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Depressive symptoms at old age : proactive management in general practice

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Chapter 1

General introduction

DEPRESSIVE SYMPTOMS AT OLD AGE: WHY SHOULD WE CARE?

Depression at old age is a much investigated topic. It is well established that not only depression, but also depressive symptoms at old age, have a negative impact on well-being,^{1,2} quality of life,³ daily functioning and mortality,⁴ and increase the risk of developing major depression.⁵⁻⁷ A systematic review concluded that depression and clinically relevant depressive symptoms within the older population in general practice and the community, tend to have a fluctuating and chronic course.⁸ Community studies also provide strong evidence that persistent depression and depressive symptoms are associated with older age, as are other factors that are highly prevalent at old age, such as somatic comorbidity and functional limitations.⁸

Furthermore, at old age depressive symptoms are reported to be both under-recognized and under-treated.⁹ Recognition is notoriously difficult, especially in the presence of (multiple) chronic somatic and cognitive diseases. Depressive symptoms are then easily misinterpreted, overlooked, or seen as normal and understandable rather than as a serious threat to well-being that needs further attention. This may hamper adequate treatment, even though both pharmacotherapy and psychological interventions have shown significant positive effects on clinical outcomes.¹⁰

All these findings lead one to conclude that depressive symptoms at old age have serious negative consequences, and to the hypothesis that these symptoms can be better treated if they are detected in a more efficient way.

PRO-ACTIVE MANAGEMENT OF DEPRESSIVE SYMPTOMS AT OLD AGE

In order to improve detection and treatment of depressive symptoms at old age pro-active strategies are advocated, such as screening older persons for depressive symptoms followed by treatment of screen-positive individuals.^{9,11} In 1996 the Dutch Council for Public Health and Health Care (in Dutch ‘Raad voor de Volksgezondheid en Zorg’ (RVZ)) advocated that this type of program should be developed. The Council considered depression to be one of the health problems at old age for which programmatic preventive interventions, such as early detection and subsequent treatment, should be realized.¹²

In this field, several studies have shown promising results. Two large randomised controlled trials in the USA evaluated the (cost-) effectiveness of combined screening and care management programs for depressed subjects ≥ 60 years in primary care. In the PROSPECT study the intervention was more effective than usual care in reducing suicidal ideation,¹³ whereas in the IMPACT study the intervention was effective in reducing depressive symptoms¹⁴ and was also cost effective.¹⁵ However, whether these positive

results would be found in a combined screening-intervention program for the oldest old in the primary care setting in the Netherlands was uncertain.

GENERAL AIM OF THIS THESIS

The main assumptions underlying this thesis are that depressive symptoms in older people are under-recognized and under-treated and that a proactive, combined screening-intervention approach in general practice might be (cost) effective. Based on these assumptions we aimed to explore (in a pragmatic way) whether a pro-active approach in primary care, by screening for depressive symptoms followed by an intervention offer to those who screened positive, would be helpful to detect and relieve the suffering from depressive symptoms at old age. Therefore, the PROMODE study (PROactive Management Of Depression in the Elderly) was designed and conducted.

OUTLINE OF THIS THESIS

Background and methodological studies

Chapter 2 describes our study on the relation of depression and/or anxiety with functional status, quality of life and mortality in individuals at the age of 90. Based on data from the Leiden 85-plus study, we tested our hypothesis that depression with concurrent anxiety has a stronger correlation with decreasing functional status and quality of life and increasing mortality risk, than depression alone. This study was performed to establish whether a screening-intervention program at old age should focus on a combination of depressive symptoms and anxiety, or on depressive symptoms alone. *Chapter 3* examines the variety of approaches to the usual care concept in pragmatic trials, and presents an overview of the problems researchers face when designing pragmatic trials with a ‘usual care’ control group. We were particularly interested in comparing individual and cluster-randomised trials regarding the influence of the study information provided (such as awareness of the intervention) on the behavior of control caregivers and control patients.

PROMODE study

Chapter 4 describes the PROMODE screening study for untreated depressive symptoms among patients ≥ 75 years in general practice. We tested the hypothesis that, to enhance participation in this oldest age group, screening could best be performed by visiting all persons who agreed to participate in screening (‘direct screening’). In addition, we compared yield and costs of two different screening methods, hypothesizing that the time-consuming and costly ‘direct screening’ method would result in a higher yield of screen-positive individuals than a less direct screening method (such as screening by self-administration of the screening questionnaire).

Chapter 5 describes our study on the influence of the administration method (self-administered versus interviewer-administered) on the scores of the screening questionnaire that was used in the PROMODE study, i.e. the 15-item Geriatric Depression Scale. This study was performed since earlier studies suggested a relation between the administration method of a screening questionnaire and its outcome score¹⁶⁻¹⁸; this became particularly relevant when we decided to use both methods in our own screening study.

Chapter 6 describes the PROMODE randomised controlled trial which investigated the effects and costs of the stepped-care intervention offered to patients ≥ 75 years who screened positive for untreated depressive symptoms, compared with usual care. Individuals aged 75-79 and ≥ 80 were evaluated separately.

Chapter 7 presents our qualitative study, performed alongside the randomised controlled trial. This study explored the limiting and motivating factors that play a role in the decision whether or not to accept a treatment offer among persons ≥ 75 years who screened positive for depressive symptoms.

Discussion of results and summaries

In *Chapter 8* the main results of our study are summarized and discussed. This chapter also addresses implications of our results for further development of strategies to reduce depressive symptoms at old age in general practice and makes recommendations for future research.

Chapters 9 and 10 present a summary of this thesis in English and in Dutch, respectively.

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