



INTRODUCTION TO MENTAL HEALTH IN OLD AGE

DR CHARLOTTE GREENWAY

OLDER POPULATION IS GROWING RAPIDLY

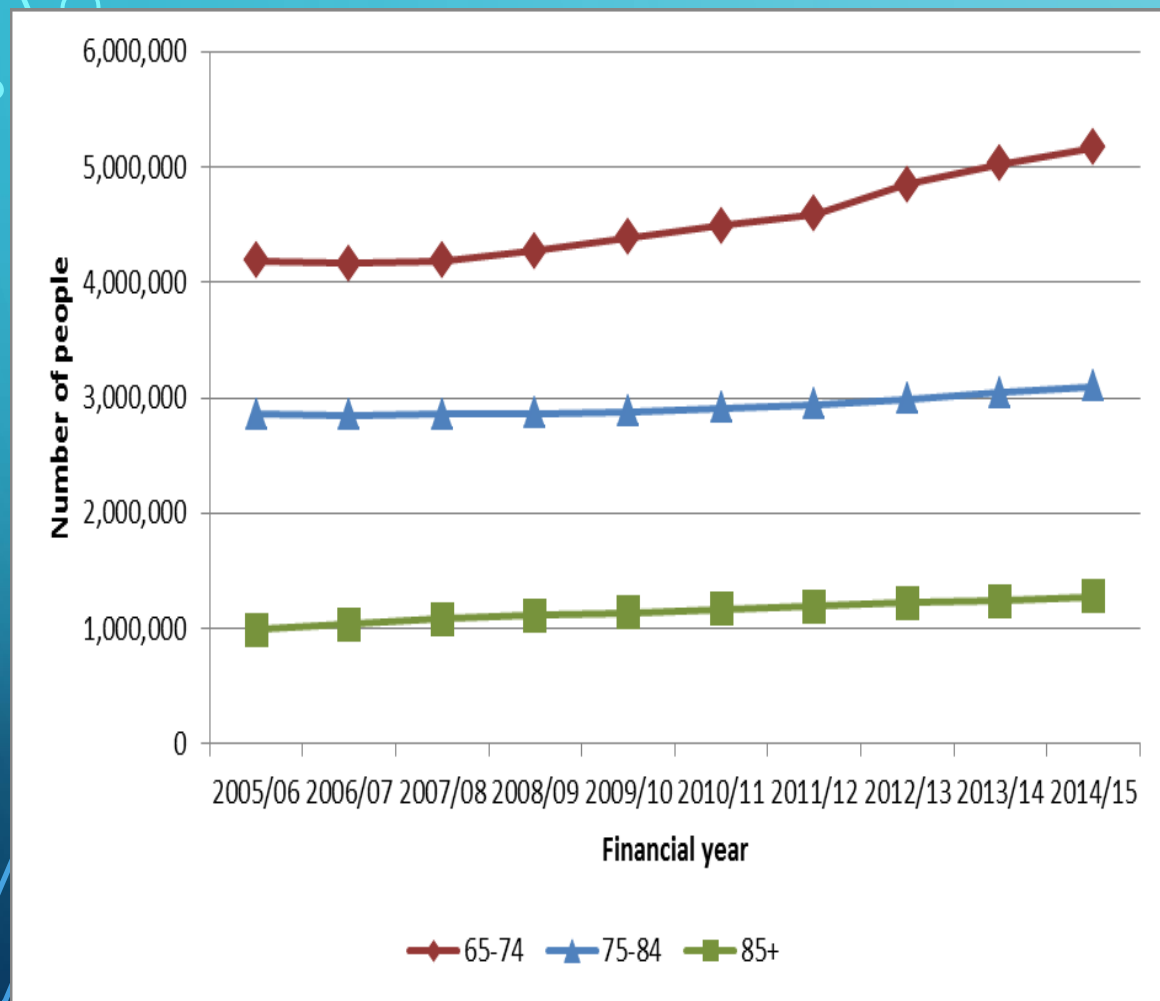


Figure 1: Number of people aged 65 or over in England by age group, 2005/06 to 2014/15

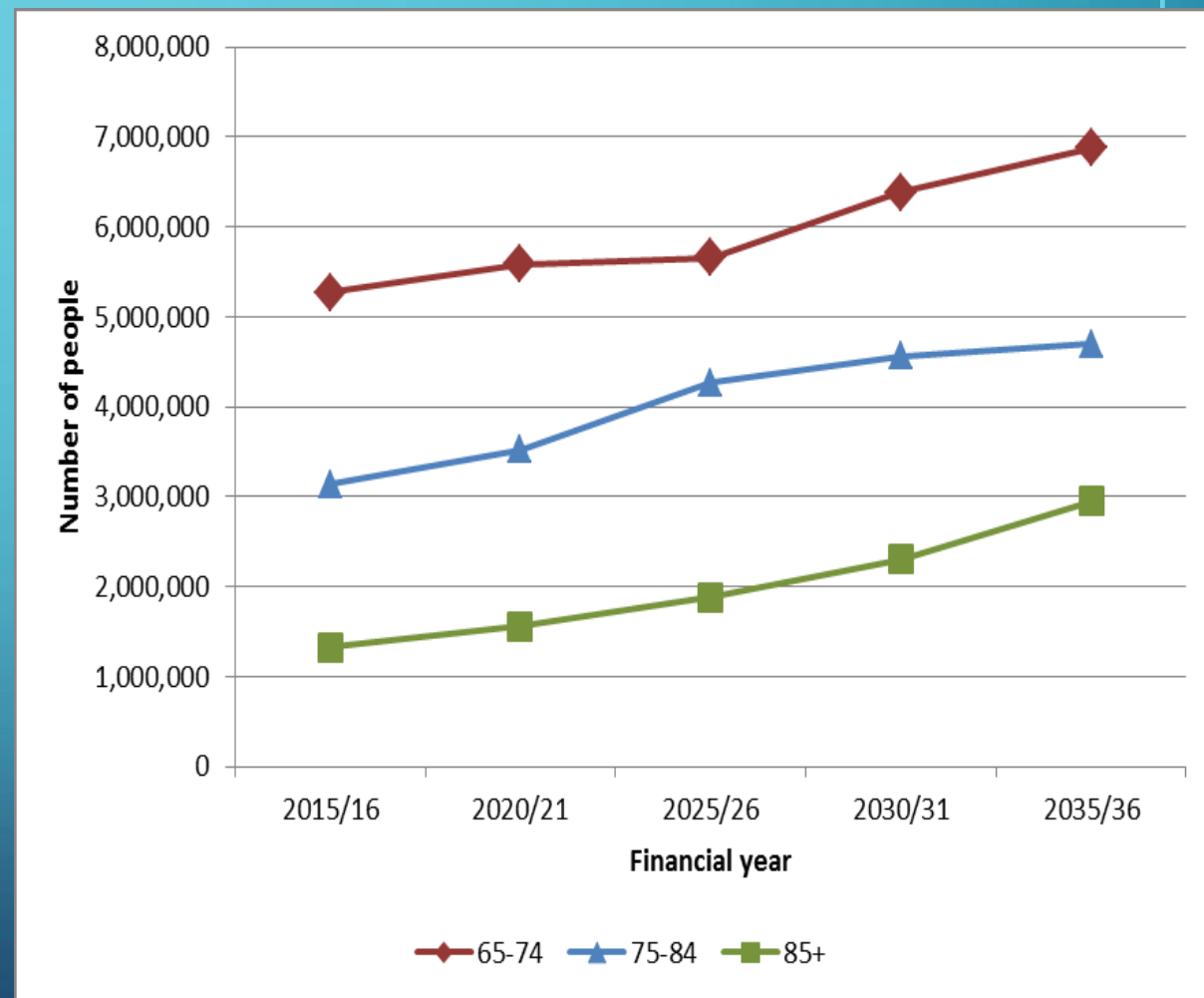


Figure 2: Projected number of people aged 65 and over in England by age group, 2015/16 to 2035/36

MENTAL HEALTH IN OLD AGE



Mental health problems are not a normal and inevitable part of the ageing process. The majority of older people enjoy good mental health and make valuable contributions to society.

Promoting mental health and well-being in later life will benefit the whole of society by maintaining older people's social and economic contributions, minimising the costs of care and improving quality of life.

FIVE MAIN AREAS THAT INFLUENCE MENTAL HEALTH AND WELL-BEING IN LATER LIFE

Discrimination

Participation in meaningful activity

Relationships

Physical health

Poverty

Discrimination on the basis of age is the most common type of prejudice experienced by people aged 55 and over = negative effect on their mental health. The stigma attached to mental illness multiplies the difficulties for older people with mental health problems.

What needs to be done?

- Promote age equality, particularly within mental health promotion
- Work with the media to improve portrayals of ageing and older people
- Educate and train all employees who have direct contact with the public to value and respect older people
- Promote intergenerational activities to strengthen understanding and respect between younger and older people
- Teach younger people about ageing so that they can prepare themselves for good mental health and well-being in later life

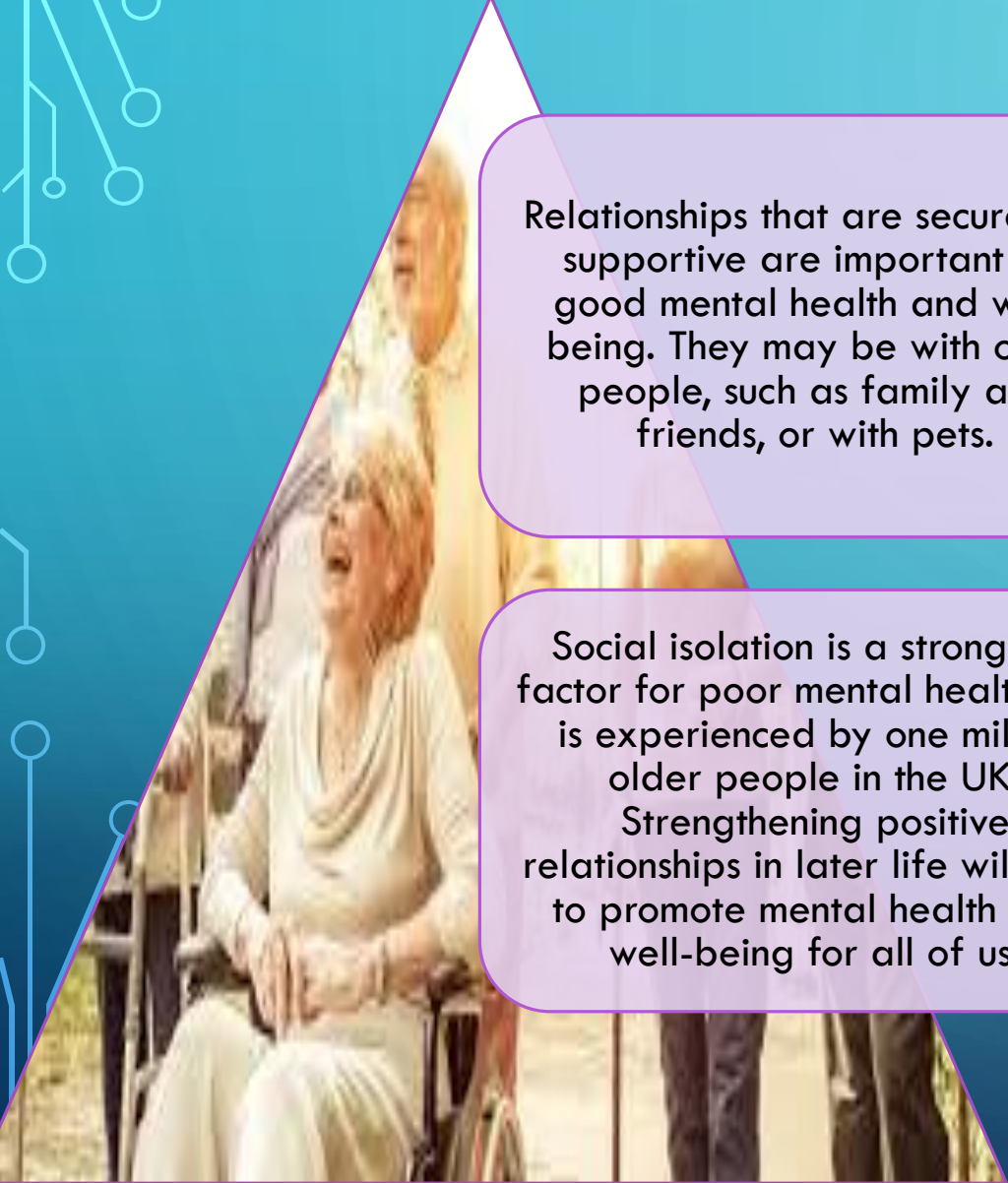
FIVE MAIN AREAS THAT INFLUENCE MENTAL HEALTH AND WELL-BEING IN LATER LIFE

Participation in meaningful activity, staying active and having a sense of purpose are just as important for the mental health and well-being of older people as they are for younger people. Yet older people face barriers to participation in many areas of public and private life.

What needs to be done?

- Recognise the skills and knowledge that older people have to contribute and provide opportunities for older people to share these with people of all ages
- Remove or reduce barriers to participation in later life
- Promote opportunities for lifelong learning for people of all ages
- Help people to take planned flexible retirement

FIVE MAIN AREAS THAT INFLUENCE MENTAL HEALTH AND WELL-BEING IN LATER LIFE



Relationships that are secure and supportive are important for good mental health and well-being. They may be with other people, such as family and friends, or with pets.

Social isolation is a strong risk factor for poor mental health and is experienced by one million older people in the UK. Strengthening positive relationships in later life will help to promote mental health and well-being for all of us.

What needs to be done?

- Recognise and strengthen the existing positive
- Tackle fear of isolation and loneliness for people of all ages
- Recognise and tackle abuse and violence that affects older people
- Provide support to people following bereavement
- Recognise the importance of pets and support pet ownership
- Recognise the importance of spiritual belief and faith communities ensure that people are able to access them
- Promote social interaction between people of all ages
- Include older people in community development initiatives

FIVE MAIN AREAS THAT INFLUENCE MENTAL HEALTH AND WELL-BEING IN LATER LIFE

Physical health and mental health are inextricably linked. Good physical health is associated with good mental health. Poor physical health is associated with poor mental health. Physical health is an important issue for many older people and improving it will improve mental health as well.

What needs to be done?

- Promote holistic definitions of health which include mental as well as physical health
- Promote physical activity for people of all ages, including people with disabilities
- Provide information, encouragement and opportunities to engage in physical activity and make other healthy lifestyle choices
- Promote a healthy diet and moderate alcohol consumption
- Improve access to fresh, affordable foods

FIVE MAIN AREAS THAT INFLUENCE MENTAL HEALTH AND WELL-BEING IN LATER LIFE

What needs to be done?

- Tackle pensioner poverty for older people
- Give people the choice to keep working in later life to maintain or increase their income
- Provide financial and practical assistance to help improve older people's homes

Poverty is a risk factor for poor mental health. Nearly two million older people in the UK live in poverty. It is not money *per se* but the things it can provide that are important to making people feel included in society in later life. Older people want to have enough money to afford decent housing, heating, travel, social activities and occasional “treats” – for themselves and for others – that allow full participation in family and community life.

DEPRESSION IN OLD AGE



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PREVALENCE OF DEPRESSION IN OLDER PEOPLE



One in four of older people in the community have symptoms of depression (Godfrey M et al, 2005).

The risk of depression increases with age so that 40% of those over 85 are affected.

A chronic disorder with the majority of older patients having a recurrence within three years (Reynolds, Perel, Frank et al (1999).

Some groups are at higher risk of depression: Care home residents (where up to 40% may be depressed (Age Concern, 2006)

Between 20 - 25% of people with dementia also have symptoms of depression (Amore, Tagariello, Laterza, Savoia, 2007).



POTENTIAL RISK FACTORS

Psychosocial factors

- Limited social support
- Bereavement
- Loss of social network
- Loneliness

Biological factors

- Female gender
- Family history of depression
- History of depression
- Negative life events

Clinical factors

- Medical illness
- Physical disabilities
- Poor health
- Multiple medications

SCREENING FOR DEPRESSION DIAGNOSIS OF DEPRESSION

A major depressive episode may include these symptoms:

- Persistent sad, anxious or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities, including sex
- Decreased energy, fatigue, feeling "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Low appetite and weight loss or overeating and weight gain
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and pain for which no other cause can be diagnosed.

Five (or more) have been present during the same 2-week period and represent a change from previous

DIAGNOSIS

Depression Assessment

Assessment/Monitoring

http://www.dementia-assessment.com.au/depression/geriatric_depression_scale_short.pdf

Patient Health Questionnaire (PHQ-9)

Geriatric Depression Scale (GDS) Short-Form

9-item, patient-rated depression scale to assess symptoms to make a tentative depression diagnosis

15-question survey that is patient-rated; scores of >5 should prompt a comprehensive assessment

http://www.cqaimh.org/pdf/tool_phq9.pdf

PHQ-9

For residents who can report mood symptoms

Based on DSM-IV criteria

Validity well established in other settings; increasing use and recognition by clinicians

Allows threshold definition AND rapid sum of a severity score that can track change over time

Used in outpatient elders, hospital, rehabilitation and home health populations

PHQ-9-OV

New observational items: only completed for residents who cannot self-report

includes irritability item

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 (Foresight Mental Capital and Wellbeing Project, 2008).

BARRIERS TO DIAGNOSING DEPRESSION



Patient factors

- **Non-specific symptoms** such as malaise, tiredness or insomnia rather than disclosing depressive symptoms.
- **Physical symptoms**, including pain, are common – depression related or not
- **Forgetfulness** may lead to concern that a patient has cognitive impairment or early dementia. (Rabins, 1996).
- 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.
- They may **misattribute symptoms** of major depression to 'just old age', (Burroughs, Morley, Lovell et al, 2006) ill health or grief.

BARRIERS TO DIAGNOSING DEPRESSION

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**'. They may feel unsupported due to a lack of availability of psychological interventions (Burroughs, Morley, Lovell et al, 2006).



BARRIERS TO DIAGNOSING DEPRESSION



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 (Rait, Burns, Chew, 1996)
- 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** (NHS Confederation, 2003).
- New contractual arrangements for primary care provide no new incentives to offer reconfigured services for older people with depression. However, initiatives to improve access to psychological therapies (IAPT) are also beginning to make psychological treatments available to older people (Department of Health, 2011).

MANAGEMENT OF DEPRESSION IN OLDER PEOPLE IN PRIMARY CARE

Case-finding and diagnosis

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?

The Quality and Outcomes Framework (QOF) (Department of Health, 2006) 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 in practice.

MANAGEMENT OF DEPRESSION IN OLDER PEOPLE IN PRIMARY CARE



Medication

Antidepressants for people with moderate to severe depression.

NICE guidelines 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.

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.

Psychological and talking therapies

Many older people express a **preference for a talking treatment** 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 (Woods, Roth, 2005; Givens, Datto, Ruckdeschel et al, 2006).

There is evidence, however, that GPs continue to refer younger rather than older people for talking treatments (Kendrick, Dowrick, McBride et al, 2009).

MANAGEMENT OF DEPRESSION IN OLDER PEOPLE IN PRIMARY CARE

Physical activity

- Exercise is recommended as a treatment for mild to moderate depression (NICE, 2009).

Psycho-social interventions

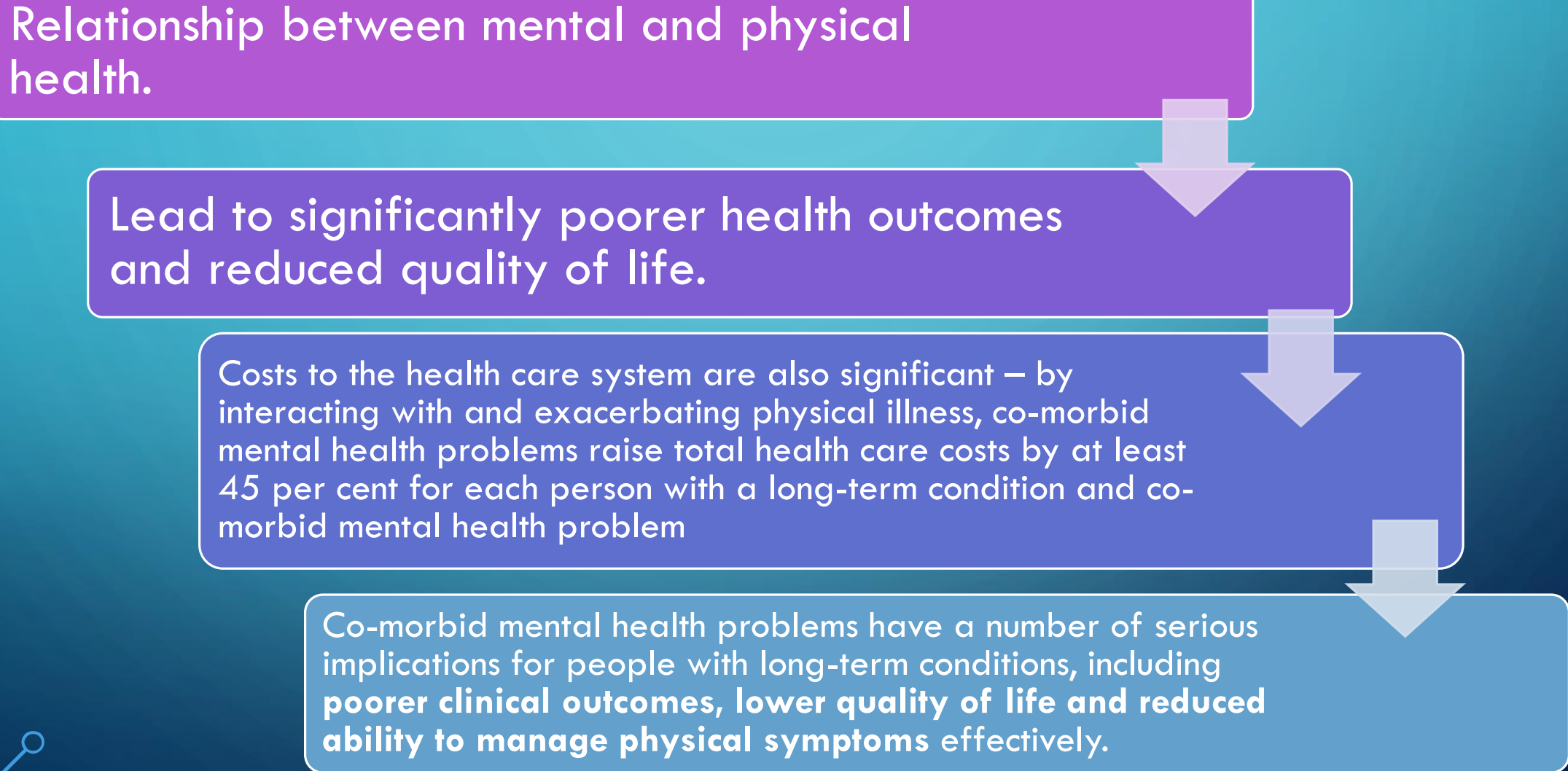
- Befriending may also be useful in management of mild depression in older people (Mead, Lester, Chew-Graham et al, 2010).

Collaborative care

- A case manager co-ordinates care and delivers a specific psycho-social intervention with or without medication management, and liaises with both the GP and the specialist mental health services. (Chew-Graham, Lovell, Roberts et al, 2007).

THE IMPACT OF DEPRESSION ON THE ELDERLY

Relationship between mental and physical health.



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graph TD; A[Relationship between mental and physical health.] --> B[Lead to significantly poorer health outcomes and reduced quality of life.]; B --> C[Costs to the health care system are also significant -- by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem]; C --> D[Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms effectively.];
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Lead to significantly poorer health outcomes and reduced quality of life.

Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem

Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including **poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms** effectively.

POORER CLINICAL OUTCOMES AND PROGNOSIS

Cardiovascular patients with depression experience 50 per cent more acute exacerbations per year (Whooley et al 2008) and have higher mortality rates (Katon 2003).

A meta-analysis suggested that depression leads to a two- to threefold increase in **negative outcomes** for people with acute coronary syndromes (Barth et al 2004).

Lesperance et al (2002) - depression increases mortality rates after heart attack by 3.5 times

Blumenthal et al (2003) – a twofold increase in mortality after heart bypass surgery over an average follow-up period of five years

Patients with chronic heart failure are **eight times** more likely to die within 30 months if they have depression (Junger et al 2005).

POORER CLINICAL OUTCOMES AND PROGNOSIS

Mental health problems can also have a major impact on symptoms and outcomes for people with COPD.

Independent of COPD severity, co-morbid mental disorders are associated with worse health status and breathlessness (Felker et al 2010).

There is some evidence that depression increases mortality rates from COPD, though this is not observed in all studies (Wilson 2006).

Furthermore, recent analysis of the United Kingdom General Practice Research Database reported that mortality rates for individuals with co-morbid asthma and depression were twice the level among those with asthma alone (Walters et al 2011).

ADVERSE HEALTH BEHAVIOURS AND POORER SELF-CARE

Self-management is at core of effective treatment for long-term conditions – but is **impeded significantly by poor mental health**, which can reduce the motivation and energy needed for self-management, and lead to **poorer adherence** to treatment plans (DiMatteo et al 2000).



A significant part of the explanation for poorer clinical outcomes is that co-morbid mental health problems can **reduce a person's ability to actively manage their own physical condition** and are associated with unhealthy behaviours such as smoking.



For similar reasons mental health problems are also associated with low attendance rates for medical appointments.

ADVERSE HEALTH BEHAVIOURS AND POORER SELF-CARE

For cardiac patients, depression has been shown to increase adverse health behaviours (eg physical inactivity) and **decrease adherence to self-care regimens** such as smoking cessation, dietary changes and cardiac rehabilitation programmes (Benton et al 2007; Katon 2003).

One study found that adverse behaviours explained much of the increase in cardiovascular events among depressed patients (Whooley et al 2008).



Similarly, **non-compliance with medication** is higher among COPD patients with depression than those without. A review found that patients with a range of medical conditions are **three times less likely to take medications as recommended if they also have depression** (DiMatteo et al 2000).

Co-morbid mental health problems lead to greater difficulties with diabetes self-care (Das-Munshi et al 2007) and are associated with **poorer dietary control** and adherence to medication (Vamos et al 2009).

LOWER QUALITY OF LIFE

There is evidence that **quality of life** for those with some **co-morbid mental and physical health problems** is considerably worse compared with the quality of life for people with two or more physical health problems.

Co-morbid mental health problems can exacerbate the level of functional disability experienced by people with long-term conditions (Molosankwe et al in press).

Schmitz et al (2007) reported much higher risks of **functional disability** in people with long-term conditions and depression compared with people with depression or long-term conditions alone.

For example, in cardiovascular diseases, **depressive symptoms can have a bigger impact on quality** of life than severity of cardiac problems (de Jonge et al 2006)

Yohannes et al (2010) the presence of co-morbid mental health problems can have a greater effect on the functional status and quality of life of people with long-term conditions than the level of severity of their physical illness

INCREASED SERVICE USE

Depression is associated with an increase in re-hospitalisation rates in cardiovascular disease – for patients with chronic heart failure the emergency admission rates are two to three times higher (Himelhoch et al 2004; Fenton and Stover 2006)

COPD patients with co-morbid mental health problems have more than **50 per cent more acute exacerbations per year** (Laurin et al 2009), experience higher rates of hospitalisation, and in one study spent twice as long in hospital as those without mental health problems (Yellowlees et al 1987).

A UK survey found that people with co-morbid mental health problems and diabetes experienced more hospital admissions and GP consultations for physical complaints (Das-Munshi et al 2007).

International studies report similar findings - the presence of mental health problems increases risk of admission by **2.8 times**, causes slight increases in length of stay, and doubles the use of outpatient services (Krein et al 2006; Vamos et al 2009).

HEALTH SERVICE COSTS

There is strong evidence that by interacting with and exacerbating physical illnesses, co-morbid mental health problems significantly increase the costs of providing care to people with long-term conditions.



Much of this evidence is from outside the United Kingdom, but it nonetheless provides relevant insights.

USA national claims data for more than nine million people showed that patients with long-term conditions who were also receiving treatment for depression or anxiety had average monthly medical costs that were between 33 per cent and 169 per cent higher over a range of conditions.

Importantly, these costs excluded direct expenditure on mental health services (Melek and Norris 2008).

THE IMPACT OF DEPRESSION

Depression in later life takes a significant toll on patients and families alike.

Family members of depressed older adults experience the moderate to high levels of general caregiver burden that dementia caregivers often report (Sewitch, McCusker, Dendukuri, & Yaffe, 2004).



Often exhibit cognitive deficits compared to healthy individuals in the same age group.

Memory and executive function - most consistently impaired (Kohler et al., 2010).

Association between Impaired cognition and altered cortisol secretion in older patients with major depression

(Fiocco et al., 2006)

THE IMPACT OF DEPRESSION

Memory functions are effected

- trouble initiating tasks
- making decisions
- planning future actions
- organizing thought.

Caused by neurotransmitter imbalances (that enable individual brain cells to "talk" to each other and store new memories).

Depression skews the types of memories people tend to recall while in the grip of melancholy. We all tend to remember happy events when we are happy and sad events when we are sad. A depressed person tends to recall mostly the negative, unhappy experiences. This can appear to family and friends as a loss of memory. It also reinforces the person's drab and negative view of life, fueling the depression.

(Pendick, 2001)

It is also well known that depression **impairs the ability to create long-term memories** - a lack of attention and concentration. Creates a loss of coordination between working, short-term, and long-term memory. A depressed person may be too inattentive and unfocused to file passing events in short-term memory. In this case, it isn't so much that the depressed person has forgotten, but that the memory was never stored in the first place.

THE IMPACT OF DEPRESSION

Depressed patients showed deficits in attention and processing, executive function, and immediate explicit recall. Implicit learning and episodic recall of the testing procedure, semantic and phonetic fluency, and retention of newly acquired verbal material after a delay period were comparable with controls. (Elderkin-Thompson, et al, 2011).

depression-executive
dysfunction
syndrome"

Patients with the DED syndrome had reduced fluency, impaired visual naming, paranoia, loss of interest in activities, and psychomotor retardation, but showed a rather mild vegetative syndrome.

THE IMPACT OF DEPRESSION



Geriatric depression has been associated with impairment in short-term memory, psychomotor functioning (Hart, et al , 1987) and visuospatial skills (Boone, 1995).



Studies of geriatric patients with major depression have documented **disturbances in executive functioning** (Lesser, et al, 1996, Butters, 2000), including impaired planning, organizing, initiating, sequencing, shifting, information processing speed, and working memory.

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