10.3 Assess depressive symptoms

An important first step when conducting an in-depth assessment for depressive symptoms is to identify and treat any potential reversible causes that can resemble or exacerbate depressive symptoms (◆). → 10.5

A health worker should also assess psychological stressors such as bereavement and traumatic events that can explain depressive symptoms.

Following this, by asking a series of questions, a health worker can identify those with depressive symptoms and distinguish depressive symptoms from depression (moderate to severe) at a primary care facility. If a person reports at least one of the core symptoms – feeling down, depressed or hopeless and having little interest or pleasure in doing things – and one or two additional signs, they may have depressive symptoms. If a person has more than two additional symptoms, they may qualify for a diagnosis of moderate to severe depression. A person with moderate to severe depression usually has considerable difficulty with daily functioning in personal, family, social or other situations.

In addition to an in-depth assessment for depressive symptoms, results of basic assessments for other linked domains of intrinsic capacity, such as cognitive decline, vision impairment and hearing loss should also be verified and in-depth assessments conducted as necessary. → 5 8 9

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See the section on depression in the *mhGAP intervention guide* for details of how to conduct an assessment. Tools can be used for the assessment of depression, e.g. the *Patient Health Questionnaire* (PHQ-9).

10.4 Manage depressive symptoms

Interventions to manage depressive symptoms should always be provided as part of a comprehensive personalized care plan responding to underlying factors, along with interventions that address other domains of intrinsic capacity.

In addition to guidance on stress management, there are multiple other ways to manage depressive symptoms including psychoeducation and brief structured psychological interventions. It is recommended to apply **a stepped care approach**, starting with a self-help low-intensity intervention (stress management) and monitoring symptoms and provision of further interventions, in case of no improvement or worsening.

10.4.1 Psychoeducation

Psychoeducation refers to educational programmes targeting an older person with depressive symptoms and their carers focused on improving understanding of their symptoms, including likely cause, symptom monitoring and coping strategies, taking into account their specific difficulties with ADL and problem-solving. This information:

- Helps improve a person's knowledge about their condition and enables informed decision-making about treatment.
- Improves understanding about how and why treatment can be helpful, encouraging adherence, and realistic expectations.
- May increase feelings of control and empowerment and reduce anxiety.
- Provides hope for recovery.
- Can improve carers' and family members' knowledge, helping them to better support the person.

It is important to provide brief amounts of information at a time, use simple language and relevant examples, and check the person or group's understanding of the information provided.

Psychoeducation can be delivered individually or in group settings if the therapeutic components are adapted for delivery in a structured psychoeducational format.

10.4.2
Brief structured psychological interventions

Psychological interventions are the informed and intentional use of clinical techniques developed from psychological principles to help people modify their psychological skills (e.g. emotional, interpersonal, behavioural and cognitive skills). If there is no improvement of depressive symptoms by providing guidance on stress management and psychoeducation, brief structured psychological interventions, such as behavioural activation therapy, CBT, problem-solving therapy and third-wave therapies, may be considered.

Different formats for the delivery of psychological interventions (average 8–10 sessions) can be considered with older people including individual and/or group face-to-face psychological treatments. Health professionals in mental health such as psychologists would usually administer these interventions. Health workers in primary care facilities could provide them if they are skilled and trained in the mental health issues faced by older people, as the benefits outweigh the harms.

While face-to-face psychological treatments are likely to have better outcomes than unguided self-help, the latter may be suitable for those who either do not have access to face-to-face psychological treatment or are not willing to access such treatments.

- **Behavioural activation therapy:** This focuses on improving mood by (re)engaging in activities that are task-oriented and used to be enjoyable, in spite of current low mood. It may be used as a stand-alone treatment, and it is also a component of CBT.
- **Cognitive behavioural therapy (CBT):** A person with depressive symptoms may have unrealistic, distorted negative thoughts that can lead to harmful behaviour. CBT, which combines thinking differently (e.g. through identifying and challenging unrealistic negative thoughts) and doing things differently (e.g. by helping the person to do more rewarding activities) can be helpful.
- **Problem-solving therapy:** A problem-solving therapy involves the systematic use of problem identification and problem-solving techniques over a number of sessions. It offers direct and practical support by breaking problems down into specific, manageable tasks and then developing coping strategies for specific problems.
- **Third-wave therapies:** These include mindfulness-based interventions, acceptance and commitment therapy, metacognitive therapy and dialectical behavioural therapy. "Mindfulness-based interventions" is used here as an umbrella term for mindfulness, meditation and yoga techniques, as well as mindfulness-based cognitive therapy and mindfulness-based stress reduction. Mindfulness consists of paying attention to what is happening in the present moment instead of being carried along by a train of thoughts about the past, future, wishes, responsibilities or regrets.

Community stakeholders can provide information on available services and support and can help break down stigma around mental health. This can be particularly effective if trusted and respected community leaders, including faith leaders, are involved. Community-based organizations can help to identify those in their communities who may be experiencing depressive symptoms and who may need support, as well as their carers, who may experience symptoms themselves. They can help by referring people to appropriate services, establishing peer support groups, organizing events to promote social participation and helping with day-to-day tasks which may be causing stress.

10.4.3
Cognitive decline → 5

Cognitive decline and dementia may be associated with depressive symptoms. Results of a basic assessment for cognitive decline should be validated and an in-depth assessment conducted as necessary. The cognitive functions that can be affected in depression are attention and memory, as well as executive functions. Depression could be a psychological response to an individual's self-awareness of mild cognitive decline that has not yet begun to interfere with daily functioning.

A person with dementia often complains of mood or behavioural problems, such as lack of interest, loss of emotional control or difficulties carrying out usual work, domestic or social activities. Psychological interventions, such as CBT, interpersonal therapy, structured counselling and behavioural activation therapy, should be considered for people with dementia and mild to moderate depression (see *mhGAP guideline*).

10.4.4
Manage moderate to severe depression

For a person with depression (moderate to severe), a more specific, targeted or tailored approach is needed. That includes assessment of potential thoughts, plans or acts of self-harm or suicide offering evidence-based interventions such as antidepressants and brief structured psychological interventions.

Asking about self-harm or suicide does NOT provoke acts of self-harm. It often reduces anxiety associated with these thoughts or acts and provides a sense of relief. However, it is important to establish a relationship with the person before asking such questions. To introduce questions about suicide, acknowledge that when people are very upset or feel hopeless, they may have thoughts about death or ending their own life and that these thoughts are not uncommon, and people should not feel ashamed.

After checking whether the person agrees to discuss these issues, questions like "In the past month, have you had serious thoughts of ending your life or a plan to end your life? Or have you taken any actions to end your life in the past year?" can be asked.

If imminent risk of self-harm or suicide is identified, the person should be referred immediately to health workers with training in mental health or specialized care, if available. Family members, friends and other colleagues or neighbours should be mobilized to monitor the person and access to means of self-harm should be removed. The person and their carers should be linked with community resources, for example, mental health or suicide phonelines that provide advice and support.

Prescription of antidepressants requires knowledge of managing mental health conditions. Antidepressant medicine alone for people with depression (moderate to severe) should only be considered when structured psychological interventions are not available.

MORE INFORMATION

- ***mhGAP intervention guide for mental, neurological and substance use disorder in non-specialized settings: mental health Gap Action Programme (mhGAP), version 2.0.*** WHO; 2016 (https://iris.who.int/handle/10665/250239).
- ***Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders, [3rd ed.].*** WHO; 2023 (https://iris.who.int/handle/10665/374250).
- ***Psychological interventions implementation manual: integrating evidence-based psychological interventions into existing services.*** WHO; 2024 (https://iris.who.int/handle/10665/376208).

10.5 Assess and manage associated diseases and risk factors

An assessment of diseases and risk factors for depressive symptoms should start by identifying and treating possible causes (◆). Common conditions and risk factors that can cause depressive symptoms include medication(s), anaemia, malnutrition, hypothyroidism, and pain. In some cases, treatment of these conditions results in improvement in depressive symptoms. If depressive symptoms persist, further assessment will be required. Uncovering possible cause(s) of depressive symptoms involves a full diagnostic work-up, sometimes including blood tests.

10.5.1 Inappropriate medication(s) ◆

Some medications can lead to depressive symptoms. These include, but are not limited to medicines that act primarily on the central nervous system, such as antihistamines, psychotropic medicines, muscle relaxants and other non-psychotropic drugs with anticholinergic properties, and steroids. The potential harm of these medicines can also outweigh their benefits for some people. Eliminating unnecessary, ineffective medicines as well as medicines that share an active ingredient reduces polypharmacy. → 4.2.4

10.5.2 Anaemia, malnutrition and hypothyroidism ◆

Various diseases affect depressive symptoms, such as heart diseases, chronic obstructive pulmonary disease, cancer, autoimmune diseases, anaemia, malnutrition and hypothyroidism. It is important to control these diseases, which can resemble or exacerbate depressive symptoms.

Anaemia and malnutrition can lead to depressive symptoms because of deficiencies of iron, vitamins such as folate, vitamin B6 and vitamin B12. Depressive symptoms can also play a role in the development of anaemia. For example, loss of appetite and lack of interest in performing daily activities (such as shopping and cooking), both associated with depressive symptoms, can reduce quality and quantity of nutrition, potentially leading to the development of anaemia and malnutrition. To manage depressive symptoms, it is crucial to manage anaemia and improve nutritional status. → 7

Hypothyroidism is a common disorder in older people, especially women. The symptoms of hypothyroidism can be non-specific such as fatigue and dry skin and can include depressive symptoms. The diagnosis of hypothyroidism usually requires a blood test and care should be managed by health workers with specialized knowledge.

10.5.3 Pain ◆

There is a bidirectional relationship between pain and depressive symptoms. Individuals reporting chronic pain often have depressive symptoms and depressive symptoms can present as physical symptoms such as vague aches and pains. Some people experience a vicious cycle in which pain worsens depressive symptoms, and the resulting depression magnifies feelings of pain. It is important to address pain and depressive symptoms in a comprehensive, holistic manner. → 6.5.2

10.5.4
Other associated conditions

The presence of the following associated conditions would suggest a different approach from treatment for depressive symptoms is needed.

- **Major loss (bereavement) in the last 6 months:** Bereavement is a normal process of loss, grief and recovery associated with death. Grief has both mental and physical effects and people grieve in different ways, for example, showing strong emotions or a limited reaction. In most cases, grief diminishes over time. A discussion on and support for culturally appropriate adjustment and/or mourning processes are important to manage grief. If a person's symptoms involve considerable difficulty with daily functioning lasting longer than 6 months and include severe preoccupation with or intense longing for the deceased person and intense emotional pain, grief disorder should be suspected. In this case, a health worker with specialist knowledge should be consulted.

- **Disability due to illness or injury:** People who experience disability due to illness or injury undergo stress; they must also cope with life transitions. The stages of adjusting to a new form of disability include shock, denial and adjustment/acceptance. Older people with new disabilities are at risk of developing anxiety and depression. In most cases the symptoms are likely to diminish over time, particularly if the person gets social support and engages in stress reduction.

- **History of mania:** Mania is an episode of mood elevation and increased energy and activity. People who experience manic episodes are classified as having bipolar disorder, characterized by alternate manic and depressive episodes. History of mania can be identified by checking several symptoms, including decreased need for sleep, increased talkativeness or rapid speech and impulsive or reckless behaviours occurring simultaneously, lasting for at least 1 week, and severe enough to interfere significantly with work and social activities or requiring hospitalization or confinement. Management of mania requires health professionals with training in mental health or specialized care, if available.

10.6
Assess and manage social and physical environments

10.6.1
Social isolation and loneliness

Loss of interest in activities that used to be interesting or pleasurable is common in people with depressive symptoms and can lead to social isolation and loneliness. It is important to try and understand any factors that may be leading to or exacerbating social isolation and loneliness, in addition to depressive symptoms, which could include challenging personal relationships. Asking an older person if there are activities they would like to try and engage with and providing support to enable this can be helpful. →11.3.3

10.6.2
Social care and support

An older person with depressive symptoms may find it difficult to manage everyday activities and may need social care and support. This can start with providing help with addressing basic needs, facilitating access to services and connecting with family and other forms of social support.

It is important to identify and discuss relevant issues that place stress on the person and/or impact their life including, but not limited to, family and relationship problems, housing, finances, access to basic security and services, stigma, discrimination and maltreatment (abuse of older people including neglect). →11.4