Conclusions - This controlled trial of primary care physicians' attitudes towards patients with schizophrenia amounts to an empirical demonstration of medical discrimination against the sufferers of this and potentially of other long term psychiatric disorders. Psychiatrists and general practitioners should share care in the management of schizophrenia and try to overcome the prejudices against such patients in an attempt to improve their overall clinical care.

PSYCHIATRY IN TRINIDAD AND TOBAGO: A REVIEW

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Significant developments in psychiatry since 1950 are traced. Difficulties experienced in the transition from institutional care to community care, and changes in psychiatric morbidity patterns over this period are discussed. The new thrust in community care, as a consequence of recent health policy and reform is presented. It is concluded that the success of this new thrust is dependent on adequate resource allocation, intersectoral collaboration and reorientation of health services.

NR5. Depression and dementia in the elderly

Chairmen: M Prince, M Philpot

THE PROGNOSIS OF DEPRESSION IN OLD AGE: THE MELBOURNE STUDY

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Controversy persists regarding the prognosis of depression in old age. Recent studies indicate that it is probably no worse than that of depression earlier in life. Many studies lack the statistical power to assess the impact of predictive variables on outcome and have excluded patients with non-major depressions about whom little is known. We aimed to assess over 200 patients aged 65 and above presenting to psychiatrists for treatment of depression. Patients had to be presenting to psychiatric services for treatment of a new depressive episode and had to meet one of DSM-III-R, ICD10, or AGECAT criteria for depression including depressive adjustment disorder and non-major depressions. They were interviewed with the Geriatric Mental Status Schedule and a range of other instruments. Follow-ups were conducted after 1 year and 3–4 years.

224 patients (mean age 75.1 ± 6.8, 64% female) were studied. 78 were inpatients in public psychiatric hospitals, 57 were inpatients in private psychiatric hospitals, 15 were inpatients in general hospital psychiatry units, 30 were liaison referrals in general and geriatric wards and 43 were outpatients or community referrals. 150 had DSM-III-R major depression but only 46 were experiencing their first episode; 13 more were bipolar. 177 met ICD10 criteria for a depressive episode and 16 for bipolar illness. There were 132 cases of AGECAT depressive psychosis and 64 of AGECAT depressive neurosis. 55% had suffered their first depression after the age of 60; this was a more common finding in the liaison group. Liaison patients had suffered more life events, while outpatients had milder depressions. A median of 4 weeks was spent in hospital. Private patients spent less time in hospital than public patients but were readmitted more often in the ensuing year.

At one year 25% of the sample had been continuously well and 7% had recovered after one or more relapses; 14% were depressive invalids, 16% were relapsed, 19% were continuously ill, 5% demented and 12% dead. Liaison patients and those with more physical illness were more likely to have bad outcomes, especially death. No other variable was a strong predictor of outcome. 3–4 year follow-up will soon be complete. So far 51% of those followed up are dead, 21% have been continuously well, 11% are depressive invalids, 3% are relapsed, 8% have been continuously ill and 5% are demented. Variables which may predict 3–4 year outcome will be fully analysed prior to the conference.

Late life depression treated by psychiatric services in Melbourne is most often recurrent, characterised by a fluctuating course with disabling residual depressive symptoms in the majority of subjects with a high death rate and a risk of dementia which does not seem to be much greater than that of the background population.

IS DEPRESSION TREATABLE IN A DISABLED ELDERLY POPULATION? A RANDOMISED CONTROLLED TRIAL

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Objective: To investigate the efficacy of psychogeriatric team intervention in treating depression in an elderly community-dwelling disabled population receiving Home Care.

Design: Randomised controlled trial with blind follow up six months after recruitment.

Setting: The community in Lewisham, South East London.

Subjects: 69 home care clients aged 65 or over with case level depression as defined by the GMS/AGECAT system. 33 were randomised to the Intervention Group (IG) and 36 to the Control Group (CG).

Interventions: Each member of the IG received an individual package of care formulated by the community psychogeriatric team which was implemented by a researcher working as a team member. The CG received normal GP care.

Main outcome measure: Recovery from depression (GMS/AGECAT case at recruitment to non-case at follow-up)

Results: Analysing the data on an intention to treat basis, 19 (58%) of the IG recovered compared with only 9 (25%) of the CG, a difference of 33% (95% CI 10 to 55). This powerful treatment effect persisted after controlling for possible confounders using logistic regression, with members of the IG nine times more likely to have recovered at follow-up compared with the CG (odds ratio 9.0; 95% CI 2.0 to 41.5).

Conclusions: Depression is treatable in the elderly Home Care population; therapeutic nihilism based on an assumed poor response to treatment in the socially-isolated, disabled elderly in the community is not justified.

THYROXINE AUGMENTATION OF FLUOXETINE TREATMENT FOR RESISTANT DEPRESSION IN THE ELDERLY: AN OPEN TRIAL

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Drug resistant depression is a confounding entity. More so in populations of elderly depressives where addition of lithium or

https://doi.org/10.1016/0924-9338(96)88805-5 Published online by Cambridge University Press

anti-depressants combinations are possibly hazardous. We present an open-trial of thyroxine augmentation in elderly patients diagnosed as suffering from resistant depression. *Methods:*Thyroxine 50 mcg/d was added to Fluoxetine 20 mg/d in patients who did not respond to previous, Non-SSRI, anti-depressant treatment, (6 weeks), nor to additional six weeks of Fluoxetine. *Subjects:* Subjects were diagnosed as suffering from major-depression, according to DSM-III-R criteria. All had normal thyroid function tests, (TSH and FT_4). There were 15 patients in our series; 9 females, 6 males; mean age 72.1 years, (+ − 6.5). *Results:* Patients depression severity was graded using The Hamilton Depression Rating Scale at baseline, (before thyroxine augmentation), and 4 weeks after initiation of treatment. Ten of 15 patients responded to thyroxine augmentation (HDRS < 10). 3/15 showed no improvement of HDRS scores and two dropped-out, due to adverse effects: diarrhea and tachycardia. *Conclusions:* Thyroxine augmentation of Fluoxetine is effective in depressed elderly subjects resistant to standard treatment, and is relatively safe.

AGE & SEX SPECIFIC INCIDENCE RATES FOR DEMENTIA IN A SAMPLE OF COMMUNITY ELDERLY WITH CONFIRMATION AFTER A FURTHER TWO YEARS

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In response to the increasing numbers of the over 65s, the Medical Research Council and the Department of Health funded this the MRC ALPHA Study (part of MRC CFAS). The main aims are to estimate the prevalence and incidence of dementia; its natural history and course; to refine measures for its early detection and to explore the relationship between clinical, neuropsychological, imaging and neuropathological measures for the diagnosis of dementia.

A sample of community elderly were drawn from the records of the Family Health Services Authority and the lists updated by General Practitioners. The sample was stratified by age and sex into five year age bands commencing with 65–69 years. All individuals were approached for an initial interview with a subsample receiving a more detailed interview three months later with both the respondent and an informant. The two interviews represent one wave of interviewing which takes two years to complete.

Three waves of interviewing have been completed. The initial interviews were held with 5222 individuals, follow-up in the second wave achieved 3523 interviews and the third wave have successfully completed 2200 interviews to date. From the second wave there were 208 incidence cases of dementia. The age specific incidence rates for each five year age band for dementia per 1000 women at risk per year are 3.5, 6.5, 11.3, 37.2, 71.0, 114.3, and 132.7 for the over 95s. The rates are similar per 1000 men at risk per year with 1.8, 9.0, 16.4, 35.4, 63.7, 74.0 and 113.6 for the over 95s. These rates will be confirmed at wave three.

Given the size of the sample, the large numbers of respondents in the older age groups and the availability of follow-up this study will provide the most accurate estimates of incidence to date.

ONE HUNDRED CASES OF ATTEMPTED SUICIDE IN THE ELDERLY. A THREE AND A HALF YEAR OUTCOME STUDY OF MORTALITY AND MORBIDITY

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Method: 100 consecutive referrals to a liaison psychiatric service of patients over 65 years who attempted suicide between 1989 and 1992 were included in the study. Comprehensive demographic and psychiatric data were collected from records made at the time of their initial assessment. All patients were traced during 1994 using information from medical records, General Practitioner notes, the Family Health Services Authority, the Office of Population Censuses and Surveys and local Coroner's records. Surviving patients that consented were interviewed using the computerised Geriatric Mental State (GMS-AGECAT).

Results: The cohort included 64 women and 36 men. The mean age was 75.8 years. 31 subjects had previously attempted suicide. 66 subjects were diagnosed as mentally ill at the time of the initial assessment, the commonest diagnosis being depression. 53 subjects had a physical illness, the commonest being chronic pain. The mean duration of follow-up was 3.5 years. All subjects were traced. 42 subjects were dead with a mean time to death of 16.2 months. 12 were suspected suicides; 5 died as a result of their index attempt. Of the remaining 7 later deaths, 2 received a coroners verdict of suicide, 3 an open verdict and 2 were reported to the coroner as possible suicides. These 7 were likely to be male, have a diagnosis of depression and be receiving psychiatric treatment. 12 subjects made a further non-lethal suicide attempt. They were all female and likely to be suffering from persistent depression and be receiving psychiatric treatment. All male repeat attempts were lethal. 31 subjects were interviewed at follow up. 8 attracted a psychiatric diagnosis, only 2 of which were not previously identified.

Conclusions: Elderly people who attempt suicide have a high mortality both from completed suicide and death from other causes. Those at risk of further self-harm are likely to be in contact with psychiatric services and to be suffering from a persistent depressive illness.

DEPRESSION, "PSEUDO-DEMENTIA" AND DEMENTIA IN THE ELDERLY. A CROSS SECTIONAL STUDY OF DISTRIBUTION AND RISK FACTORS

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The prevalence, association and risk factors for depression and dementia were analyzed in a prospective study on n = 212 elderly in- and outpatients. Sociodemographic data, physical findings, CAT-scan and EEG, as well as psychological tests for cognitive performance and for affective symptoms are reported. 41% of the patients showed mild, 13% severe cognitive deficits. Depression was diagnosed in 23% of the severely impaired and in 16% of the cognitively mild or unimpaired patients. Increasing age, female sex and low premorbid intellectual level were significantly associated with reduced cognitive function. There was however no statistical association of dementia and depression. The prominent risk factor for depression was prior affective illness, but not cognitive deficits or social situation. CAT-Scan and EEG were abnormal in half of the patients, however, did not correlate with cognitive impairment or the presence of depression. Preliminary data of a 12-month follow-up indicate a small, insignificant improvement of depressed patients over time, while the non-depressed tend to deteriorate. From the present of data, the notion of "pseudodementia" is not supported, rather, cognitive impairment in depressed patients seems to represent genuine cognitive impairment. Depression and dementia coincide frequently in elderly patients, but they are associated with different risk factors.