids work, that spectacles are available and appropriate, or that large-print or 'talking books' are to hand. Personal needs (handbag, books and drink) should be easily accessible for those who need wheelchairs or who are immobile. Residents who are unstable on their feet should be encouraged and trained to use the appropriate walking aids.

Care staff can act as advocates for residents with a physical illness. They should feel able to raise anxieties—for example, whether pain or breathlessness is being adequately controlled or if current medication is appropriate, particularly if the patient is reporting side-effects. Frail and infirm patients may not be able to report concisely on their health problems in a brief interview. While a regular review of each resident's health should occur in the home, a key worker should be able to suggest a specific reassessment of a problem. The key worker also has a role in feeding back information to the resident concerning the results of such an assessment, so that he or she understands that as much as possible is being done to help.

### Responsibility

Care staff should ideally be able to detect depression among residents, whether at admission or during the stay in the home. They should be able to engender a trusting and sensitive relationship, in which the patient can express distress (without fear of criticism) about their current physical health, their life within the home, their losses and their fears for the future, their boredom or loneliness. Care staff will, therefore, need better training in depression—its recognition, its

assessment and in monitoring of treatment response—than currently occurs.

The process of detection and improved management is likely to be more effective if there are links between homes and the local old age psychiatric service, perhaps with regular visits by a community psychiatry nurse or a member of the medical staff who are available to discuss or supervise individual cases and to provide some continuing education.

### The GP's role

The person to co-ordinate treatment must be the visiting general practitioner, who should assess any patient identified by care staff as likely to be depressed in order

**Table 1: Criteria for the diagnosis of major depression**

A diagnosis of major depressive illness can be made in the presence for two weeks of at least one of:

- Lowered mood
- Loss of interest or pleasure

Plus five or more of the following:

- Weight loss or gain
- Insomnia or hypersomnia
- Agitation or reduced psychomotor function
- Fatigue or loss of memory
- Feelings of worthlessness or excessive guilt
- Reduced concentration
- Recurrent thoughts of death, suicidal thoughts or attempts

to decide whether antidepressant medication is appropriate and to suggest any helpful psychological approaches to care staff. Again, it may be necessary to alert general practitioners to the high prevalence rates of depression among those in residential care and that appropriate treatment will successfully lower this rate.

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#### References

- 1 Wearer S, Hafner H, Mann A H, et al. Prevalence and course of depression among elderly residential home admissions in Mannheim and Camden, London. *Int Psychogeriatr* 1990; 7: 4: 479-93
- 2 Mann A H. Depression: a cause for concern in residential care. *Geriatric Med* 1998; 28: 11: 43-6
- 3 Banerjee S, Shamash K, Macdonald A J D, Mann A H. Randomised controlled trial of effect of intervention by psychogeriatric team on depression in frail elderly people at home. *Br Med J* 1996; 313: 1058-61
- 4 Ames D. Depression among elderly residents of local authority residential homes. *Br J Psych* 1990; 156: 567-75
- 5 Masand P S. Depression in long term care facilities. *Geriatrics* 1999; 50 (Suppl 1): 516-524