

projectors. The videotapes contain interviews by general medical practitioners. The package was available from the College at a price of £30. So far we have distributed 500 and no longer have any in stock. Two further video training packages are currently in production, the first is aimed at teaching GPs basic cognitive techniques and the second will be targeting counsellors working in primary care.

Although I am disappointed that Dr Snaith has not appreciated the full extent of our educational programme so far, I am pleased to have the opportunity to correct a false impression that may have been shared by other readers.

PAYKEL, E.S. & PRIEST, R.G. (1992) Recognition and management of depression in general practice: consensus statement. *British Medical Journal*, **305**, 1198–1202.

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Screening for mental illness in the elderly

Sir: Noble's study (*Psychiatric Bulletin*, February 1994, **18**, 111–112) on the content of over-75s health checks by Norfolk GPs is similar to one we undertook in Milton Keynes. We surveyed all 29 local general practitioners (GP) principals on their methods of screening the over-75s and received replies from 27 (93%). At least 16 (59%) of practices used questionnaires for screening. None appeared to use a validated depression rating scale, but 9 (33%) did attempt to identify depression – a typical method being a scale such as 'no problems' (score=0), 'discontented' (score=2), 'very unhappy' (score=4). Cognitive function was generally better examined with 14 (52%) of practices specifically testing it, e.g. a 10-item test covering memory, orientation and concentration. Those routinely involved in screening included: GPs (56%), practice nurses (67%), district nurses (48%), health visitors (11%) and 'others' (4%). General comments were also obtained – 6 (22%) expressed dissatisfaction with routine screening describing it as 'unnecessary', 'wasteful of time and energy' and 'intrusive'. Only 1 (4%) was positive – describing screening as 'worthwhile' – the remaining 20 (74%) expressed no particular opinion on its value.

We agree with Noble that opportunities for early diagnosis of depression are being missed. Nevertheless, our study suggests that a substantial minority (33%) of GPs in Milton Keynes attempt to identify depression – albeit using inadequate techniques. This could be improved with better training, more appropriate methods

and closer links with psychogeriatric services. One potentially useful screening instrument for depression in general practice is BASDEC (an adaptation of the depression scale for the Brief Assessment Schedule as a set of cards). This has been shown to be quick, valid and acceptable in screening elderly medical in-patients (Adshead *et al*, 1992).

Community studies of depression and dementia in the over-65s have shown high prevalence rates of 11.3% and 5.2% respectively (Copeland *et al*, 1987). Screening seems a logical way to identify these common illnesses but at least six (22%) of our GPs are not convinced that routine screening is worthwhile. At present there is a lack of strong evidence to change their minds. We echo Noble's call for greater co-operation and research between psychiatrists and GPs to resolve this question.

ADSHEAD, F., DAY CODY, D. & PITT, B. (1992) BASDEC: a novel screening instrument for depression in elderly medical inpatients. *British Medical Journal*, **305**, 397.

COPELAND, J.R.M., DEWEY, M.E. & WOOD, N. (1987) Range of mental illness among the elderly in the community: prevalence in Liverpool using the GMS-AGECAT Package. *British Journal of Psychiatry*, **150**, 815–823.

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Evaluation of counselling services

Sir: Having recently completed an evaluation of the first three years of a counselling service for carers of people attending the Bristol Memory Disorders Clinic, we would like to expand on the ideas put forward by Michael King (*Psychiatric Bulletin*, February 1994, **18**, 65–67). Our evaluation has shown that there are many unresolved difficulties associated with this exercise.

First, one has to decide on an end point. At what stage can you say that counselling has been successful? We originally thought that a mark of success in our setting would be to keep people out of institutional care. But many counselling sessions has involved helping carers let go, while maintaining their own integrity and that of their relationship with the person with dementia.

There are difficulties associated with how to measure emotions in an objective way, and how to measure change in these emotions. When working with a progressive condition like dementia, it is possible that counselling is perceived as beneficial but there is little or no change on a quantitative scale. Doctors work from a scientific background and are used to looking for hard data, but we have found that it is very difficult to measure emotion and stress solely in these terms.

Furthermore, in our field, we have had difficulty finding suitable instruments. Most are American and do not 'translate' well. They put much emphasis on the financial burden of caring, which has not been an issue in this country (although we recognise that it is becoming a more important factor with changes in health and community care).

One has to decide who is going to undertake the evaluation. It is impossible for a counsellor to evaluate objectively his or her own work. Clients must feel able to respond honestly and without prejudice. In our case, we reassured carers that their relative would suffer no lack of care if they (the carer) decided not to participate in the evaluation, or if their comments were uncomplimentary.

We decided, after much thought and consultation with colleagues in the University of Bristol Social Work Department, to use a balance of quantitative and qualitative data. We used the HAD (Zigmond & Snaith, 1983) together with the CADI and CASI (Nolan *et al.*, 1989, 1990) to give us hard data which would provide only a background, and supplemented this with the results of a semi-structured interview administered by an unbiased researcher from the Social Work Department.

We have found that a counselling service for carers of people with dementia is extremely beneficial in helping them to cope with their caring.

KING, M.B. (1994) Counselling services in general practice.

The need for evaluation. *Psychiatric Bulletin* 18, No 2, 65.

NOLAN, M. & GRANT, G. (1989) Addressing the needs of informal carers: a neglected area of nursing practice. *Journal of Advanced Nursing* 14, 950-961.

— *et al.* (1990) Stress is in the eye of the beholder: reconceptualising the measurement of carer burden. *Journal of Advanced Nursing* 15, 544-555.

ZIGMOND, A. & SNAITH, R. (1983) The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica* 67, 361-370.

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Victims of childhood sexual abuse

Sir: I read with interest the article by Macpherson & Babiker, (*Psychiatric Bulletin*, February 1994, 18, 70-72) on 'Who works with adult victims of childhood sexual abuse?'. The need for agreed strategies involving training, supervision and inter-agency co-operation to deal with this increasingly common problem should not, however, be confined to adult mental health services alone.

As a child psychiatrist, my major focus in abuse work is directed towards victims who have

yet to reach adulthood. My own experience, however, as well as that of other authors (Goodwin *et al.*, 1981), is that among incestuous families, mothers have often been victims of child sexual abuse themselves, which has often not been previously disclosed. The importance of the support of the mother in determining the prognosis of the child is recognised within our own service by the provision of professional therapeutic support for non-abusing parents as well as appropriate therapy for the child. While this input for parents is designed primarily to enable them to support their children, our experience would suggest that they often use this contact with professionals to explore issues from their own past, including disclosure of their own experiences of abuse. Many of these women appear to be in need of long-term psychotherapeutic support which lies outside the remit of a child psychiatric service. I would suggest therefore that there is a need for agreed strategies involving close co-operation between child and adult mental health services to deal with the parents of abused children who have themselves been victims of childhood sexual abuse.

GOODWIN, J., MCCARTHY, T. & DIVASTO, P. (1981) Prior incest in mothers of abused children. *Child Abuse and Neglect*, 5, 217-221.

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Suicide prevention

I read with interest the letter concerning suicide and its prevention by Ashbridge & Milne (*Psychiatric Bulletin*, February 1994, 18, 110) and would like to add further, and I think more radically, to the author's comments in questioning the feasibility of achieving the *Health of the Nation* goals.

The reasons and circumstances which lead people to attempt or commit suicide are complex and varied and underlying treatable psychiatric illness is only one factor to be considered.

In the rhetoric of prevention of suicide, the political and personal reasons behind what is essentially a desperate and angry act fail to be addressed. Unemployment and its effects on self-esteem, quality of life, level of distress and suicidal behaviour is an example of a significant factor which is being almost totally overlooked by government in the discourse of suicide prevention and in setting targets for improvement of the nation's health. (For a recent study linking unemployment to suicide risk see Pritchard, 1992).

Aimed to assuage the guilt of the politicians, soothe administrators and encourage the search