Is personal care important in the diagnosis of depression in older people?

For over 40 years, GPs have been told that they fail to diagnose depression.[1,2] Some studies, however, suggest[2,3] that clinically significant depression (moderate to severe depressive illness) is detected by GPs at later consultations by virtue of the longitudinal patient–doctor relationship and it is milder forms, which may recover spontaneously, that go undetected and un-treated. More recent studies in primary care suggest that the probability of prescribing antidepressants was associated to the severity of the depression, although almost half of the patients who were prescribed antidepressants were not depressed.[4] Other authors draw attention to the dangers of the erroneous diagnosis of depression in patients with a slight psychological malaise and little functional repercussion leading to the risk of unnecessary and potentially dangerous medicalisation.[5]

Depressive disorder affects about one in 10 people aged over 65 years,[6] making it the most common mental health disorder of later life. Depression frequently coexists with long-term physical conditions[7] and is itself associated with physical limitation, greater functional impairment, increased use of healthcare provision, and higher mortality.[8] Older people have the highest suicide rate for women and second highest for men. In contrast with younger people, self-harm in older people usually signifies mental illness, mostly depression, with high-risk of completed suicide.[9] Low levels of detection and treatment of late-life depression[10] have been highlighted in primary care,[11] where evidence suggests a relapsing or chronic course.[12] Detection of depression may be poor if primary care clinicians lack the necessary consultation skills or confidence to diagnose late-life disorders correctly. However, two-thirds of older people with serious depression have symptoms that fit poorly with current classifications of mood disorders. These classifications have been generated to reflect symptoms observed in younger people, and have inherent limitations for diagnosis of depression in older people whose presentation may differ because of aging, physical illness, or both.[13] Thus, older people can present with non-specific symptoms such as malaise, tiredness, or insomnia rather than disclosing depressive symptoms. In addition, physical symptoms, in particular pain, are common and which the primary care clinician may feel represents organic disease; or forgetfulness which leads to concern that this patient has cognitive impairment and early dementia. However, once detected, depression in older people is treatable.[13–15]

There is confusion over what constitutes an ‘older person’, which is compounded by demographic statistics using cut-off of 60 years, and health services often using 65 years. The important point to note is the demographic change that is projected: with the UK population aged over 60 years rising from 21.2% in 2008 to 29.4% by 2050.[16] It is incumbent on health and social care services to respond to the changing needs produced by such demographic changes. There is a strong argument for a redistribution of resources to reflect the rising number of older people and to redress the injustice that can deny older people access to care and treatment that meets need.[16]

Two papers in the Journal this month shed some light on approaches to detection and management[17,18] of depression in older people.

Van Marwijk *et al*[17] suggest that there is evidence that collaborative care (structured care in which non-medical specialists have a greater role in augmenting the care) will improve the outcomes of depression in the short and longer term. Their study, however, concluded that this disease management programme for older primary care patients with major depression was, in general, only slightly more beneficial than care-as-usual. The majority of patients in both groups no longer had a diagnosis of depression at follow-up, possibly, because the patients included in the study had mild forms of depression, so recovery might be expected. In addition, the GPs who participated in the study were highly selected, already interested in depression and familiar with existing guidelines, so care-as-usual provided to control group patients may be already optimal. What is interesting, is the report that of the 95 patients with major depression in the intervention group, only 70 agreed to participate in the study (74%), which may reflect the willingness, or not, of the patients (and the GPs), to accept the diagnosis of depression and its subsequent treatment. Previous research[19] supports this, suggesting that health professionals and patients normalise depressive symptoms, attributing sadness as a normal reaction to chronic ill health and loss. Van Marwijk *et al*[17] suggest that a disease management approach with active follow-up is vital, but this may be ‘not too far from current usual care’. This strategy can be facilitated by relational continuity, which is known to be valued by older people and people with chronic conditions[20,21] and yet may be under threat from proposed changes in primary care.[21]

Mallon and Peat[18] remind us that older people with musculoskeletal pain frequently experience comorbid depressive symptoms that often go undetected. They present findings from a study which involved screening of patients aged 50 years and over, comparing detection of depression by GPs in routine consultations with a self-administered postal questionnaire (HADS). They suggest that the currently recommended ultra-short screening questions fail to identify a large number of those with depressive symptoms including six out of eight patients with severe symptoms. A limitation of the

study is, as the authors acknowledge, that without direct observation of the consultation it is difficult to know how the GPs had adapted and integrated these screening questions into the consultation. They also suggest that the patients in the surgery consultation may 'choose to prioritise their pain, rather than their psychological health, yet feel able to admit low mood when at home'. The authors give no information about whether the patients were consulting their 'usual' GP during the index consultations, and thus do not consider whether this might be a factor in their participants apparently being unwilling to divulge symptoms of distress. What this study does confirm, however, is that the single use of a screening instrument, either as part of a cross-sectional study[2] or as part of routine clinical work as stipulated by the GMS contract,[22] may fail to detect depression in older people. It has been suggested that using an additional question 'is this something with which you would like help?'[23] may improve the performance of the screening questions. However, others caution that the use of such screening instruments may encourage practitioners to take a reductionist, biomedical approach, diverting them from a broader bio–psycho–social approach to both diagnosis and management of patients with depressive symptoms.[24]

Everybody's Business[25] was launched in 2005 to improve health and social care practice at the front line. Of particular note, the Lets Respect Programme led by CSIP (Care Services Improvement Partnership) was designed to help nursing staff in acute hospitals become more aware of the mental health problems that many of their older patients experience. By encouraging a more psychologically-minded approach the programme aimed to provide these nurses with a richer range of options for diagnosis and management. This programme is now being further developed for use in residential homes and primary care with resources that will provide valuable educational aids for clinicians. General practice could learn much from CSIP's approach and resources, and the opportunity to work together should be grasped.

We cannot afford to ignore depression in older people, whether we are clinicians, researchers, health service managers, or commissioners of care. While primary care places itself at the forefront of health care for older people, there are important developments on the horizon.[21] Thus, it is vital to embrace new evidence-based interventions[15] but also incorporate broader initiatives such as those developed by CSIP.[25] Meanwhile, we are reminded by the papers in this Journal that GPs need to be aware of the high prevalence of depression in older people and those who are physically ill. In addition, we should recognise the limitations of simplistic screening questions[24] and value the development and maintenance of a trusting relationship between doctor and patient, which might encourage disclosure of depressive symptoms by older people in the primary care consultation.

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