Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings

Module on Common Mental Health Problems in Older Adults

2019
Acknowledgments

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<th>Name</th>
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Chapter 1: Introduction

Mental health is an important aspect of individual's well-being. The World Health Organization (WHO) conceptualise mental health as 'a state of well-being in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.

1.1 Epidemiology of mental health problems

The World Health Organization’s World Mental Health Survey Initiative found that mental health problems were common across the globe but the prevalence varied widely across countries. For example, the lifetime prevalence of any anxiety disorders and mood disorders ranged from 4.8 to 31.0% and 3.3 to 21.4% respectively in different parts of the world.

According to the Global Burden of Disease study 2010 (GBD), mental and substance use disorders were the leading global cause of all non-fatal burden of disease, accounted for 7.4% of all disability-adjusted life years (DALYs) worldwide. Depressive disorders and anxiety disorders accounted for 40.5% and 14.6% respectively of DALYs caused by mental and substance use disorders. It was estimated that the disease burden caused by mental disorders would continue to rise, with unipolar depressive disorders emerging as the non-communicable disease leading to the greatest DALYs by 2030.

A local study, the Hong Kong Mental Morbidity Survey found that common mental disorders (CMD; defined as depressive and anxiety disorders in the survey) were positively associated with female gender, being divorced or separated, alcohol misuse, substance dependence, lack of regular physical exercise, and a family history of mental disorder. However, among individuals with CMD, only 26% had consulted mental health services in the past year; while less than 10% consulted general practitioners or family physicians. Lack of mental health service usage was significantly more likely in men and those with lower educational attainment. The study concluded that, apart from attention to psychosocial risks, health and lifestyle factors were important considerations for mental health promotion; service utilization for individuals with CMD in Hong Kong remained suboptimal, and would be enhanced by strengthening community primary care.
Another local cross-sectional survey also found that depression was common in primary care settings. The survey made use of the Patient health Questionnaire-9 (PHQ-9) instrument to screen for depression among waiting room patients of 59 primary care doctors. It found that the prevalence of PHQ-9 screened positive patients was 10.7%, and 23.1% of those who were screened positive received a diagnosis of depression by the doctor.

1.2 Common mental health problems in older adults

Older adults are at risk of mental health problems, as they may lose their ability to live independently due to limited mobility, chronic pain, frailty or other physical problems. Besides, life events such as bereavement or a decline in socioeconomic status with retirement or disability are more common in older adults. All of these factors can lead to isolation, loss of independence, loneliness and psychological distress in older adults. On the other hand, CMD like anxiety disorders and depressive disorders are associated with significant psychosocial disability, functional impairment, loss of productivity, poor quality of life and economic loss.

The common mental health problems of older adults encountered in primary care settings are depression, anxiety disorders, stress related disorders, and dementia. It is important for primary care doctors to be familiar with the symptoms of these common mental health problems, so that early detection and intervention can be made for our older adults.

**Depression**

Standard diagnostic criteria for depression such as International Classification of Diseases, 11th edition (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) both require the presence of either a depressed mood or a loss of interest or pleasure together with other relevant symptoms for 2 or more weeks.

**Anxiety disorders**

The anxiety disorders include a variety of diseases such as generalised anxiety disorder, panic disorder, specific phobia, agoraphobia, etc. The Hong Kong Mental Morbidity Survey found that generalised anxiety disorder was the most prevalent among other anxiety disorders in the older age group (aged above 65 years).

**Stress related disorders**

Older adults are prone to experience life events such as bereavement, social isolation, serious physical illness which result in disability and dependence. Maladaptive response to severe stress can lead to various psychological symptoms resulting in problems in daily functions, and may result
in acute stress reaction/disorders and adjustment disorders in these older adults.

**Dementia**
Dementia, a syndrome in which there is deterioration in memory, thinking, behaviour and the ability to perform everyday activities, mainly affects older adults. For the recognition and management of dementia, please refer to the module on cognitive impairment, *Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings*\(^1\).
1.3 The role of primary care doctors in managing older adults with common mental health problems

Primary care doctors are readily accessible in the community, providing holistic, patient-centred, continuous and comprehensive care to patients and their families. They are the companions of older adults with common mental health problems in several ways: recognition, management, appropriate referrals to specialists and allied health professionals, and supporting the older adults’ families and caregivers in need.

The following diagram illustrates the role of primary care doctors in managing older adults with common mental health problems:
Chapter 2: Promote mental wellness

Healthy ageing enables older adults to take an active part in society and to enjoy independent and good quality of life. It means optimizing physical, social, and mental health of the older adults, so that they can continue to make valuable and important contributions to the society.

Ageing is associated with other life transitions such as retirement, and the death of friends and partners. Enhancing the knowledge and understanding of the physical and psychological changes of ageing such as changes in functioning, cognitive abilities, and mental problems can help both the older adults and their care-takers to adapt the changes.

Common mental problems of older adults\(^{15}\) include:

1. Distress and sense of helplessness due to physical deterioration in function, for example, blurred vision and hearing difficulty
2. Adjustment difficulty after retirement, for example, loss of financial independence, feeling of emptiness, lack of life goal, etc.
3. Social isolation, and feelings of out of touch with the world owing to the rapid changing environment
4. Loss of confidence and self-worth, misconception that family members and society no longer respect them
5. Sense of loneliness as adult children leave the family

Mental health of older adults can be improved through promoting active and healthy ageing by primary care doctors. Leading healthy lifestyle, participation in meaningful activities, keeping good physical health and active mind, and building strong personal relationships are the key factors of healthy ageing. These strategies help to keep the mind of older adults in good shape and optimize their resilience during down times\(^{16-18}\). **Box 1** shows what older adults, their families and friends can do for the prevention of depression and anxiety.
Box 1. Tips for preventing depression and anxiety (Adapted from Centre for Health Protection\textsuperscript{18})

<table>
<thead>
<tr>
<th>What older adults can do for themselves</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enhance knowledge</td>
</tr>
<tr>
<td>• Know more about depression and anxiety</td>
</tr>
<tr>
<td>2. Think positive</td>
</tr>
<tr>
<td>• Maintain a positive attitude towards self, the world and the future</td>
</tr>
<tr>
<td>3. Keep healthy lifestyle</td>
</tr>
<tr>
<td>• Exercise every day. Eat healthy. Do not smoke, drink or abuse drugs, maintain regular bedtime and good sleeping habit</td>
</tr>
<tr>
<td>4. Maintain good physical health</td>
</tr>
<tr>
<td>• Collaborate with care providers on the management of medical conditions such as hypertension, diabetes mellitus, hyperlipidemia, etc.</td>
</tr>
<tr>
<td>5. Enjoy life</td>
</tr>
<tr>
<td>• Make time for leisure and hobbies. Do something enjoyable every day</td>
</tr>
<tr>
<td>6. Keep mind active through life-long learning</td>
</tr>
<tr>
<td>• Keep an eye on current issues and avoid losing contact with society</td>
</tr>
<tr>
<td>• Know community resources to reduce social isolation</td>
</tr>
<tr>
<td>7. Develop personal relationships</td>
</tr>
<tr>
<td>• Spend time and talk with trusted friends or relatives who can offer support. Connecting with others who face similar challenges or stresses</td>
</tr>
<tr>
<td>• Care for the family members and contribute, for example, by helping in childcare which can add to the sense of self-worth and living enjoyment</td>
</tr>
<tr>
<td>• Share experiences and wisdom with the younger generation, for example, by acting as advisor and volunteer</td>
</tr>
<tr>
<td>8. Be aware of own condition</td>
</tr>
<tr>
<td>• Look for stressors. Avoid setting goals that are hard to achieve and worrying too much</td>
</tr>
<tr>
<td>• Seek help early if problem persist</td>
</tr>
<tr>
<td>9. Maintain financial independence</td>
</tr>
<tr>
<td>• Have advanced planning in finance to safeguard standard of living. Seek help from government in case of need</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What family and friends can do for the older adults with depressed persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Be with them and not to disparage their feelings:</td>
</tr>
<tr>
<td>• Invite them out for walks, outings or other activities that they may enjoy</td>
</tr>
<tr>
<td>• Talk and listen to them with appropriate reassurance. Point out realities and offer hope.</td>
</tr>
<tr>
<td>2. Discuss with their doctor if having any doubt.</td>
</tr>
<tr>
<td>3. Encourage and assist them in seeking help</td>
</tr>
<tr>
<td>4. Find out about local support group and attend the meeting with them whenever possible</td>
</tr>
<tr>
<td>5. Do not overlook or ignore suicidal cues, any comments about suicide or death. If indicated, keep them company, report to the doctor or call for immediate help</td>
</tr>
</tbody>
</table>
Chapter 3: Assessment of common mental health problems in primary care settings

Recognition of common mental health problems in older adults in primary care setting is challenging since they may present with various somatic symptoms masking typical symptoms of depression or anxiety. Further interpretation of somatic symptoms is also complicated by the presence of comorbidities. Older adults may also under-report psychiatric symptoms in fear of stigma regarding mental illness. For some older adults, in the context of neurodegeneration, although the symptoms do not meet the standard diagnostic criteria of mental disorders such as depression and anxiety disorders, their conditions may still be significant and cause distress which should also be addressed and managed. Owing to the diversity of clinical presentations, a dedicated approach for assessment and management of mental health problems in primary care setting is thus necessary and has been proposed.

In this chapter, the identification and assessment of common mental health problems in older adults in primary care setting are discussed. The assessment algorithm is shown in Chapter 3.1.
### 3.1 Algorithm for the assessment of common mental health problems in older adults in primary care setting

#### Presentations of common mental health problems

<table>
<thead>
<tr>
<th><strong>Physical</strong></th>
<th><strong>Behavioural</strong></th>
<th><strong>Psychological</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor sleep</td>
<td>Self-neglect</td>
<td>Loss of pleasure/sadness</td>
</tr>
<tr>
<td>Unexplained somatic symptoms</td>
<td>Excessive reassurance seeking</td>
<td>Sense of hopelessness/helplessness</td>
</tr>
<tr>
<td>Chronic fatigue</td>
<td></td>
<td>Irritability</td>
</tr>
<tr>
<td>Memory complaints</td>
<td></td>
<td>Anxiety/worries</td>
</tr>
</tbody>
</table>

#### Opportunistic screening of depression

Positive

#### Assessment in primary care settings (Ch. 3.5)

**Symptoms of depression (Ch. 3.5.1)**

- ≥ 5 of the following symptoms for at least 2 consecutive weeks; at least one symptom must be either i. or ii.: 
  i. Depressed mood  
  ii. Markedly diminished interest or pleasure in almost all activities  
  iii. Significant change in weight or appetite  
  iv. Insomnia or hypersomnia  
  v. Psychomotor agitation or retardation  
  vi. Fatigue or loss of energy  
  vii. Feelings of worthlessness or excessive or inappropriate guilt  
  viii. Diminished ability to think or concentrate, or indecisiveness  
  ix. Recurrent thoughts of death, or suicidal ideation or attempt  

- Assess co-existing psychiatric symptoms, e.g. features of anxiety disorders, hx of mania/hypomania, psychotic symptom, and substance abuse  
- Assess the impact of the depressive episode upon occupational and interpersonal functioning

**Possible underlying medical conditions & contributing factors (Ch. 3.5.2)**

- Examples:  
  - Thyroid dysfunction  
  - Pain, e.g. pain from osteoarthritis  
  - Drugs, e.g. steroids  
  - Comorbidities, e.g. chronic lung diseases, heart diseases, diabetes mellitus, cancer, visual/hearing impairment, tinnitus  
  - Neurological diseases, e.g. stroke, Parkinson’s disease, cognitive impairment  
  - Other occult conditions, e.g. infection, malignancy, metastasis

**Psychosocial history (Ch. 3.5.3)**

- Recent stressors/major loss (especially within 6 months) & coping strategies  
- Family (marital status, children)  
- Living condition & household structure  
- Financial/social support  
- Level of education  
- Smoking and alcoholic intake  
- Daily functioning  
- Caregiver status  
- Personal and family history of depression or other mental health problems  
- Contact with mental health services & treatment received

**Any red flags features? (Ch. 3.5.4)**

- e.g. Risk of harm to self/others, features of psychosis or mania

**Presence of underlying/contributing medical condition(s)?**

- Yes

**Features support diagnosis of depression and/or anxiety?**

- Yes

**Management of depression and/or anxiety in primary care settings (Ch. 4.2 and 4.3)**

- Management of other significant mental health complaints in primary care settings (Ch. 4.4)

**Urgent referral to a psychiatrist or an emergency service as appropriate**

- If condition does not improve

**Manage accordingly and reassess**

- No
3.2 Effective communication

Using effective communication skills allows primary care doctors to deliver good quality care to older adults with common mental health problems. The core communication skills include:

- Create an environment that facilitate open communication
  e.g. ensure privacy, facilitate trust, establish rapport, and keep information confidential
- Involve the patients, as well as their caregivers and family if possible, in all aspects of assessment and management
- Empathetic listening
- Be friendly, respectful, and non-judgmental
- Use good verbal skills
  e.g. simple language, open-ended questions, summarising and clarifying statements
- Respond with sensitivity when the patients disclose difficult experiences and acknowledge their feelings

3.3 Presentations of common mental health problems in older adults

Older adults with underlying common mental health disorders may present with various somatic or psychological symptoms. The following presentations in the older adults should alert primary care doctors for further evaluation of the presence of common mental health disorders (see Chapter 3.5), especially if medical causes have been excluded. Physical and behavioural presentations are highlighted in the following sections.

A. **Physical**
   Poor sleep, chronic fatigue, unexplained somatic complaints, memory complaints

B. **Behavioural**
   Self-neglect, excessive reassurance seeking

C. **Psychological**
   Loss of pleasure, sadness, sense of hopelessness, helplessness, irritability, anxiety, worries
3.3.1 Poor sleep

Insomnia is classified as either primary or comorbid. Primary insomnia implies that no other cause of sleep disturbance has been identified. Comorbid insomnia is more common and is most often associated with mental health problems (e.g. depression, anxiety or substance use disorders), medical disorders, medications, and other primary sleep disorders (e.g. obstructive sleep apnoea or restless legs). The comprehensive assessment of poor sleep should include the following history:

- **Nature of poor sleep(s)** (one or more of the followings):
  - difficulty in falling asleep
  - difficulty in maintaining sleep
  - early morning awakening
  - non-restorative sleep

- **Presence of associated symptoms and drug history**: which may hint possible underlying cause(s), e.g.
  - snoring (sleep apnoea)
  - breathlessness, cough (heart failure, asthma, chronic obstructive airway disease), pain, nocturia
  - drug history, includes prescription and non-prescription drugs and remedies

- **When**:
  - episodic or persistent (chronic) insomnia
  - the duration it has existed

- **How it started**:
  - any triggering events such as recent major loss or other psychosocial stressors

- **Why** (subjective and objective factors):
  - the older adult’s ideas and concerns (subjective);
  - sleep hygiene (objective): i.e. habit and environment, for example:
    - daytime napping
    - spending too much time in bed
    - insufficient daytime activities
    - insufficient bright light exposure
    - coffee/ tea/ alcohol consumption
    - adverse ambient factors: e.g. humid heat (affecting the body’s thermoregulation during sleep), disturbing lighting or noise
    - using electronic screen products, watching television on bed
    - pets on bed
    - noisy bed partners

- **Duration of sleep**:
  - may be estimated by the use of sleep diary
A detailed list of comorbidities of insomnia is available in Annex 1. Comorbid conditions identified in the history should be managed accordingly. If underlying mental health problems are suspected, further assessment should be followed (Chapter 3.5). Management of poor sleep such as sleep hygiene is discussed in Chapter 4.

### 3.3.2 Unexplained somatic symptoms

Medical unexplained symptoms are common in primary care, ranging from an estimated 15-50 % of all primary care consultations in different studies\(^{28-34} \). They are defined as symptoms having little or no basis in underlying organic disease, or when organic disease exists, the symptoms are inconsistent with it or out of proportion to it\(^{35} \). Some of the common symptoms include chest pain, fatigue, dizziness and headache\(^{36} \). In clinical practice, the following features may point to unexplained somatic symptoms\(^{37} \):

- Physical symptoms which persist and remain unexplained following adequate examination, investigations, and explanation by the doctor
- Frequent medical visits in spite of negative investigations
- Co-existing symptoms of depression and anxiety

Assessment of medically unexplained symptoms should aim at excluding underlying medical pathology. Alarming features of serious underlying diseases should not be missed (Table 1). The likelihood of mental health problem (anxiety or depression) increases with increasing number of unexplained somatic symptoms\(^{37} \). Further assessment of underlying mental health problems (see Chapter 3.5) are particularly important when medical pathology has been excluded.
Table 1. Alarming features that raise suspicion of serious underlying diseases 39, 40

<table>
<thead>
<tr>
<th>Alarming features</th>
<th>Examples of potential serious underlying disease</th>
</tr>
</thead>
</table>
| Recent onset of fatigue in a previously well older adult | Malignancy  
Anaemia  
Cardiac arrhythmia  
Renal failure  
Diabetes mellitus |
| Unintentional weight loss | Malignancy  
Infection  
Diabetes mellitus  
Hyperthyroidism |
| Abnormal bleeding | Anaemia  
Gastrointestinal malignancy |
| Shortness of breath | Anaemia  
Heart failure  
Cardiac arrhythmia  
Chronic obstructive pulmonary disease |
| Unexplained lymphadenopathy | Malignancy |
| Fever | Serious infection  
Hidden abscess |
| Recent onset or progression of cardiovascular, gastroenterological, neurological or rheumatological symptoms | Autoimmune disease (e.g. rheumatoid arthritis)  
Malignancy  
Arrhythmia  
Parkinson’s disease  
Multiple sclerosis |

The presence of depressive and anxious mood is also common in patients with dementia. In people presenting with memory and functional decline suggestive of dementia, it is also important to recognise that motivational mood disturbances are prevalent psychological symptoms of dementia.

3.3.3 Memory complaints

Memory complaints are common in older adults with cognitive impairment or mental health problems such as depression. Both conditions may share many similar features including apathy, the inability to concentrate, social withdrawal, and dramatic changes in mood and affect. Patient presented with memory complaints should be carefully evaluated for symptoms of depression.
Table 2 shows the differentiation of depression and dementia\textsuperscript{41}. For recognition and management of cognitive impairment, please refer to the Module on Cognitive Impairment, Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings\textsuperscript{14}.

### Table 2. Differentiating dementia and depression\textsuperscript{41}

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Dementia</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Insidious, indeterminate</td>
<td>Relatively rapid, associated with mood changes</td>
</tr>
<tr>
<td>Duration of symptoms</td>
<td>Usually long</td>
<td>Usually short</td>
</tr>
<tr>
<td>Orientation, mood, behaviour, affect</td>
<td>Impaired, inconsistent, fluctuating</td>
<td>Intact, diurnal variation depressed/anxious, complaints worse than on testing</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Consistent; stable or worsening</td>
<td>Inconsistent, fluctuating</td>
</tr>
<tr>
<td>Neurologic defects</td>
<td>Often present (e.g., agnosia, dysphasia, apraxia)</td>
<td>Absent</td>
</tr>
<tr>
<td>Disabilities</td>
<td>Concealed by patient</td>
<td>Highlighted by patient</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>Present</td>
<td>Present</td>
</tr>
<tr>
<td>Memory impairment</td>
<td>Doesn’t remember recent events, often unaware of memory loss. Onset of memory loss occurs before mood change.</td>
<td>Concentration poor, patient complains of memory loss of recent and remote events, follows onset of depressed mood</td>
</tr>
<tr>
<td>Psychiatric history</td>
<td>None</td>
<td>Often, history of depression</td>
</tr>
<tr>
<td>Answers to questions</td>
<td>Near answers</td>
<td>“Don’t know” answers</td>
</tr>
<tr>
<td>Performance</td>
<td>Tries hard but is unconcerned about losses</td>
<td>Does not try hard but is more distressed by losses</td>
</tr>
<tr>
<td>Associations</td>
<td>Un sociability, uncooperativeness, hostility, emotional instability, reduced alertness, confusion, disorientation</td>
<td>Appetite and sleep disturbances, suicidal thoughts</td>
</tr>
</tbody>
</table>

#### 3.3.4 Self-neglect

Self-neglect is defined as the failure or refusal to address one’s own basic physical, emotional, and/or social needs (National Centre on Elder Abuse, 2014)\textsuperscript{42}. Presentations that primary care doctors may encounter include:

- Appear disheveled/ in poor hygiene
- Not adhering to diet advice, prescribed medications and medical appointments; or refusing
Depression is present in approximately 51% to 62% of older adults who self-neglect\textsuperscript{42}. Therefore, any features that indicate a lack of interest in daily routine or self-care should prompt an evaluation for depression, as well as other possible underlying mental or physical conditions (see Chapter 3.5).

### 3.3.5 Excessive reassurance seeking

Excessive reassurance seeking can be defined as ‘the relatively stable tendency to excessively and persistently seek assurances from others regardless of whether such assurance has already been provided’\textsuperscript{43}. Excessive reassurance seeking is often driven by anxiety and acts to worsen and perpetuate it. This can cause personal and caregiver exhaustion, present challenges to the doctor–patient relationship and result in unnecessary referrals, investigations or procedures\textsuperscript{44}. Meta-analytic review supported that excessive reassurance seeking predicts depression and interpersonal rejection\textsuperscript{45}. Primary care doctors should be aware that older adults who present with excessive reassurance seeking may have underlying mental health problems and should be carefully evaluated (see Chapter 3.5).

### 3.4 Opportunistic screening of depression

Since early diagnosis and treatment of depression in older adults can improve quality of life and functional status, and may help prevent premature death\textsuperscript{46, 47}, screening of depression in the primary care setting is well supported by overseas guidelines and recommendations\textsuperscript{48-51} provided that adequate resources and systems are in place to ensure accurate diagnosis, appropriate management and regular follow up.

The Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings recommends \textit{opportunistic screening of depression in older adults}\textsuperscript{52}. (Level 2+, Grade B)

On the other hand, although evidence supporting routine screening for anxiety disorders in primary care setting is not well established, primary care doctors should proceed to further assessment if the older adults have features suggestive of underlying anxiety disorder.
3.4.1 Depression screening tools

Both 15-items Geriatric Depression Scale (GDS-15) and Patient Health Questionnaire-9 (PHQ-9) are reliable and valid tools for depression screening and are widely used at local settings\textsuperscript{53,54}. Shorter, validated versions such as 4-items Geriatric Depression Scale (GDS 4) Cantonese version\textsuperscript{55-57} and Patient Health Questionnaire-2 (PHQ-2)\textsuperscript{58-60} are also suitable for use in primary care setting.

A. Geriatric Depression Scale (GDS)

GDS is specifically developed for use in geriatric patients, and it contains fewer somatic items. It formats frame questions within the past week and responses require only a “yes” or “no,” making comprehension easier for older adults. GDS-15 score of ≥ 8; or GDS-4 score of ≥ 2 is suggestive of depression.

Cantonese versions of GDS-15 and GDS-4 are listed in Annex 2 of this Module.

B. Patient Health Questionnaire (PHQ)

PHQ was primarily developed for use in primary care setting. PHQ-9 consists of nine questions and the score can range from 0 to 27. PHQ-9 scores of 5, 10, 15 and 20 represents mild, moderate, moderately severe and severe depression respectively, therefore it is suitable for disease severity stratification and monitoring of treatment progress.

Cantonese versions of PHQ-9 and PHQ-2 are listed in Annex 3 of this Module.

Primary care doctors should inform the older adults on the purpose before initiating the screening. Screening tools assist but do not replace clinical judgment. Positive screening test results should be followed by appropriate evaluation by primary care doctors (see Chapter 3.5).
3.5 Assessment in primary care settings

Primary care doctors should conduct a more detailed assessment when the older adults have complaints or presentations which may indicate underlying psychological distress (Chapter 3.3), or if the opportunistic screening of depression is positive (Chapter 3.4). The aims of this assessment are:

1. To determine the presence of specific common mental health problems (e.g. depression and anxiety disorders), and assess its severity;
2. To identify underlying and potential reversible medical conditions contributing to the common mental health problems;
3. To recognise psychosocial problems including caregiver status;
4. To look for important features that may need immediate intervention or referral.

These aims can be achieved by detailed assessment focusing on the following areas:

- Symptoms of depression (Chapter 3.5.1)
- Possible underlying medical conditions and contributing factors (Chapter 3.5.2)
- Psychosocial history (Chapter 3.5.3)
- “Red flag” features (Chapter 3.5.4)

If the diagnosis of depression is established, primary care doctors should proceed with management (Chapter 4.2). Anxiety symptoms should also be assessed because anxiety disorder may co-occur with depression and should be managed accordingly (Chapter 4.3). Primary care doctors should also manage older adults who have significant mental health complaints but do not fit into classic diagnosis of depression or anxiety disorders, especially in the context of memory and cognitive decline suggestive of dementia (Chapter 4.4).

3.5.1 Symptoms of depression

Depression is a priority mental health condition in non-specialised health care settings and should be carefully looked for during mental health assessment. In addition to history taking, primary care doctors should also examine the mental status of the patient.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) requires the presence of five or more of the symptoms in Box 2 for at least two consecutive weeks; at least one symptom must be either depressed mood, or a loss of interest or pleasure. The symptoms should also cause clinically significant distress or impairment in functioning, and should not attributable to the physiological effects of a substance or to another medical condition.
Box 2. Depressive symptoms (adapted from DSM-5)\textsuperscript{13}

<table>
<thead>
<tr>
<th>Depressed mood</th>
<th>Fatigue or loss of energy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Markedly diminished interest or pleasure in almost all activities (anhedonia)</td>
<td>Feelings of worthlessness or excessive or inappropriate guilt</td>
</tr>
<tr>
<td>Significant change in weight or appetite</td>
<td>Diminished ability to think or concentrate, or indecisiveness</td>
</tr>
<tr>
<td>Insomnia or hypersomnia</td>
<td>Recurrent thoughts of death, or suicidal ideation or attempt</td>
</tr>
<tr>
<td>Psychomotor agitation or retardation (observable by others)</td>
<td></td>
</tr>
</tbody>
</table>

The degree of functional impairment and/or disability should be taken into account during the assessment which may help define the severity of depression (Box 3).

Box 3. Definition of depression (adapted from The National Institute for Health and Care Excellence (NICE))\textsuperscript{61, Note}

**Mild depression:** Few, if any, symptoms (see Box 1) in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment.

**Moderate depression:** Symptoms or functional impairment are between 'mild' and 'severe'.

**Severe depression:** Most symptoms (see Box 1), and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

Note: For patient presents with fewer than five depressive symptoms, the term “subthreshold depressive symptoms” has been used.

### 3.5.2 Possible underlying medical conditions and contributing factors

Many medical conditions can possibly account for the older adults’ mental health complaints/presentations, for examples:

- Thyroid dysfunction
- Pain, e.g. pain from osteoarthritis
- Adverse effect of drugs, e.g. steroids
- Comorbidities, e.g. chronic lung diseases, heart diseases, diabetes mellitus, cancer, visual/hearing impairment, tinnitus
- Neurological diseases, e.g. stroke, Parkinsonism, cognitive impairment
- Occult conditions, e.g. infection, malignancy and metastasis
Primary care doctors should review the older adult’s health records, take relevant history, conduct appropriate physical examination and consider selective investigations, e.g. thyroid function test, if appropriate.

Physical/ contributing factors recognised should be managed accordingly; consult relevant specialists for assessment and management if in doubts. If the situation has improved, reassurance, open follow up and back to usual care would be adequate. Referral to a geriatrician should be considered for management of complex multiple co-morbidities, frailty, polypharmacy, and geriatric syndromes.

Dementia has certain clinical features resembling common mental health problems in older adults. Refer to the Module on Cognitive Impairment, Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings for details.

In case physical/ contributing factors have not been identified, primary care doctors should continue to evaluate the mental health and psychosocial findings.

### 3.5.3 Psychosocial history

Seeking information from the older adults and caregivers in following areas, and problems identified should be managed accordingly:

- Stressors or major loss (e.g. bereavement): especially in the recent 6 months, and their coping strategies
- Family: marital status, children
- Living condition/ household structure
- Financial/ social support
- Level of education
- Smoking and alcohol intake
- Daily functioning at home and in the relationships
- Caregiver status
- Mental health history:
  - family history of psychiatric illnesses
  - history of depression or other mental health problems
  - contact with mental health/ psychiatry service
  - treatment received/ receiving
3.5.4 “Red flag” features

If the patient has any one of the following “red flag” features, they should be urgently referred to psychiatrist or accident and emergency service for timely assessment and intervention as appropriate:

I. Risk of suicide, harm to self or others
   - Ask about self-harm does not provoke acts of self-harm; it often reduces anxiety associated with thoughts and acts of self-harm and help the person feel understood
   - However, try to establish a relationship before asking questions about self-harm
   - Ask the person to explain reasons for harming themselves
   - Be alert to impulsivity or impaired judgment which may increase risk of harm to self or others
   - Explore the ideas and plans — the stronger the intention and the more feasible and lethal the means is, the more urgent psychiatric referral would become necessary
   - Assess the patient for prior history of suicide attempts, and family history of suicidal behaviour
   - The Hospital Authority has implemented the Elderly Suicide Prevention Programme (ESPP) since 2002 to provide multi-disciplinary services to older adults with suicidal tendency at psychogeriatric fast track clinics. Information is available from: http://www.ha.org.hk/espp/

II. Features suggestive of psychosis
   - Most recognised features are hallucinations (e.g. hearing voices or seeing things that are not there) and delusions (e.g. fixed false beliefs not shared by others in the person’s culture).
   - Common presentations of psychosis are listed in Box 4.

Box 4. Symptoms suggestive of psychosis
   - Hearing voices or seeing things that are not there
   - Fixed false beliefs not shared by others in the person’s culture
   - Lack of realisation that one is having mental health problems
   - Marked behavioural changes, neglecting usual responsibilities related to work, domestic or social activities
   - Agitated, aggressive behaviour, decreased or increased activities
III. Features of mania

- In bipolar disorder, prescribing antidepressants alone without a mood stabiliser (e.g. lithium, carbamazepine or valproate) can lead to mania.
- Primary care doctors should review patient’s past mental health problem and history of contact with mental health/psychiatric service in the psychosocial history to determine the possibility of underlying bipolar disorder.
- For a depressive episode, if several of the symptoms of mania listed in Box 5 occur simultaneously for at least one week, interfering work or social activities significantly or required hospitalisation, bipolar disorder is likely.
- Hypomania in bipolar II disorder may be more difficult to identify since the symptoms of elevated mood are usually more persistent but less obvious with no function impairment.
- Examples of useful questions in history taking include:
  - Have you ever experienced a period of time when you felt happier or more energetic than usual, for no particular reason?
  - And if so, did you notice during such times that your thoughts were more rapid, or you had more ideas, required less sleep or were more talkative than usual?
  - Did others notice this too? What did they say?
  - How long did these last? Did they have any impact or effect on your life, work or relationships?

Box 5. Symptoms of mania

- Abnormally and persistently elevated, expansive, or irritable mood
- Abnormally and persistently increased activity or energy
- Plus three (or more) of the following symptoms (four if the mood is only irritable) that are present to a significant degree and represent a noticeable change from usual behaviour:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility
  - Increase in goal-directed activity or psychomotor agitation
  - Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
Chapter 4: Management of common mental health problems in primary care settings

When a diagnosis of mental problems is made, primary care doctors should provide appropriate and personalised management to the older adults concerned. The management goals include:

- Symptom remission
- Relapse and recurrence prevention
- Improvement of daily functioning and quality of life
- Promotion of mental wellness

In recent years, collaborative care models have been shown to be cost-efficient for primary care practice to improve outcomes of common mental health problems in different populations including older adults\textsuperscript{19,63}. The collaborative care team usually consists of primary care doctors and other professionals such as allied health professionals and psychiatrists, and implements a measurement-guide care plan based on evidence-based practice guidelines\textsuperscript{64}. Similar approach has been adopted in the Integrated Mental Health Programme (IMHP) of the Hospital Authority, where there is close collaboration among key workers (e.g. nurses, social workers, and occupational therapists), family medicine doctors and liaison psychiatrists. Patients are stratified and monitored with validated tools in the programme, and depending on the levels of severity, self-management support and protocol-driven management including counselling service and pharmacological treatment are offered in primary care settings.

In this chapter, the management of depression (Chapter 4.2), anxiety (Chapter 4.3) and other significant mental health complaints (Chapter 4.4) in primary care settings are discussed. Algorithm for the management of these common mental health problems in older adults in primary care settings is shown in Chapter 4.1.
4.1 Algorithm for the management of common mental health problems in older adults in primary care settings

Managing depression in older adults in primary care setting

Older adult with depression

Any of the followings?
- Moderate and severe depression
- Past history of moderate or severe depression
- Symptoms persist and do not respond adequately to initial interventions
- Symptoms complicate the care of physical problems

No

Consider non-pharmacological interventions (A) first

Yes

Consider both non-pharmacological interventions (A) and pharmacological interventions (B)

A. Non-pharmacological interventions for depression (Ch. 4.2.1)

Involve allied health professionals if appropriate

1. Psychoeducation
   - Provide information
   - Clarify uncertainty and misconceptions
   - Explain treatment options
   - Encourage self-monitoring

2. Promoting self-care
   - Reduce stress, e.g. relaxation exercise, mindfulness-based therapy (Annex 5)
   - Strengthen social support and mobilise community resources (Annex 6)
   - Maintain healthy lifestyle, e.g. physical exercise, sleep hygiene (Table 3)
   - Promote functioning in daily activities

3. Managing comorbidities

4. Taking care of the caregivers

5. Psychological treatment if available
   - e.g. problem solving therapy, interpersonal therapy, cognitive behavioural therapy as appropriate

6. Follow up and active monitoring (Ch. 4.5)
   - Consider using PHQ-9 (Annex 3) for monitoring progress

7. Consider referral to relevant specialist if necessary (Ch. 4.2.3)

B. Pharmacological interventions for depression (Ch. 4.2.2)

Antidepressant therapy (Table 4)

1. Initiating antidepressant
   - Choose selective serotonergic receptor inhibitor (SSRI) as first line unless contraindicated
   - Provide information (Box 6)
   - Select appropriate agent with consideration of comorbidities and drug interactions (Table 5)
   - Start with the lowest dose and titrate gradually to therapeutic dose if necessary (Table 6)
   - Do not initiate augmentation therapy with another antidepressant or psychiatric agent in primary care
   - Check serum sodium if indicated

2. Monitoring
   - Review response, adherence, adverse effects, suicidality regularly
   - Adjust treatment if necessary

3. Continuation and maintenance
   - Prevent relapse or recurrence by continuing same dose as for acute phase, duration of treatment tailored to individual relapse risk
   - Need to be cautious about withdrawal of antidepressant in the elderly depression. Relapse is more likely than adults
   - Withdraw antidepressant gradually over 4 weeks or longer after completing continuation or maintenance therapy to prevent discontinuation symptoms
Module on Common Mental Health Problems in Older Adults

Managing anxiety in older adults in primary care setting

Older adult with anxiety

Diagnose generalised anxiety disorder (GAD) if the followings are present:
- Excessive anxiety and worry about a number of events or activities, and difficult to control the worry ≥ 6 months
- At least three of the following ≥ 6 months
  - Restlessness
  - Easily fatigued
  - Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance
- Impairment in daily functioning
- Disturbance not explained by substance, medical or other mental disorders

Generalised anxiety disorder

Any of the followings?
- Marked functional impairment
- Inadequate response to previous non-pharmacological interventions

Consider non-pharmacological interventions (C) first

Yes

Consider both non-pharmacological interventions (C) and pharmacological interventions for anxiety (D)

C. Non-pharmacological interventions for anxiety (Ch. 4.3.1)

Involve allied health professionals if appropriate

1. Psychoeducation
2. Promoting self-care
   - Reduce stress e.g. relaxation exercise, mindfulness-based therapy (Annex 5)
   - Strengthen social support and mobilise community resources (Annex 6)
   - Maintain healthy lifestyle
   - Promote functioning in daily activities
3. Managing comorbidities
4. Taking care of the caregivers
5. Psychological treatment if available
   - e.g. cognitive behavioural therapy
6. Follow up and active monitoring (Ch. 4.5)
   - Consider using GAD-7 (Annex 4) for monitoring progress
7. Consider referral to relevant specialist if necessary (Ch. 4.3.3)

D. Pharmacological interventions for anxiety (Ch. 4.3.2)

1. Antidepressant (Table 4)
   - Choose selective serotonergic receptor inhibitor (SSRI) as first line unless contraindicated
   - Provide information (Box 6)
   - Select appropriate agent (Table 5)
   - Start low and go slow, titrate to therapeutic dose if necessary (Table 6)
   - Check serum sodium if indicated
   - Review response, adherence, adverse effects, suicidality regularly
   - Prevent relapse or recurrence by continuing treatment tailored to individual relapse risk
   - Withdraw gradually after completing continuation or maintenance therapy
2. Other adjuvant agents
   - Other adjuvant agent such as anxiolytic should only be used after balancing benefits and risks with close monitoring
Managing other significant mental health complaints in older adults in primary care setting

Older adult with other significant mental health complaints

Does the older adult seek help to relieve symptoms or have considerable difficulty with daily function because of the symptoms?

No

Observe condition and provide appropriate advice

Yes

Has the older adult been exposed to extreme stressors, e.g. major loss, recent exposure to a potential traumatic event?

No

Management of other significant mental health complaints (E)

Yes

- Initiate management of other significant mental health complaints (E)
- Monitor condition & watch out for possibility of psychiatric conditions (e.g. prolonged grief disorder or PTSD) if symptoms persist and/or daily functioning affected

E. Management of other significant mental health complaints (Ch.4.4)

1. Do not routinely use antidepressant or anxiolytics
2. When no underlying physical condition is identified that fully explain the presenting somatic complaints
   - Acknowledge symptoms
   - Avoid ordering more investigations unless there is a clear medical indication
   - Correct any unrealistic expectations on investigations
   - Communicate with patient about the normal clinical and test findings and reassure that no serious disease has been identified
   - Ask for their own explanation of the cause of symptoms and elicit their concerns
   - Discuss potential links between the person’s emotions/stress and symptoms
   - Promote self-care: reduce stress, strengthen social support, maintain healthy lifestyle and promote functioning in daily activities
3. Support and give advice to the caregivers
4. Arrange follow up for active monitoring of the progress
4.2 Management of depression in primary care settings

After careful evaluation, for older adults with clinical features that are suggestive of depression, a personalised treatment plan should be developed in collaboration with the older adults and their caregivers. In general, non-pharmacological (i.e. psychosocial) interventions should be offered in all treatment plans depending on the resources available. Further interventions, such as pharmacological interventions should be considered when the symptoms are prominent, affect functioning, or when the response to non-pharmacological interventions is inadequate. Coordinated collaboration with allied health professionals and psychiatrists should be considered if necessary. Caregivers should be supported and any emotional disturbance that arises should be identified and managed as appropriate.

The clinical outcome of the older adults should be carefully monitored in follow up, and can be tracked with structured rating scales (e.g. PHQ-9) similar to the way that primary care doctors follow clinical outcomes of other treatments such as blood pressures in the treatment of hypertension. Treatments are systematically adjusted for patients who do not improve as expected, using evidence-based medication treatments and/or psychotherapies as appropriate.

4.2.1 Non-pharmacological interventions

A. Psychoeducation

Psychoeducation is usually the first step intervention to patients experiencing depression or anxiety. It is easy to implement and has been shown to be effective. The following information should be included in psychoeducation:

- Provide information e.g. depression is common and is treatable; it is not a sign of weakness or “normal” ageing process
- Clarify uncertainty and misconceptions
- Explain treatment options and importance of adhering to treatment
- Encourage self-monitoring of symptoms, including thoughts of self-harm or suicide, and ways to manage if these thoughts appear

B. Promote self-care

Self-care is an important component of patient-centred care, which involves the things people can do to protect their health and manage illness, empowering them to take control of their own health and well-being.
i. **Reduce stress**
- Help the patient address current psychosocial stressors, e.g. problems in family, relationship, housing, finances, alcohol and drug misuse, abuse and neglect
- Assist the patient to manage stress by relaxation techniques, e.g. deep breathing and progressive muscular relaxation exercises, mindfulness-based therapy (refer to Annex 5 for instructions), problem solving techniques (see below) and refer as appropriate

ii. **Strengthen social support**
- Help the patient identify supportive family members and friends and involve them as much as possible and appropriate
- Reactivate the patient’s social network and reinitiate prior social activities
- Mobilise community resources (Annex 6), e.g. elderly centres, counselling service, outreach service and support group

iii. **Maintain healthy lifestyle**
- Maintain regular sleep schedule and improve sleep hygiene (Table 3)
- Maintain regular physical activity. Attention should be paid to avoid exercise-related injury and optimise tolerability in older adults
- Practise mind body exercises such as tai chi, which are beneficial for a range of stress-related symptoms
- Abstain from alcohol and tobacco, limit caffeine intake to avoid triggering of anxiety symptoms

iv. **Promote functioning in daily activities**
- Provide support to continue regular social, educational and occupational activities

C. **Manage comorbidities**
- Identify and manage any comorbidities, e.g. pain arising from degenerative arthritis, stroke, Parkinson’s disease, incontinence, cognitive, hearing and visual impairment
- Optimise medications, avoid polypharmacy, aware of possible drug interaction especially when pharmacological interventions are considered (Chapter 4.2.2)

D. **Psychological treatment**
- Brief, structured psychological interventions can be offered to older adults with depressive symptoms, delivered by health care professions with a good understanding of mental health care for older adults
- The following psychological interventions are examples that have been reported
efficacious in older adults with depression$^{72-75}$:

- **Problem-solving therapy (PST):** identify and prioritise problems, break them down into specific manageable tasks, solve problems, develop appropriate coping behaviours for problems

- **Interpersonal therapy (IPT):** focus on clarification and resolution of difficulties in current interpersonal relationships

- **Cognitive behavioural therapy (CBT):** aim at identifying and modifying distorted, negatively biased thoughts

- Online guides for practitioners:
  - Group Interpersonal Therapy (IPT) for Depression (available from: [http://www.who.int/mental_health/mhgap/interpersonal_therapy/en/](http://www.who.int/mental_health/mhgap/interpersonal_therapy/en/))

- Clinical Psychological Service of the Social Welfare Department provides various types of psychological services to the general public as referred by social workers of the Social Welfare Department. Some non-government organisations also provide clinical psychological services in the community (see **Annex 6**).
### Table 3. Factors that may affect sleep and relevant advice on sleep hygiene

<table>
<thead>
<tr>
<th>Factors that may affect sleep</th>
<th>Relevant advice on sleep hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Poor sleep schedule</strong></td>
<td></td>
</tr>
<tr>
<td>- Frequent daytime napping</td>
<td>Maintain a regular sleep schedule</td>
</tr>
<tr>
<td>- Spending too much time in bed</td>
<td>Avoid daytime naps, especially if they are longer than 20–30 minutes or occur late in the day</td>
</tr>
<tr>
<td></td>
<td>Avoid going to bed until you are drowsy and ready to sleep</td>
</tr>
<tr>
<td></td>
<td>Sleep as long as necessary to feel rested, then get out of bed</td>
</tr>
<tr>
<td><strong>2. Inappropriate lifestyle activities</strong></td>
<td></td>
</tr>
<tr>
<td>- Insufficient daytime activities</td>
<td>Exercise regularly for at least 20 minutes, preferably more than 4–5 hours prior to bedtime</td>
</tr>
<tr>
<td>- Insufficient bright light exposure</td>
<td>Maintain sufficient bright light exposure in daytime</td>
</tr>
<tr>
<td>- Late evening exercises</td>
<td>Avoid late or heavy dinner</td>
</tr>
<tr>
<td>- Late heavy dinner</td>
<td>Avoid caffeinated beverages after lunch</td>
</tr>
<tr>
<td>- Excess caffeine</td>
<td>Avoid alcohol in late afternoon and evening</td>
</tr>
<tr>
<td>- Evening alcohol consumption</td>
<td>Avoid smoking or other nicotine intake, particularly during the evening</td>
</tr>
<tr>
<td>- Smoking in the evening</td>
<td></td>
</tr>
<tr>
<td><strong>3. Anxiety</strong></td>
<td></td>
</tr>
<tr>
<td>- Anxiety and anticipation of poor sleep</td>
<td>Avoid force oneself to sleep</td>
</tr>
<tr>
<td>- Clock watching</td>
<td>If not able to fall asleep within 15–20 minutes, get out of bed and return only when drowsy.</td>
</tr>
<tr>
<td></td>
<td>Perform relaxation techniques (see Annex 5)</td>
</tr>
<tr>
<td><strong>4. Poor sleeping environment</strong></td>
<td></td>
</tr>
<tr>
<td>- Environmental factors (e.g. room being too warm, too noisy or too bright; pets on the bed or in the bedroom; active or noisy bed partners)</td>
<td>Adjust the bedroom environment as needed to decrease stimuli (e.g. reduce ambient light, turn off television or radio, avoid screen time before bed)</td>
</tr>
<tr>
<td>- Watching television or engaging in other stimulating activities at night</td>
<td></td>
</tr>
</tbody>
</table>
4.2.2 Pharmacological interventions

A. General considerations

Antidepressants are the mainstay of drug treatment in depression and are considered to have similar efficacy in treating depression in older adults\(^\text{79-81}\) as well as those with physical illnesses\(^\text{82}\). For subthreshold depressive symptoms or mild depression, the effectiveness of antidepressant may be limited\(^\text{61, 83-85}\) and should only be considered if there is past history of moderate or severe depression, or the symptoms persist and do not respond adequately to initial non-pharmacological interventions or complicate the care of physical problems\(^\text{41, 85}\). Summary on antidepressant therapy for depression in primary care settings is shown in Table 4. Information that should be given to patient when prescribing antidepressant is shown in Box 6.

### Box 6. Information that should be given to patient when prescribing antidepressant\(^\text{19, 61, 85}\)

- Gradual onset of therapeutic effect which may take several weeks
- No addictive property of antidepressant
- Importance of drug compliance
- Potential side effects may be experienced in the initial period but they usually resolve
- Potential interactions with other medications
- Risk and nature of discontinuation symptoms
- Importance of continuing treatment after remission for relapse prevention
### Table 4. Summary on antidepressant therapy for depression in primary care setting (Adapted from the NICE and British Association for Psychopharmacology\(^{61, 85, 86}\)).

<table>
<thead>
<tr>
<th>1. Initiating antidepressant</th>
<th></th>
</tr>
</thead>
</table>
| i. Choose an antidepressant | ➢ Consider selective serotonin reuptake inhibitor (SSRI) as the first line agent if there is no contraindication (Table 5)  
➢ *If the patient had taken antidepressant before,*  
- select previous agent if the response was good and patient tolerated it well  
➢ *If the patient had not taken antidepressant before,*  
- select an agent after reviewing patient’s psychiatric conditions, tolerability of adverse effects, likelihood of overdose, coexisting medical conditions and drugs, and patient’s and caregiver’s preference\(^{86}\) |
| ii. Provide information | ➢ Provide relevant information to patient (Box 6) |
| iii. Start an antidepressant | ➢ Start an antidepressant with the lowest starting dose and titrate gradually to therapeutic dose if necessary (Table 6)  
➢ Consider limiting the total amount of antidepressant drug available to the patient\(^{86}\)  
➢ Augmentation therapy with another antidepressant or psychiatric agent should not be initiated by primary care doctors |
| iv. Check serum sodium in selected patients | ➢ Check when hyponatraemia is suspected, e.g. patient exhibits lethargy or delirium\(^{87}\)  
➢ Consider checking for high-risk patients (see paragraph under SSRIs) 2-4 weeks after starting therapy\(^{65}\) |

<table>
<thead>
<tr>
<th>2. Monitoring</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Review regularly</td>
<td>➢ Review response, adherence, adverse effects, suicidality(^{86}) in 1-2 weeks, then at intervals of 2-4 weeks in first 3 months, and then longer if the response is good but should be individualised according to patient’s condition</td>
</tr>
</tbody>
</table>

(Table continued on next page)
### 2. Monitoring (Continued)

| ii. Monitor adverse effects | ➢ When adverse effects develop early in the course of antidepressant treatment, consider\(^{61}\):
|                           | - monitor closely for mild symptoms, or
|                           | - switch antidepressant, or
|                           | - add short-term benzodiazepine (usually no longer than 2 weeks) for significant anxiety, agitation or insomnia as appropriate (see Chapter 3.3.2) |
| iii. Monitor response      | ➢ Review patient’s symptoms and functioning to determine response. It has been suggested that > 20 – 30 % reduction from baseline in a depression rating scale after 2-4 weeks indicates early improvement\(^{88}\)
|                           | ➢ When there is no or inadequate response after 3-4 weeks with a therapeutic antidepressant dose\(^{61}\):
|                           | - check drug compliance (particularly if there is no response after 2 weeks) and increase level of support
|                           | - review diagnosis and manage perpetuating factors (e.g. alcohol, drug misuse, comorbidity, psychosocial factors)
|                           | ➢ When response is still inadequate after the above measures, consider\(^{61}\):
|                           | - increase the dose as appropriate if there is no significant side effects, or
|                           | - switch antidepressant (same or different class) if there are side effects or if the patient prefers, or
|                           | - refer patient to specialist especially if there is no response to two adequate treatment course
|                           | ➢ When there is some improvement by 4 weeks\(^{61}\),
|                           | - continue treatment for another 2 to 4 weeks,
|                           | - then consider switching to another antidepressant if the response is still not adequate or there are side effects
|                           | ➢ When the patient develops a manic episode\(^{23}\):
|                           | - discontinue antidepressant since it may trigger a manic episode in untreated bipolar disorder
|                           | - refer patient to specialist

(Table continued on next page)
Table 4. Summary of antidepressant therapy for depression in primary care setting (Continued)

<table>
<thead>
<tr>
<th>3. <strong>Continuation and maintenance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. <strong>Prevent relapse or recurrence</strong></td>
</tr>
<tr>
<td>➢ Duration of treatment should be tailored to the individual relapse risk.(^\text{86})</td>
</tr>
<tr>
<td>➢ Continue same dose as for acute phase for at least 6-9 months after full remission in patients at lower risk of relapse, e.g. first episode and no other risk factors.(^\text{86})</td>
</tr>
<tr>
<td>➢ Continue the same dose for at least 2 years for people at risk of relapse, e.g. when there is (are)(^\text{61}):</td>
</tr>
<tr>
<td>- residual symptoms</td>
</tr>
<tr>
<td>- two or more episodes with significant functional impairment in the recent past/ multiple previous episodes</td>
</tr>
<tr>
<td>- history of severe or prolonged episodes</td>
</tr>
<tr>
<td>- history of inadequate response to treatment</td>
</tr>
<tr>
<td>- severe consequences if relapse, e.g. suicide attempts, loss of functioning, severe life disruption, etc.</td>
</tr>
<tr>
<td>➢ Longer treatment duration may also be beneficial in patients with:</td>
</tr>
<tr>
<td>- Presence of other psychiatric disorders treatable with antidepressants (e.g. generalised anxiety disorder)</td>
</tr>
<tr>
<td>- Concurrent physical problems (e.g. after stroke, myocardial infarction) and psychosocial difficulties</td>
</tr>
<tr>
<td>➢ Seek specialist advice if in doubt about the need and the duration of prolonged maintenance therapy</td>
</tr>
</tbody>
</table>

(Table continued on next page)
Table 4. Summary of antidepressant therapy for depression in primary care setting (Continued)

<table>
<thead>
<tr>
<th>3. Continuation and maintenance (Continued)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ii. Stop antidepressant after completing continuation or maintenance therapy</td>
<td></td>
</tr>
<tr>
<td>➢ Need to be cautious about withdrawal of antidepressant in the elderly depression. Relapse is more likely than adults</td>
<td></td>
</tr>
<tr>
<td>➢ Withdraw slowly, gradually over 4 weeks or longer if on drugs with short half-life (e.g. paroxetine, venlafaxine) when stopping antidepressant. Monitor for discontinuation symptoms and recurrence</td>
<td></td>
</tr>
</tbody>
</table>
| ➢ If discontinuation symptoms occur:
  - monitor and reassure if symptoms are mild
  - consider reintroducing the original antidepressant at the dose that was effective (or another antidepressant with a longer half-life from the same class) if symptoms are severe, and reduce the dose gradually while monitoring symptoms |
**Table 5.** Selected drug interactions and important considerations on choosing antidepressant (Information as at 2018 Jan) (Adapted from NICE\textsuperscript{85}, full version of table is available from: [http://www.ncbi.nlm.nih.gov/books/NBK82914/](http://www.ncbi.nlm.nih.gov/books/NBK82914/))

*Note: This table is by no means exhaustive and is for reference only. Primary care doctors should refer to the product inserts for any special precautions and contraindications of individual drug. Whenever there is doubt, primary care doctors should consider referring the patients to psychiatrist for assessment and drug selection.*

<table>
<thead>
<tr>
<th>Important considerations</th>
<th>Antidepressant to avoid or use with caution</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concurrent drug treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory agents</td>
<td>SSRIs, SNRIs</td>
<td>High risk of gastrointestinal bleeding with SSRIs/SNRIs Offer gastroprotective agents (e.g. proton pump inhibitors) if no suitable alternative</td>
</tr>
<tr>
<td>Warfarin, heparin</td>
<td>SSRIs, SNRIs</td>
<td>SSRIs/SNRIs may enhance anticoagulant effect and increase risk of bleeding</td>
</tr>
<tr>
<td>Macrolides (e.g. erythromycin, clarithromycin)</td>
<td>TCAs, Mirtazapine, Venlafaxine</td>
<td>Use with TCA may increase the risk of QT prolongation Plasma levels of mirtazapine and venlafaxine may be increased by macrolides</td>
</tr>
<tr>
<td>Opioid analgesics (e.g. tramadol)</td>
<td>SSRIs, SNRIs</td>
<td>Increased risk of central nervous system toxicity and/or serotonergic effects with SSRIs/SNRIs</td>
</tr>
<tr>
<td>5HT-1 agonists (triptans) for migraine</td>
<td>SSRIs, SNRIs</td>
<td>Increased risk of central nervous system toxicity and/or serotonergic effects with SSRIs/SNRIs</td>
</tr>
<tr>
<td>Theophylline</td>
<td>Fluvoxamine</td>
<td>Fluvoxamine inhibits theophylline metabolism</td>
</tr>
<tr>
<td>Tamoxifen\textsuperscript{87}</td>
<td>SSRIs</td>
<td>SSRIs may interfere with effect of tamoxifen via blocking CYP2D6 function\textsuperscript{87, 88}. As a reduced effect of tamoxifen cannot be excluded, co-administration with potent CYP2D6 inhibitors (e.g. paroxetine, fluoxetine) should whenever possible be avoided\textsuperscript{89}</td>
</tr>
</tbody>
</table>

**Comorbid medical conditions**

| Cardiovascular disease | TCAs, Venlafaxine, Citalopram, Escitalopram | TCA may increase the risk of postural hypotension and arrhythmia Venlafaxine may exacerbate hypertension and at higher dose, may exacerbate cardiac arrhythmia Citalopram and escitalopram should also be avoided in patient at risk of prolonged QT interval |
| Prostatism | TCAs, Paroxetine | TCA – anticholinergic side effects Paroxetine may have higher rate of anticholinergic side effects than other SSRIs |
| Glaucoma | | |
| Epilepsy | Complex interactions with anticonvulsants – seek specialist advice |
Table 6. Examples of antidepressants in the treatment of depression in old adults (Information as at 2018 Jan) (Adapated\textsuperscript{21, 23, 89-92})

Notes: The dosages are listed for reference only. Primary care doctors should always refer to the product inserts and international guidelines for up-to-date information.

<table>
<thead>
<tr>
<th>Antidepressants: generic name</th>
<th>Recommended initial dosage for older adults</th>
<th>Usual maintenance dosage for older adults</th>
<th>Risk of drug interaction</th>
<th>Remarks*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective serotonin reuptake inhibitors (SSRIs) – Usually as the first line agents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sertraline</td>
<td>25mg daily</td>
<td>25-50mg daily, up to 100mg daily</td>
<td>Low</td>
<td>May have higher incidence of diarrhoea than other SSRIs\textsuperscript{80}</td>
</tr>
<tr>
<td>Citalopram</td>
<td>10mg daily</td>
<td>20 mg daily\textsuperscript{93,94}</td>
<td>Low</td>
<td>Risk of QT prolongation</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5mg daily</td>
<td>10mg daily\textsuperscript{94}</td>
<td>Low</td>
<td>Risk of QT prolongation</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>10mg daily</td>
<td>20mg daily, up to 40mg daily</td>
<td>Moderate</td>
<td>May have higher incidence of discontinuation symptoms and more anticholinergic effects than other SSRIs\textsuperscript{85,86}</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>10mg daily</td>
<td>20mg daily, up to 40mg daily</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Vortioxetine</td>
<td>5mg daily</td>
<td>5-10mg daily</td>
<td>Low</td>
<td>Also works by direct modulation of various serotonin receptors</td>
</tr>
<tr>
<td><strong>Serotonin noradrenaline reuptake inhibitors (SNRIs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duloxetine</td>
<td>30mg daily</td>
<td>30-60mg daily</td>
<td>Low</td>
<td>Possible worsening of hypertension. Higher doses may exacerbate cardiac arrhythmia. High toxicity in overdose. Duloxetine should be avoided in patients with liver disease\textsuperscript{96}</td>
</tr>
<tr>
<td>Venlafaxine, extended release</td>
<td>37.5mg daily</td>
<td>75-150mg daily</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td><strong>Noradrenergic and specific serotonergic antidepressant (NaSSA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>15mg daily</td>
<td>15-30mg daily, up to 45mg daily</td>
<td>Low</td>
<td>May cause sedation</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trazodone</td>
<td>25mg daily at bedtime</td>
<td>75-150mg daily in divided doses</td>
<td>Moderate</td>
<td>Sedative effect</td>
</tr>
</tbody>
</table>

* Abrupt discontinuation of antidepressant treatment can precipitate withdrawal symptoms or relapse.
B. Types of antidepressants

I. Selective serotonin reuptake inhibitors (SSRIs)

SSRIs are usually recommended as the first-line pharmacological treatment for depressive and anxiety disorders when drug therapy is considered because they are generally better tolerated and safer in overdose.\textsuperscript{86, 95}

The following points should be noted on the selection of different SSRIs:

1. Sertraline, citalopram and escitalopram have fewer drug interactions and are considered as the preferred choice for older adults who are also taking other medications.\textsuperscript{72, 96}
2. Citalopram and escitalopram are associated with prolonged QT intervals and they should not be used in patients who are at risk of such conditions.\textsuperscript{93, 94}
3. Fluoxetine and paroxetine have higher risk for drug interactions.\textsuperscript{97}
4. Paroxetine is also associated with a higher incidence of discontinuation symptoms.\textsuperscript{61, 86} and anticholinergic adverse effects.\textsuperscript{98}

The adverse effects of SSRIs include agitation, dizziness, headache, insomnia, nausea, diarrhoea, sexual dysfunctions, rash, weight loss\textsuperscript{84} or weight gain\textsuperscript{99, 100}, as well as increased risk of falls in older adults\textsuperscript{101}. There is increased risk of hyponatraemia\textsuperscript{102, 103} especially in older women, older adults with low body weight, renal failure or medical comorbidity, and those on diuretics.\textsuperscript{65, 72} When used with non-steroidal anti-inflammatory agents, SSRIs are associated with significant risk of upper gastrointestinal bleeding\textsuperscript{104} and gastroprotective agents (e.g. proton pump inhibitors) should be offered if there is no suitable alternative.\textsuperscript{85}

II. Serotonin noradrenaline reuptake inhibitors (SNRIs)

SNRIs, e.g. venlafaxine, act in a similar way to SSRIs but on both serotonin and noradrenaline systems. Their adverse effect profiles are similar to SSRIs (see above), in addition to noradrenergic effects especially at higher dose such as high blood pressure, increased pulse rate, dilated pupils, dry mouth, excessive sweating and constipation.\textsuperscript{105} There is high toxicity in case of overdose.
III. **Tricyclic antidepressants (TCAs)**

TCAs are effective antidepressants and their sedating properties may be useful in depressive patients with sleeping difficulty\(^{106}\). However, their use can be limited by adverse effects which may include arrhythmias, weight gain, impaired memory and concentration that can precipitate delirium, orthostatic hypotension that may lead to dizziness and falls, in addition to other anticholinergic effects such as dry mouth, blurring of vision, constipation, urinary hesitation and sexual dysfunction\(^{84}\). TCAs should be avoided in patients with cognitive impairment, narrow-angle glaucoma or prostatic hypertrophy. There is high toxicity in case of overdose.

IV. **Other antidepressants or augmentation therapy**

Mirtazapine is a noradrenergic and specific serotonergic antidepressant (NaSSA) and is often used as second-line for the treatment of depression. Unlike SSRIs, it is not associated with adverse effects of anxiety, agitation or gastrointestinal upset\(^{107}\). It (as well as bupropion) has a lower rate of sexual dysfunction\(^ {73}\). Common adverse effects include dry mouth, sedation and weight gain. It may increase serum cholesterol levels. Agranulocytosis has been reported\(^ {105}\).

Trazodone belongs to the class of serotonin receptor antagonists and reuptake inhibitors (SARIs). Its sedative effect may help sleeping. Common adverse effects include drowsiness, headache, dizziness and dry mouth. Other less common adverse effects include orthostatic hypotension, QT interval prolongation, cardiac arrhythmia, and rarely priapism and suicidal ideation\(^ {108}\).

Monoamine oxidase inhibitors, or augmentation therapy of antidepressant with other agent such as another antidepressant, antipsychotic or lithium should only be prescribed by specialists due to potential serious harmful effects and the need for careful monitoring\(^ {84},^{85}\).

Possible drug interactions, specific precautions and dosages of some of the commonly used antidepressants are summarised in Table 5 and 6.

C. **Herbs and nutritional supplements**

St John’s wort (Hypericum perforatum) should not be recommended as treatment of depression because of uncertainty about appropriate doses, persistence of effect, variation in the nature of preparations and potential drug interactions including life-threatening serotonin syndrome with antidepressants\(^ {61},^{67},^{109}\). There is also insufficient and inconsistent evidence to recommend
nutritional supplements such as vitamin D, magnesium, omega-3 polyunsaturated fatty acids as an effective treatment of depression\textsuperscript{63, 110, 111}.

### 4.2.3 Referrals

During the initial evaluation, prompt psychiatric referral should be considered if the older adults have tendency to harm themselves or others, or present with symptoms suggestive of underlying psychosis or mania.

Referral to psychiatrist should also be considered when the following condition(s) is/are present in the assessment or subsequent follow up\textsuperscript{41, 66, 72, 86}:

- Unclear diagnosis
- Severe or psychotic depression
- Bipolar disorder
- Failure of or intolerance to treatment especially after two adequate treatment trials
- Complicated psychosocial conditions such as co-existing alcoholism, drug misuse, pathological personality disorder
- Complicated comorbid medical conditions for which expertise is required regarding drug selection
- Need for psychosocial interventions that are not available in primary care settings

Referral to geriatrician should be considered for management of complex multiple co-morbidities, frailty, polypharmacy, and geriatric syndromes.

The Hospital Authority has implemented the Elderly Suicide Prevention Programme (ESPP) since 2002 to provide multi-disciplinary services to older adults with suicidal tendency at psychogeriatric fast track clinics. Information is available from: http://www.ha.org.hk/espp/
4.3 Management of anxiety in primary care settings

Anxiety disorders are prevalent and commonly present in primary care. Anxiety disorders in older adults can be effectively treated with psychological intervention such as cognitive behavioural therapy and pharmacotherapy\textsuperscript{112}. Primary care doctors should check for comorbid depression, and offer treatment for depression first when it is moderate or severe, in order to improve the overall function of the older adults\textsuperscript{95, 113}. Older adults and their caregivers should be involved in the decision on the treatment strategies.

Generalised Anxiety Disorder (GAD), according to the Hong Kong Mental Morbidity Survey\textsuperscript{5}, is the most prevalent among other anxiety disorders in the older age group (aged above 65 years). A formal diagnosis of GAD using the Diagnostic and Statistical Manual of Mental Disorders, 5\textsuperscript{th} edition (DSM-5)\textsuperscript{13} includes excessive anxiety and worry about a number of events and activities, and difficulty controlling the worry. The anxiety is often associated with physical symptoms, such as sleep disturbance, restlessness, muscle tension, gastrointestinal symptoms, and chronic headaches. Symptoms should be present for at least 6 months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Identification and assessment of anxiety disorders may be helped by the use of tool such as Generalised Anxiety Disorder 7-item (GAD-7) scale\textsuperscript{114}. GAD-7 is a self-reported questionnaire for identifying and severity measuring of generalised anxiety disorder, with a score of 10 or more having good diagnostic sensitivity and specificity\textsuperscript{114}. Greater GAD-7 scores correlate with more functional impairment\textsuperscript{115}. Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. The GAD-7 has been found to be sensitive to change and can be used to monitor symptom severity over time\textsuperscript{116}. Cantonese version of GAD-7 is listed in Annex 4 of this Module.

The management of GAD is discussed in this chapter.

4.3.1 Non-pharmacological interventions

Similar to depression, non-pharmacological (i.e. psychosocial) interventions should be offered in all treatment plans if possible. The clinical outcome can be monitored with the use of validated tools (e.g. GAD-7). Treatments are adjusted for those who do not improve as expected. Further interventions, such as pharmacological interventions should be considered when functioning is significantly impaired or when the response to non-pharmacological interventions is inadequate.
A. **Psychoeducation**

Through a good doctor-patient relationship, primary care doctors can provide psychoeducation to older adults with anxiety, which is an important lead to treatment options such as relaxation, exercise and cognitive behaviour therapy\(^{117}\).

- Provide information, e.g. anxiety is common and is treatable; the nature of anxiety and physiological response to fear (fight-flight response)
- Explain treatment options and importance of adhering to treatment
- Encourage self-monitoring of symptoms, including thoughts of self-harm or suicide, and ways to manage if these thoughts appear

B. **Promote self-care**

1. **Reduce stress**
   - Help the patient address current psychosocial stressors, e.g. problems in family, relationship, housing, finances, alcohol and drug misuse, abuse and neglect
   - Assist the patient to manage stress by relaxation techniques, e.g. deep breathing and progressive muscular relaxation exercises, mindfulness-based therapy (refer to Annex 5 for instructions), problem solving techniques and refer as appropriate

2. **Strengthen social support**
   - Help the patient identify supportive family members and friends and involve them as much as possible and appropriate
   - Reactivate the patient’s social network and reinitiate prior social activities
   - Mobilise community resources (Annex 6), e.g. elderly centres, counselling service, outreach service and support group

3. **Maintain healthy lifestyle**
   - Maintain regular sleep schedule and improve sleep hygiene (Table 3)
   - Maintain regular physical activity. Attention should be paid to avoid exercise-related injury and optimise tolerability in older adults\(^{71}\)
   - Practise mind body exercises such as tai chi, which are beneficial for a range of stress-related symptoms\(^{71}\)
   - Abstain from alcohol and tobacco, limit caffeine intake to avoid triggering of anxiety symptoms

4. **Promote functioning in daily activities**
   - Provide support to continue regular social, educational and occupational activities
C. **Manage comorbidities**

- Identify and manage any comorbidities, e.g. pain arising from degenerative arthritis, stroke, Parkinson’s disease, incontinence, cognitive, hearing and visual impairment
- Optimise medications, avoid polypharmacy, aware of possible drug interaction especially when pharmacological interventions are considered (Chapter 4.3.2)

Cl. **Specific psychological interventions**

- Cognitive behavioural therapy (CBT) is useful in treating many anxiety disorders including GAD, and is usually provided by trained practitioners or allied health profession for cognitively intact and motivated older adults
  - Cognitive portion: recognise and replace worrisome thoughts with adaptive ones, formulate coping strategies and test them in real life
  - Behavioural portion: involve gradual exposure and desensitisation to cope with the fearful situations or triggers which is usually the first-line treatment for specific phobia. However, it may be difficult for GAD since the source of anxiety is frequently unidentifiable

### 4.3.2 Pharmacological interventions

Pharmacotherapy for many of the anxiety disorders generally consists of: (1) antidepressants, mostly SSRIs, are used for a period of time to prevent future anxiety; (2) anxiolytics, mostly benzodiazepines (BDZs), are used as a short-term measure to treat acute anxiety without preventing future occurrences.

**A. Antidepressants – selective serotonergic receptor inhibitors (SSRIs)**

SSRIs are usually used as first-line drugs when pharmacological treatment of anxiety disorders is considered. The principle of initiating and continuing antidepressant drug in the management of anxiety disorder generally follows that of depression (Chapter 4.2.2).

However, it should be noted that:

- The therapeutic indications of SSRIs for specific types of anxiety and related disorders can vary in different countries and international guidelines. Primary care doctors are reminded to refer to the product inserts for details;
- For patients with anxiety disorders or for patients who are susceptible to the stimulatory effects of SSRIs, it is advisable to start low (e.g. half of the recommended dose or less) and go slow.
The effect may start with a delay of 2-4 weeks (in some cases up to 6-8 weeks)\textsuperscript{123}, and a treatment period of up to 12 weeks may be needed to assess adequate efficacy of the drug\textsuperscript{95};

Although the optimal duration of continuing treatment in many of the anxiety disorders is still undetermined\textsuperscript{95}, it has been recognised that the treatment should continue for at least 6 to 24 months after remission for relapse prevention, and should be stopped only if all or almost all symptoms disappear\textsuperscript{123}. For example, for generalised anxiety disorder, it has been recommended that the treatment should continue for at least one year\textsuperscript{113}, and may be 18 months or more in other international guideline\textsuperscript{95}.

Second line agents such as selective noradrenergic receptor inhibitors (SNRIs) and pregabalin are sometimes used in secondary care.

**B. Anxiolytics – benzodiazepines (BDZs)**

BDZs may help anxiety symptoms of generalised anxiety disorder\textsuperscript{95} but are also associated with various adverse effects (see below). BDZs should only be used in crisis situations with regular monitoring when the anxiety symptoms or insomnia are severe, disabling and causing extreme distress\textsuperscript{85} or as an adjuvant to antidepressants rather than the sole treatment for anxiety disorders\textsuperscript{124} after careful consideration on the benefits and potential harms. Primary care doctors should not prescribe BDZs to addiction-prone individuals (e.g. with substance or alcohol dependence) and patients with respiratory failure\textsuperscript{86}, and should limit the amount of drugs supply to avoid any stocking by the patient\textsuperscript{125}. Treatment should be tapered off gradually to avoid withdrawal symptoms\textsuperscript{86, 125}. All BDZs are classified as dangerous drugs under the Dangerous Drugs Ordinance in Hong Kong which requires medical practitioners to keep detail record of their prescriptions.

The adverse effects of BDZs\textsuperscript{125} include drowsiness, sedation, muscle weakness, dizziness, headache, confusion, dysarthria, tremor, visual disturbances, urinary retention or incontinence, gastrointestinal disturbances, amnesia, and dependence can occur with prolonged use. In older adults, the adverse effects of BDZs are more prominent\textsuperscript{126} which include increased risk of fall (and its consequences such as traumatic brain injury and fracture)\textsuperscript{127} and cognitive impairment\textsuperscript{128}.
C. Other agents

The following agents are not used as the main pharmacological management of anxiety but have been used as an alternative to alleviate anxiety symptoms or improve sleep disturbance in clinical practice.

I. Non-benzodiazepines hypnotics

These “Z drugs”, e.g. zolpidem and zopiclone, are effective in treating insomnia, and may have less daytime sedation due to faster onset and shorter duration of action. They can cause drowsiness, impaired memory, hallucinations, psychomotor retardation, withdrawal symptoms, tolerance, dependence, behaviour disturbance, falls and other adverse reactions\textsuperscript{129-132}. Therefore, they should be used as a short-term measure reserved for patients with severe sleep disturbance\textsuperscript{86,129}.

II. Antihistamines

Although hydroxyzine has been used as a second-line or adjunctive treatment for controlling acute anxiety in generalised anxiety disorder\textsuperscript{95,123,124,133,134}, like other first-generation antihistamines, it is identified as a potentially inappropriate medication for older adults because of its highly anticholinergic effects\textsuperscript{135}. There is also lack of strong evidence to support the efficacy of first-generation antihistamines on improving sleep\textsuperscript{129,136,137}. Treatment with sedating antihistamines should be determined on an individual basis after careful consideration on the benefits and potential harms.

III. Beta-blockers

Beta-blockers (e.g. propranolol) may help to reduce anxiety symptoms associated with sympathetic nervous system hyperactivity and have been prescribed to improve “performance anxiety”\textsuperscript{95}. However, there is insufficient evidence to support their efficacy and their routine use in anxiety disorders\textsuperscript{138}. Therefore, treatment should be determined on an individual basis.
4.3.3 Referrals

Referral to psychiatrist should be considered when the following condition(s) is/are present:\cite{86,113,115,122-124}:

- Unclear diagnosis
- Severe anxiety e.g. marked functional impairment
- Psychotic symptoms
- Tendency to harm oneself or others
- Failure of or intolerance to treatment especially after two adequate treatment trials
- Complicated psychosocial conditions such as co-existing alcoholism, drug misuse, pathological personality disorder
- Complicated comorbid medical conditions for which expertise is required regarding drug selection
- Need for psychosocial interventions that are not available in primary care settings

Referral to geriatrician should be considered for management of complex multiple co-morbidities, frailty, polypharmacy, and geriatric syndromes.
4.4 Management of other significant mental health complaints in primary care settings

In primary care settings, it is not uncommon that older adults present with psycho-somatic complaints that cannot be fully explained by physical causes or obvious mental health conditions such as depression or anxiety disorders. These complaints are considered significant when the older adults seek help to relieve these symptoms or have considerable difficulty with daily functioning because of the symptoms. Primary care doctors should initiate further assessment for underlying significant distress and stressors, followed by active intervention\(^{23}\) (see below). On the other hand, watchful waiting and appropriate advice such as healthy lifestyle may be sufficient for older adults who present with milder complaints not associated with distress or disturbance of daily functioning after careful evaluation.
A. General management

A trustful relationship with the older adults and their caregivers should be established. Appropriate examination and/or investigations should be carried out to rule out physical causes. Current psychosocial stressors should be addressed and managed. Antidepressants and anxiolytics should not be used routinely unless there is clear indication after balancing benefits and risks. The general management of other significant mental health complaints are summarised in Box 7.

**Box 7. General management of other significant mental health complaints**

- Acknowledge the symptoms that cause significant distress
- Avoid unnecessary investigations
  - Avoid ordering more investigations which may cause unnecessary worry and adverse effects unless there is a clear medical indication
  - Correct any unrealistic expectations on investigations
- Provide explanation
  - Communicate the normal clinical and test findings and reassure that no serious disease has been identified
  - Ask for their own explanation of the cause of symptoms and elicit their concerns
  - Explain that emotional suffering/stress often involves the experience of bodily sensations, such as stomach aches, muscle tension, etc.
  - Discuss potential links between the person’s emotions/stress and symptoms
- In all case, apply practice of reducing stress, strengthening social support and promoting healthy lifestyle and functioning (Chapter 4.2.1)
- Give support and appropriate advice to the caregivers
- Arrange follow up for monitoring the progress

B. For person exposed to extreme stressors

I. Person with major loss

Major loss such as loss of significant one, property, or one’s own health and wellbeing, can result in grief which can be a normal emotional reaction to loss, and will diminish over time in most cases. In case of the person still experiences significant symptoms (such as severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain) affecting daily functioning for more than 6 months, prolonged grief disorder should be suspected and referral to specialist should be made.
II. Person with reactions to recent exposure to a potential traumatic event

Examples of reactions include palpitations, aches and pains, gastric upset, headaches, sleep disturbance, sadness, anxiety, irritation and aggression. In most case, the symptoms are likely to diminish over time, particularly if the person gets rest, engages in stress reduction, and social support.

However, post-traumatic stress disorder (PTSD) should be suspected and referral to specialist should be made if the symptoms persist for at least 1 month, involve considerable difficulty with daily functioning, which include
- recurring frightening dreams, flashbacks or intrusive memories of the events accompanied by intense fear or horror;
- deliberate avoidance of reminders of the event;
- excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements
4.5 Follow up

Primary care doctors should provide timely follow up to older adults with depression, anxiety or other significant mental health complaints, to monitor their progress and review their psychosocial needs. Structured rating scale such as PHQ-9 for depression and GAD-7 for anxiety can be used as a quantitative measure to monitor the clinical outcome of the older adults. Treatments should be systematically adjusted for patients who do not improve as expected. More frequent follow up is necessary for selected patients (e.g. prominent symptoms, significant distress, initiation or adjustment of medications).

Table 7. Important tasks to be fulfilled during follow up of older adults with mental health problems in primary care settings

<table>
<thead>
<tr>
<th>For the patient</th>
<th>For the caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Review symptoms</td>
<td>➢ Identify and acknowledge psychological distress and impacts on caregivers</td>
</tr>
<tr>
<td>➢ Manage comorbidities, e.g. pain</td>
<td>➢ Assess the caregivers’ needs to ensure necessary support and resources</td>
</tr>
<tr>
<td>➢ Monitor the abilities in daily functions and review any new needs for care</td>
<td>➢ Assess for and treat underlying depression</td>
</tr>
<tr>
<td>➢ Assess safety risks and risks of harm to patient or caregivers</td>
<td>➢ Provide resources on training and support to caregivers in taking care of the patient</td>
</tr>
<tr>
<td>➢ Review and optimise medication regime</td>
<td>➢ Provide information on day care centre, respite or residential care if needed</td>
</tr>
<tr>
<td>➢ Review diagnosis and treatment plan if necessary</td>
<td></td>
</tr>
</tbody>
</table>
Annex 1. Comorbidities of insomnia

<table>
<thead>
<tr>
<th>1. Psychiatric conditions</th>
<th>2. Medical conditions</th>
<th>3. Neurological conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Pulmonary</td>
<td>Neurodegenerative disease</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Chronic obstructive pulmonary disease</td>
<td>Alzheimer disease</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Bronchial asthma including nocturnal asthma</td>
<td>Parkinson disease</td>
</tr>
<tr>
<td>Post-traumatic stress</td>
<td></td>
<td>Neuromuscular disorders including painful peripheral neuropathies</td>
</tr>
<tr>
<td></td>
<td>Rheumatologic</td>
<td>Cerebral hemispheric and brainstem strokes</td>
</tr>
<tr>
<td></td>
<td>Arthritis</td>
<td>Brain tumours</td>
</tr>
<tr>
<td></td>
<td>Fibromyalgia</td>
<td>Traumatic brain injury causing post-traumatic insomnia</td>
</tr>
<tr>
<td></td>
<td>Chronic pain</td>
<td>Headache syndromes (migraine, cluster, hypnic headache, and exploding head syndromes)</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td>Fatal familial insomnia, a rare prion disease</td>
</tr>
<tr>
<td></td>
<td>Heart failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ischaemic heart disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nocturnal angina</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endocrinology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hyperthyroidism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urinary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nocturia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gastroesophageal reflux</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dermatologic (eg, pruritus)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Menopause</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lyme disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acquired immunodeficiency syndromes (AIDS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic fatigue syndrome</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Medications</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Central nervous system stimulants</td>
<td></td>
</tr>
<tr>
<td>Central nervous system depressants</td>
<td></td>
</tr>
<tr>
<td>Bronchodilators</td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td></td>
</tr>
<tr>
<td>Beta antagonists</td>
<td></td>
</tr>
<tr>
<td>Glucocorticoids</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Other sleep disorders</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless legs syndrome/Willis-Ekbom disease</td>
<td></td>
</tr>
<tr>
<td>Periodic limb movement disorder</td>
<td></td>
</tr>
<tr>
<td>Sleep-disordered breathing</td>
<td></td>
</tr>
<tr>
<td>Circadian rhythm disorders</td>
<td></td>
</tr>
<tr>
<td>Delayed sleep-wake phase disorder</td>
<td></td>
</tr>
<tr>
<td>Advanced sleep-wake phase disorder</td>
<td></td>
</tr>
<tr>
<td>Irregular sleep-wake rhythm disorder</td>
<td></td>
</tr>
<tr>
<td>Shift work disorder</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Independent insomnia disorders</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term insomnia disorder</td>
<td></td>
</tr>
<tr>
<td>Chronic insomnia disorder</td>
<td></td>
</tr>
<tr>
<td>Other insomnia disorder</td>
<td></td>
</tr>
</tbody>
</table>
Annex 2. Geriatric Depression Scales

A) Geriatric Depression Scale 15-item (GDS-15) - Cantonese Version

老人抑鬱短量表 (GDS-15) – 廣東話口語化版本

在施行此短量表時，先說出題目的口語化版本“問<1>”，若在個別題目中受試者對於問題內容未能掌握清楚，或在評分方面出現問題，則需依序讀出“問<2>”。個別較難理解的題目，則設有“問<3>”。給受試者未能掌握“問<2>”的意思，則需讀出“問<3>”。

評分方法：請依照每條題目的評分方法，給予該題目分數。受試者在短量表的總分是15條題目的分數總和（即最多是15分）。在個別題目中，如受試者最終未能掌握題目內容，或未能給予確實答案，則不用給予任何分數。為統一填寫短量表總分的格式，可參考下列方法：

<table>
<thead>
<tr>
<th>受訪者所得分數</th>
<th>受訪者最終能回答的題目總數</th>
</tr>
</thead>
</table>

例一：12/15 即受試者回答所有題目並15題(15)，總分則為12分(12)
例二：12/13 即受試者最終只能回答13題(13)，總分則為12分(12)
總分≧8 指示有抑鬱的傾向。

### 樣例題目

<table>
<thead>
<tr>
<th>問題</th>
<th>口語化版本</th>
<th>評分方法</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 問&lt;1&gt;：喺上個禮拜裏面，你滿唔滿意自己嘅生活呢？&lt;br&gt; 問&lt;2&gt;：佢你係滿意多啲，抑或唔滿意多啲呢？</td>
<td>0 1</td>
<td></td>
</tr>
<tr>
<td>2. 問&lt;1&gt;：喺上個禮拜裏面，你有冇放棄好多以前啲活動或者嗜好呢？&lt;br&gt; 問&lt;2&gt;：喺上個禮拜裏面，好多以前你鍾意做啲啲，係咪已經冇做啦？&lt;br&gt; 問&lt;3&gt;：喺上個禮拜裏面，你喺朝早或日頭冇冇做啲啲做啲？ 例如：晨運，落街行啲，同人傾偈，或者響屋企做啲家務呢？</td>
<td>1 0</td>
<td></td>
</tr>
<tr>
<td>3. 問&lt;1&gt;：喺過去呢個禮拜裏面，你係咪覺得生活空虛呢？&lt;br&gt; 問&lt;2&gt;：喺上個禮拜裏面，你係咪覺得做人都幾百無聊賴呢？</td>
<td>1 0</td>
<td></td>
</tr>
<tr>
<td>4. 問&lt;1&gt;：喺上個禮拜裏面，你係咪成日覺得好煩悶呀？</td>
<td>1 0</td>
<td></td>
</tr>
<tr>
<td>5. 問&lt;1&gt;：你上個禮拜心情係咪成日都唔好呢？&lt;br&gt; 問&lt;2&gt;：喺上個禮拜裏面，係咪你開心啲，定係唔開心啲？</td>
<td>0 1</td>
<td></td>
</tr>
<tr>
<td>6. 問&lt;1&gt;：喺上個禮拜裏面，你係咪有冇擔心有啲唔好啲會發生喺你身上呢？</td>
<td>1 0</td>
<td></td>
</tr>
<tr>
<td>7. 問&lt;1&gt;：喺上個禮拜裏面，你係咪成日都覺得開心啲？&lt;br&gt; 問&lt;2&gt;：喺上個禮拜裏面，係咪你開心啲，抑或唔開心啲呢？</td>
<td>0 1</td>
<td></td>
</tr>
<tr>
<td>8. 問&lt;1&gt;：喺上個禮拜，你係咪有冇覺得無論做乜啲，都係冇用呢？&lt;br&gt; 問&lt;2&gt;：喺上個禮拜，你係咪有冇覺得無論做乜啲，都係冇補於事呢？</td>
<td>1 0</td>
<td></td>
</tr>
<tr>
<td>9. 問&lt;1&gt;：喺上個禮拜裏面，嘿咪掛念留低啲老人院 / 屋企，都唔想落街做啲&lt;br&gt; 有新意啲事呢？&lt;br&gt; 問&lt;2&gt;：喺上個禮拜裏面，你係咪願留低啲老人院 / 屋企，都唔想落街做啲&lt;br&gt; 特別啲事情呢？</td>
<td>1 0</td>
<td></td>
</tr>
</tbody>
</table>
### B) Geriatric Depression Scale 4-item (GDS-4) - Cantonese Version

**老人抑鬱短量表 (GDS-4) - 廣東話口語化版本**

4-items Geriatric Depression Scale (GDS-4) has been shown to be an excellent alternative to GDS 15. With the cut-off point of 2 or more, it has the sensitivity of 76% and specificity of 65% in the age group 60 to 74. In the group aged 75 years or more, it has the sensitivity of 60% and specificity of 81%

在施行此短量表時，先說出題目的口語化版本“問<1>”，若在個別題目中，受試者對於問題內容未能掌握清楚，或在評分方面出現問題，則需依次序讀出“問<2>”。總分≥2 指示有抑鬱的傾向。

<table>
<thead>
<tr>
<th>項目</th>
<th>問&lt;1&gt;</th>
<th>問&lt;2&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. 問&lt;1&gt;: 唔上個禮拜裏面，你有冇覺得你嘅記性比其他老人家差呢？&lt;br&gt;問&lt;2&gt;: 唔比起兩三個禮拜前，你上個禮拜記性冇有差到呢？</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. 問&lt;1&gt;:唔上個禮拜裏面，你冇有覺得做人係一件好事呢？&lt;br&gt;問&lt;2&gt;:唔上個禮拜裏面，你覺得做人係有意思嘅，係唔係呢？</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>12. 問&lt;1&gt;:唔上個禮拜裏面，你係咪覺得自己好無用呢？&lt;br&gt;問&lt;2&gt;:唔上個禮拜裏面，你冇有覺得自己完全冇用呢？</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. 問&lt;1&gt;:唔上個禮拜，你係咪覺得精力充沛呢？&lt;br&gt;問&lt;2&gt;:唔上個禮拜，你係咪好夠精力呢？ 或 唔上個禮拜，你係咪好夠精神呢？</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14. 問&lt;1&gt;:唔上個禮拜裏面，你有無覺得你嘅處境係無晒希望呢？</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>15. 問&lt;1&gt;:唔上個禮拜裏面，你係咪覺得大部份人嘅情況都好過你呢？</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>總分</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

備註：如得分是2分或以上，須進一步評估長者的情緒狀況
Annex 3. Patient Health Questionnaire

A) Patient Health Questionnaire (PHQ)-9

The Patient Health Questionnaire (PHQ) was primarily developed for use in primary care setting. The Chinese version of PHQ-9 has been translated and validated locally.

The PHQ-9 scoring system can be used for disease severity stratification and monitoring. The change of symptom frequency and severity can be reflected by the change of scores, and thus it can also be used to monitor the change of depressive symptoms with treatments.

<table>
<thead>
<tr>
<th>(請用「√」勾選你的答案)</th>
<th>完全沒有</th>
<th>幾天</th>
<th>一半以上的天數</th>
<th>近乎每天</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 做任何事都覺得沉悶或者根本不想做任何事</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. 情緒低落、抑鬱或絕望</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. 難於入睡；半夜會醒或相反地睡覺時間過多</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. 覺得疲倦或活力不足</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. 胃口極差或進食過量</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. 不喜歡自己 - 覺得自己做得不好、對自己失望或有負家人期望</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. 難於集中精神做事，例如看報紙或看電視</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. 其他人反映你行動或說話遲緩；或者相反地，你比平常活動更多 - 坐立不安、停不下來</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. 想到自己最好去死或者自殘</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(1-9題) 總分

<table>
<thead>
<tr>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
</tr>
<tr>
<td>0-4</td>
</tr>
</tbody>
</table>
B) Patient Health Questionnaire (PHQ)-2

The PHQ-2 includes the first two items of the PHQ-9. The PHQ-2 has the advantage of easy to administer, training time is minimal and subject acceptance is high.

The purpose of PHQ-2 is not to establish diagnosis or to define severity, but rather to screen for depression in a “first step” approach.

As a screening tool, the PHQ-2 has similar performance to the PHQ-9 in identifying older adults with depression. Scores for PHQ-2 range from 0-6. A PHQ-2 score of 3 or more has a sensitivity of 84% and a specificity of 90% for a major depression. Patients with positive screen for PHQ-2 should be further evaluated by PHQ-9 or other validated tools.

<table>
<thead>
<tr>
<th>In the past two weeks, how often have you been troubled by the following? (Please circle your answer)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>1. Doing anything feels boring or just doesn't want to do anything</td>
</tr>
<tr>
<td>2. Mood low, depressed or绝望</td>
</tr>
</tbody>
</table>
Annex 4. Generalised Anxiety Disorder (GAD)-7 scale

GAD-7 has been translated and validated locally. It was shown to have good reliability for the diagnosis of generalized anxiety disorder. Scores of 5, 10, and 15 represent cut points for mild, moderate, and severe anxiety, respectively.

Though designed primarily as a screening and severity measure for generalised anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for anxiety disorders, a recommended cut point for further evaluation is a score of 10 or greater.

<table>
<thead>
<tr>
<th>在過去兩個星期, 你有多經常受以下問題困擾?</th>
<th>完全沒有</th>
<th>幾天的天數</th>
<th>一半以上的天數</th>
<th>近乎每天</th>
</tr>
</thead>
<tbody>
<tr>
<td>(請用「√」勾選你的答案)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 感到緊張、不安或煩躁</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. 無法停止或控制憂慮</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. 過份憂慮不同的事情</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. 難以放鬆</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. 心緒不寧以至坐立不安</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. 容易心煩或易怒</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. 感到害怕, 就像要發生可怕的事情</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>總分</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 5. Stress reduction techniques

A) 渐進式肌肉鬆弛練習 (Progressive Muscular Relaxation):

◆ 肌肉鬆弛能有效放鬆身心。剛開始練習時可能需要 20 至 30 分鐘才能完成，但在熟練之後只需時大約 15 分鐘。

◆ 持續而有系統的練習，對失眠、疲倦、焦慮等有一定幫助。

練習步驟：

1. 舒適地躺臥或坐下，然後合上眼睛。

2. 先把雙手握拳，維持數秒後，在完全放鬆平伸。再重複一次。

3. 將注意力轉移到雙臂，彎曲，然後平伸，重複一次。再依次重複收緊及放鬆以下部位，直到全身的肌肉放鬆。
   - 肩膊縮起，然後放鬆
   - 皺起前額及眼睛，然後放鬆
   - 咬緊牙齒，然後放鬆（放鬆時口部微微張開）
   - 挺胸收緊背部，然後放鬆
   - 吸氣使腹部膨氣，然後呼氣放鬆
   - 腳尖向前挺，以收緊大腿，然後放平
   - 腳尖朝上指向自己，令小腿拉緊，然後放平

4. 保持平穩自然的呼吸，盡量收緊時吸氣，放鬆時呼出，同事用心感受每個部位放鬆的感覺。
B) 深呼吸鬆弛練習 (Deep Breathing Relaxation):

◆ 人在緊張的狀態時，呼吸會比較淺和急促，令肌肉繃緊，而緩慢和均勻的深呼吸，會讓全身鬆弛起來。

練習步驟：
1. 舒適地躺臥或坐下，合上眼睛，將注意力集中在腹部。
2. 想像自己的腹部是一個未充氣的氣球，然後慢慢由鼻孔吸氣，令腹部慢慢脹起。
3. 閉氣約 3 秒後，慢慢呼氣，心裏暗念「放鬆」，腹部將洩氣氣球般慢慢平復下來。
4. 重複以上步驟 5 至 10 次，盡量每日安排時間練習。

C) 靜觀減壓 (Mindfulness-Based Stress Reduction)

「靜觀」是有意識地，不加批判地將注意力集中在當下一刻。透過有系統的自我認識及反省的過程，減輕身心疾病的困擾，改善精神健康。可嘗試以下方法，體驗一下「靜觀」：

◆ 安靜地坐下或躺下約 5 分鐘，緩慢地深呼吸，注意力集中在鼻尖或腹部。

◆ 到公園散步約 10 分鐘，留心自己的步伐、踏足地面時的感覺，並配合呼吸，例如踏第一步時吸氣，第二步時呼氣，第三步時再吸，如此類推。

◆ 「靜觀」進食：先深呼吸幾次，提醒自己要專注，用餐期間盡量不要談話，然後全心享受口中食物，細細感受食物的味道，或數算咀嚼的次數，例如每一口食物咀嚼 15 至 20 次才吞嚥，都可以幫助你專注其中。

資料來源：衞生署長者健康服務。《投資健康人生第 1 冊》。天地圖書：2009 年 7 月
Annex 6. Community resources

Disclaimers: This list is not exhaustive and is for reference only. Links to other websites are inserted for the convenience of the readers and do not constitute endorsement of material at those sites, or any associated organisation, product, or service. It is the responsibility of the readers to make their own decisions about the relevance or accuracy, currency and reliability of information found on those sites. Fee may be applied to services provided by certain organisations.

1. Community centres

<table>
<thead>
<tr>
<th>Elderly Centre Services</th>
<th>長者中心服務</th>
</tr>
</thead>
<tbody>
<tr>
<td>• District Elderly Community Centres</td>
<td>長者地區中心</td>
</tr>
<tr>
<td>• Neighbourhood Elderly Centres</td>
<td>長者鄰舍中心</td>
</tr>
<tr>
<td></td>
<td>■ counselling service, educational and developmental activities, volunteer development, concern visit, canteen service, caregiver support</td>
</tr>
<tr>
<td>• Social Centres for the Elderly</td>
<td>長者活動中心</td>
</tr>
<tr>
<td></td>
<td>■ social and recreational activities, provision of information on community resources, referral service to other social resources, caregiver support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrated Community Centre for Mental Wellness</th>
<th>精神健康綜合社區中心</th>
</tr>
</thead>
</table>

2. Financial support

<table>
<thead>
<tr>
<th>Social Security and Benefits</th>
<th>社會保障及津貼</th>
</tr>
</thead>
<tbody>
<tr>
<td>• e.g. Social Security Allowance (SSA) and Comprehensive Social Security Assistance (CSSA) Scheme, Senior Citizen Card Scheme</td>
<td>Information is available from the website of Social Welfare Department: <a href="http://www.swd.gov.hk/">http://www.swd.gov.hk/</a></td>
</tr>
</tbody>
</table>
### 3. Supporting resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>eElderly</td>
<td><a href="https://www.e123.hk/">https://www.e123.hk/</a></td>
</tr>
<tr>
<td>Elder Academy</td>
<td><a href="http://www.elderacademy.org.hk/">http://www.elderacademy.org.hk/</a></td>
</tr>
<tr>
<td>Hong Kong Housing Society Webpage on Elderly Services</td>
<td><a href="http://www.hkhselderly.com/">http://www.hkhselderly.com/</a></td>
</tr>
<tr>
<td>Senior Citizen Home Safety Association</td>
<td><a href="http://www.schsa.org.hk/">http://www.schsa.org.hk/</a></td>
</tr>
</tbody>
</table>

### 4. General information

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly health service, Department of Health</td>
<td><a href="http://www.elderly.gov.hk/">http://www.elderly.gov.hk/</a></td>
</tr>
<tr>
<td>HK Familylink Mental Health Advocacy Association</td>
<td><a href="http://www.mooddisorder.hk/">http://www.mooddisorder.hk/</a></td>
</tr>
<tr>
<td>Institute of Mental Health, Castle Peak Hospital</td>
<td><a href="http://www3.ha.org.hk/cph/imh/index_chi.asp">http://www3.ha.org.hk/cph/imh/index_chi.asp</a></td>
</tr>
<tr>
<td>Joyful@HK</td>
<td><a href="https://www.joyfulathk.hk/">https://www.joyfulathk.hk/</a></td>
</tr>
<tr>
<td>Kwai Chung Hospital</td>
<td><a href="http://kch.ha.org.hk/TC/default">http://kch.ha.org.hk/TC/default</a></td>
</tr>
<tr>
<td>Smart Patient, Hospital Authority</td>
<td><a href="http://www21.ha.org.hk/smartpatient/SPW/zh-HK/Welcome/">http://www21.ha.org.hk/smartpatient/SPW/zh-HK/Welcome/</a></td>
</tr>
<tr>
<td>The Mental Health Association of Hong Kong</td>
<td><a href="http://www.mhahk.org.hk">http://www.mhahk.org.hk</a></td>
</tr>
</tbody>
</table>
5. **Counselling and support hotlines**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist Oi Kwan Social Service - Emotional support and mental health consultation Hotline</td>
<td>2535 4135</td>
</tr>
<tr>
<td>Caritas Family Crisis Support Centre - Crisis Line</td>
<td>18 288</td>
</tr>
<tr>
<td>Hong Kong Family Welfare Society - Family Careline</td>
<td>2342 3110</td>
</tr>
<tr>
<td>Hospital Authority - Mental Health Direct</td>
<td>2466 7350</td>
</tr>
<tr>
<td>Social Welfare Department - Hotline Services</td>
<td>2343 2255</td>
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</tbody>
</table>

6. **Suicide prevention hotlines**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Prevention Services</td>
<td>2382 0000 (24-hour)</td>
</tr>
<tr>
<td>The Samaritan Befrienders Hong Kong</td>
<td>2389 2222 (24-hour)</td>
</tr>
<tr>
<td>The Samaritans</td>
<td>2896 0000 (24-hour, multi-lingual)</td>
</tr>
</tbody>
</table>

7. **Bereavement support**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Comfort Care Concern</td>
<td><a href="http://www.cccg.org.hk">http://www.cccg.org.hk</a></td>
</tr>
<tr>
<td>Society for the Promotion of Hospice Care</td>
<td><a href="https://www.hospicecare.org.hk/">https://www.hospicecare.org.hk/</a></td>
</tr>
</tbody>
</table>
References


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