

Aged Care Mental Health - Depression

Depression is common among people living in residential aged care, but it should not be considered a normal part of ageing.

AIHW: 62.5% of people aged 65+ entering permanent residential aged care (2017-2022) had at least mild depressive symptoms; 16% had major symptoms.

Early recognition matters: staff may be the first to notice changes in mood, behaviour, appetite, sleep, participation or function.

WHAT MIGHT YOU NOTICE	COMMON CONTRIBUTORS IN AGED CARE	WHAT CAN HELP?	WHEN TO ESCALATE
- Persistent low mood - Loss of interest or pleasure - Withdrawal from activities - Sleep or appetite change - Fatigue / low motivation - Poor concentration or functional decline	- Bereavement or loss - Loneliness / social isolation - Loss of independence - Chronic pain or illness - Reduced mobility - Transition into residential care	- Meaningful social connection - Physical activity where appropriate - Psychological therapy - Good sleep routines - Address pain and other contributing factors - Medication when clinically indicated	- New or marked behavioral change - Rapid decline in mood or function - Suspected medicine-related adverse effects Thoughts of self-harm or suicide require immediate clinical assessment and escalation

Common antidepressants seen in Australian aged care - key risks to remember

CLASS / EXAMPLES	WHY COMMONLY USED	IMPORTANT RISKS IN OLDER RESIDENTS
SSRIs Sertraline, escitalopram, citalopram	Common first-line options for depression; may also be used for anxiety	Hyponatraemia/SIADH, nausea, bleeding risk, dizziness/falls; QT prolongation is relevant with citalopram/escitalopram
Mirtazapine	Depression; may be useful when insomnia or poor appetite coexist	Sedation, dizziness, increased appetite/weight, falls; hyponatraemia can occur
SNRIs Venlafaxine, duloxetine	Depression/anxiety; duloxetine may also be used for neuropathic pain	Hyponatraemia, dizziness/falls; venlafaxine can increase BP and cause withdrawal if stopped abruptly
TCAs Amitriptyline, nortriptyline	Sometimes used for depression; low-dose amitriptyline is also used for neuropathic pain	Anticholinergic effects, sedation, postural hypotension, cognitive impairment, cardiac effects and falls

MEDICATION REVIEW MATTERS: Review the indication, benefit, duration and adverse effects

- Watch particularly for falls/sedation, hyponatraemia, bleeding risk, anticholinergic burden and interactions with other CNS-active medicines.
- Antidepressants should generally not be stopped abruptly; deprescribing requires individualised tapering and monitoring.

Recognise deterioration early, respond supportively to distress and symptoms of mental illness, and promote mental wellbeing.

Palliative Care: Medications Used in End-of-Life Care

QUICK REFERENCE GUIDE

SYMPTOM	COMMON MEDICATIONS	WHY ARE THEY USED?	KEY CONSIDERATIONS
Pain	- Morphine - Hydromorphone - Fentanyl	First-line opioids for moderate to severe pain. Morphine also helps to relieve breathlessness. Hydromorphone and fentanyl are alternatives when morphine is unsuitable (e.g. renal impairment, itch).	- Assess pain regularly. - Monitor constipation, nausea and sedation. - Consider renal function for medication choice. - Check equivalence between opioid products when converting. - Hydromorphone is approximately five times more potent than morphine. - Fentanyl is preferred in morphine intolerance or significant renal impairment.
Breathlessness (Dyspnoea)	- Morphine - Fentanyl	Reduces the sensation of breathlessness and improves comfort.	- Low doses are often effective. - Combine with positioning, airflow and reassurance - Fentanyl is an alternative where morphine is unsuitable.
Anxiety/Terminal Restlessness	- Midazolam - Clonazepam	Rapid relief of anxiety, terminal restlessness and distress.	- Midazolam has a rapid onset, but short duration of action. - Clonazepam lasts longer but may accumulate, causing oversedation. - Clonazepam oral liquid should be dosed as number of drops (1 drop = 0.1mg). - Clonazepam drops are blue in colour; may stain teeth and saliva.
Delirium/Agitation	- Haloperidol - Midazolam - Clonazepam	Manage distressing delirium or agitation when non-pharmacological strategies are insufficient.	- Consider reversible causes first. - Seek specialist advice for persistent symptoms.
Nausea & Vomiting	- Metoclopramide - Haloperidol - Ondansetron	Treat nausea / vomiting.	- Avoid metoclopramide in bowel obstruction. - Ondansetron is preferred in Parkinsonism or extrapyramidal disorders/Lewy Body Dementia.
Respiratory Secretions (Noisy Breathing)	- Hyoscine butylbromide - Glycopyrronium	Reduces terminal respiratory secretions and improves comfort.	- Most effective when commenced early. - Repositioning also assists. - Review response regularly.
Constipation	- Macrogol - Senna - Lactulose	Prevent and treat opioid-induced constipation.	- Patients on regular opioids are likely to require constipation management. - Encourage fluids if appropriate.

References:

- SA Health Pharmacological Management of Symptoms for Adults in the Last Days of Life Clinical Guideline 2026 ([SA Health Fact Sheet Template - Green on White - Helix Position A](#))
- SA Health Prescribing Guidelines for the Pharmacological Management of Symptoms for Adults in the Last Days of Life ([Prescribing+Guidelines_Last+Days+of+Life_V3.pdf](#))
- Therapeutic Guidelines: Palliative Care
- Australian Medicines Handbook 2026