Management of depression and anxiety in older people

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Declarations of interest

Member of NICE Depression in adults (update) Guideline Development Committee

Co-author of MindEd module on treatments for depression in older people
Anxiety disorders in older people

Generalised anxiety disorder most common – up to 11%

Strong association with physical illness

Often comorbid with depressive disorder and associated with greater functional impairment, greater suicide risk, and worse health outcomes
Depression highly prevalent in older people

Major depression in community: 4.6% to 9.3%
Sub-threshold symptoms: 4.5% to 37.4%
  Meeks, TW et al, J Affective Disord, 129, 2011

Major depression in care homes 40%
Case-level depression

Sub-threshold depression
Depression persists

Over six years:

Remitted - 23%

Fluctuating course – 44%

Severe, chronic course – 32%

Beekman et al. Arch Gen Psych 59 2002
Risk factors for depression in older people

- Physical illness
- Poor social support
- Bereavement
Depressive symptoms have a different profile in older people

Increase in motivational symptoms

\textit{loss of interest, poor concentration, lack of enjoyment}

Reduction in affective symptoms

\textit{depression, tearfulness, wish to die}

Prince, Me et al B J Psych, 174, 1999
Psychotic depression

- nihilistic delusions
- delusions of guilt
- delusions of inadequacy
- delusions of disease
- derogatory auditory hallucinations
Psychotic depression

Psychosis may be subtle, intermittent or concealed

Often not diagnosed accurately, even in specialist settings

Rothschild, Winer et al. 2008

Often inadequately treated

Andreeescu, Mulsant et al. 2007
Vascular depression

Proposed depression sub-type with vascular risk factors, vascular lesions and impaired executive function

Severity of vascular lesions associated with poorer response to antidepressant treatment

Steffens, DC et al Journal of ECT, 17, 2001
Depression in dementia

50% of Alzheimer’s patients have clinically significant depressive symptoms

Lyketos et al. J Neuropsych Clin Neuroscience 1997;
Starkstein et al. Am J Psych 2005

20% meet criteria for major depressive disorder

Enache et al. Current Opinion in Psychiatry 2011
Late onset depression and dementia

Depression occurring for the first time in late life may represent prodrome to Alzheimer’s dementia

Bennett and Thomas, Maturitas, May 2014
Probable or possible Alzheimer’s dementia

Cornell Scale for Depression in Dementia $\geq 8$

Improvement in Cornell scale for Depression in Dementia (CSDD) at 13 weeks regardless of treatment allocation (sertraline, mirtazapine or placebo) (sustained at 39 weeks)

Lancet, 2011
Do not routinely offer antidepressants to manage mild to moderate depression in people living with mild to moderate dementia.

For people living with mild to moderate dementia who have mild to moderate depression and/or anxiety, consider psychological treatments.

Research recommendation: what are the most effective psychological treatments for managing depression or anxiety in people living with dementia at each stage of the condition?
Local study: PATHFINDER

Multi-centre randomised controlled trial recruiting from July 2019

Adapt and manualise Problem Adaptation Therapy (PATH) for NHS

Establish clinical and cost-effectiveness of PATH+TAU compared to TAU
SSRIS most commonly prescribed and use increasing

All classes associated with increased mortality, falls, fractures, GI bleeding

SSRIs most highly associated with falls and hyponatraemia

Coupland et al 10.1136/bmj.d4551, 2011
Improving Access to Psychological Treatments

When able to access treatment, older people make good recoveries with low levels of attrition


However, referral rates from primary care of older adults to an IAPT service are lower than those of younger adults

Novel intervention for depression: collaborative care

• straddles primary and secondary care
• telephone support from case manager
• symptom monitoring and active surveillance
• behavioural activation delivered according to a protocol
• facilitated by computerised case management system

Gilbody S et al, JAMA, 317, 2017
Case-level depression

Sub-threshold depression
Treatment of depression and anxiety in primary care

Assess and discuss non-pharmacological steps

Consider offering SSRI or mirtazapine

Titrate and monitor for side-effects over first month

Review at 6 months: consider longer treatment

Managing anxiety

A primary, lifelong, and recurrent problem?
Think generalised anxiety disorder and consider psychological treatment or SSRI

A new problem?
Assess further for depressive illness and dementia
Managing depression – general approach

- Look out for motivational symptoms, use rating scale
- Promote social activity
- Keep dementia in mind
- Keep depression on the agenda in chronic physical illness and educate patient and family
Video – depression in older people

https://www.rcpsych.ac.uk/mental-health/problems-disorders/depression-in-older-adults
Safe and reliable mental health advice for older people and those who care for them

MindEd online resources for patients and families

mindedforfamilies.org.uk/older-people/
Prescribing SSRIs in older people

Sertraline or citalopram (citalopram max. dose 20mg)

Consider bleeding risk (NSAIDs, previous GI bleed)

Consider hyponatraemia risk
How long to continue antidepressant?

No straightforward answer, little evidence

Consider potential harms (interactions, hyponatraemia risk)

Consider risks of stopping treatment (recurrent depression, patient’s risk history when depressed, age)

Consider discussing with psychiatrist
When to refer to secondary care

- Suspected bipolar disorder
- Psychotic symptoms
- Significant substance abuse
- Failure to respond to two antidepressants
- Possibility of dementia
- Significant risks (suicide, self-neglect)

Hyponatraemia
<table>
<thead>
<tr>
<th>Drugs causing interaction with antidepressants</th>
<th>Effect of interaction</th>
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</thead>
<tbody>
<tr>
<td>Antipsychotic drugs</td>
<td>Hyponatraemia</td>
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<tr>
<td>Loop and thiazide diuretics</td>
<td></td>
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<tr>
<td>Antiepileptic drugs</td>
<td></td>
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<tr>
<td>Antiparkinsonian drugs</td>
<td></td>
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<tr>
<td>Anticoagulants</td>
<td>Increased bleeding</td>
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<tr>
<td>Non-steroidal anti-inflammatory drugs</td>
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<tr>
<td>Erythromycin</td>
<td>Impaired cardiac conduction</td>
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<td>Tamoxifen</td>
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<td>Quinine</td>
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<td>Anti-arrythymic drugs</td>
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<tr>
<td>Other classes of anti-depressant with serotonergic action</td>
<td>Serotonin syndrome</td>
</tr>
</tbody>
</table>

Risk factors for hyponatraemia

- Previous hyponatraemia
- Low weight
- Psychosis
- Heart failure
- Severe renal impairment
- Diabetes mellitus
- Hypertension
- Chronic obstructive pulmonary disease