

# **The mental health of older people in primary care: a review of the literature.**

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## **ABSTRACT**

**Background:** Given its position as the first point of contact and gatekeeper to additional and specialised services and treatments, primary care has a crucial role to play in ensuring continuity of care for older individuals with mental health disorders.

**Aim:** The purpose of the current review was to answer the following key question: “What aspects of primary care are effective in the prevention, recognition and management of mental health issues among older people; for whom do they work, in what circumstances and why?”

**Method:** The approach taken for the identification and evaluation of the literature drew upon ‘Realist Synthesis’ methodology.

**Findings:** More evidence is needed on the recognition and management of mental health disorders in older people. Routine health checks for older people should incorporate screening for depression and dementia. More work is needed to standardise approaches to the measurement of mental health outcomes. Consideration should be given to the wider use of non-pharmacological interventions for managing the symptoms of dementia within primary care. Primary care clinicians should select a screening tool and familiarise themselves with it to become more efficient in screening for dementia. In view of the benefits of group support for families and carers, this service should be more widely available.

**Conclusions:** An efficient and effective primary care system is central to high quality mental health service provision for older adults.

**Relevance to practice.** As the first point of contact, primary care practitioners have a key role to play in the prevention and management of mental health problems among older people.

## **INTRODUCTION**

Despite increased recognition of our ageing population, little is known about the prevalence of mental ill health and the factors influencing the mental health of older people. The National Service Framework for Older People (Department of Health, 2001) recommended that older people experiencing mental health problems should have access to treatment and support. The need for detailed information on mental health morbidity and the impact of variations in the access to and use of individual services have also been identified as key research priorities in the Bamford Review (2007).

Ageing is associated with an increased prevalence of mental disorders. Most older people have good mental health, but older people are more likely to experience events that affect emotional well-being, such as bereavement or disability. The Department of Health in England estimates that approximately 40% of older people seeing their GP, 50% of older people in general hospitals, and 60% of care home residents, have a mental health problem (National Institute for Mental Health in England 2005). Common mental disorders are strongly associated with physical disability; over a third (37%) of people interviewed in this age group had difficulty with one or more common daily tasks, such as personal care, housework and getting out and about (Evans et al 2003b). Other major risk factors include disability, cognitive deficits, loss of social networks and low social support, and negative life events (Elliott 2007).

Depression is the most common psychiatric disorder in later life. A recent large population study suggested prevalence in older people stood at 8.7% and rose to 9.7%, and it is comorbid with dementia (Iliffe 2007). Co-morbidity of depression with other diseases is also common and medical illness increases the risk of suicide in among older people (Elliott 2007). In addition to depression, dementia constitutes a further substantial public health concern among the older population. The

most recent 'Dementia 2010' report commissioned by the Alzheimer's Research Trust estimated that 1.3% of the UK population suffer from Dementia (Health Economics Research Centre, 2010).

Primary care has a crucial role to play in ensuring continuity of care for older individuals with mental health disorders. Given its position as the first point of contact for individuals with mental health disorders and the gatekeeper to additional and more specialised mental health services and treatments, it is imperative that primary care functions effectively in the recognition and management of mental health disorders as well as engaging in preventative interventions

## **AIM**

The purpose of the current review was to answer the following key question: "What aspects of primary care are effective in the prevention, recognition and management of mental health issues among older people; for whom do they work, in what circumstances and why?"

## **SEARCH METHODS**

A 'Realist synthesis' methodology was used for the identification and evaluation of the literature for the review. Realist synthesis (Pawson, 2006) was developed as a method of studying complex interventions in response to the perceived limitations of traditional systematic review methodology which, it is argued, follows a highly specified and intentionally inflexible methodology, with the aim of assuring high reliability. A realist review in contrast, follows a more heterogeneous and iterative process, which is less amenable to prescription but which needs to be equally rigorous.

## **ANALYSIS PROCESS**

The following steps indicate the process adopted by the authors in the completion of the review, highlighting how the process was guided by realist synthesis principals. The specific steps included (1) Identification of the question (2) Clarification of the purpose of the review (3) Development and articulation of the programme theories (4) Search for the evidence (5) Appraisal of the evidence (6) Extraction of the results and (7) Synthesis of the findings.

## **FINDINGS**

### **Identification and management of mental health problems**

The identification and management of mental health problems is a key issue for older people. Ell (2007) and earlier Ahururu-Driscoll and colleagues (2004) argued that there was poor recognition of psychiatric illness, specifically depression, in older people by GPs and health care workers generally, potentially linked to factors such as; denial of problems and symptoms by older person, insidious nature of onset can impede recognition, co-morbidity, tolerance of unusual behaviours in remote and rural areas, acceptance of cognitive decline in older people and a lack of trained staff with expertise in early detection and prevention of mental health problems. Others argue that even if depression is recognized, it is often left untreated with only a small minority receiving treatment or referral (Iliffe 2007). Ahururu-Driscoll et al. (2004) in their review concluded that there was limited material available for primary care based geriatric services making it difficult to draw strong conclusions about effectiveness. Bruce et al. (2005) reviewed community and home-based approaches to the management of mental health disorders in older people. There was considerable variation in the approach to management in the home or community and in some studies primary care took the lead; in other studies, other professionals took the lead. They concluded that despite the heterogeneity, there was some support for home-based mental health services for older adults who have limited access to traditional practice-based models. Some of the more rigorous studies

were associated with a reduction in psychiatric symptoms but more work is needed to standardise approaches to measure mental health outcomes and characterise the intervention.

### **Treatment**

While treatments for depression are the same as for general population adults, a number of reviews were identified that specifically focused on older people. Despite a number of reviews supporting psychotherapy for the treatment of depression however, there are few that examine efficacy in older people specifically. A review by Wilson et al. (2008) identified five trials with older people and found evidence to support CBT over waiting list controls. Frazer and colleagues (2005) looked at a range of approaches to treating depression in older people. They identified 5 RCTs of CBT with older people and, reflecting findings above, found there were benefits in terms of reducing depressive symptoms. However, they found one study to suggest that people suffering from a stroke did not benefit from CBT. The review by Frazer et al. (2005) also identified four RCTs looking at the impact of PST and while three of the four found a positive change in depressive symptoms in older people, one of the studies did not. Nonetheless, the authors concluded that there was some support for the use of PST with older people. In terms of other therapies, Frazer et al. (2005) found support for psychodynamic psychotherapy, reminiscence and life review but insufficient evidence to comment on IPT as an effective therapy for older people. Frazer et al. (2005) identified tentative support for exercise as a treatment for depression in older people. However, the Task Force on Community Preventive Services found insufficient evidence available to determine the effectiveness of exercise interventions on reducing depression. It should be noted the studies reviewed did find improved scores on depression symptom scales, but none of the studies reported results for depressed subjects so it is unclear whether or not clinically significant changes could be expected in these populations.

### **Dementia in primary care settings.**

Holsinger et al (2007) reviewed the evidence of the accuracy of screening for dementia among over 60s in primary care. They identified 29 studies assessing 25 screening instruments. They concluded that screening tests to identify dementia in older people in primary care settings vary in diagnostic accuracy and administration time. While no single instrument is ideal for all settings, Holsinger et al concluded that clinicians should select one primary tool and familiarise themselves with it to become more efficient in screening for dementia. In an earlier review Harvan et al (2006) evaluated the available evidence on screening methods for dementia to determine the most accurate and efficient tools for use in primary care. Their review identified 20 relevant studies. They concluded that the Mini Mental State Examination (MMSE) has high sensitivity and specificity in outpatients older than 65 years when age- and education-specific cut-offs are used. The clock drawing test has lower sensitivity and specificity when used alone; however, in combination with the MMSE, its sensitivity is higher than that of the MMSE while specificity is slightly lower. Subjective memory complaints contribute diagnostic information; however, objective memory performance is a stronger predictor of future dementia. All measures are subject to influence by age, education, and other physical factors.

Despite the availability of screening tools, dementia is probably under-diagnosed and under treated with an estimated 50% of primary care patients over 65 not diagnosed by their primary care physicians. Iliffe et al (2009c) suggest this problem of under-diagnosis is probably not due to lack of diagnostic skills, but the interaction of case-complexity, pressure on time and the negative effects of reimbursement systems. Koch et al (2010) conducted a systematic review to explore the barriers to dementia diagnosis within primary care. They located 11 studies (six qualitative, three quantitative, and two with mixed methodologies). Six themes emerged powerfully from the research that can be grouped into doctor factors, patient or societal factors, and system factors. Doctor factors consist of barriers such as diagnostic uncertainty or insufficient knowledge or experience, as well as disclosing the diagnosis, stigma attached to dementia, and therapeutic nihilism. Patient or societal factors

included stigma, as well as delayed presentation which could be because of stigma, but also because of many other reasons. Finally the systems factors included time constraints and lack of support (which were the most often-identified factors), as well as financial or remuneration issues. Koch et al conclude that additional research on routine screening in primary care to bolster the current evidence, use of nurses as evaluators of cognition, and utilization of specialists is needed.

### **Non-Pharmacological Treatments**

There are between 12 and 20 people with dementia on an average GP list. People with dementia often need specific information and support, and their GP plays a vital role in enabling them to manage their condition (Alzheimer's Society, 2008.) In most cases, dementia is progressive and incurable, and interventions are used to relieve symptoms and improve quality of life of patients and their carers. Deterioration in cognitive symptoms is a core symptom of dementia, and this has been the major target of drug trials in dementia. However, changes in functional ability (activities of daily living), disturbances in behaviour and mood, and comorbid emotional disorders are also important and can have considerable effects on the quality of life of patients and their carers. Hulme et al (2010) conducted a review of reviews on the effectiveness of non-pharmacological treatment for patients with dementia. They judged 25 of the 33 located reviews to be of high or good quality. The evidence from the reviews suggests three different interventions effective for people with dementia: music or music therapy, hand massage or gentle touch and physical activity or exercise. However even for these interventions, the evidence is mixed or limited. For example, within music or music therapy methodological limitations were highlighted that included weak study designs and small sample numbers but the positive effects were consistent across the studies. In respect of massage or touch therapies, although the reviews suggest that they do work in reducing agitation in the short term and can help with eating there was no conclusive evidence that massage reduces wandering, anxiety or aggressiveness. Hulme et al note that the interventions included in each of the

categories, whilst placed in generic categories (such as music therapy or massage and touch) are diverse.

### **Support for Carers**

In general support for carers tends to fall into three categories (1) work with families as a whole which including interventions drawing on family therapy models, or services provided in the home by, say, family support workers (2) Educational programmes – including training and psycho-educational interventions and (3) Breaks from caring including day care, in-home respite care, institutional respite and mixed respite services. In a recent review of reviews, Parker et al (2010) included five reviews focused on interventions for carers of people with dementia or (Cooke, 2001; Pusey, 2001; Peacock, 2003; National Collaborating Centre for Mental Health, 2007; Cooper, 2007) and two reviews which focused on carers of stroke victims or frail elderly relatives (Stoltz 2004, Victor 2009). Two reviews focused on psychosocial interventions (Cooke, 2001; Pusey, 2001). The remaining five each encompassed a diverse range of interventions (Peacock, 2003; Stoltz, 2004; NCCMH, 2007; Cooper, 2007; Victor, 2009).

Evidence about carers' mental health was a common outcome reported in the included reviews. For example, Peacock (2003) identified three RCTs which reported findings about the impact of interventions on carers' levels of depression. Only one (an education programme) reported positive findings in relation to depression in carers. The other two trials showed no effect on overall psychological well-being, including depression and strain, from education interventions or from case management. Similarly, Pusey (2001) also reviewed psychosocial interventions and identified over 20 studies that examined outcomes relating to depression. Half of the eight identified RCTs or controlled studies reported a positive effect of the intervention; half did not. Victor (2009) identified 16 studies looking at a range of carer 'support workers' in health and social care, or the voluntary sector. These were people who specialised in working with carers and included GP-based carer

support workers; South Asian advocacy workers; mental health specialist carer support workers; support workers for carers of people with dementia; support nurse work with carers of people with lung cancer; and stroke specialist support workers. Parker et al (2010) report that there was some evidence to suggest that this type of intervention contributed to carers' improved psychological well-being but the evidence was relatively weak and in studies where the research design was stronger, the findings of improvements in carer wellbeing were less convincing. Two studies examining the outcomes of GP-based health interventions for carers suggested that this form of support could also deliver better outcomes in terms of carers' emotional well-being.

A more recent systematic review and meta-analysis of group support for carers/family of patients with dementia (Chien et al. 2011) found some benefits of this approach. The meta-analysis of 30 studies found group support had a positive impact on caregivers' psychological well-being, depression, and social outcomes. The review found that the use of theoretical models and length and intensity of group sessions had a significant impact on the effect sizes for psychological wellbeing and depression. For example, psycho-educational groups showed a significantly higher effect in the outcome variables for psychological well-being and depression. Both educational and psycho-educational groups demonstrated significant positive effects in the outcome variable of burden, but the educational group appeared to be more effective in this regard. This finding suggests that educational groups can provide immediate information and advice on caregiving skills, ways of self-adjustment, handling and legal issues and thereby facilitate caregivers' access to available resources that can reduce their burden in patient care quickly. Psycho-educational groups not only provide practical information on patient care, but also focus on caregivers' psychological and emotional status as well as establishing a social, supportive network, and are more effective at improving caregivers' psychological well-being and depression.

## **DISCUSSION**

What aspects of primary care are effective in the prevention, recognition and management of mental health issues across the lifespan; for whom do they work, in what circumstances and why?

Considering the available evidence, it is difficult to provide a definitive answer to the overall research question. Rather than identifying a strong evidence base which demonstrates effective primary care practice in prevention, recognition and management of mental health disorders, the current review highlights inconsistencies in available evidence and substantial research gaps.

As outlined in the Bamford Report on mental health promotion (2006), primary care has a crucial role to play in the early identification of common mental health problems among older people. While methods of assessment will ultimately vary depending on the mental health disorder or sub-population under consideration, standard guidelines consistently emphasise the need for comprehensive assessments based on standardised criteria with due consideration to the need for a holistic assessment which considers potential co-morbidities both mental and physical.

Review studies focusing on the assessment of depression among the general population indicated that a significant proportion of people with depression are not diagnosed when they attend primary care (Williams et al. 1995; Mitchell et al. 2009 (National Collaborating Centre for Mental Health 2010)). Mitchell and colleagues go on to suggest that while GPs are able to rule out depression in most people who are not depressed with some accuracy, difficulty arises in diagnosing depression in all true cases. In contrast to the evidence which suggests poor recognition of depression in older adults, the current review identified strong evidence demonstrating the effectiveness of screening tools for the detection of dementia (Harvan et al, 2006; Holsinger et al, 2007). Therefore, while a variety of tools and processes for mental health assessment exist, evidence suggests that there is considerable variation in practices relevant to particular psychiatric conditions and across client groups. There is little evidence of consistent use of standardized instruments and it can be

concluded from the evidence reviewed that assessment processes are inconsistent and often reactive.

Focusing specifically on mental health among the older population, Ell (2007) and Ahururu-Drisco (2004) identified a number of features that may hinder recognition of mental disorders. Further research is required to determine if these specific influences apply to the wider population. With specific reference to dementia, the review suggests that despite the availability of screening tools, dementia is probably under-diagnosed and under treated with an estimated 50% of primary care patients over 65 not diagnosed by their primary care physicians. Iliffe et al (2009c) suggest this problem of under-diagnosis is probably not due to a lack of diagnostic skills, but the interaction of case-complexity, pressure on time and the negative effects of reimbursement systems.

Evidence on recognition of mental health disorders also presents a mixed picture. Review level evidence suggests that assessment tools for the detection of dementia such as the MMSE are being effectively used in primary care. Primary care appears to work effectively in ruling out depression, using targeted assessment processes. Despite the availability of a range of standardised instruments that are specific to particular client groups and/or disorders, there is little evidence to suggest consistency in their use. Review level evidence suggests that this lack of consistent evidence coupled with lack of treatment seeking and co-morbid presentations has a marked impact on the effectiveness of current assessment processes. Furthermore, aside from limited evidence on the use of family and carer support in the management of dementia, there is a distinct lack of information on the consideration of user/carers wishes in treatment decision making, management of mental health disorders in rural areas and effective management of mental health issues in older people.

## **CONCLUSION**

The results of the current review should be interpreted with a number of limitations in mind. Firstly, the review primarily considers review level evidence relating to effective service delivery in primary care. Qualitative reviews were not considered in the current review. Given that the overall research question is somewhat qualitative in focus, a review of qualitative data on this subject area presents a specific opportunity for future research. Despite the limitations of this review, it provides a comprehensive overview of available review-level evidence relating to the effectiveness of primary care mental health services for older people and their families.

## **IMPLICATIONS FOR PRACTICE**

More work is needed to standardise approaches to the measurement of mental health outcomes. Routine health checks for older people should incorporate screening for depression and dementia. In view of the evidence supporting the benefits of PST and CBT in reducing depressive symptoms among older people, these services should be more widely available. Recognising the benefits of group support for families and carers, this service should be more widely available. In the management of dementia, primary health care staff should consider referring people who show signs of mild cognitive impairment for assessment by memory assessment services to aid early identification of dementia. Additionally, consideration should be given to the wider use of non-pharmacological interventions (music therapy, hand massage and physical activity/exercise) within primary care. It is also recommended that primary care clinicians should select a screening tool and familiarise themselves with it to become more efficient in screening for dementia.

## **REFERENCES**

References available on request from the authors.

**Footnote**

*This above manuscript is part of a larger 'Rapid Review of Mental Health in Primary Care'*

*commissioned by the HSC Research & Development Division Public Health Agency, Northern Ireland.*

*[www.publichealth.hscni.net/sites/default/files/Primary%20Care.pdf](http://www.publichealth.hscni.net/sites/default/files/Primary%20Care.pdf)*