

Consensus Guidelines

for Assessment and Management of Depression in the Elderly

***Consensus Guidelines for Assessment and
Management of Depression in the Elderly***
Faculty of Psychiatry of Old Age, NSW Branch, RANZCP

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Foreword

The *Consensus Guidelines for the Assessment and Management of Depression in the Elderly* have been produced through collaboration between the Centre for Mental Health, NSW Health Department, and the Faculty of Psychiatry of Old Age, Royal Australia and New Zealand College of Psychiatrists (RANZCP).

The main beneficiaries of the *Guidelines* will be General Practitioners, Health Care Workers in Community Aged Care Services and Adult Mental Health Services. The aim of the *Guidelines* is to improve the capacity of service providers to identify and manage depression in elderly persons. In this process it is expected that access and referral to expertise in the field of old age psychiatry will be improved significantly.

These *Guidelines* are a blueprint for the development of good practice protocols that aim to assist service providers in the management of the elderly who have depression.



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Guidelines

Guidelines

The Guidelines are for use in conjunction with the accompanying Flow Charts (See pages 7-11)

Target group

- General Practitioners
- Health Care Workers in Community Aged Care Services
- Health Care Workers in Adult Mental Health Services

Purpose of guidelines

The purpose of the guidelines is to improve:

- the identification of:
 - elderly persons at risk of developing depressive disorders
 - elderly persons who have depressive disorders
- the management of elderly persons with depressive disorders
- access and referral to experts in Psychiatry of Old Age.

Scope of depression

‘Depressed mood’, while being a normal emotional state and expected in response to many of life’s events, should be distinguished from the psychiatric disorder that causes sustained impairment in physical, social and psychological functioning. ‘Anxious mood’ may be included within the same categories.

Range of conditions

- Major Depression
- Bipolar Disorder occurring as depression
- Major Depression due to a medical condition or its treatments
- Dysthymia, or Chronic Depression

- Complicated Bereavement
- Anxiety conditions
- Adjustment to changes in physical health, social circumstances and stage of life issues that cause depressed or anxious mood
- Abnormal Illness Behaviour

These conditions need to be considered if they are occurring new in old age, as well as recurring patterns from earlier adult life.

It is the recognition of the severity of the mood disorder and the intention to treat that is most important, rather than the specific type of disorder.

Diagnosis

The **Differential Diagnosis** in an elderly person will include:

- dementia
- delirium
- the signs and symptoms of a medical illness itself
- substance dependence and abuse

*(Although these conditions may also be **co-existing** with a depression.)*

Signs of risk for depression in the elderly

In the past

- Previous episodes of Major Depression, mania
- Previous sustained depressive responses to life events
- Personality disorder, or pronounced traits that are dysfunctional, eg, dependence borderline obsessional
- Previous psychiatric disorder
- Chronic physical illness

Recent

- New, potentially life-threatening or potentially chronic illness
- Substance dependence +/- abuse
- Major life event, especially losses (relationships, finance, position/role)
- Cognitive change
- Move to institutional accommodation (there is a higher incidence of depressive disorders as a whole (25%+) and major depression (15%+) within the first year of admission of people to a nursing home)

Symptoms of depression in the elderly

The older person may describe the usual signs and symptoms of depressive disorders, being: *low mood, reduced energy, anhedonia, loss of interest, sleep and appetite disturbance, guilty ideas, psychomotor reduction or increase, impaired concentration and reduced clarity of thought.*

However, particularly relevant to the elderly are:

- **cognitive impairment** generally of recent onset, which may be severe
- **somatic symptoms** over a range of systems.

The assessment of depressive disorder in the person *who already has a dementia* is difficult, especially in the person who has impaired expressive language function. Relevant issues to consider include the *occurrence of recent changes* such as:

- a recent change in behaviour
- a recent change in psychomotor function
- a recent deterioration of biological function – sleep, appetite
- development of depressed affect.

It may be difficult to distinguish the natural progression of a dementia but sudden downturns in the above, unexplained by the development of new intercurrent physical discomfort or illness, should signal that depression be considered.

Your local Old Age Psychiatrist may recommend appropriate tools if you are interested.

Patients who may require an expert opinion

Severe or unusual symptoms

Assessment by a psychiatrist is recommended in any older person who develops a depressive disorder in which any of the following occur or are suspected:

- suicidal ideas or plans
- psychotic signs – *delusions, hallucinations, disorganised thought*
- behaviour disturbance with safety implications for self or others
- new and significant cognitive deterioration
- depression in the context of new physical illness or its treatment
- diagnostic uncertainty
- treatment failure

Suicide

The rate of suicide in the male population aged over 65 years is as high as the well-publicised rates for young males between 18 and 25 years. The elderly may have fewer people with an interest in their well-being, their social reclusiveness may be greater, and the risks unquestioned and unasked. There is no risk of precipitating self-harm by asking about it in an understanding manner, and such questions may allow relief of anxiety, which such ideas generate. The subject may be opened by questions such as:

“On a particularly bad day, do you think about dying....?”

Investigations

Screening tools

There is no shortcut to diagnosis of depressive disorders, which does not include asking several critical questions and matching the responses with an assessment of emotional state, in the light of knowing about the risk factors listed above.

Minimum questions concerning...

- **mood** – ‘can you tell me how your spirits are this week’
- **interest** – ‘what usual interests have you been keeping up’
- **sleep** – ‘what is your sleep pattern’

...may be supplemented by other questions about pleasure in activity, appetite and weight, and about ideas of reduced self-worth, hopelessness, and thoughts of being better dead. This latter issue needs specific questions about suicidal ideas and plans.

There are a number of assessment scales that may be used to complement clinical assessment of elderly people who may have depression. Among these scales are:

- *EBAS-DEP – The Even Briefer Assessment Scale for Depression*, Allen N, et al. A Brief Sensitive Screening Instrument for Depression in Late Life, Age and Ageing, 1994, 23:213–218.
- *The Geriatric Depression Scale (short form)* – D’Ath P, et al. Screening, detection and management of Depression in primary care attenders. The acceptability and performance of the 15 item geriatric Depression Scale and the development of shorter forms. Family Practice, 1994, 11:260–266.

Co-existing and complicating conditions

The newly depressed older person warrants investigation for presence of common underlying physical conditions and investigations relevant to the expression of somatic symptoms at the time of presentation. However, there should not be a delay in commencing treatment for a depressive illness, which is severe – investigations can continue in parallel.

Depression is **NOT** a diagnosis of exclusion. Its recognition as a cause of morbidity in the older person will lead to more effective management. Too often physical symptoms are pursued to exhaustive ends while clear psychological symptoms are ignored.

In all cases of major depression of new onset or altered presentation compared to previous episodes, notwithstanding investigations being conducted for a particular physical illness, the following investigations may be considered after physical examination:

- full blood count
- electrolytes, creatinine, urea
- random blood sugar
- thyroid function
- urine microscopy
- cerebral scan.

Other tests may include B12/folate, chest x-ray, liver function, calcium.

Management – general issues

Goals of management

- Reduce the symptoms of depression
- Improve and maintain a level of social functioning appropriate to the individual’s ability
- Improve contact with helping agents and agencies that may continue to provide support
- Allow continued residence in current accommodation if desired by the older person
- Eliminate risk of suicide
- Improve physical health
- Provide education for carers of the person with depression

The setting of management

Most depressive disorders will be managed with the older person remaining in their own usual accommodation. The requirement for more regular visits by people known to the patient – relatives, the treating practitioner, close friends – is most useful to support the person through a difficult condition. Planned and expected visits can be a comfort to the patient. The absence of all but a treating practitioner may make it necessary to refer to local helping agencies who can respond quickly – the essence of support is that it is personal, starts soon, occurs regularly and predictably, but may be brief.

Hospital referral and management is likely to be required for depressive disorders, and for any of the other disorders within the depression spectrum, where:

- **personal safety cannot be ensured** suicidal ideas/ plans, absence of support
- the depression has produced **significant physical decline which impairs ADL** function to the degree that they cannot look after themselves
- **continued decline in weight and state of hydration**
- **psychotic features exist**

Non-pharmacological management

Nature of management strategies

Supportive therapy

Central to the management of any Depressive Disorder is the presence of a treating professional who attempts to and sustains an engagement with the person, a dialogue based on understanding the depressed person's symptoms, and allowing that person to ventilate problems for discussion and resolution. This is the essential *supportive therapy*. It must be regular, preferably of a predictable duration, and allows for questions by the 'therapist' as well as new input by the patient. Encouragement and optimism by the therapist to the patient are the modes of support, whatever the subject matter discussed.

Various forms of talking therapies have been developed, some based on formal training around manual-directed formats. These therapies, while having semi-structured formats, and requiring the therapist to maintain a focus of problem as agreed with the patient, nevertheless have a basis in support and energy by the therapist. The essence of some of these formal therapies can be done by any willing professional, with guidance from a psychiatrist or other trained professional. Some of these formal therapies are:

Cognitive therapy

The focus is on questioning the rational basis for the depressed person's beliefs, which are often persistently and illogically negative and generalised to everything in the person's life. The questioning may follow the lines of:

- why do you believe...?
- what evidence do you have...?
- what are other possible explanations/solutions...?

The desired outcome is to have the depressed person reduce their tendency to generalise pessimistic ideas about their own actions/health.

Behaviour therapy

The aim is to encourage the patient to engage in a series of activities within their physical capabilities, which are most likely to be pleasurable, and to minimise engaging in chores or disliked activities, based on pre-depressed activity. Feedback by the patient comes in the form of their self-report about their mood during and after activities – activities which give pleasure (or demonstrate improved function) should positively reinforce these same activities to occur more often and be encouraged.

Physical activity of a regular scheduled nature, within reasonably expected physical ability, may be one form of behaviour that has benefits for the depressed person.

Social interactions, often avoided by the person with depression for reasons of shame or guilt, should be encouraged if they can be seen as a potential source of encouragement and positive feedback. Relatives and friends of the depressed person may be spoken to about their assistance, with the permission of the patient.

Behavioural and cognitive therapies are often combined.

Interpersonal therapy

By consideration of the various important relationships in the patient's life, and the areas in which these have become less successful as perceived by the depressed person, strategies can be discussed and enacted which improve the depressed person's views and the way the relationships work.

Frequency of review

The scheduling of weekly review in the first few weeks is appropriate. This will allow assessment of management strategies (non-pharmacological and pharmacological) and progress of symptoms, and reinforce that the condition is being taken seriously.

More frequent review, for example the next day, will be needed for **suicidal ideas** or **psychotic symptoms** provided that the safety of the patient has been assured for the intervening period by:

- a contract made with the patient for safety
- a plan made for the patient to enact should they be overwhelmed by their depressive thoughts and mood
- important others, where possible encouraged to contribute to such a plan of review.

It is not appropriate to keep depressed mood with safety risks private from others who may help, and a patient's desire for privacy in this regard cannot be agreed to.

Pharmacological management

Medication is likely to be needed where there is any sustained depressive disorder and when non-pharmacological strategies are not achieving their goals. Useful signs to indicate commencing medication are:

- presence of biological signs, disturbed sleep, appetite and energy changes
- diurnal variation in mood worse in the morning
- agitation or retardation
- depression with any psychotic features.

All prescribers should acquaint themselves with the relevant drug prescribing information, including drug interactions, before using any medication.

Doseage recommendations can be obtained from the official prescribing information and from publications such as Psychotropic Drug Guidelines.

Essential guide to using any antidepressant

- Beneficial effects may take 2 to 3 weeks to begin and continue from then.
- All antidepressant medications have been shown to be effective. Personal familiarity with a few, across different groups, is of assistance in making a choice for patients with different clusters of symptoms and sensitivity to side effects.
- An adequate trial of any one medication is a minimum 4-6 weeks at the maximum tolerated dose.
- Once remission has occurred, the same dose should be maintained.
- Medication may not be forever, but 12 months is a reasonable period of treatment after full recovery from a first episode.

Continuation beyond this should be discussed with a psychiatrist, and will depend on:

- the severity of the index episode
- the frequency of past episodes
- adequacy of remission.

Anti-depressant medicines

First line

A patient who has been successfully treated with an anti-depressant in the past may have a trial of that same medication in a recurrence, provided there are not any new contraindications for that medication.

On the basis of a more acceptable profile of side-effects in the elderly, the usual first choices for antidepressants would come from the following:

- SSRI – citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
- SNRI – venlafaxine
- MAO-I – moclobemide
- nefazadone
- mianserin
- mirtazepine

Second line

The medications used as a second line are all effective antidepressants, which have the potential to give more side-effects to the elderly, such as:

- anticholinergic effects, dry mouth, confusion, constipation.
- postural hypotension
- toxicity in overdose
- affect cardiac rhythm in those predisposed

The second line medications are the:

- **Tricyclic antidepressants** – agents without significant active metabolites are preferred for the elderly, being nortryptiline, dothiepin
- **MAO-inhibitors** – phenelzine.

Agents which may augment antidepressants

After discussion with a psychiatrist, a second mood stabilising medication may be used to augment the partially beneficial effects of a first antidepressant. Lithium carbonate and liothyronine (T3) are used in this regard.

Antipsychotic medications are often used in the early stages of a depression where psychotic features are troublesome – a few weeks might be the maximum time. They are usually a temporary addition to the antidepressant and have a strong potential to cause extra-pyramidal movement disorders if continued longer term.

Other agents used to treat depression

The use of other herbal preparations has some community use but at this stage the effectiveness of these preparations remains contentious given the small number of published studies and cohort selection. It is necessary to ask about their use by every patient because of the known interactions with conventional antidepressant medications.

Hospital management

Most patients with any type of depression will be managed where they reside. Some will require temporary increase in support, which may come from spouse, family, friends and neighbours. Community Services should be sought to augment these possibilities.

Admission to hospital can be essential where the depression:

- is severe enough to impair reasonable daily living function and supports cannot be put in place
- has safety issues – suicidal ideas or plans, psychotic signs, severe psychomotor agitation or retardation
- has not responded to fair treatment.

Hospital treatment, in addition to supporting personal function, may offer:

- further trials of medication
- **Electroconvulsive Therapy**, perhaps the most effective antidepressant therapy, with a safety profile better than some medications, and a more rapid onset of action than antidepressant medications.

Prognosis

The most serious problem in the management of mood disorders in the elderly, after non-recognition, **is a failure to give adequate treatment for long enough**. Outcome studies have shown that adequate treatment, whether the person is at home or in institutional care, has a good chance of recovery from the episode of depression. You may expect at least 50% of your patients to make a full recovery and at least a further 25% to make some improvement. Continuing treatment and maximising the range of supportive treatments used will increase the chances of recovery.

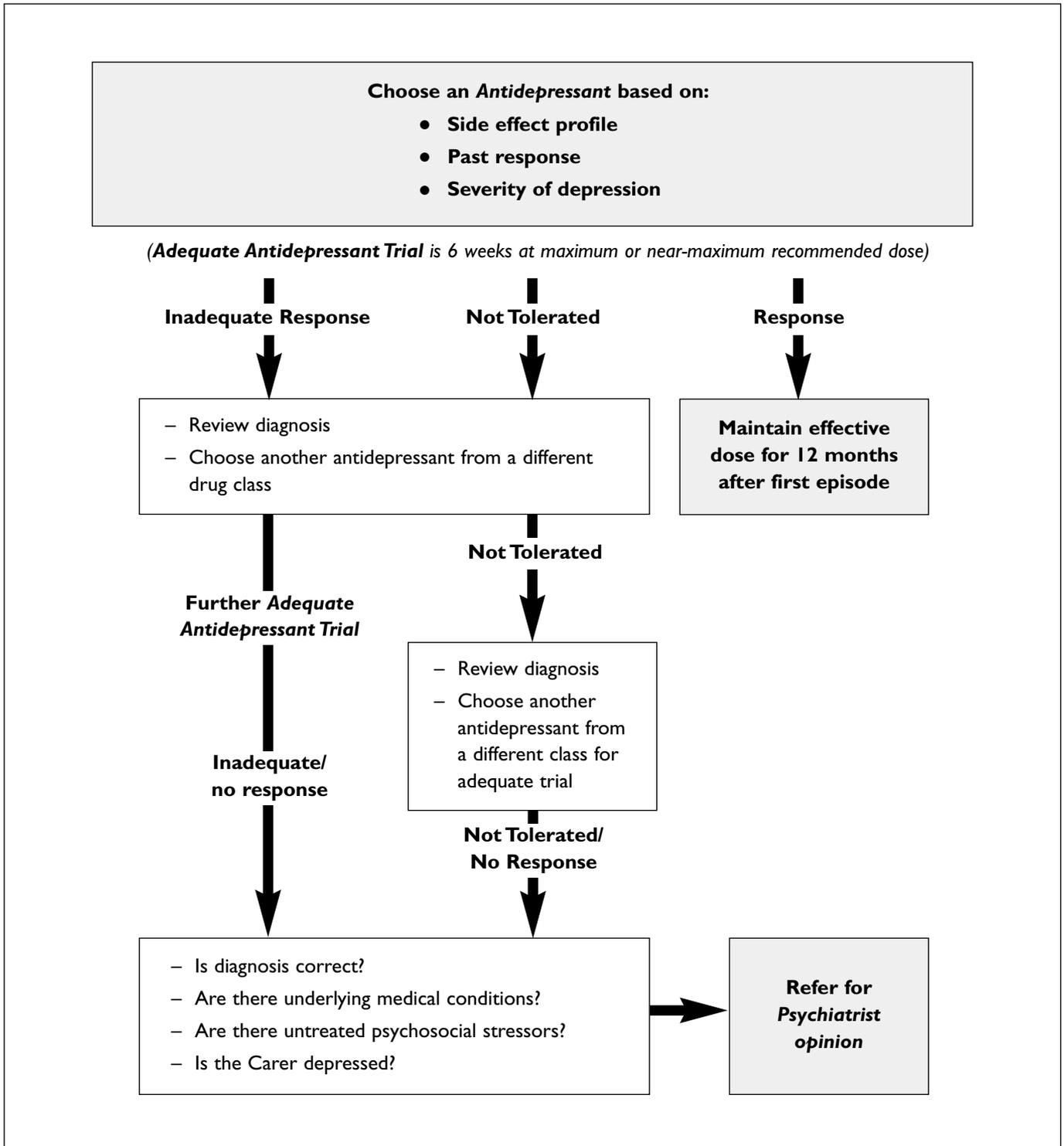
Supportive treatments including:

- the talking therapies
- practical improvements to physical and social surroundings
- optimising management of underlying physical illness and disability

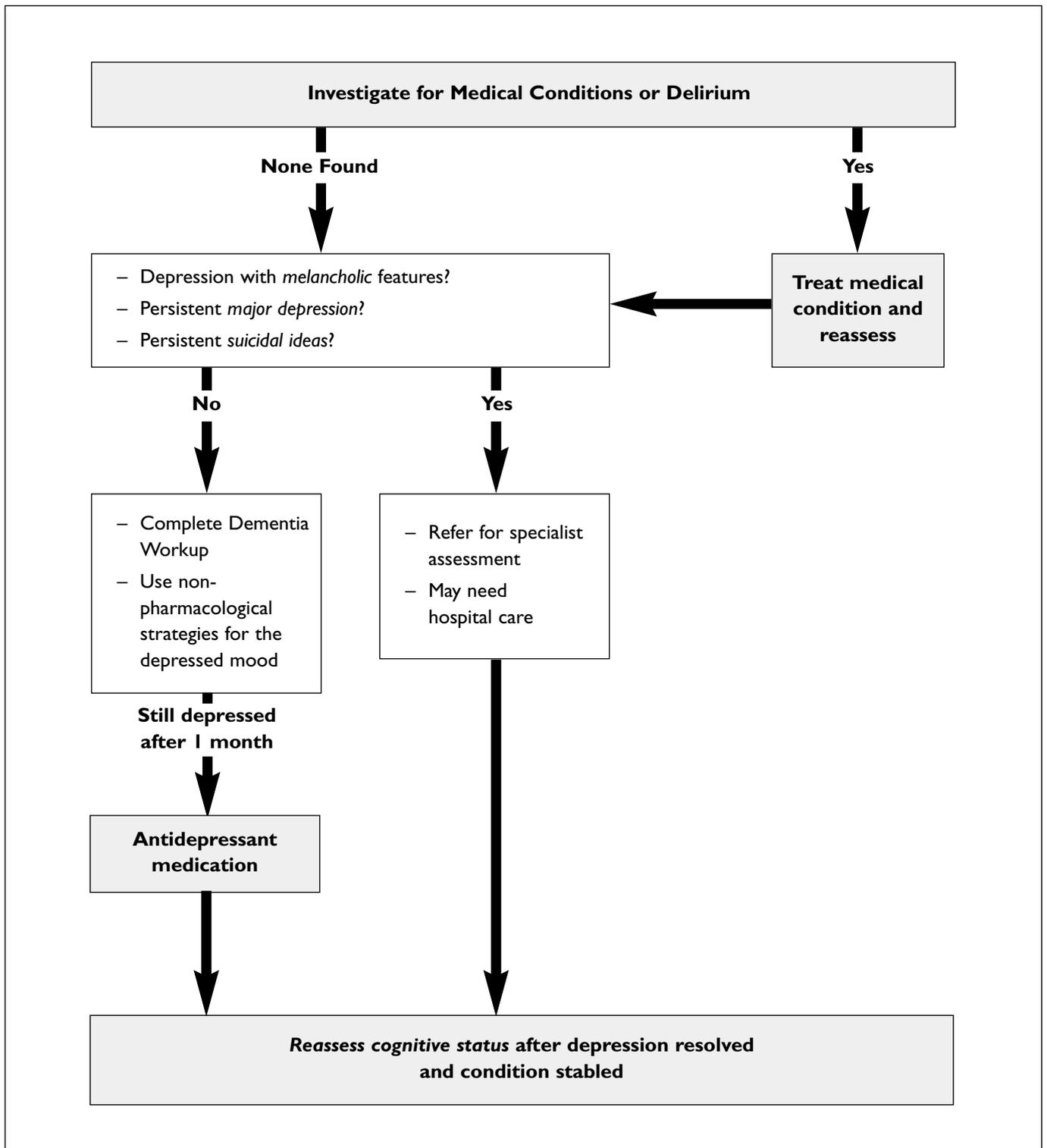
.. will all contribute to patient well-being and recovery.

Flowcharts

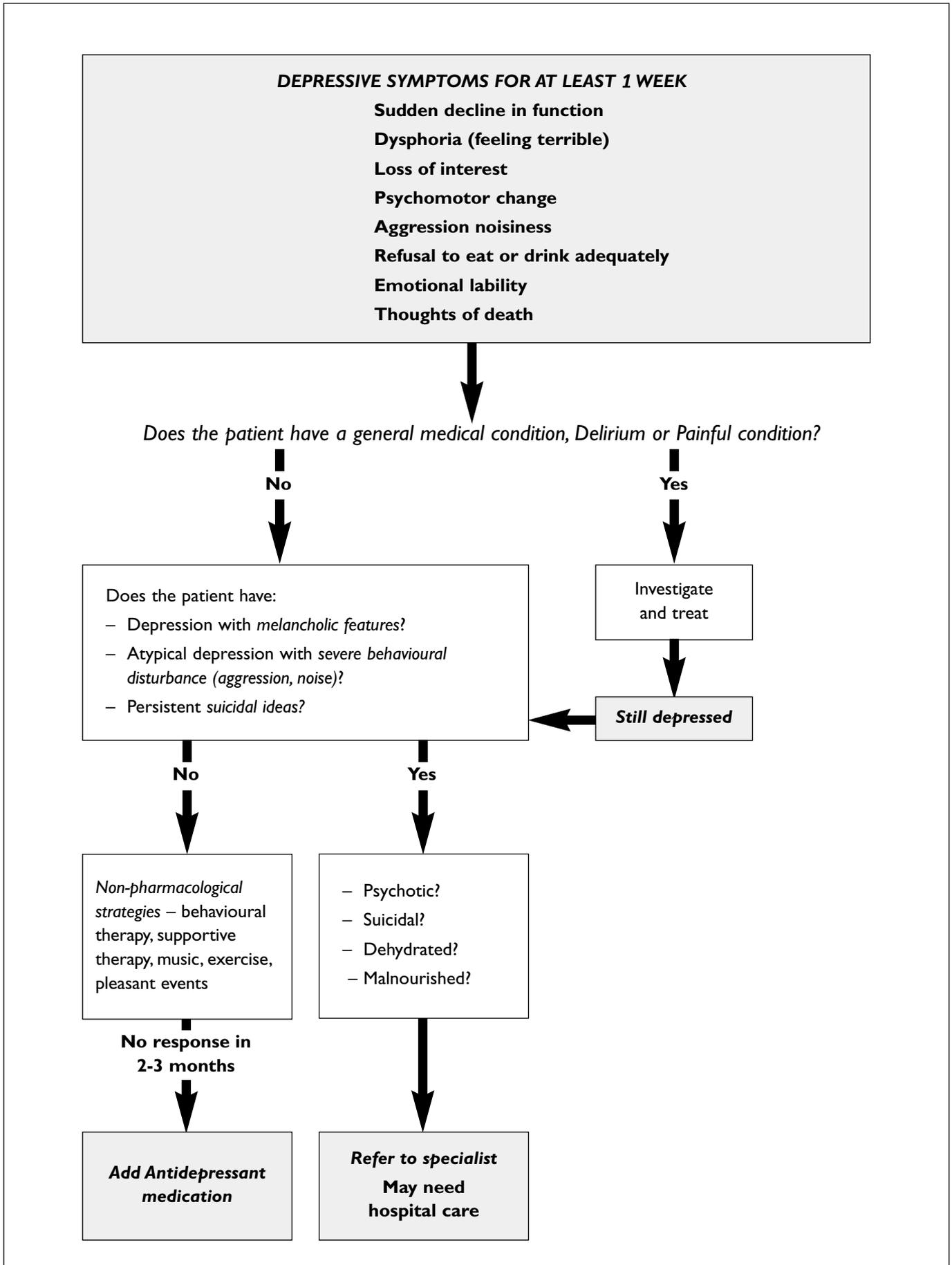
A. Use of antidepressant medication in the elderly



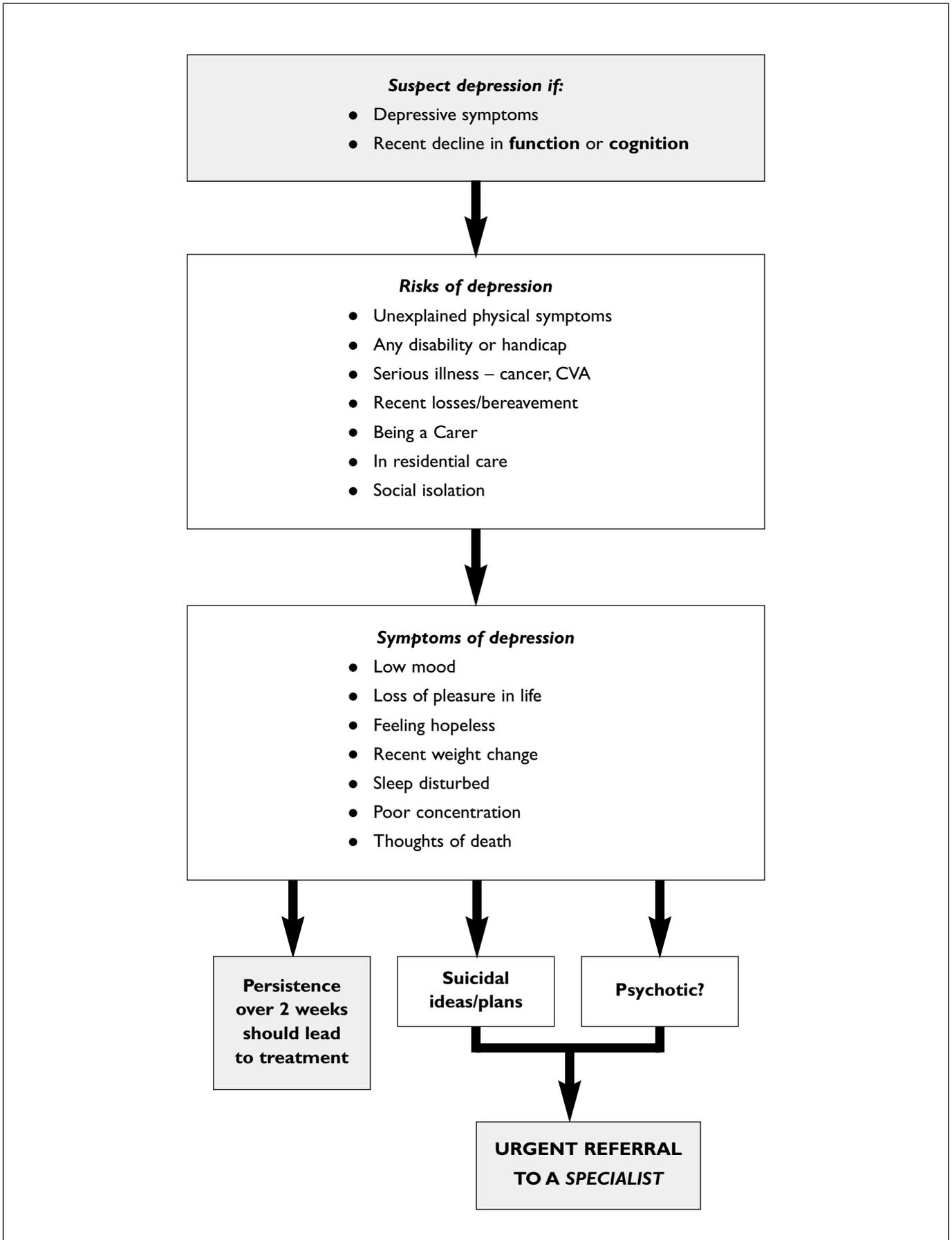
B. Management of depression with cognitive impairment at initial presentation



C. Management of depression in a patient with dementia



D. Detection of depression in the elderly



E. Suicide: risk assessment and management

