

Improving the detection and management of depression in aged care

By Dr Tanya Davison MAPS, Professor Marita McCabe FAPS and Associate Professor David Mellor MAPS, School of Psychology, Deakin University

Despite increased recognition of the impact of depression on the wellbeing of individuals, families, and communities, the significance of depression for frail, elderly members of our society is given scant acknowledgement. Yet older adults living in aged care facilities represent a particularly high risk group for depression, with recent prevalence estimations of major depressive disorder in the range of 14 to 26 per cent, well above those of the general population (Davison et al., 2007). Although there are fewer studies of older people who receive aged care services in their own homes, available evidence suggests that this group is also characterised by high levels of depression.

This vulnerability to depression is significant. Depression in aged care populations is often associated with marked disability and functional decline, and untreated depression in late life often results in a chronic depressive illness, with poor prognosis for recovery. Depressed older people have an increased mortality rate, and depression worsens the outcomes of many medical illnesses and leads to increased risk of hospitalisation, thus further compromising reduced quality of life.

Management of depression in aged care

Unfortunately, as in other countries, in Australia we are failing to meet the needs of our depressed frail elderly. Research suggests that at least 50 per cent of cases of depression in aged care settings are not picked up by GPs and remain untreated (Davison et al., 2007).

There are a number of possible explanations for the low rate of detection. The identification of depression in aged care settings is challenging, given the high comorbid rates of dementia, medical illness, and declines in physical and cognitive functioning, all of which can complicate diagnosis. Recognition of depressive symptoms is made more difficult by the tendency of older populations to under-report symptoms or to present with largely physical symptoms. Detection of depression may also be hampered by the short consultation times available with GPs, and the predominant focus in aged care settings on physical illness and care, rather than mental health and emotional wellbeing. Depressed symptoms may be dismissed as normal or understandable in these settings. It might be expected that nursing and personal care staff, who have frequent and intimate contact with older people, would be well placed to notice signs of depression. However, the majority of aged care staff have traditionally received little or no training in this area, and research has demonstrated they often fail to recognise depression among their care recipients.

When older people with depression have been asked to comment on the treatment they have received for their illness, their responses raise concern. In one recent study in residential facilities in Melbourne, only one quarter of the residents currently prescribed an antidepressant medication appeared to be aware of their diagnosis or treatment (Davison et al., 2007). Furthermore, depressed aged care residents have

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indicated that their GPs do not routinely enquire into emotional symptoms, raising concerns about the monitoring of treatment progress (Mellor et al., 2006). Very few aged care residents in Australia receive psychological treatment for depression. This situation shows no signs of improving. While the introduction of Medicare rebates under the new Better Access initiative has improved access to psychological services among members of the general population, older people residing in Commonwealth funded residential facilities are not eligible for assistance under this initiative.

Improving the detection of depression

Efforts to improve the detection of depression in aged care have focused on improving the skills of care staff, with some evidence of success. One example is the *beyondblue* aged care depression training program, which is designed to improve the knowledge and self-efficacy of aged care staff in residential and community settings in detecting depression and in making appropriate referrals to senior staff and medical practitioners. To date the program has been piloted in Melbourne and Queensland, and has been well received by aged care services with promising results (McCabe et al., in press). Current research tracking residents with depression will determine whether this program leads to improved long-term outcomes for the mental health of older people.

Another initiative that has potential to improve detection rates is the introduction of the Aged Care Funding Instrument. This is a multifaceted assessment of the care needs of each resident, which includes a well-validated screening tool for depression, administered by aged care staff to all residents. However, the aim of the assessment protocol is to determine the level of government funding provided to the residential facility, rather than to increase the recognition of depression among the facility's residents. Anecdotal reports suggest that in practice many aged care staff have reported difficulty in administering the instrument, and do not feel competent in determining whether depression is present or in taking appropriate action should a resident appear to be depressed. It remains to be seen whether the use of this routine screening will result in more referrals to GPs and improve the treatment of depression in residential care.

Psychological interventions for depression

Once older people with depression are identified, there is growing evidence that psychological interventions are effective. Treatment guidelines recommend cognitive therapy, supportive psychotherapy, problem-solving, behaviour therapy, and interpersonal therapy for use with older adults (Alexopoulos et al., 2001). These therapies are generally considered as effective in older people as they are in younger people, although there have been far fewer outcome studies conducted with older samples. Most available studies have been of community patients, and there is less outcome research with aged care recipients, a population characterised by significant levels of cognitive and functional impairment and medical comorbidity. While there is growing evidence that group and individual psychotherapy may reduce symptoms of depression in residential care settings (see Hyer et al., 2005 for a review), methodological weaknesses limit interpretation of the results, long-term outcomes are unclear, and no single treatment modality has shown a consistent advantage.

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Despite limited research evidence, a combination of antidepressants and psychotherapy is typically presented as the preferred treatment option for late-life major depression, and psychotherapy recommended as a sole treatment for less severe presentation or for depression initiated by an identifiable stressor (Alexopoulos et al., 2001). However, rates of physician referral for psychotherapy continue to be low. Low referral rates may reflect a lack of awareness of the effectiveness of psychotherapy for late-life depression, an absence of available clinicians to provide psychological interventions, financial difficulties in accessing psychological services, or reluctance of older patients to engage in psychotherapy. This is disappointing, given emerging evidence of better treatment outcomes for frail older people with depression from interventions delivered by multidisciplinary mental health specialists compared to standard care delivered by GPs.

Potential roles for psychology

With the ageing of the population, there will be a large increase in the number of older people with depression who require mental health care. The number of psychologists with training and expertise in working with frail older persons is likely to be inadequate to meet these needs. To date, psychologists have been a rare presence within the aged care sector, and our profession has yet to realise the contribution that it can make to improve the wellbeing of aged care recipients and their carers. While some postgraduate clinical programs include content on working with older adults, further emphasis is required, including clinical placements in aged care settings to improve the competence of psychology graduates.

Psychologists could play a major role in assisting in the assessment and treatment of depression in aged care. Training in caring for older people with comorbid depression and dementia would be particularly welcomed by staff. In order to improve access to psychologists, GPs and other referrers need to be made aware of the potential benefits of psychotherapy to their patients. Unfortunately, for many aged care residents, access to psychologists will only be made possible through changes to the eligibility for Medicare funding. Other service delivery options, for example working collaboratively with primary and aged care services to enhance patient outcomes, also require exploration.

Psychologists are also missing opportunities to contribute to our understanding of mental health problems in later life. While there is growing awareness of risk and protective factors for depression among younger adults, there is an absence of information relating to older adults in aged care, who experience complex patterns of medical and functional decline. Research in this area would aid in developing appropriate preventative approaches to improve individuals' experiences of aged care, particularly in making the transition to a residential facility. Evaluations of psychological treatments in aged care settings are also urgently required, with a particular focus on which strategies are most effective for older people with significant cognitive, functional and medical impairments.

Recommendations for improving the management of depression in aged care

Clinical

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- Increase the numbers of public and private psychologists in aged care settings
- Promote the benefits of psychological treatment of depression
- Train GPs and aged care staff in the care of depressed aged care recipients, including those with comorbid dementia
- Establish routine depression screening linked to referral for assessment and treatment
- Develop approaches for shared care of patients.
- Seek ways to allow patients to stay in their own homes for longer.

Research

Identify risk and resilience factors for late-life depression
Conduct methodologically rigorous treatment outcome research

The principal author can be contacted at tanya.davison@deakin.edu.au.

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