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10.1 Introduction

Depression is more common in older people with long-term physical conditions (see Chap. 5). As expected this is particularly true in people with brain diseases: 20–40 % of people with Parkinson’s disease, [1] 25–50 % with dementia [2] and about a third of people after stroke [3]. Anxiety is also common in older adults, though consistently reported as less so than in younger adults. A problem with prevalence figures is the variety of anxiety disorders and their different definitions, but overall anxiety disorders occur in about 5 % of people over 65 during a 12-month period, compared with about three times this prevalence in younger adults [4]. The development of anxiety in an older person with no previous history of anxiety should be taken to suggest the real problem is depression with anxiety [5], and anxiety is a predictor of poor outcome [6].

Anxiety may increase the risk of hospital admission, and the presence of both anxiety and depression can lead to difficulties for discharge back home and in the immediate post-discharge period.

The impact of anxiety and depression on hospital admission and discharge will be considered in the following cases.

10.2 Case Study 1

Mrs H is a 74-year-old woman living alone in a deprived urban area. She had apparently enjoyed good physical and mental health although seemed to have been a little too dependent on her husband and their three children. She had never worked

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outside the home and had only a limited social network, all of whom were joint friends with her husband. When her husband died suddenly of a stroke when she was 72, she was bereft. Her children rallied round to support her, and all initially seemed well. However, after 6 months or so, she began ringing the out-of-hours service frequently and making appointments at her GP practice weekly or more often. Her concerns were about vague physical symptoms, such as headache, dizziness, palpitations and pain, which were always difficult to localize, and she appeared increasingly tense. Physical assessment and blood tests were normal, and on questioning by her GP, she admitted to worrying about how she would cope and when anxious to experiencing tingling in her limbs and palpitations.

Paracetamol and other analgesics did not help her vague pain symptoms, and she declined referral to the primary care mental health team (PCMHT), or third sector agencies (Anxiety UK), [7] to help with her anxiety symptoms. She became increasingly withdrawn, and her children became concerned about her weight loss and requested a home visit. The GP found her very low in mood, complaining of headache and vague pain and possibly having lost weight. She said she could not sleep, and there were again no features on examination suggesting a physical cause of her symptoms. Mrs H denied any thoughts of harming herself, but admitted that she sometimes wished she was dead. This GP suggested that she might take an antidepressant but she declined.

That evening Mrs H called an ambulance and was taken to A&E, where she became distressed, crying and saying she was going to die, pleading for someone to help her. After several hours, having been refused assessment as 'too old' by the local crisis team, she was assessed by the on-call junior psychiatrist who admitted her.

On the ward, she did not exhibit any significant depressive symptoms, but the nurses found her very dependent, frequently asking for help to do ordinary tasks such as dressing. If left alone for much time, she sought out staff, often in a flustered state complaining of feeling worried about her health and that she was a terrible burden on her family. She often caught one of the ward doctors to plead for a physical assessment, though these and investigations never identified any physical health concerns. Discussion with her children during visits gradually revealed that Mrs H had not only always wanted her husband to do everything but that she had 'always been a worrier' and 'complained about her health all the time'.

A case conference was held, and her social worker reported Mrs H to be well known as a frequent caller over the last couple of years who had had undergone assessments but then declined the services offered. At the case conference, it was agreed with Mrs H and her family that she return home to have a home assessment by a social worker, to have weekly input from the community mental health nurse, and a follow up by a consultant psychiatrist in 6 weeks. However, some concern was expressed about how agreeable Mrs H really was to this as she had seemed to enjoy being on the ward and was unsettled by the prospect of discharge. The day before her discharge she cut herself on the left forearm, pleading that she could not cope, but it appeared with no intention of significantly harming herself.

Somatic symptoms in older people may be manifestations of an affective illness, although exclusion of underlying physical causes should be more carefully

considered than in younger adults, so it is important that physical examination and investigations, including indicated blood tests, are conducted.

The presence of anxiety and depression increases use of services including GP attendance [8] ('frequent attenders') and admission [9].

The use of case-finding questions for anxiety (see Chap. 5) is key to the identification of anxiety in patients who attend frequently, particularly with a range of physical symptoms. The clinician should also be aware of the increased use of alcohol in people with anxiety. Key informant information can be useful, as in case 1 where it became apparent that anxiety and 'dependent' traits were longstanding features of Mrs H. Such features may only surface when the social circumstances alter, in this case, the loss of her husband on whom she had depended. Assessment of risk is just as important in patients where anxiety symptoms appear to predominate (see Chap. 5) as in depression. Residual anxiety symptoms are a problematic feature in late-life depression and frequently refractory to standard drug treatments.

Admission of people with anxiety to hospital can exacerbate their problems, and intensive home-based support would have been more appropriate, in the above case, including the clinical team encouraging Mrs H to have a social work assessment and support through community-based services. This can be facilitated through an integrated care approach [10].

10.3 Case Study 2

Mr Patel is an 82-year-old man who lives with his extended family in the suburbs of a large city. He has asthma and diabetes, treated hypertension and was recently told that he has 'something wrong with his kidneys', but he is normally mobile and active. One evening, his family took to A&E following an episode of chest pain. They were keen to take him home, but the doctor told him that he might have had a heart attack, so he was admitted to the Coronary Care Unit, although he only stayed there one night and is now on a ward surrounded by 'old people'. He is now very worried about his heart, but no one has confirmed whether he had a heart attack, and no one has explained why all his tablets have been changed. He cannot sleep because of all the noise in the ward at night. He pleads with his family to take him home and is discharged after two further days in hospital.

Following discharge, his sons become increasingly concerned that their father is withdrawn and quiet; he used to be such a pleasure to be with but is now irritable if anyone speaks to him. He has started to take his meals into his own room and declines to go out on family visits. The family is upset that no one from Mr Patel's practice have visited since he was discharged, and the social care package that was promised lasted only a week, because they were told that there were sufficient family members in the house to support Mr Patel to get dressed and take his tablets. They began to agree when Mr Patel said that 'no one cares' and were concerned that he was not taking his tablets properly.

Depression is two to three times more common in a range of cardiovascular diseases including cardiac disease, coronary artery disease, stroke, angina,

congestive heart failure, or following a heart attack [11]. Prevalence estimates vary between around 20 % and 50 % depending on the conditions studied and the assessment approach used, but the two- to threefold increase compared with controls is consistent across studies. Anxiety problems are also common in cardiovascular disease [12, 13]. Outcomes from cardiovascular care are poorer for patients with co-morbid mental health problems, even after taking severity of cardiovascular disease and patient age into account. Cardiovascular patients with depression experience 50 % more acute exacerbations per year [12] and have higher mortality rates [14]. People with diabetes who also have co-morbid mental health problems are at increased risk of poorer health outcomes and premature mortality [14].

Given the significant impact on prognosis, it is unsurprising that co-morbid mental health problems also substantially increase patients' use of health services for their physical problems. Increased service use translates into substantial additional costs. Not only does depression increase the risk of hospital admission, but it can also cause delayed discharge, so highlighting the role of hospital clinicians in detecting depression in in-patients under their care. Case 2 illustrates the need for social care professionals not to assume that because a person is living with an extended family, they would not benefit from input. Again, the role of the primary care team in case-finding for depression in patients [15] recently discharged from hospital for their physical health problems is vital. If depression is detected in patients with physical health problems, collaborative care arrangements between primary care and mental health specialists can improve outcomes with no or limited additional net costs [16].

10.4 Suggestive Activities

Do you have any patients or clients who are 'frequent attenders' or make what you feel are unnecessary demands on your service? How could you manage them better?

A person who has had a recent hospital admission is at risk of depression: what systems do you have in place to identify this?

Key Points

- Somatic symptoms in older people may be manifestations of an affective illness, although exclusion of physical causes needs to be more carefully considered than in younger adults.
- The first presentation with anxiety-related symptoms in an older person may suggest a depressive illness.
- Residual anxiety symptoms are a problematic feature in depression in older people and frequently refractory to standard drug treatments.

- Admission of people with anxiety disorders to hospital can exacerbate their problems.
- Hospital admission can precipitate depression in older people.
- Collaborative care arrangements between primary care and mental health specialists can improve outcomes with no or limited additional net costs.
- Innovative forms of liaison psychiatry demonstrate that providing better support for co-morbid mental health needs can reduce physical health care costs in acute hospitals.
- Practitioners should be aware of the risk of depression in patients as an inpatient and then after discharge.

References

1. Lieberman A. Depression in Parkinson's disease – a review. *Acta Neurol Scand.* 2006;113(1): 1–8.
2. Ballard C, Bannister C, Solis M, Oyebode F, Wilcock G. The prevalence, associations and symptoms of depression amongst dementia sufferers. *J Affect Disord.* 1996;36(3–4):135–44.
3. Gaete JM, Bogousslavsky J. Post-stroke depression. *Expert Rev Neurother.* 2008;8(1):75–92.
4. Byrne G. Anxiety disorders in older people. In: Denning T, Thomas AJ, editors. *Oxford textbook of Old Age psychiatry.* Oxford: Oxford University Press; 2013. p. 589–602.
5. Thomas AJ. Depression in older people. In: Denning T, Thomas AJ, editors. *Oxford textbook of old age psychiatry.* Oxford: Oxford University Press; 2013. p. 545–69.
6. Azar AR, Chopra MP, Cho LY, Coakley E, Rudolph JL. Remission in major depression: results from a geriatric primary care population. *Int J Geriatr Psychiatry.* 2011;26(1):48–55.
7. <https://www.anxietyuk.org.uk>.
8. Neal RD, Heywood PL, Morley S. 'I always seem to be there' – a qualitative study of frequent attenders. *Br J Gen Pract.* 2000;50:716–23.
9. Morris et al. *BMC family practice.* 2012; 13:39 <http://www.biomedcentral.com/1471-2296/13/39>.
10. <https://www.gov.uk/enabling-integrated-care-in-the-nhs>.
11. Fenton WS, Stover ES. Mood disorders: cardiovascular and diabetes comorbidity. *Curr Opin Psychiatry.* 2006;19(4):421–7.
12. Goodwin RD, Davidson KW, Keyes K. Mental disorders and cardiovascular disease among adults in the United States. *J Psychiatr Res.* 2009;43(3):239–46.
13. Whooley MD, de Jonge P, Vittinghoff E, Otte C, Moos R, Carney RM, Ali S, Dowray S, Na B, Feldman MD, Schiller NB, Browner WS. Depressive symptoms, health behaviors, and risk of cardiovascular events in patients with coronary heart disease. *JAMA.* 2008;300(20):2379–88.
14. Katon WJ. Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. *Biol Psychiatry.* 2003;54(3):216–26.
15. Meader N, Mitchell AJ, Chew-Graham C, Goldberg D, Rizzo M, Bird V, et al. Case identification of depression in patients with chronic physical health problems: a diagnostic accuracy meta-analysis of 113 studies. *Br J Gen Pract.* 2011;61(593):e808–20.
16. Katon WJ, Lin EHB, Von Korff M, Ciechanowski P, Ludman EJ, Young B, et al. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med.* 2010;363(27): 2611–20.