

Management of depression in older people: why this is important in primary care

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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 both of psychological interventions and antidepressants for the treatment of depression in older people
- Referral to an Old Age Mental Health Team 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 two antidepressant treatments or psychological therapy
- Interventions to increase social participation, physical activity, continued learning and volunteering, and reduction of fuel poverty can prevent depression, particularly in older people

Changing demographics

In 2008, there were 18.3 million people aged 60 and older in UK.¹ By 2033, the number of people in the UK aged 75 and over is projected to increase from 4.8 million to 8.7 million. 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 so that 40% of those over 85 are affected. Major depression is a chronic disorder with the majority of older patients having a recurrence within three 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 most at risk.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. Thus, mental and physical health problems of 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.

- Increased mortality: a diagnosis of depression in those over 65 increased subsequent mortality by 70%.¹² Depression is associated with 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 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 11% increased risk of stroke.¹⁶

Risk factors for depression in older people

- Recent (less than 3 months) major physical illness or hospital admission
- Chronic illness
- In 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

- 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
- Increased burden of physical symptoms²¹ and functional impairment.²²
- Reduced compliance with medication, which impacts on outcomes of other chronic medical illness.^{23,24}

Suicide

Older people have the highest suicide rate for women and second highest for men,²⁵ and this is the one age group where rates have not declined. In contrast with young people, self-harm in older people usually signifies mental illness, mostly depression, with high risk of completed suicide²⁶.

Most depression is managed in primary care

Primary care is on the front-line in dealing with older people's mental health, supporting families and managing people with complex co-morbidities. Most people with mental health problems are managed in primary care, with only six per cent 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 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.²⁹

Barriers to diagnosing depression

Ageism

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

Patient factors

Older people can 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. Forgetfulness may lead to concern that a patient has cognitive impairment or early dementia.³¹ Older people may have beliefs that prevent them from 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 of distress.

This may lead practitioners to overlook psychological distress and focus solely on physical aspects of the presentation.³³

Practitioner factors

Primary care practitioners may lack 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 a lack of availability of psychological interventions.³²

System factors

The barriers described above are likely to be particularly difficult for those from lower socioeconomic and minority groups who have 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, which may disadvantage older depressed people who may have difficulties in attending 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 also 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 with patients, including older people.³² The Quality and Outcomes Framework (QOF) of the new General Medical Services (GMS) Contract (Department of Health, 2006)³⁷ requires GPs and practice nurses to use two screening questions within the previous 15 months in order to increase the detection of depression in patients with diabetes and heart disease.

A further question, 'Is this something you want help with,' may increase the usefulness of the case finding questions

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.

in practice.³⁸ An assessment of 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 any consultation with an older person.

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, and factors preventing the patient from acting on such ideas or plans.

Exclusion of organic cause

Since symptoms of depression can be caused by anaemia, kidney disease, liver disease and diabetes, an examination and the bloods tests highlighted 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.

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, gastrointestinal 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 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

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 – drugs, 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 aspects of the problems.

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 prevents the patient acting on thoughts or plans.

Focused physical examination:

- focused neurological examination
- BP and pulse.

May 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), vitamin D.

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 psych-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). Thus, 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 psychosocial interventions (including IAPT), what to expect and waiting times is vital.

Ongoing support

On-going monitoring and review by the primary care practitioner, accompanied by written information to support a patient taking anti depressants and/or receiving a psychological therapy, is important. The practitioner has a role in sign posting to third sector agencies (if acceptable to the patient), and thus should be familiar with groups and local networks in the locality. When

treatment is not leading 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 an Old Age Mental Health Team, or single point of entry team, is indicated.

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 be helpful.

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 in extended families. This may seem difficult, as they may not share the viewpoint of the health provider on depression. So 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 more chronic conditions who have seven-fold increased risk of depression.⁵⁵ Home insulation and improved central heating have also resulted in 40-50% decrease in depression and anxiety.⁵⁶

Mental health promotion

Psychosocial interventions are effective in improving mental wellbeing, 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 wellbeing, as are learning and volunteering.⁶¹⁻⁶³ Trials of psycho-educational interventions for family care-givers have shown significant improvements in caregiver burden, depression, subjective wellbeing and perceived care-giver satisfaction.⁶⁴

Conclusions

Depression in older people is common. Despite the existence of effective interventions it still goes undetected, with significant impacts on quality of life, physical health, and mortality. Important issues for primary care practitioners include adequate detection and treatment as well as 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 enhance numbers 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 wellbeing and also reduce the risk of depression in older people, and mental health promotion can occur through increased social participation, physical activity, continued learning and volunteering. ■

