Treatment-Refractory Depression in the Elderly: An Audit of Primary Care Referrals to Psychiatric Services in Swindon, U.K.

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Background: Our objective was to audit primary care referrals for depression to assess prereferral quality of antidepressant treatment.

Method: We performed a retrospective audit of referrals from primary care to the Department of Old Age Psychiatry in Swindon, Wiltshire, U.K., for a new episode of depression, excluding life-threatening cases, between January 1, 1997, and December 31, 1998. To determine if treatment before referral met criteria for an adequate trial, for audit purposes we defined an adequate trial as 8 weeks at maximal dose as specified by the British National Formulary.

Results: A computer search identified 58 referrals: 33 cases were excluded—3 notes were unavailable for audit, 7 were wrongly coded, 8 were life-threatening, and 15 were non–primary care referrals. Of the 25 evaluable patients, 2 had had an adequate duration of treatment and 6 were taking maximal doses of antidepressants, but none was taking a dose for an adequate duration.

Conclusion: Patients referred to secondary care for depression are often undertreated prior to referral, which may explain why the patients in this retrospective audit had failed to respond. Primary care physicians should be encouraged to use medication in elderly patients that requires little or no dose titration at high doses and for at least 8 weeks before considering the patient to be treatment refractory.

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Over the last 10 years, the role of primary care in depression management has been transformed with the introduction of newer therapeutic interventions, initially with selective serotonin reuptake inhibitors (SSRIs) (e.g., fluoxetine and paroxetine) but also serotonergic and noradrenergic reuptake inhibitors (SNRIs) (venlafaxine and mirtazapine), monoamine oxidase inhibitors (MAOIs), triazalopyridines (trazodone), phenylpiperazines (nefazodone) and others, often with several modes of action. With newer drugs has come a lot of "spin" from drug companies vying for a bigger slice of the market. Claims of greater efficacy, faster onset of action, and fewer side effects have, not surprisingly, wooed both the general public and medical profession toward these newer and more expensive products.

Expectations have now also increased, and both patients and doctors appear ever more impatient to achieve a response to medication. In 1994, Kerr[1] compared the antidepressant prescribing practices of general practitioners (known as family practitioners in the United States) and psychiatrists; 52% of general practitioners and 17% of psychiatrists reported using lower than recommended doses for adult patients. In addition, 40% of general practitioners and 7% of psychiatrists used a shorter than recommended period for continuation of therapy (less than 4 months). Guidelines for management of depression in the elderly[2] published and distributed to all general practitioners in the United Kingdom state that antidepressants take between 4 to 8 weeks to produce an effect, and reaffirm that titrating doses up to therapeutic levels is important.

We audited our referrals for depression to ascertain if patients being referred had been treated at an adequate dose for a reasonable length of time.

METHOD

We audited the records of patients referred to the Department of Old Age Psychiatry in Swindon, Wiltshire, U.K., for a new episode of depression, to ascertain how many had true treatment-refractory depression and how many simply failed to receive adequate treatment (dose and/or duration) prior to referral.

For the purpose of our audit, we defined an adequate trial of treatment with an antidepressant as one that constituted 8 weeks at maximal dose. Maximal dose was defined by dosing guidelines for the elderly as documented in the British National Formulary. (These are likely to be similar to the U.S. Food and Drug Administration [FDA] guidelines and are available in Table 1 for comparison.) We excluded all life-threatening depression and referrals not emanating from primary care physicians.

A retrospective audit of all referrals to the Department of Old Age Psychiatry was undertaken by searching the department's database to identify all patients aged over 65 years coded for depression with a new referral between January 1, 1997, and December 31, 1998. The hospital notes for these patients were then pulled and hand-searched to identify the following: (1) nature of the referrals, i.e., general practitioner–initiated; (2) referral due to life-threatening depression (an exclusion criterion); (3) type of medication the patient was taking at referral; (4) dose of medication taken; and (5) duration of medication taken.

Where insufficient details existed in the hospital notes, general practitioners were contacted by telephone for further information.

Table 1. Assessment of Antidepressant Treatment in Referrals for Depression to a Geriatric Psychiatry Department[a]

Patient	Drug	Maximum Dose (mg) From BNF	Dose (mg) 24 h	Duration of Treatment	Adequate Dose	Adequate Duration	Adequate Dose and Duration
1	Nefazadone	400	200	4 d	No	No	No
2	Paroxetine	40	20	4 wk	No	No	No
3	None[b]						
4	Dothiepin	150	75	3 d	No	No	No
5	Sertraline	200	100	2 wk	No	No	No
6	Dothiepin	150	150	10 d	Yes	No	No
7	Fluoxetine	20	20	4 wk	Yes	No	No
8	None[b]						
9	None[c]						
10	Sertraline	200	50	6 wk	No	No	No
11	Sertraline	200	150	4 wk	No	No	No
12	None[d]						
13	Paroxetine	40	20	6 d	No	No	No
14	None[b]						
15	Paroxetine	40	20	6 wk	No	No	No
16	None[c]						
17	Fluoxetine	20	20	23 d	Yes	No	No
18	Citalopram	40	20	0 d	No	No	No
19	Sertraline	200	100	Months	No	Yes	No
20	None[b]						
21	Dothiepin	150	100	4 wk	No	No	No
22	None[b]						
23	Sertraline	200	100	7 mo	No	Yes	No
24	Fluoxetine	20	20	4 wk	Yes	No	No
25	Paroxetine	40	40	10 d	Yes	No	No

[a]Abbreviation: BNF = British National Formulary.
[b]No reason given.
[c]Patient referred for advice on starting medication.
[d]Patient referred for memory problems.

RESULTS

A computer search identified 58 patients; of these, only 55 sets of notes were available to search. Of these 55 patients, 7 were wrongly coded and did not have depression, 8 had life-threatening depression, and 15 were referred from sources other than primary care practitioners.

This left only 25 patients. Of these, 1 patient was referred with memory problems and was not taking any antidepressants. Two patients were referred for medication advice without antidepressant medication having been started. The first of these was taking multiple medications, and the general practitioner was requesting assistance prior to starting medication. The second patient had previously tried numerous different antidepressants, and again, the general practitioner was asking for help in the selection of an appropriate drug. Five patients had not started any medication, with no identifiable reasons given, prior to referral. Five patients were taking maximum doses of antidepressants prior to referral, but none for an adequate duration, while 2 had adequate duration of treatment but not at maximal doses. Ten had started taking medication prior to referral both at inadequate dose and for too short a duration. No patients fulfilled our search criteria for treatment-refractory depression, and only 3 of the 25 patients were taking tricyclic antidepressants.

DISCUSSION

Community studies have identified a prevalence of depressive symptoms from 12% to 15% in people aged over 65 years.[3] With a local elderly population base of 42,000, then, we should expect depression to occur in 5040 to 6300. We received referrals at a rate of 0.8% over 2 years, or 0.4% annually. Cole and Yaffe[4] estimate a prevalence for moderate-to-severe depression of 2.7%, with only 20% of those cases identified by primary care practitioners (0.54%) and only half of them referred for psychiatric help (0.27%). These local primary care referrals for North Wiltshire are thus compatible with Cole and Yaffe's findings (0.27% and 0.4% being similar).

There is clearly vast underdiagnosis and undertreatment of depression in the elderly, which will need much reeducation to tackle. MacDonald[6] and Mullan et al.[7] showed that, although primary health care teams are often aware of the presence of depression in the elderly, they infrequently make a diagnosis or start treatment. Depression screening tools such as the 15-item Geriatric Depression Scale[8] or its 4-item abbreviation[9] may encourage those of us working in primary care to document a diagnosis of depression more often.

In England and Wales, the suicide rate is at its highest among people aged over 65.[5] Disturbingly, of the 100 cases that Cattell and Jolley[5] studied, at least 60% had clinical depression, yet only 25% were on antidepressant therapy, with 43% having seen their general practitioner in the month before suicide. Furthermore, only 14% were in contact with mental health services. Thirdly, therefore, if we are going to attempt to make an impact on suicide levels as well as moderate-to-severe depression, a shift in treatment toward secondary care is necessary, or perhaps secondary care needs to shift toward or even integrate with primary care. It is clear from prevalence levels of depression that secondary care physicians are barely able to see the iceberg, yet alone treat the tip of it. Because even a small rise in referrals could rapidly overwhelm secondary care services, any changes in referral patterns will need to involve such innovations as mood disorder clinics, increased use of specialized nursing skills, and a reduction of the primary/secondary care interface.

Fourthly, our audit shows the importance of careful selection when choosing an antidepressant. As primary care physicians become bombarded with an ever-increasing array of antidepressants, it is important to review critically which antidepressants to use. Older tricyclic antidepressants should not be used routinely in the elderly,[10] because of their more frequent use at subtherapeutic doses than SSRIs as well as their toxicity. Preferred antidepressants for a practice formulary should require little or no dose titration, with low incidence of side effects.

Finally, it must not be forgotten that antidepressants take several weeks to start working. Few of the patients in our audit had been treated for over 8 weeks, and, although some of these referrals may be defensible on the basis of severity of depression, it would be hard to deny that, given a bit more patience (and with correct dosing), many of these patients would not have required secondary care input.

CONCLUSION

In summary, it is important to attempt to increase identification of depression, and, when a diagnosis is made, to then treat it appropriately. A suitable antidepressant at an adequate and preferably maximal dose should be tried for at least 8 weeks (except where suicidal ideation or risk exists), before the depression is labeled treatment refractory. More consideration needs to be made as to how primary care physicians can utilize the experience and facilities of secondary care for depressed patients more effectively.

Drug names: citalopram (Celexa), fluoxetine (Prozac), mirtazapine (Remeron), nefazodone (Serzone), paroxetine (Paxil), sertraline (Zoloft), trazodone (Desyrel and others), venlafaxine (Effexor).

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