current increase in asthma deaths may be increasing atmospheric pollution.⁵

In this study, collecting the data blind and the absence of obvious change in gradient occurring when the doctors learnt of the date mining started excluded bias as the cause of the changes recorded. The sustained change in gradient after the start of mining suggests that the cause of the change had also continued. Thus it could not be due to seasonal or other transient factors.

Our findings are *prima facie* evidence to support the practice's concern about the risks to the general population from the open cast coal site. The results of this small study give cause for national concern in view

of the current increasing trend towards open cast mining in Britain.

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BASDEC: a novel screening instrument for depression in elderly medical inpatients

Fiona Adshead, Diana Day Cody, Brice Pitt

Royal Postgraduate Medical School, Hammersmith Hospital, London W12

Fiona Adshead, senior house officer, department of medicine for the elderly
Diana Day Cody, senior registrar, department of psychological medicine
Brice Pitt, professor of psychiatry of old age

Correspondence to (and free copies of BASDEC through): Professor Pitt.

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Depression is a common cause and consequence of ill health in old people.¹ It hinders rehabilitation and hastens death, yet the diagnosis is often missed in medical wards.²

Screening questionnaires such as the geriatric depression scale (GDS)³ help with recognising depression, which can then be assessed for treatment. The brief assessment schedule (BAS)⁴ was used successfully by lay interviewers to screen for depression among residents of old people's homes.⁵ In a typical hospital ward, however, the questions are too easily overheard.

We compare the GDS with a novel adaptation of the depression scale of the BAS as a deck of cards (BASDEC, BAS depression cards) in screening geriatric inpatients for depression.

Method and results

BASDEC comprises 19 cards, 8.2 cm×10.4 cm, with statements derived from the depression scale of the BAS in large black print on a white background. They are presented one at a time, to be answered "True" or "False" according to the subject's present feelings. Every response of true gains one point, except "I've given up hope" and "I've seriously considered suicide," which each score two. "Don't know" responses, which are discouraged, score half a point. The maximum score is 21.

The study was carried out in the wards of the department of medicine for the elderly in the Hammersmith Hospital. Willing, cognitively intact patients who could understand English and read large print were given BASDEC and the GDS. The interviewer read the 30 questions of the GDS to those who could not read them.

A total of 79 subjects were offered BASDEC and one refused; 79 were offered the GDS and seven refused. Of the 72 subjects completing both tests, 21 were men, 51 women, with a mean age of 78.9. BASDEC took a mean 3.4 minutes to complete (range 2.0-8.0), the GDS a mean 6.8 minutes (range 4.0-12.0).

Cut off scores for possible "caseness" were 7 for BASDEC⁴ and 14 (out of 30) for the GDS.³ A psychiatrist (DDC) who was blind to the scores obtained on the screening instruments confirmed caseness: (either primary or secondary affective disorder or dysthymic disorder) or not. This interview almost always took place within three days of the screening procedure and in the same half of the day.

Twenty three subjects scored 7 or more on BASDEC and 23 scored 14 or more on the GDS, and the psychiatrist diagnosed 24 cases (four primary affective disorder, 18 secondary affective disorder, two dysthymic disorder). The relations between caseness according to the respective screening instruments and the psychiatrist are shown in the table. Although there were conflicting results between the instruments in 10 patients (four cases and six non-cases), both instruments performed identically well, having a sensitivity of 71%, a specificity of 88%, a positive predictive value of 74%, and a negative predictive value of 86%.

"Caseness" and psychiatric diagnosis on brief assessment schedule depression cards (BASDEC) and geriatric depression scale (GDS)

	Psychiatric case BASDEC		Not a psychiatric case BASDEC		Total
	<7	≥7	<7	≥7	
GDS <14	5	2	39	3	49
GDS ≥14	2	15	3	3	23
Total	7	17	42	6	72

Comment

The psychiatrist's diagnosis of 24 of the 72 subjects (33%) as suffering from some form of depressive disorder (in most cases secondary to their physical illness) used an extra dimension—the duration of symptoms. Though the screening instruments reflect the mood of the day to some extent, both performed well.

BASDEC proved an effective, user friendly way of screening medically ill elderly patients for depression in a ward setting. The GDS took twice as long to administer, and more patients refused it.

Novel, highly acceptable, and sufficiently valid, BASDEC deserves to be tried wherever a high prevalence of depression among the elderly is expected. It may also prove useful in general practice.

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