

## **Depression in older people is underdiagnosed**

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# Depression in older people is underdiagnosed

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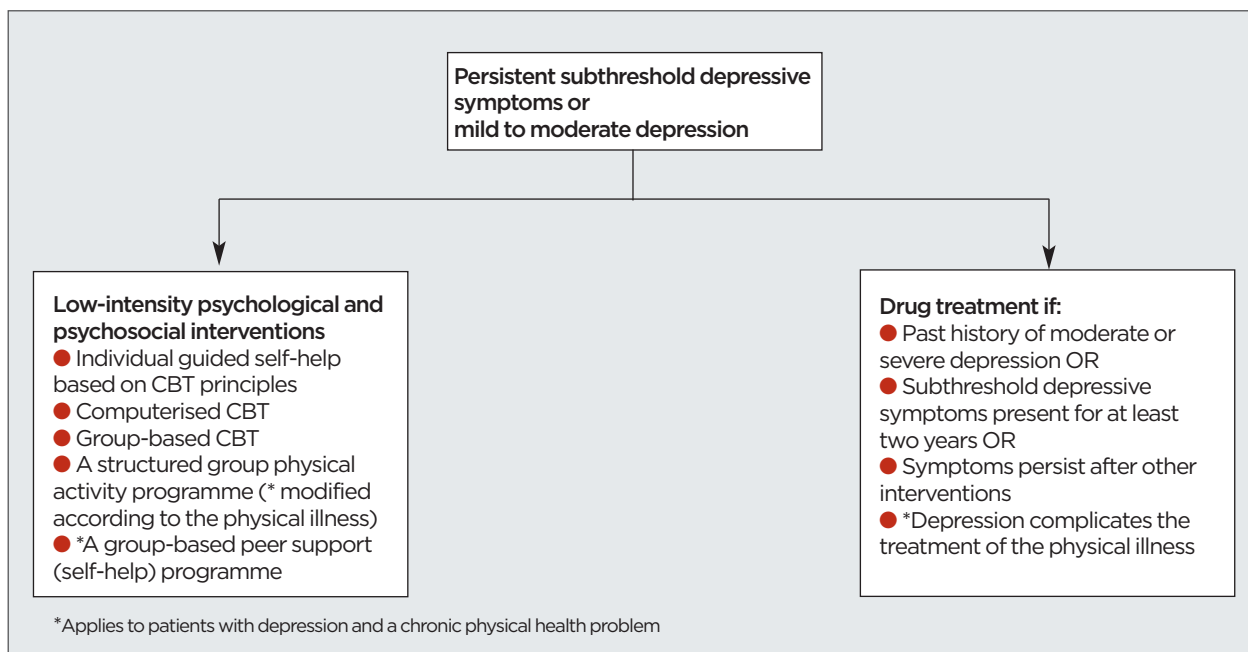
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## FIGURE 1

Management of mild to moderate depression in older people (adapted from NICE CG90 and CG91)



**How** should patients be assessed?

**What** are the management options?

**Which** patients should be referred?



**DEPRESSION IS MORE COMMON IN OLD AGE THAN DEMENTIA,<sup>1</sup> YET IS UNDERDIAGNOSED**

and undertreated. The reasons for this may relate to the overlap of presenting symptoms with 'normal' distress, which can make a diagnosis difficult, or to a lack of recognition of the importance of the condition by clinicians, patients and their families.

Regardless of age, depression can present with low mood in addition to other biological changes e.g. in sleep and appetite, and psychological changes e.g. low self-esteem and guilt, see table 1, p20. However, it is important to recognise that patients may not always present in such a typical way. Other presenting features that may indicate depression include anxiety, a preoccupation with somatic symptoms, and a change in function, with reduced interest in previously enjoyed activities.<sup>2,3</sup> Changes in

cognitive performance, particularly reduced executive function, e.g. planning activities, and poor attention and memory may be prominent,<sup>4</sup> and this can lead to difficulty distinguishing depression from dementia.

**'Depression is more common in old age than dementia yet is underdiagnosed and undertreated'**

## RISK FACTORS

Patients with a previous history of depression and anxiety disorders are at increased risk of depression in later life. Age-related disabilities and changes to physical health are major

risk factors for depression in older people. Vascular diseases, including stroke, myocardial infarction and diabetes increase the risk of depression, both through direct effects on the brain and the psychological effects of suffering a major illness.<sup>5-7</sup> Likewise, dementia is a risk factor for the development of depression.<sup>8</sup>

While biological factors are predominant, psychological factors such as loneliness and loss of a valued role, as well as social factors related to retirement, bereavement and reduced independence may all increase the risk for depressive disorder.<sup>9-12</sup> In later onset depression, genetic risk factors are less relevant and possibly different from those in younger people.<sup>13,14</sup>

## ASSESSMENT

Because of the frequency of putative reasons for distress in old age, consideration of depressive illness as a differential diagnosis is important. »

**Table 1**

**Diagnostic criteria for depression**

|                      | ICD-10 <sup>33</sup>                                                                                                                                                                                                                                                                                      | DSM-IV <sup>34</sup>                                                                                                                                                          |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Core criteria</b> | Symptoms present most of the time for at least two weeks; not secondary to drug or alcohol misuse, medication, medical disorder or bereavement                                                                                                                                                            |                                                                                                                                                                               |
| <b>Symptoms</b>      | Depressed mood, anhedonia, weight change, reduced appetite, disturbed sleep, psychomotor agitation or retardation, loss of energy, reduced libido, feelings of worthlessness and guilt, poor concentration, indecisiveness, thoughts of death or suicide, delusions, hallucinations                       |                                                                                                                                                                               |
| <b>Severity</b>      | <p><b>Mild</b><br/>2–3 symptoms; able to continue with daily activities</p> <p><b>Moderate</b><br/>≥ 4 symptoms; difficult to continue daily activities</p> <p><b>Severe</b><br/>Several symptoms which are marked and distressing; ordinary activities impossible, psychotic symptoms may be present</p> | <p><b>Minor</b><br/>≥ 2 symptoms, with minimal effect on function</p> <p><b>Major</b><br/>≥ 5 symptoms, with clinically significant distress or impairment in functioning</p> |

Thereafter, assessment and diagnosis are largely based on a careful history. This should focus on eliciting current features of depression, which have been present for at least two weeks, and are associated with a significant change in function, see table 1, above.

Screening tools for depression can be useful to identify key symptoms and to quantify their severity, both aspects that will guide further investigation and management.

The screening tools available range from a set of very simple questions to more complex, detailed assessments, some are available in electronic format.

## **‘It is important to exclude organic disorders that may mimic symptoms of depressive disorder’**

The commonly used Patient Health Questionnaire (PHQ-9), is a clinician administered tool that assesses all DSM-IV inclusion criteria for major depressive disorder as well as including an additional item assessing psychosocial impairment.<sup>15</sup>

Self-administered questionnaires

include the General Health Questionnaire (GHQ),<sup>16</sup> the Centre for Epidemiological Studies Depression rating scale (CES-D)<sup>17,18</sup> and the Geriatric Depression Scale.<sup>19,20</sup>

If depression is suspected, it is important to exclude organic disorders that may mimic symptoms of depressive disorder, including anaemia, B12 and folate deficiency and hypothyroidism.

Cognitive assessment in depression is more difficult; a patient with depression is likely to show impaired cognitive assessment scores with significant overlap in scores with mild cognitive impairment and even dementia.

Where there is doubt over the diagnosis, a trial of antidepressant treatment can be undertaken with cognitive assessment repeated at a later stage, alternatively a referral to old age psychiatry services may be appropriate.

## **MANAGEMENT**

Various interventions are effective and the choice is guided by patient preference, as well as the duration and previous course of illness, past response to treatment, comorbidities and likelihood of adherence and potential adverse effects.<sup>19,21</sup>

Management involves a stepped care framework where the least intrusive, most effective intervention is provided first. However, slavish

**Table 2**

**Side effects of SSRIs**

- Headache
- Nausea
- Insomnia
- Agitation
- Sexual dysfunction
- Hyponatraemia (increased risk in patients on diuretics)
- Increased risk of bleeding

adherence to this principle should be discouraged. GPs should have ready access to the patient’s past history, so that mild symptoms can be readily identified as precursors of an episode of more severe illness, warranting a more energetic treatment approach, particularly if this treatment has been successful in the past.

## **‘Vascular diseases increase the risk of depression both through direct effects on the brain and psychological effects’**

In mild depression, general advice on sleep hygiene and getting more structure into the day, together with active monitoring is recommended. Befriending may also be helpful.<sup>22</sup> These services are generally provided by charities such as Age UK. They offer telephone services or regular one-to-one visits from a volunteer to the older person’s home. Referrals can be made via different routes, including self-referral, referral from family members or healthcare professionals.

In patients with sub-threshold depressive symptoms and mild to moderate depression one or more of the low-intensity psychological interventions should be offered. There is good evidence for the effectiveness of psychological interventions in older people, including CBT, problem solving therapy and behavioural activation.<sup>23–27</sup>

Many older people resist the use of antidepressants and express a preference for a psychological treatment.<sup>28</sup> Despite this, the evidence shows that older people are less likely

**Table 3****Interactions of SSRIs (adapted from NICE CG90)**

| Medication               | Recommended antidepressants                                                                                                                            |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| NSAIDs<br>Aspirin        | <ul style="list-style-type: none"> <li>Do not offer SSRIs or co-prescribe proton pump inhibitors</li> <li>Consider mirtazapine or trazodone</li> </ul> |
| Warfarin<br>Heparin      | <ul style="list-style-type: none"> <li>Do not offer SSRIs</li> <li>Consider mirtazapine</li> </ul>                                                     |
| Selegiline<br>Rasagiline | <ul style="list-style-type: none"> <li>Do not offer SSRIs</li> <li>Consider mirtazapine or trazodone</li> </ul>                                        |

to be referred to specialist psychological services, compared with younger people.<sup>29</sup> Exercise is also recommended as a treatment. For patients with depression and chronic physical illness, the programme should be modified according to their needs.<sup>21</sup> Antidepressants should not be prescribed routinely for mild depression, see figure 1, p19.<sup>19</sup>

When the response to initial interventions is inadequate, or in people with moderate and severe depression, an antidepressant or a high-intensity psychological intervention should be considered, see figure 2, below. Antidepressants are effective in older people, and the

principles of prescribing are the same as those for younger people.<sup>19,30,31</sup>

NICE guidelines suggest that a generic SSRI should be first-line treatment. It is important to inform patients about the discontinuation effects of antidepressants at the beginning of the treatment. Choice of antidepressant should be guided by comorbidities which are common in older patients, as well as the side-effect profile. Sertraline and citalopram are preferred drugs in people with chronic physical illness because they have a lower propensity for interactions.

One antidepressant should be tried for at least four weeks, before switching to another SSRI or an antidepressant from a different class, e.g. mirtazapine or venlafaxine. Although in old age there is a greater vulnerability to side-effects, see table 2, opposite, and the rate of metabolism is altered, it is important to use therapeutic doses of antidepressants. The treatment should be continued for at least six months (preferably at least two years) and should be stopped gradually.

In those who have had recurrent depression, long-term treatment for relapse prevention is recommended. For treatment-resistant depression, augmentation with lithium or an antipsychotic or the addition of a second antidepressant is recommended, but this usually requires consultation with a psychiatrist.<sup>19</sup>

If the response to either pharmacological or psychological intervention is inadequate, combining antidepressants with CBT should be considered. In moderate to severe depression associated with a chronic physical illness and functional impairment collaborative care may be effective. In this approach the case manager will provide long-term co-ordination of care and liaise with the GP and mental health services.<sup>21,32</sup>

## ‘Older people are less likely to be referred to specialist psychological services’

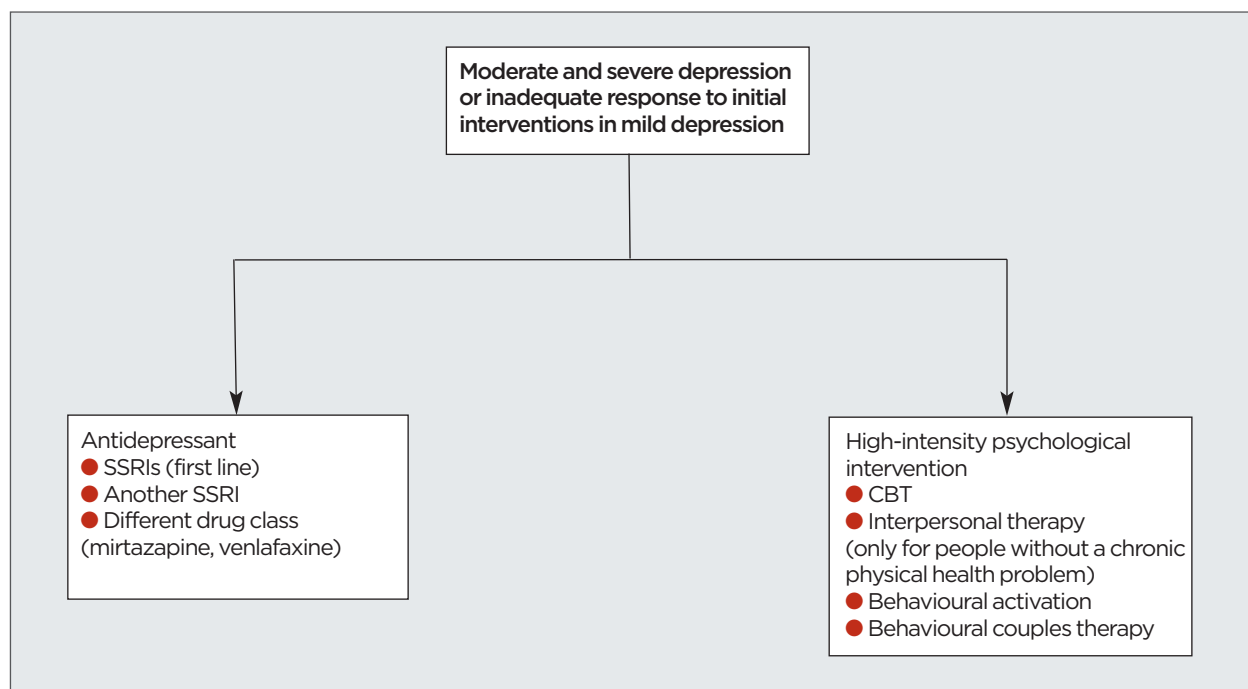
### REFERRAL

Most patients with depressive disorders are treated in primary care. Referral to specialist mental health services, old age psychiatry or single point of entry, is indicated, in the following situations:

- Diagnostic difficulty e.g. differentiating between depression and cognitive impairment
- Poor response to treatment
- Psychotic symptoms
- Significant psychiatric comorbidity
- Risk of self-neglect or suicide »

**FIGURE 2**

Management of moderate and severe depression in older people  
(Adapted from NICE CG90 and CG91)



## key points

### SELECTED BY

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**Depression is more common in old age than dementia** yet is underdiagnosed and undertreated. It is important to recognise that patients may not always present in a typical way, features that may indicate depression include anxiety, a preoccupation with somatic symptoms, and a change in function. The presence of understandable triggers and causes should not deter GPs from offering treatment, as long as symptoms are pervasive and continuously persist beyond two weeks.

**Age-related disabilities and changes to physical health** are major risk factors for depression in older people. Vascular diseases, including stroke, myocardial infarction and diabetes increase the risk of depression, both through direct effects on the brain and the psychological effects of suffering a major illness. Likewise, dementia is a risk factor for the development of depression. Psychological factors such as loneliness and loss of a valued role, as well as social factors related to retirement, bereavement and reduced independence may also increase the risk. Patients with a previous history of depression and anxiety disorders are at increased risk of depression in later life.

**Assessment and diagnosis are largely based on a careful history.** This should focus on eliciting current features of depression, which have been present for at least two weeks, and are associated with a significant change in function. It is important to exclude organic disorders including anaemia, B12 and folate deficiency, and hypothyroidism that may mimic symptoms of depressive disorder.

**In mild depression, general advice on sleep hygiene and getting more structure into the day, together with active monitoring is recommended.** There is good evidence for the effectiveness of psychological interventions in older people, including CBT, problem solving therapy and behavioural activation. Exercise is also recommended as a treatment but antidepressants should not be prescribed routinely for mild depression.

**In people with moderate and severe depression,** an antidepressant or a high-intensity psychological intervention should be considered. A generic SSRI should be first-line treatment, sertraline and citalopram are preferred drugs in patients with chronic physical illness because they have a lower propensity for interactions. It is important to use therapeutic doses of antidepressants. The treatment should be continued for at least six months. In those who have had recurrent depression, long-term treatment for relapse prevention is recommended. Referral to specialist mental health services is indicated when there is diagnostic difficulty, poor response to treatment, psychotic symptoms, significant psychiatric comorbidity or a risk of self-neglect or suicide.

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In the case of poor response to treatment, it is important to consider compliance, concurrent medication, comorbidities (e.g. optimal control of symptoms and signs of physical illness), continuing psychosocial stressors such as bereavement and loneliness, excessive alcohol consumption and onset of dementia before referring to specialist services.

While recognising such factors and treating them, as far as possible, to remove causes and confounders, the specific treatment of depressive disorders should remain a priority.

The presence of understandable triggers and causes should not deter GPs from offering treatment, as long as the symptoms are pervasive and continuously persist beyond two weeks. Depression in older age responds to treatment just as it does in younger patients, if anything, the risk of relapse is higher, and continuous prophylactic treatment is more likely to be necessary.

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## Useful information

### NICE guidance

The NICE guidelines on depression (CG90 and CG91) are available on the website. [www.nice.org.uk](http://www.nice.org.uk)

### Age UK

[www.ageuk.org.uk](http://www.ageuk.org.uk)

### Depression UK

[www.depressionuk.org](http://www.depressionuk.org)

### Depression Alliance

[www.depressionalliance.org](http://www.depressionalliance.org)

### Royal College of Psychiatrists

[www.rcpsych.ac.uk/healthadvice/problemsdisorders/depressioninolderadults.aspx](http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/depressioninolderadults.aspx)