Depression in elderly inpatients: are we doing enough?

As medical students, we are often informed that we are the 'best people' to talk to elderly inpatients, because we have the time to listen to their stories without the looming spectre of other never-ending ward jobs. We are told to make the most of this opportunity, as it is a luxury that will not be afforded to us come qualification.

In effect, this is probably true and many medical students, the authors included, enjoy conversing with our patients. Many hours are spent discussing patients' life stories and experiences. Often these are joyful recollections of events in the past, but with alarming frequency patients instead talk of their pain and fear, their family woes and more often than not, their loneliness. This is often the first insight into the mental state of the patient. While students may have the time and eager ear to listen, hopefully passing the information on, many patients' stories go untold, with any underlying depression unidentified and untreated.

Impact and interventions

Depression in the elderly is an increasingly recognized problem, its prevalence uncertain. It has been estimated at 17.7% in a UK hospital inpatient setting (Cullum et al, 2006), with other studies finding higher prevalence rates. Worryingly, in this group depression has been shown to be associated with increased mortality, including suicide. Covinsky et al (1999) demonstrated a 34% higher mortality rate in medical patients with depressive symptoms compared to those without over a 3-year period. They found this association to be independent of co-morbid illness, functional or cognitive impairment. This results in significant increased health-care costs to the NHS (Katon et al, 2003).

In 2001 the National Service Framework for Older People recommended early recognition and treatment of depression to reduce the symptoms and co-morbidities associated with the condition (Department of Health, 2001). Elderly patients suffering from depression respond to both psychological and pharmacological treatment for the condition. In 2001, a Cochrane review by Wilson et al identified efficacy with use of selective serotonin-reuptake inhibitors, tricyclic antidepressants and monoamine oxidase inhibitors given for at least 6 weeks. These agents have been found to be effective in depressed older people both in community and inpatient settings. The study further demonstrated the efficacy of these antidepressants in patients with significant intercurrent physical illness, itself a risk factor for depression.

A further Cochrane review by Wilson et al (2008) looked more specifically into studies of behavioural therapies such as cognitive behavioural therapy in older people. It found some evidence that, over a broad age range, cognitive behavioural therapy may be beneficial. Specifically in older patients, however, the evidence for efficacy was less clear.

Disappointingly, as a result of a lack of resources among other reasons, behavioural and psychodynamic therapies are often overlooked in favour of simpler and less expensive pharmacotherapy, despite being a recommendation of the National Service Framework for Older People (Department of Health, 2001). In addition, all patients with depression must have a risk assessment and consideration given to their social needs, particularly if these are a contributing factor to the depressive state (Department of Health, 2001).

Current limitations

Despite the wide availability of effective treatments for depression in older patients, it remains an under-recognized and under-diagnosed condition with one UK community-based study noting that, despite patients with depression being high users of health services, only 10% of those presenting were being appropriately managed (Livingston et al, 1997). These relatively low levels of detection in the community make it even more important to use the opportunity of an inpatient admission to screen and begin treatment for affected patients.

In addition, elderly patients are much more likely to present atypically with somatic symptoms such as pain and nausea or with psychiatric symptoms such as memory impairment, generalized anxiety and sleep disturbance (Katona et al, 1997). These can be difficult to interpret among other significant medical symptoms. The attitude of health-care professionals to aging also appears to be an important factor in the initiation of an intervention. Studies have found a widespread view that depression is a normal and inevitable aspect of aging. It has also been suggested that depression is of secondary importance in patients with concurrent medical conditions (Wilson et al, 2001). This is a particularly worrying finding considering the link between depression and increased morbidity and mortality.

Screening

Screening tools have been introduced in an attempt to diminish this under-diagnosis. The Geriatric Depression Scale is the screening method recommended by the British Geriatric Society and the assessment tool taught at many medical schools. However, this is a lengthy assessment and hence it is frequently not used.

Short scales are available, and include a shortened Geriatric Depression Scale (D'Arth et al, 1994). Pomeroy et al (2001) showed this to have comparable sensitivities and specificities to the full Geriatric Depression Scale for detection when used in medically unwell older patients. The shorter Geriatric Depression Scale is a simple 15-question questionnaire with yes or no answers which provides a score relative to a depression scale. In addition simply asking patients if they are depressed has been found to be effective. These shorter screening tools have the potential to improve depression detection rates in elderly patients without excessively increasing the workload of health-care professionals.

Unfortunately, while often effective and easy, screening tools dominate the life of the geriatric doctor or nurse. Falls, infection, activities of daily living and cognitive impairment assessment tools are all currently in place to varying degrees in geriatric wards. Singly these are valuable and relatively time-sparing tools, but when added together place quite a burden on the practitioner and even the patient who may be bewildered by questionnaire after questionnaire.

The future

Ideally all new medical inpatients should be screened for depression. Every member of the health-care team from health-care assistant to medical student must be alert for and educated about the presentation of depression in older patients. All those in contact with patients should be encouraged to document and discuss any concern, however minor, with senior colleagues and the medical team responsible for the patient.

The education of medical and paramedical staff must include the notion that depression is not inevitable and that it is easily remedied in many patients if identified correctly. The medical team must take any information passed on or picked up themselves seriously and consider appropriate referral to older adult liaison psychiatry services within their trust. It is also important that the team inform the GP to conduct appropriate follow up on discharge, at a minimum by inclusion in the discharge summary.

Conclusions

Small, encouraging steps are being taken to promote the recognition and treatment of the depressed older person. Many tools are available to aid detection and diagnosis, but more emphasis must be placed in the education of hospital staff in the use of these tools and screening of these patients. Hospital practitioners must take responsibility for the mental health of older patients and not leave this solely to primary care services. Patients recognized as being depressed must be commenced on therapy as soon as possible, given adequate follow up and referred for a psychiatric assessment where appropriate. BJHM

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KEY POINTS

- Depression in the elderly is under-detected and under-treated.
- The inpatient setting provides an ideal opportunity to screen for depression.
- The ill elderly are at significantly increased risk of depression.
- Depression is readily treated in older people.
- All health-care team members must be vigilant for signs and symptoms of depression.