Using screening tools to identify the risk or presence of depression in older people

Prevalence of depression is high among older people, but is difficult to identify and often poorly managed. Screening tools can help to ensure early referral

INTRODUCTION
It is well acknowledged that depression is widespread (Osborn et al, 2003; Sharp and Lipsky, 2002) and is the most prevalent mental health problem for older people (Age Concern, 2007). The condition affects one in five people over 65, rising to two in five in those over 85 (Mental Health Foundation, 2008).

A literature review, focusing on depression screening in older people, highlighted four main issues:

● The problem – the prevalence of depression, its causes, difficulties in diagnosis, prognosis and its impact;
● Screening for depression – which tools are available? Arguments for and against the use of screening tools;
● Treatment – pharmacological and alternative approaches;
● The future – how can we improve the management of mild depression in primary care settings?

THE PROBLEM
Murray and Lopez (1997) warned that by 2020 depression will be the world’s most disabling condition, secondary to cardiovascular disease. This suggests by 2021, an astounding 3.5 million older people will be suffering with symptoms of depression, rising to five million by 2051 (Age Concern, 2007).

The causes of depression are so wide ranging that the surge in incidence predicted by Murray and Lopez (1997) seems understandable. Reasons for the onset of depression are broad and some are listed in Box 1. The condition has far reaching effects, which include individual suffering and economic costs to health and social services (Table 1).

Depression can also have a detrimental impact on family life, as relatives may need time off work to care for family members, which can put great strain on carers (Louch, 2008). The costs of the condition to society is another area of concern, and include those of informal care and growing medical costs (Louch, 2008). NICE (2009) estimates the economic cost of lost working days associated with depression to be £8bn in the UK.

PRACTICE POINTS

● Risk factors for depression (Box 1) should be considered during assessment to help recognise patients at risk.
● Awareness of and observation for symptoms of the condition in older people is vital.
● When deciding which screening tools to use in practice, nurses should review these tools and consider how user friendly they are.

Diagnosis
Despite the significant problems caused by depression, it is well documented that the illness is poorly diagnosed and insufficiently treated (Louch, 2008). It is frequently

BOX 1. POSSIBLE CAUSES OF DEPRESSION

| Illness | Medications: beta-blockers, antihypertensives and sedatives | Unemployment |
| Bereavement | Pain | Poverty |
| Previous history of depression | Being widowed | Alcohol misuse |
| A fall | Marital separation | A significant change in personal circumstances, such as retirement, moving house or empty nest syndrome |
| A fracture sustained in a fall | Persistent relationship trouble | Social isolation |
| Hypothyroidism | Smoking | Nutritional deficiencies |
| Parkinson’s disease | Being a victim of crime | Low physical fitness levels |
| Dementia | Loneliness | |
| A familial history of depression | Homelessness | |

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Depression is a common mood disorder affecting at least 20% of older people and has been predicted to become one of the world’s most disabling illnesses. Perhaps due to its wide range of signs and symptoms, the condition remains notoriously complex to diagnose. Management is typically inadequate and prognosis is bleak. This article examines the use of screening tools for mild depression in those over 65 in primary care, to help determine whether screening would aid recognition and improve patient outcomes.
encountered in primary care (Gilbody et al, 2003) and should be suspected if any two of the main symptoms or any of the other signs (Table 1) continue for at least two weeks (Mental Health Foundation, 2007).

So, why does depression appear to be such a complex condition to diagnose? First, the main rationale for poor diagnosis in those aged over 65 appears to be that emotions are rarely discussed during GP consultations (Sharp and Lipsky, 2002). Second, the typical GP consultation time is too brief for doctors to be able to identify mood problems (Sharp and Lipsky, 2002). Finally, many GPs receive no extra training in the recognition of depressive disorders (Clinical Standards Advisory Group, 2000). These factors may explain why GPs may not detect depression, and suggest screening aids may be useful to support clinical judgement.

Prognosis

The literature review identified the prognosis of older people with depression as extremely unfavourable. One longitudinal study on this group highlighted that almost 75% had died or had a long term, severe illness within three years of onset of the mental illness (Denihan et al, 2000). This is a substantial figure, which highlights the poor outlook for undiagnosed people and again supports the use of a screening tool.

In addition, depression is known to increase disability, whether mild or major (NICE, 2009). This is a key point, as an increase in disability can affect people in numerous ways – for example, the length of time taken to rehabilitate following a fall could increase, purely as a result of the depression.

Furthermore, older people have one of the highest rates of suicide, of which depression is the leading cause (Mental Health Foundation, 2007).

Depression is therefore considered to be a significant, disabling illness that has an extremely detrimental impact on individuals, affecting multiple aspects of life, and carries the risk of incomplete recovery.

SCREENING

The five screening tools that were cited most frequently for patients with normal cognitive function are shown in Box 2.

A disadvantage of these tools is that they are self completed; a National Statistics study (2003) suggested that patients from lower socioeconomic groups underestimate symptoms associated with depression when completing self assessment questionnaires.

Other factors to consider when using self completion tools are that patients’ visual acuity and reading and writing skills need to be adequate to achieve accurate results. If patients are unable to complete the tools satisfactorily, healthcare professionals could be denied a true picture of their mental status.

This finding would support the use of assessment tools carried out by practitioners. However, it is common knowledge that extra paperwork is not popular with nursing staff, and the only tools identified that were developed for staff to complete were those that assess the severity of depression, rather than aid diagnosis.

Using screening tools

The Hospital Anxiety and Depression Scale (HADS) is recommended for use in patients who are medically unwell rather than the general population (National Institute for Mental Health in England et al, 2009). The Zung Self Rating Depression Scale (ZSDS) is aimed at patients deemed to be at high risk of depression (Sharp and Lipsky, 2002), while the Patient Health Questionnaire (PHQ) and Beck Depression Inventory (BDI) are unsuitable for those under 65 (Louch, 2008).

In addition, cross cultural assessment is an area that warrants further attention if using an assessment tool, as the BDI, for example, has reduced value when used in certain cultures (Kerr and Kerr, 2001).

Although these findings may decrease the popularity of screening tools, the literature review highlighted the Geriatric Depression Scale (GDS) as the best universal assessment tool, which can be used with healthy patients and those who are medically unwell (National Institute for Mental Health in England et al, 2009).

The review of screening tools begs one important question: would improved recognition of depression lead to its enhanced management and improve patient outcomes? Despite recommendations for the GDS, there are arguments against using such a tool, including that the act of screening alone will not influence patient outcomes (Gilbody et al, 2005).

Gilbody et al’s (2008) review of randomised controlled trials, incorporating more than 7,500 patients, revealed that routinely administered depression screens had little influence on identification of the condition.

NICE (2009) advocates being alert to possible depression, particularly in people who have a past history of the condition and long term physical health problems with associated functional impairment. Determining which older people fall into these categories may prove time consuming for staff so, rather than apply a lengthy assessment tool, NICE (2009) recommends asking people who might have depression the following two questions:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

However, such simple means of screening may not be the answer, as one large scale study demonstrated. Almost 14,000 people aged over 75 were assessed for depression using the GDS-15; the findings were
MANAGING DEPRESSION

Antidepressants: While depression is treatable and the most widespread reversible mental illness (Anderson, 2001), the literature review revealed it is poorly managed.

It is important to remember antidepressants are not the only treatment option. In fact, NICE (2009) says these drugs should not be used routinely to treat persistent subthreshold symptoms or mild depression because the risk-benefit ratio is poor, although they should be considered for certain patients in these groups (see guidance for full details).

For those prescribed antidepressants, the literature suggests the dosage is frequently inadequate (Clinical Standards Advisory Group, 2000). This may be a contributing factor in treatment failure (Denihan et al, 2000), especially if patients experience medication side effects.

In addition, older people who are believed to be depressed are less likely to be offered treatment as depression is frequently associated with the ageing process (Mental Health Foundation, 2007). However, this is incorrect; old age does not cause depression (Age Concern, 2002).

Alternative treatment: in the UK, many patients are treated with antidepressant medication, but a greater number need an alternative form of intervention (National Statistics, 2003). Alternative forms of treatment for persistent subthreshold symptoms and mild to moderate depression include (NICE, 2009):

- Advice on sleep hygiene;
- Active monitoring – which includes arranging a further assessment, normally within two weeks;
- Low intensity psychosocial interventions – one or more of individual guided self-help, computerised cognitive behavioural therapy and/or a structured group physical activity programme.

In addition to these strategies, the use of exercise is supported because of its effects of enhancing mood, improving cognitive function and reducing anxiety; it is also less expensive than medication (Louch, 2008). However, a Cochrane review on the use of exercise to treat depression established that, although it helps to improve symptoms, it is not clear which form of exercise is beneficial or how useful it is in alleviating depression (Mead et al, 2009). The evidence therefore indicates that exercise on prescription is an area that warrants further exploration as its effectiveness remains unclear.

Despite NICE (2009) guidance recommending giving sleep hygiene advice, literature on this was extremely limited.

While alternatives to the pharmacological management of depression exist, the literature showed not all GPs are aware of specific therapies for mental health problems, and indistinct referral pathways can prevent patients being referred for psychological therapy (Clinical Standards Advisory Group, 2000). Gilbody et al (2005) argued alternative interventions are not effective in enhancing patient outcomes by themselves, and recommended a form of collaborative care.

IMPROVING THE MANAGEMENT OF MILD DEPRESSION

After the impact of depression, the problems surrounding its diagnosis and treatment options had been analysed, the ideal form of management for mild depression in primary care settings was reviewed. The literature review found many recommendations for collaborative care (Gilbody et al, 2005; Unutzer et al, 2002), which appears to be the way forward in terms of treating depressive disorders.

Collaborative care is a model for managing depression: the programmes vary but the concept remains the same (Baldwin et al, 2003). It may involve enhanced patient supervision by a primary care mental health lead plus problem solving treatment and antidepressant management (Unutzer et al, 2002). The main component is depression is managed via multiple interventions rather than with one single method.

Unutzer et al’s (2002) study of 1,800 people highlighted that almost half of patients on such a programme experienced improved outcomes with more satisfaction in the care they received and a reduction in symptoms of low mood. Katon et al’s (1999) smaller scale study on 228 moderately depressed patients on the collaborative care scheme indicated a greater recovery rate from depression, compared with those who were receiving antidepressant therapy only.

NICE (2009) recommends combining drug treatment and psychological therapy for people with moderate and severe depression. However, this review reveals evidence of benefit also in cases of mild depression.

CONCLUSION

Depression is a great cause for concern for both individual patients and for society. Nurses play a vital role in helping to recognise the condition and refer older people who show signs of the condition for intervention. Screening may be in the form of a depression assessment tool or the simpler two question screen approach.

The evidence presented in this review has highlighted that, after depression has been diagnosed, it is crucial for patients to be referred to a collaborative care scheme if we are to improve the quality of care and see effective intervention with improved patient outcomes.

REFERENCES

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