Letters

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Authors' response

We thank Bahri and Hilton[1] for their interest in our paper.[2] We can assure them that there was no upper age limit in our study. That said, we were aware that studies like ours, involving waiting room screening, may offer a less popular mode of recruitment to older people (relative to recruitment by GP).[3] The latter method would clearly not have been appropriate in our study, but the option to take home materials may have helped to minimise this effect. Bahri and Hilton's inappropriate extrapolation of our statistics ('this suggests that almost no participants were over the age of 65 years') is wholly incorrect. In fact, 204 (23%) of participants were aged ≥65 years.

We share Bahri and Hilton's second concern regarding why there was an age difference in recognition of depression. We have a report in preparation that examines the issue of age with regard to prevalence of significant depressive symptoms, their recognition, and treatment. Others have found that differences may be explained in part by factors such as severity of symptoms. Thompson *et al* 2001, found that once adjusted for severity, age was not a factor associated with detection.[4] The relationship of age to the recognition of depression is also a concern at the other end of the spectrum. Bower *et al* 2000, found that recognition of psychiatric morbidity was most likely among patients in the 40–49 year age group when compared with aged 18–29 years.[5] Lecrubier 2007, commenting on findings from the Psychological Problems in General Health Care study (where detection in the age group 18–24 years was found to be low) speculated that GPs might have a low index of suspicion for younger patients.[6]

We did not set out to answer the complex question of what caused the increase in antidepressant prescribing. Instead we sought to test the hypothesis that the increase in antidepressant prescribing was due to inappropriate GP prescribing. This hypothesis was rejected and our findings complement those of Moore *et al*.[7] Indeed, in our discussion we cited a preliminary account of their work as providing an explanation for the rise in antidepressant prescribing,[8] (at the time, their full paper had not been published). We also made the point in our original paper that 'an increase in duration of antidepressant therapy would represent an improvement in practice'.[2]

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Community pharmacists and the helpful GP prescriber

The RESPECT trial of pharmaceutical care researchers wondered if a detailed medical history would help community pharmacists be more active in patient medication delivery, for example by suggesting alternative drugs.[1] At my practice we have been providing clear reasons for the drug prescribed on our prescriptions for over 5 years now. The Clinical Indications[2] process provides detailed GPs' clinical prescribing decisions for the unattached community pharmacist. For the pharmacist it makes the medicine use review easy to perform with the addition of allergies and adverse drug reactions on the attached prescription slip enhancing this process. Nevertheless, it has been rare for an alternative drug to be suggested as this still requires much more detailed knowledge of the patient.

As many older patients are on numerous drugs (an average of seven in the RESPECT study) and many have failing cognition, it can be even more important in team care to indicate the necessity for medication and be able to confidently reinforce its importance. One area of communication that has worked