Detecting and managing depression in older people

THE Royal College of General Practitioners and the Royal College of Psychiatrists have run a Defeat Depression Campaign since 1992. This is aimed at improving public and professional awareness of depression, and thereby, improving its detection and management.[1,2] A recent initiative within the Campaign has been the publication of a Consensus Statement on Recognition and Management of Depression in Late Life in General Practice.[3] Our purpose in writing this Editorial is to highlight and justify some of the key messages of this Consensus Statement.

Community studies suggest that the point prevalence of depression (severe enough to warrant treatment) in people aged 65 years and over is about 15%, suggesting that 45 older patients on the average general practitioner (GP) list will be significantly depressed at any given time. Studies of primary care attenders (as well as those in hospital or residential care settings) reveal prevalence rates approximately double those found in representative community samples.[4] There is no clear relationship with age within the elderly, but most studies suggest a female:male ratio of 3:2.[5] Depression in old age is strongly associated with poor physical health as well as with loss events, poverty and social isolation.[6] However, it must be emphasized that the majority of older people do not become depressed despite multiple adversity. The cost of depression in old age (in terms of excess health and social service utilization) are likely to be very high. Recent unpublished evidence from a community study (G Livingston, personal communication) suggests that direct costs are of the order of £1 billion per year in the UK, and that considerable excess costs remain, even after allowing for the effects of associated social isolation and physical disability.

Thus, the primary care setting is ideal for detecting depression in older people, both opportunistically in surgery attenders and through the mandatory over-75 health checks. Therefore, it is surprising that primary care studies show that only a small minority of the elderly depressed are identified or treated. The classic study by Macdonald[4] found that, when GPs were asked directly whether individual elderly patients they had seen were depressed, they detected depression in 95% of those who fulfilled diagnostic criteria for depression. Despite this, they only intervened in 10% of cases. Similarly low treatment rates have been confirmed in other studies in both GP attenders[7] and community samples.[8]

The gap between recognition and intervention is striking and needs explanation. Possible reasons include attitudes held by both patients and their doctors as well as problems in diagnosis. The GP factors may include the erroneous and ageist beliefs that depression is understandable (or even inevitable) in the face of multiple loss, deteriorating health and impending death; that older people are too frail to tolerate physical treatments or too inflexible to benefit from talking treatments; and that GPs are helpless to mediate improvement in their patients' social circumstances. Some GPs are also more likely to feel lacking in expertise in initiating treatment of depression in older patients.[9] Older depressed patients may not recognize their symptoms are constituting an emotional rather than a physical illness or share the belief that little can be done to help. Diagnostic difficulties arise from the relative absence of overt low mood in older depressed patients whose presenting symptoms are more likely to be altered sleep and/or appetite, agitation, and multiple somatic complaints.[10] There is recent evidence that major depression is likely to be missed in the presence of physical illness[11] and that psychological symptoms are much less likely to result in a correct diagnosis of depression if invoked late in the consultation.[12]

Depression in old age carries a worse prognosis than earlier in life. This is reflected not only in high rates of persistence and recurrence,[13] but also in increased mortality, particularly in men.[14] Some of the excess mortality is attributable to the associated between depression and poor physical health,[6] but Murphy *et al*[14] have demonstrated that the mortality remains elevated, even after allowing for baseline physical illness. Some of the excess reflects the high suicide rate in the elderly (again, particularly in men) and the strong link in old age between suicide and depression.[15,16] The similarly strong links in old age between deliberate self-harm (DSH), and both depression and subsequent suicide[17] emphasize the need for careful assessment of all acts of DSH by older people, and suggest that the best way to reduce the suicide rate in old age is to improve the detection and management of depression in this population.

The Royal College of General Practitioners[18] recommends that screening for depression (using the Geriatric Depression Scale, GDS[19]) be incorporated into the over-75 health check. The GDS is certainly both feasible and effective in the primary care context,[20] and is amenable to administration by other members of the primary care team. However, screening is only worthwhile if it improves patient outcome; this has not so far been demonstrated.

Clinical trials suggest that both antidepressants and cognitive-behavioural treatment are as effective for depression in old age as they are earlier in life.[21,22] Cognitive-behavioural treatment is seldom available in primary care setting, and therefore, antidepressant drugs are the usual first-line choice. Older tricyclic antidepressants probably carry a greater burden of side-effects (such as postural hypotension and resultant falls, and urinary retention) than their newer and more expensive successors such as the SSRIs.[21] Newer antidepressants are also less dangerous in overdose[15] and can be given safely to a higher proportion of older patients.[7] There is also evidence that relapse rates are markedly reduced (for as long as 2 years) by continued antidepressant treatment.[23] However, a recent study of GP prescribing intentions suggests a widespread reluctance to prescribe antidepressants to elderly people in doses conventionally regarded as adequate and a similar reluctance to continue antidepressant prescriptions for more than 3–6 months.[24] Non-medical members of a primary care team may have an important role in managing depression in old age. A recent study[25] has demonstrated the effectiveness of a primary care nurse in implementing care plans devised by a multidisciplinary old age psychiatry team.

Where does all this leave us? Clearly, there is a need for more primary-care-based research into the natural history of depression in older people, and how it may be better acknowledged and managed. Any primary-care-based training (of GPs and other practice staff) needs to be evidence-based, and tailored to an individual practice's needs and to the resources and support available to it. The consensus view arrived at by the Defeat Depression Campaign needs to be translated into effective practice-based multi-professional training. The RCGP Unit for Mental Health Education in Primary Care is currently working

on this with the assistance of 'LIFT', a non-promotional educational programme funded by Marion Hoeschst Roussel. Any training that is developed needs to take into account the learner's perceived training needs[26] and be well evaluated.[27] In addition, there is, as ever, a need for government support for practice-based mental health training in this area, which has the potential to achieve far greater change than any number of published reports or didactic lectures.

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INVITATION TO TENDER

Promoting Cultural Awareness

For the production of two training packages aimed at general practice registrars and medical students.

In order to secure improvements in the provision of medical care to people from different cultural backgrounds, the Royal College of General Practitioners invites interest from organisations for the production of two educational packages. These packages will help facilitate the teaching of culture in a health care context.

The project is expected to last two years commencing in June 1996, and will be overseen by a steering group appointed by the Royal College of General Practitioners.

The initiative is funded by the Department of Health.

The total funding available for the project is £35,000.

The deadline for applications is 30 April 1996.

Further details of the project can be obtained from Mrs Razvana Kurkic, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London, SW7 1PU, telephone 0171 581 3232 ext 277.