Nursing Practice Review
Mental health

Assessing and managing depression in older people

In this article...

- The prevalence and presentation of depression in older people
- How to identify mental health needs in physically ill patients
- Managing depression for inpatients on general wards

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Abstract

Depression is the most common mental health condition in people aged 65 and over. It can have a detrimental effect on quality of life and reduce patients’ ability to manage their health. Nurses caring for older people with physical health problems are in an ideal position to identify depression; this article outlines how general nurses can do so and ensure their patients receive the appropriate mental health care.

Depression can occur as a result of major life changes. It affects an estimated two million people over the age of 65 in the UK and is the most common mental illness in later life. It is thought that 22% of men and 28% of women aged ≥65 years are affected (Mitchell, 2011), rising to 40% of older inpatients (Butler and Lewis, 1995).

There is widespread undertreatment of depressive disorders in older persons (Barry et al, 2012) and the National Institute for Health and Clinical Excellence (2009, now the National Institute for Health and Care Excellence) recommends that particular attention is paid to the mental health needs of patients with a physical health problem. Untreated depression in inpatients can lead to increased mortality, longer hospital stays and institutionalisation, physical dependence and reduced general health (Royal College of Royal College of Psychiatrists Working Group of the Faculty of Old Age Psychiatry, 2005). Gotlib and Hammen (2009) support this view and suggest untreated depression increases morbidity and mortality. Those who are depressed tend to experience more pain, which affects both the trajectory of and recovery from illness (Gureje, 2007). Patients with depression may also be at risk of self-neglect by failing to maintain adequate fluid and dietary intake, having poor personal hygiene and not taking medication.

Common mental health problems on admission
Depression can be confused with delirium, mild cognitive impairment and dementia. Unlike textbooks, where indexed chapters separate different mental disorders, there is often less clarity in practice. Symptoms overlap in and conditions may coexist. Some patients will not disclose symptoms for fear of being labelled “mentally ill”.

Many signs of depression may appear to be physical symptoms, such as chronic fatigue, unexplained pain syndrome and disproportionate complaints associated with a physical disorder (Baldwin, 2008). It is important for general nurses to have a good understanding of the "3 Ds" – depression, dementia, delirium – and the symptoms associated with each so they can distinguish between physical and mental health problems (Box 1).

Identifying depression
There is a link between depression and long-term physical illness (NICE, 2009). Often depression can be triggered by an ongoing life-limiting physical condition or health problem, such as diabetes, chronic obstructive pulmonary disease or cardiac problems (Wrycraft, 2009). Hackett et al (2005) identified higher rates of depression in people with heart failure, stroke, Parkinson’s disease and end-of-life renal failure.

Keywords: Depression/Older people/ Holistic care

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Depression is common in later life
Hospitals focus significant resources on patients who need emergency, intensive and round-the-clock acute care. Nurses provide physical care but also counselling, advice and education, drawing on interpersonal and communication skills to address psychological components of holistic care. This is supported by the Nursing and Midwifery Council (2010), which requires all nurses to recognise and interpret signs of normal and deteriorating mental and physical health, and respond promptly. Yet the majority of depressive disorders may go unrecognised and untreated in a busy adult ward. General nurses may not feel confident asking patients about depression due to a lack of knowledge and skills to recognise symptoms.

**Assessment tools**

Individuals are normally assessed for depression through one-to-one interviews and by taking a history. They should be asked to describe their recent symptoms and express their mood (Bradley Adams, 2012). Assessments must be patient-centred and appropriate communication skills should be used to encourage patients to talk about how they feel. Nurses may use self-assessment tools that allow people to identify issues they see as problematic and pinpoint what they are concerned about.

Screening tools may be useful in detecting depression but nurses must take into account the need for training when using rating scales, and the need for them to be valid and reliable. Quick and simple rating scales are more likely to be used than those that are difficult or laborious.

NICE (2009) supports general hospital services screening patients with a physical health problem for depression using two set questions (Box 2). The questions are simple and quick to administer, and help to identify those at risk of depression. They have a sensitivity of 95% and a specificity of 66%.

There is evidence that Yeasavage et al’s (1982) Geriatric Depression Scale (GDS) is a useful self-rating tool for screening older people for depression in general hospital settings (Dennis et al, 2012). It has a simple yes/no format of 30 questions, but there are shorter 15-item and a four-item versions (D’ath et al, 1994) (Fig 1). The GDS is endorsed by the Royal College of Physicians and the British Geriatric Society (1992).

**Managing hospital depression**

**Medical treatment**

Treatment strategies may be limited by patients’ physical comorbidities and medical treatment they are receiving. It is unlikely that a treatment of psychological therapy combined with social interventions will be the first choice for a patient who is confined to bed, for example.

Unsurprisingly, the medical model of management of depression usually dominates the hospital arena for younger and older adults. Selective serotonin re-uptake inhibitors such as fluoxetine and citalopram are the recommended first-line drugs (NICE, 2009). The choice of antidepressant will take into account any physical factors the patient has and their current prescribed medication.

The drug’s effectiveness can only be seen once the patient has been taking the right dose for the right length of time. Antidepressants are thought to take at least two weeks to have a beneficial effect, and any early response is likely to be a placebo effect (Quitkin et al, 1984). However, an early response in the first week can help predict the efficacy of the antidepressant (Taylor et al, 2006).

**Shared-care initiative**

There are noticeable differences between mental health and general wards. However, all care must be holistic and it is important that mental and physical health needs are considered together. At a general hospital, a shared-care ward can treat patients with equally demanding mental and physical health needs (Rooke and Morgan, 2010). The admission criteria for these wards are that the patient must be over 65 years of age with both a physical “medical” problem and an active mental health problem.
The shared-care ward has equal input from mental health and medical teams. This flexibility can help patients with the transition between the two ward types. Hanna et al (2008) found shared-care wards were an effective model for delivering care to this complex patient group, particularly as the wards offered shared decision making between disciplines, rather than the usually more unilateral approach on a general medical ward. Rookie and Morgan (2010) found “shared care” patients were more likely to be discharged home than to care homes, and spent significantly less time in hospital with fewer transfers to other wards.

**Liaison mental health team**

The initial assessment of mental health needs must be undertaken by the nurses or other professionals in the specialist area where the patient is based. Safe and effective immediate mental health care is essential. If more complex and life-threatening mental health symptoms or concerns are found, the patient should be referred to specialist older people’s mental health services (Box 3).

Many general hospitals have multidisciplinary liaison older person’s mental health teams, comprised of nurses, social workers, consultants, registrars, an occupational therapist and a psychologist. The LOPMHFT has several functions, including rapid expert assessment and interventions, assessing and advising on treatment and providing follow-up services for patients.

The scale and nature of this service’s operation will depend on local needs. According to the Centre for Mental Health and Mental Health Network NHS Confederation (2012), some hospitals appear to have little or no provision of organised mental health support, while others have large in-house specialist teams.

**Conclusion**

Health professionals, particularly general hospital nurses, are likely to come across patients with mental health problems such as depression, dementia and delirium. General nurses must be aware of the mental health needs of patients who are physically ill and deliver safe, effective holistic healthcare through assessment, screening and evidence-based treatments. MT

**References**


D’Athis et al (1994) Screening, detection and management of depression in elderly primary care attenders. The acceptability and performance of the 5-item Geriatric Depression Scale (GDS5) and the development of short versions. Family Practice; 11: 3, 260-266.


**SCAle (GDS-4)**

Are you basically satisfied with your life? Yes NO

Do you feel that your life is empty? YES No

Are you afraid that something bad is going to happen to you? YES No

Do you feel happy most of the time? YES No

GDS-4 score: ___/4

Score 1 for answers in block capitals. 2-4 = Depressed, 1=Uncertain, 0=Not depressed

**Fig. 1. FOUR-ITEM GERIATRIC DEPRESSION SCALE (GDS-4)**

**Box 2. SET QUESTIONS TO IDENTIFY DEPRESSION**

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

**Box 3. SPECIALIST SERVICE REFERRALS**

Indications for referral to specialist older person’s mental health service include:

- Suicide – statements of intent
- Suicide – deliberate self-harm (all)
- Symptoms consistent with hallucinations or delusions (psychosis)
- Inadequate response to two different classes of antidepressants
- Diagnosis uncertain
- Complex symptoms, and/or multiple physical problems

