'Too many older people are given antidepressants instead of therapy'

This headline for an article by Denis Campbell caught my eye in the Guardian of February 12th. The article drew on a review paper from Rachael Frost and others which had been published recently in the British Journal of General Practice. Their aim was to discover how healthcare professionals respond when they identify depression in an older person.

They were doing this because older people are important and perhaps getting more so as their number grows. Depression is also important: it is seen in severe forms in almost 10 percent of people aged 75 years and above, and in milder forms up to almost 40percent of this age group. Depressive symptoms equate to a reduced quality of life and are associated with reduced life expectation, decline in cognition, decline in functional abilities and increased use of health services.

Rachael Frost and her colleagues looked at 1471 published studies which might have addressed the question of how depression in older people is managed in primary care by GPs, nurses and other healthcare professionals. 141 papers justified a full reading and only 27, mostly from the UK, the USA or Australia, were considered in a deep analysis. This entailed reading and codifying the content line by line.

They identified five themes:

- 'Avoidance of medicalisation of social circumstances': This equated to the belief by these relatively young healthcare professionals that most depression in older people is understandable: attributable to being old, bereavement, loneliness, frailty and functional decline, and therefore inevitable and not amenable to therapy. Social manoeuvres such as attending a day centre were approved of but are not always effective, treatment of physical health problems has limitations, so that symptoms may persist or progress. Some healthcare professionals did admit to offering support and encouragement to work with patients to gain an adaptation to changed physical and social circumstances.
- Assumptions about older people and mental health: Depression is seen as a normal part of ageing associated with isolation and loss of abilities. Few papers made reference to previous life experience, especially the occurrence of episodes of depression from which recovery had been achieved. Symptoms offered to the doctor are often physical equivalents of depressed mood 'hidden depression', but even when low mood was admitted and identified, few people were referred for psychotherapy. Older people, like younger people, say they would prefer talking therapies, but they and their doctors doubt such approaches will be effective. 'Old people do not change.' Psychiatric diagnosis is felt to carry stigma, referral to Psychiatry is a last resort. Even a prescription of an antidepressant is felt to be stigmatising.
- Prioritising physical health: Lack of time and perceived lack of training in mental health mean that attention to physical health needs is felt to be the best use of resources.
- Postcode lottery of therapeutic options: the availability of psychological treatment differs around the country. Differing treatment options are represented in different places. There is a perception that waiting times for IAPTS (Improving Access to Psychological Therapies) is long. (In fact published studies suggest that a median wait is four weeks – this may be a function of rationing imposed by protective referrers. This includes choosing to refer disproportionately few old people). In addition healthcare professionals believe that IAPs have too narrow eligibility criteria, are poorly integrated with other services, are at odds with the needs and preferences of older people, and their interventions are felt to be of too short duration. 'When nothing else could be offered, GPs and community nurses tended to provide support themselves to the older person in various ways, or prescribe antidepressants.'

- Variations in skills, interest and perceived role in the management of depression were evident and influenced what might happen: some practitioners felt at home with listening to their patients, exploring matters with them and achieving a therapeutic relationship. Others would say that lack of training or experience meant that they should refer on to other experts. The role of families is mentioned in the single papers from India and Taiwan, more so than the studies from western countries.

The review sets the scene with the reflection that when older people are recognised to be depressed, they are rarely referred on to specialist services but are managed in primary care. 87 percent will be prescribed an antidepressant. Improving Access to Psychological Therapies services (IAPTS) are accessible directly from primary care but only 3.5 percent of IAPT referrals are of older people. If you are aged 85 years or older your chances of meeting IAPT is one fifth of the likelihood for people in the 55-59 age bracket. There is outrage here that older people are relegated to second-class care characterised as pill-pushing (antidepressants have their limitations, have side effects and interact with other medication which older people are often obliged to take), rather than sharing in the benefits of expert talking therapy.

I understand that NHS England has targets to increase referrals of older people to IAPTs. I wonder if this is wise or justified. It might be justified if uniformity across the age bands is the objective. But the implication within this systematic review that talking therapy alone is preferable to the prescription of antidepressants is worrying. The belief that older people's depressive symptoms are usually 'understandable' and will be unmoved by therapy of any kind is dangerous. Forty years ago suicide rates were highest amongst older men and women. These rates have fallen in this country though not in all parts of the world. This change for the better may be traced to a range of factors including improvements in the social and economic status of older people, improvement in their general health, but also greater awareness of depression, the availability of specialist psychiatric services for older people, and the informed use of antidepressants as a component of treatment in primary care and by specialist services. Electroconvulsive Therapy (ECT) is powerfully effective when depression remains severe and unresponsive to other treatments, but is used less often because of early and effective treatment by other means.

It is important to recognise these successes, rather than be diverted by statistics of service usage alone. The creation of specialist services such as IAPTS can foster the belief that others can do nothing worthwhile – aptitudes and skills which are available can be downgraded, diminished and lost, to be replaced by a queue, waiting list and demands for more money for the super-specialist service, in this and other contexts. (Jobs for the boys and girls?).

Similarly the argument for 'treatment' which is either listening/talking or medication is false: in every situation therapy has to be based in understanding and this can only come from listening to the patient and to others who know them and their story well. Listening gives openings for further investigation and to talking as a component of a treatment plan, which will almost always include family, lay supporters and faith leaders and well as healthcare professionals. It may also include the prescription of appropriate psychotropic medication.

Depression, often mixed with anxiety, is the most common mental health problem encountered in old age. It can be helped and is being helped quite effectively. We can do better but let us not lose what has been gain by insisting on either/or models of treatment. Strengthening the skills and confidence of family, friends and primary healthcare supported by specialist services is likely to be more achievable and preferable to reliance on self-contained psychotherapy facilities.

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