



MENTAL HEALTH

Living well for longer

Management of Depression in Older People: Why this is Important in Primary Care

KEY LEARNING POINTS

- » One in four older people have symptoms of depression that require treatment.
- » Fewer than one in six older people with depression discuss their symptoms with their GP, and only half of these receive adequate treatment.
- » Physical illness increases the risk of depression.
- » Untreated depression is the leading cause of suicide among older people, with men living alone at particularly high risk.
- » There is good evidence for the effectiveness of both psychological interventions and antidepressants for the treatment of depression in older people.
- » Referral to a Mental Health Team for Older People or single point of entry should be considered if there is: diagnostic difficulty, risk of self-harm or suicide, neglect, or poor response to a course of 2 antidepressant treatments or psychological therapy.
- » Interventions to increase social participation, physical activity, continued learning, volunteering, and reduction of fuel poverty can prevent depression, particularly in older people.

Depression is under-detected in older people, with only one in six older people with depression discussing their symptoms with their GP, and less than half of these receiving adequate treatment.

Changing demographics

In 2008, there were 18.3 million people aged 60 and older in UK¹. It's expected that the number of people aged 85 and over will grow from 1.3 million in 2008 to 3.3 million in 2033. For those aged 85 and over, the projected increase is from 1.3 million in 2008 to 3.3 million.¹

Prevalence of depression in older people

One in four of older people in the community have symptoms of depression.^{2,3} The risk of depression increases with age and 40% of those over 85 are affected. Major depression is a chronic disorder. The majority of older patients have a recurrence within 3 years.⁴

Some groups are at higher risk of depression: care home residents (where up to 40% may be depressed⁵) and older South Asians are more likely to be affected.⁶ Between 20-25% of people with dementia also have symptoms of depression.⁷

Co-morbidity of mental and physical illness

Co-morbidities are the norm in later life. Because of this, mental and physical health problems in older people are entwined and manifested in complex co-morbidity.⁸

Physical illness is associated with increased risk of depression.

- Depression is three times as common in people with end-stage renal failure, chronic obstructive pulmonary disease and cardiovascular disease than in people who are in good physical health.^{9,10}
- Depression is more than seven times more common in those with two or more chronic physical conditions.¹¹

Depression is also associated with increased mortality and risk of physical illness.

The majority of patients presenting as emergencies to surgeons are elderly, including those under the care of general, orthopaedic, urological and vascular surgeons. Many suffer distress or depression during and after their surgical episode.

- Increased mortality: a diagnosis of depression in those over 65 increases subsequent mortality by 70%.¹² Depression is associated with a 50% increased mortality after controlling for confounders, which is comparable with the effects of smoking.¹³
- Increased risk of coronary heart disease: depression almost doubles the risk of later development of coronary heart disease, after adjustment for confounding variables.^{14,15}
- Increased risk of stroke: increased psychological distress is associated with an 11% increased risk of stroke.¹⁶
- Other conditions: prospective population-based cohort studies show that depression is linked with later colorectal cancer,¹⁷ back pain,¹⁸ irritable bowel syndrome¹⁹ and multiple sclerosis.²⁰

- Surgical conditions: depression can cause reduced physical activity and poor muscle tone. In turn, this may contribute to osteoporosis, falls and a number of the 75,000 hip fractures that occur annually in the UK.
- Increased burden of physical symptoms: this can lead to further functional impairment.²²
- Reduce compliance with medication; this impacts on the outcomes of other chronic medical illnesses.²⁴

Suicide

Older people have the highest suicide rate for women and second highest for men. These rates have not declined, though they have across all other age groups. In contrast with young people, self-harm in older people usually signifies mental illness, mostly depression, and has a high risk of completed suicide.²⁶

Most depression is managed in primary care

Primary care is on the front-line in dealing with the mental health of older people, supporting families, and managing people with complex co-morbidities. Most people with mental health problems are managed in primary care, with only 6% of older people with depression receiving specialist mental health care.²⁷ Older people consult their GP almost twice as often as other age groups.²⁸ Despite this, depression is under-detected in older people, with only 1 in 6 older people with depression discussing their symptoms with their GP, and less than half of these receiving adequate treatment.²⁹

Barriers to diagnosing depression

Ageism

Age-related decline in mental well-being should not be seen as inevitable. The expectations of both older people and society in general regarding well-being in later life should be higher.³⁰

Patient factors

Older people may present with non-specific symptoms such as malaise, tiredness or insomnia rather than disclosing depressive symptoms. In addition, physical symptoms, including pain, are common and the primary care clinician may feel these indicate organic disease. Similarly, forgetfulness can lead to concern that a patient has cognitive impairment or early dementia.³¹ Older people sometimes have beliefs that prevent them seeking help for depression, such as a fear of stigma or that antidepressant medication is addictive. Furthermore, they may misattribute symptoms of major depression to 'just old age',³² ill health or grief. Older people from black and minority ethnic backgrounds often do not see psychiatric services as appropriate. People from different ethnic groups may present with culturally specific idioms of distress. For instance, South Asians often somatise their distress using 'sinking heart' or 'gas in abdomen' (gola) as a symptom. This may lead practitioners to overlook psychological distress and focus solely on the physical aspects of the presentation.³³

Risk factors for depression in older people

- Major physical illness or hospital admission in the last 3 months
- Chronic illness
- Receipt of high levels of home care, including residential care
- Recent bereavement
- Social isolation and loneliness
- Excessive alcohol use
- Fuel poverty
- Persistent sleep problems
- Living in a care home
- Dementia
- Some ethnic groups are at higher risk

When treatment is not leading to improvement, consider compliance, co-morbidities, concurrent prescribing, excessive alcohol use, continuing loss and loneliness, or a diagnosis of vascular dementia.

Practitioner factors

Primary care practitioners may lack the necessary consultation skills or confidence, to correctly diagnose later life depression, or may see the symptoms as part of the ageing process. They may be wary of opening a 'Pandora's box' in time-limited consultations and instead collude with the patient in what has been called 'therapeutic nihilism'.³² They may feel unsupported due to the lack of availability of psychological interventions.³²

System factors

These barriers are likely to be particularly difficult for those from lower socioeconomic and minority groups who have a higher risk of physical and mental ill health as well as disability.⁶

Mental health services for older people in the UK tend to be separated from general medical services. This can disadvantage older depressed people who may struggle to attend different sites for mental and physical disorders.³⁴ New contractual arrangements for primary care provide no new incentives to offer re-configured services for older people with depression.³⁵ However, initiatives to improve access to psychological therapies (IAPT) are beginning to make psychological treatments available to older people.³⁶

Management of depression in older people in primary care

Case-finding and diagnosis

General Practitioners (GPs) experience difficulties in negotiating the diagnosis of depression.³² The Quality and Outcomes Framework of the General Medical Services (GMS) Contract³⁷ did require primary care clinicians to use two case-finding questions when reviewing people with diabetes and heart disease. These indicators have been

withdrawn from QOF, but GPs and practice nurses should still consider using them in consultations with older people.

A further question, 'Is this something you want help with?' may increase the usefulness of the case finding questions in practice.³⁸ An assessment of the severity of the depression should then be made by the practitioner using a schedule such as PHQ-939 or the HADS.⁴⁰

Since five out of six older people with depression do not discuss their symptoms with their GP, these case-finding questions could be used in all consultations with older people.

Areas to cover during the consultation

The practitioner should cover five areas in the primary care consultation when depression in an older person is suspected. In addition, it is vital that the practitioner explores with the patient ideas and plans for self harm, as well as any factors preventing them from acting on those plans.

Exclusion of organic cause

Since symptoms of depression can be caused by anaemia, kidney disease, liver disease and diabetes, an examination and the relevant blood tests should be performed to exclude an organic cause for the patient's symptoms.

Management options

Medication

There is a good evidence base for the management of depression in older people: antidepressants are effective⁴¹ for people with moderate to severe depression. The principles of prescribing antidepressants are the same as those for prescribing for younger people. NICE guidelines⁴² suggest that first line treatment should be with an SSRI (selective serotonin reuptake inhibitor). Choice of antidepressant should be guided by the patient's previous experience of an antidepressant, and by co-morbidities and side effects. Tricyclic antidepressants (TCAs) should not be initiated in primary care, but are occasionally suggested by secondary care for use in treatment-resistant depression.⁴³ Amitriptyline is frequently started in primary care for older people with chronic pain, but co-prescribing of both a TCA and an SSRI should be avoided. Mirtazepine is useful when poor sleep and anxiety are the main symptoms, but side-effects include sedation and weight gain, which can be problematic.

At least four weeks of one antidepressant should be tried (and concordance ensured) before changing to another SSRI or an antidepressant of a different class.⁴² Side effects with SSRIs include insomnia, agitation, headache, sexual dysfunction, gastro-intestinal disorders (including GI bleeding, so care must be taken if the patient is prescribed aspirin) and hyponatraemia. Antidepressants should be continued for at least six months.⁴² Long term treatment for relapse prevention should be considered in people who have had recurrent depression.

Psychological and talking therapies

Many older people express a preference for a talking treatment⁴⁴ and there is

Case-finding for depression



During the past month, have you often been bothered by feeling down, depressed or hopeless?

During the past month, have you often been bothered by having little interest or pleasure in doing things?

A **YES**

to either question is considered a positive test.

A **NO**

response to both questions makes depression highly unlikely.

good evidence for the effectiveness of a number of psycho-social interventions such as Cognitive Behavioural Therapy (CBT), Behavioural Activation and Problem Solving Treatments.^{45,46,47} There is evidence, however, that GPs continue to refer younger rather than older people for talking treatments.⁴⁸

Physical activity

Exercise is recommended as a treatment for mild to moderate depression.⁴²

Psycho-social interventions

Befriending may also be useful in management of mild depression in older people.⁴⁹

Collaborative care

Studies from the US⁵⁰ suggest utilising a collaborative care approach may be effective. In this model, a case manager co-ordinates care and delivers a specific psycho-social intervention (behavioural activation or problem solving treatment) with or without medication management, and liaises with both the GP and the specialist mental health services. Initial evidence from the UK⁵¹ is promising.

Shared decision-making

It is vital that the primary care practitioner explores the patient's view of their problem and the options that might be available to them. This should include discussions with carers and family (with the patient's consent). If antidepressants are going to be prescribed, a full discussion about these drugs, the time they take to work and the possible side effects is needed. Similarly, a discussion about the patient's views on talking treatments or psycho-social interventions (including IAPT), what to expect, and waiting times is vital.

Ongoing support

Ongoing monitoring and review by the primary care practitioner, accompanied by written information to support a patient taking antidepressants and/or receiving a psychological therapy, is important. The practitioner has a role in signposting to third sector agencies (if acceptable to the patient), and should be familiar with local groups and networks. When treatment does not lead to improvement in the patient's symptoms, it is vital that the GP considers compliance, co-morbidities, concurrent prescribing, excessive alcohol use, continuing loss and loneliness, or a diagnosis of vascular dementia. At this stage, discussion with and/or referral to a Mental Health Team for Older People, or single point of entry team, is recommended.

Culturally sensitive interventions

Pharmacological and psychological interventions

There is little research to support any particular pharmacological therapy being specifically beneficial for older people from minority ethnic communities. The general considerations about prescribing antidepressants discussed above should be followed, but there is a particular need for detailed explanation about the basis for suggesting medication.

Encouraging older people from minority ethnic communities to attend community and faith-based groups organised by the voluntary sector can often provide much-needed social support. Links with local mental health community development workers can also be helpful.

Despite being an equally effective treatment, GPs continue to refer younger rather than older people for talking treatments.

Areas to cover in a primary care assessment of depression:

History:

- sensitive exploration of symptoms
- identification of triggers
- previous history of depression
- recent bereavement
- maintaining factors such as drugs or alcohol
- review of medications (including benzodiazepines and self-medication)

Substantiating the history by talking with a carer or family member (with the patient's consent) can help to clarify certain aspects of the problem.

Mental state assessment:

- PHQ-9
- evidence of psychotic symptoms
- thoughts of self-harm
- use of Mini-Mental State Examination (MMSE) or GP-COG where cognitive impairment is suspected

Risk assessment:

- thoughts of self-harm
- previous self-harm
- explore whether plans have been made
- ask what is preventing the patient from acting on any thoughts or plans

Focused physical examination:

- neurological examination
- BP and pulse

This may help help identify contraindications to certain classes of anti depressants.

Appropriate investigations:

- blood tests including full blood count, biochemistry (including calcium), glucose, liver and thyroid function tests, haematinics (B12 and folate), and vitamin D

Older people with two or more chronic conditions who have seven-fold increased risk of depression.

Working with the family

The social stigma of depression may cause families to deny, conceal, delay, or even fail to seek treatment. This calls for public education within a cultural framework, as well as collaborative efforts by minority ethnic communities and healthcare providers. It is particularly important to keep the family 'on board' where older people live with extended family. This can be difficult, as they may not share the viewpoint of the health provider on depression. In these cases, efforts to educate not only the patient but also carers becomes all the more important, particularly regarding issues around medication use, side effects and time delay in symptom improvement.⁵²

Depression in care homes

Depression occurs in 40% of people living in care homes and often goes undetected.² Training care staff to recognise possible symptoms of depression can improve detection,⁵³ and using a collaborative care approach to management is effective in improving outcomes.⁵⁴

Prevention of mental illness and promotion of mental wellbeing

Mental illness prevention

Given the prevalence of depression and known risk factors, a significant proportion is preventable, particularly for higher risk groups, such as those with two or more chronic conditions who have seven-fold increased risk of depression.⁵⁵ Home insulation and improved central heating have resulted in 40-50% decrease in depression and anxiety.⁵⁶

Mental health promotion

Psychosocial interventions are effective in improving mental well-being, as is support for older people before and during adversity.^{57,58} Health promotion interventions can significantly reduce social isolation and loneliness, while training in the use of the internet to increase social support has also been shown to reduce complaints of loneliness and depression.^{59,60} Walking and physical activity programmes are also effective in promoting well-being, as are learning and volunteering.⁶¹⁻⁶³ Trials of psycho-educational interventions for family caregivers have shown significant improvements in caregiver burden, depression, subjective wellbeing and perceived caregiver satisfaction.⁶⁴

Conclusions

Depression is common in older people. Despite the existence of effective interventions, it still goes undetected and has a significant impact on quality of life, physical health, and mortality⁶⁵. Important issues for primary care practitioners include adequate detection, treatment and prevention. Primary care practitioners can use case-finding tools and need to develop the skills and competence to diagnose and support people with depression. Increased availability of psychological services for older people will increase the number receiving effective treatment. In addition, interventions need to be tailored to older people's perspectives, and the social as well as the psychological emphasised. A number of interventions can improve well-being and reduce the risk of depression in older people. Mental health promotion can occur through increased social participation, physical activity, continued learning and volunteering. ■

Useful resources

Depression in Older Adults: Leaflet from the Royal College of Psychiatrists |

www.rcpsych.ac.uk/healthadvice/problemsdisorders/depressioninolderadults.aspx

Physical & Mental Health Resources: link to Royal College of Psychiatrists website |

www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh.aspx

E-learning on Older People's Mental Health | www.elearning.rcgp.org.uk

NICE guideline (CG 90) | Depression in adults: The treatment and management of depression in adults | <http://www.nice.org.uk/guidance/cg90>

Age UK | www.ageuk.org.uk/get-involved/campaign/

Depression Alliance | www.depressionalliance.org

Friends in Need | www.friendsinneed.co.uk

Depression Alliance Video Clip "Friends in Need" | <http://youtu.be/N9M11kMuxE>

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