Chapter 1

General introduction
“That there are in fact few things that you like, and that you really feel a little ashamed about. Because there are many things that are fun. But of course you also have to do things yourself, and you postpone that, time after time. Like I will go to see the doctor some time, or I will read a book about it. But because of that it takes much longer, which makes you run away from it a little. Absurd, what do I have to complain about? But still it is there, and you just keep going on like that. [...] It will take some more time, at least for me, to take that step.”

A 75 year-old female ‘Lust for Life’-respondent

Depressive symptoms in older persons

The prevalence of depressive symptoms (i.e. all depressive syndromes deemed clinically relevant that do and do not fulfil criteria for a major depressive disorder) in community-dwelling older persons are estimated at 13.5%. Despite this high prevalence, depressive symptoms in many older persons remain undetected and untreated although efficacious treatments are available. A Dutch study found that 67% of older persons with a major depression were not recognised by their general practitioner as being depressed. The prognosis of undetected depression is poor, since 67% of older persons with an undiagnosed depression are still depressed one year later.

Depressive symptoms are accompanied by considerable burden since they significantly contribute to a reduced quality of life, impaired functioning and mortality, and may lead to an excess use of health services. Subclinical depression is the most important risk factor for developing a major depressive disorder, which ranks second amongst diseases with the most leading causes of disability worldwide.

There are several reasons why older persons with depressive symptoms are reluctant to discuss their emotional distress with health care professionals: they may attribute their depressive symptoms to normal aging or physical ill-health (‘justifiable depression’), prefer to manage problems by themselves, avoid bringing up affective symptoms due to fear of stigma, aversion to treatment with antidepressants, low expectations of available treatment in general or specifically to interventions delivered by their general practitioner.

Health care providers on the other hand may also experience barriers in recognising and treating older persons with depressive symptoms. General practitioners could play a key role in the detection of late life depressive symptoms since most older persons are seen in primary care for other conditions. General practitioners may be hampered to recognize depressive symptoms in older persons due to the same attribution process to normal aging, their reluctance to discuss depressive symptoms with older persons because of perceived stigma, limited awareness, a lack of confidence in their management skills, and being cautious of opening ‘Pandora’s box’ in time-limited consultations.
Strategies to improve treatment for older persons with depressive symptoms

Several strategies have been proposed to improve the detection and management of late life depression. One of those strategies concerns the detection by mass screening of older persons with depressive symptoms who have not (yet) asked for help. This outreaching approach might improve case finding and serves to early detect persons with depressive symptoms at risk of developing a major depressive disorder or persons with an untreated depression.

A second strategy to improve the provision of evidence-based interventions regards the use of collaborative care. Collaborative care is a care model that includes the involvement of multiple health care professionals, a structured plan of symptom management, scheduled follow-up measurements and inter-professional communication\textsuperscript{18} and has been found to have an effective impact on depression outcomes.\textsuperscript{19} For this study, we further specify two other strategies that aim at improving the delivery of effective interventions to reduce depressive symptoms that could show a significant overlap with collaborative care: stepped care models and preference-led care. In stepped care programmes effective interventions are initially offered at the lowest intensity as possible (e.g. guided self-help). Higher intensity treatments are provided when indicated (e.g. counselling). Stepped care has been recommended in several international guidelines.\textsuperscript{20-22} Preference-led interventions, that are tailored to older persons’ needs by offering them multiple treatment options to choose from, has shown to enhance treatment initiation and adherence.\textsuperscript{23}

Various randomised clinical trials aimed at providing outreaching care for older persons with depressive symptoms have carried out stepped care models or preference-led care. Table 1 presents an overview of these studies. Most of them have shown to be moderately or strongly effective in preventing the onset of depressive disorders\textsuperscript{24,25} or in reducing depressive symptoms.\textsuperscript{26-33} However, some studies found that their intervention programme was not superior to usual care.\textsuperscript{31-33} Although these randomised clinical trials have shown promising results, it is unknown whether these programmes are also effective when implemented in daily practice. Further, only two studies - that also included younger adults - integrated the strategies of stepped care models and preference-led care into one trial; all the other studies exclusively consisting of older persons were designed as single-strategy trials.\textsuperscript{24-29,31,32} It is yet unknown what impact an intervention programme combining these two strategies has on late life depressive symptoms in the real world under practice circumstances. Therefore we conducted the ‘Lust for Life’ study to explore the implementation of an outreaching intervention programme that offered stepped care, preference-led interventions to reduce depressive symptoms in community-dwelling older persons.
### Table 1: Overview of randomised controlled trials with an outreaching intervention programme to reduce depressive symptoms in older adults.

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<tr>
<th>Authors</th>
<th>Sample</th>
<th>Strategy</th>
<th>Intervention(s) offered</th>
<th>Results at 12 months follow-up</th>
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</table>
| Bruce et al (2004) – JAMA   | 598 older persons (60-94 years old) from primary care clinics with major or minor depression | Preference-led interventions | AD or interpersonal therapy | - Significant reduction of depressive symptoms from 18.6 to 9.8 in the intervention group vs. 17.6 to 10.4 in the control group on the HDRS (B=-1.8 (-3.1 to -0.5), p= .006).  
- Higher treatment response (≥ 50% decrease in HDRS-scores): 52.1% in intervention group vs. 42.0% in usual care group (OR= 2.0 (1.1 to 3.8)). |
| Ciechanowski et al (2004) - JAMA | 138 older persons (mean age 73) from the community with minor depression or dysthymia | Stepped care       | 1) PST  
2) referral to GP | - Significant reduction of depressive symptoms from 1.3 to 0.82 in the intervention group vs. 1.2 to 1.0 in the control group (B=0.19 (-0.40 to -0.02) on the HSCL-20  
- Higher treatment response (≥ 50% decrease in HSCL-20 scores): 43% in intervention group vs. 15% in usual care group (OR=5.21 (2.01 to 13.49)). |
| Dozeman et al (2012) – Int Psychoger | 185 older persons (mean age 84) from homes for the elderly with subclinical depression and/or anxiety | Stepped care       | 1) Watchful waiting  
2) Activity scheduling  
3) Life review  
4) Referral GP | - Significant reduction of the incidence of major depression: 6.5% in the intervention group vs. 14.1% in the control group (IRR=0.26 (0.12-0.80)). |
| Unützer et al (2002) - JAMA | 1801 older persons (mean age 71) from primary care with major depression or dysthymia | Preference-led interventions | AD or PST | - Significant reduction of depressive symptoms from 1.7 to 1.0 in the intervention group vs. 1.7 to 1.4 in the control group (B=-0.4 (-0.46 to -0.33), p<.001) on the SCL-20  
- Higher treatment response (≥ 50% decrease in SCL-20 scores): 44.7% in intervention group vs. 19.2% in usual care group (OR=3.45 (2.71-4.38)). |
| Van 't Veer et al (2009) - Arch Gen Psych | 170 older persons (mean age 81) from primary care with subclinical depression and/or anxiety | Stepped care       | 1) Watchful waiting  
2) Self-help course  
3) PST  
4) Referral to GP | - Significant reduction of the incidence of major depression: 11.6% in the intervention group vs. 23.8% in the control group (RR=0.49 (0.24-0.98)). |

**Abbreviations:** AD = antidepressant medication  
GP = General Practitioner  
PST = Problem Solving Treatment
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<tr>
<td><strong>Intervention programmes superior to usual care</strong> (in samples that also included younger adults)</td>
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<td>Davidson et al (2012) – Arch Int Med*</td>
<td>157 younger and older adults (mean age 60) admitted to the hospital with acute coronary syndrome and depressive symptoms</td>
<td>Preference-led interventions</td>
<td>AD or PST</td>
<td>• Significant reduction of depressive symptoms from 19.0 to 13.2 in the intervention group vs. 19.6 to 17.7 in the control group (t= 3.03, p=.003) on the BDI.</td>
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</table>
| Katon et al (2004) – Arch Gen Psychiatry | 329 younger and older adults (mean age 58) from primary care clinics with diabetes and (sub)clinical depression | Stepped care / preference-led interventions | 1/2) AD or PST 3) referral to mental health care | • Significant reduction of depressive symptoms (mean scores unknown, F=4.96, p=.03)  
• Higher treatment response (> 50% decrease in SCL-90 scores): 41.1% in intervention group vs. 31.7% in usual care group (OR=1.47 (0.90-2.39)). |
| **Intervention programmes not superior to usual care** |
| Apil et al (2012) – Int J Ger Psych | 136 younger and older adults (mean age 67) with a past (not current) major depression | Stepped care | 1) Watchful waiting 2) Self-help course 3) Group course 4) Referral to GP | • No significant reduction in relapse rate of major depression: 28.2% in the intervention group vs. 21.9% in the control group (OR=1.4, p>0.05) |
| Patel et al (2010) – Lancet* | 774 younger and older adults (24% was 60 years or older) from primary care with major depression (subgroup amongst persons with other common mental disorders) | Stepped care / preference-led interventions | 1) AD or interpersonal therapy 2) referral to clinical specialist | • No significant differences in recovery rates: 53.6% in the intervention group vs. 50.4% in the control group (RR=1.05, p=.69). |

*Abbreviations: AD = antidepressant medication  
GP = General Practitioner  
PST=Problem Solving Treatment  
*6 months follow-up
Table 1 (continuation)

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<td>Van der Weele et al (2012) – Age and Ageing</td>
<td>239 older adults (median age 80) from primary care with subclinical depression.</td>
<td>Stepped care</td>
<td>1) Coping with depression course</td>
<td>• No significant reduction of depressive symptoms; scores changed from 12 to 10 in the intervention group vs. 14 to 10 in the control group (ICC =0.045, p = 0.09) on the MADRS.</td>
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<td>2) Referral to GP</td>
<td>• No beneficial effect of the interventions on the treatment response (&gt;50% decrease in MADRS-scores): 21% in the intervention group vs. 33% in the control group (p=.05).</td>
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Abbreviations: AD = antidepressant medication  GP = General Practitioner  PST=Problem Solving Treatment  * 6 months follow-up
Aims of this thesis
The main aim of this thesis was to explore facilitating and hindering factors to the implementation of an outreaching programme that offered stepped care, preference-led interventions to reduce depressive symptoms in community-dwelling older persons of 65 years old and over. Our second aim was to determine the clinical effectiveness of this intervention programme when implemented in the real world of daily practice.

Chapter 2 evaluates the clinical effectiveness of this intervention programme on the reduction of late life depressive symptoms compared to usual care. In chapter 3 we provide a contextualised understanding of factors affecting the implementation of the ‘Lust for Life’ intervention programme. In chapter 4 we use a mixed-methods approach to provide an overview of factors that facilitate or hinder older persons’ acceptance of the intervention programme. Chapter 5 uses data from the Netherlands Study of Depression and Anxiety (NESDA) to describe which reasons are provided by adults with a depressive and/or anxiety disorder for not receiving treatment while perceiving a need for help. Chapter 6 examines the modifying role of older persons’ self-perceived needs for care in the outcome of the ‘Lust for Life’ programme. Chapter 7 focuses on the association between feelings of loneliness in older persons with depressive symptoms and mental health consequences. Finally, in chapter 8 we provide a summary and discussion of the results presented in the previous chapters, and clinical implications of our findings are presented.
REFERENCE LIST


