The detection and prevention of depression in older people

The Gerontological Nursing Demonstration Project for Scotland is dedicated to promoting the principles and practice of gerontological nursing and the development of evidence-based practice and professional networking. The project brings to fruition a commitment from Scotland’s strategy for nursing to establish a model for networking that could be used to develop, disseminate and implement best practice in the care of older people (Scottish Executive Health Department, 2001).

To date the project has published the best practice statement, Nutrition for Physically Frail Older People (Nursing and Midwifery Practice Development Unit, 2002), and is working on statements for the promotion of physical activity and good oral health for older people. This article reports on the development of the recently completed best practice statement, Working with Older People Towards Prevention and Early Detection of Depression (NHS Quality Improvement Scotland, 2004).

The prevention of depression

In response to health policies aimed at improving the mental health of older people (Department of Health, 2001; Audit Commission, 2000), the prevention and early detection of depression was selected as a topic for the project’s second best practice statement. We decided to focus on prevention and early detection of depression, because the treatment of clinical depression often requires the specialist assessment and therapeutic skills of mental health nurses.

We wanted to demonstrate that general nurses play a key role in responding to the risk factors for depression and that they can use a simple screening tool to detect depression at an early stage.

The focus for this particular best practice statement is the care of older people who are moving to continuing care facilities such as community hospitals or care homes (nursing) and older people awaiting hospital discharge or who are experiencing a comparable period of instability in their lives.

**Depression in later life**

Depression is not a normal part of ageing but it is the most common mental health problem in later life. We chose to use Snowdon’s (1998) description of depression for the project: ‘A collective term referring to disorders in which the central feature is a lowering of mood, usually accompanied by reduced ability to enjoy or take interest in one’s usual activities.’ Comprehensive definitions of mild, moderate, and severe depression are provided by the World Health Organization (1999).

### References

- Source: Adapted from Matthew (1996)
As with other health conditions, the presentation of depression in an older person may be different from that of a younger adult. For example, they may exhibit more psychotic or delusional symptoms and may confuse the reduced need for sleep that is associated with ageing, with symptoms of depression (National Institute of Mental Health, 2001; Ryden et al, 1999).

Early UK studies cited by the Audit Commission (2000) of people aged 65 and over living in their own homes indicate that 10-16 per cent suffer from depression. More recently a UK-wide study of people aged 75 and over living in their own homes estimated that eight per cent of older people develop moderate depression, and 3.1 per cent severe depression. Women and older age groups were found to be at increased risk of developing depression (Osborn et al 2002). Older people living in care homes appear to be at particular risk of developing depression with prevalence estimated at 20-40 per cent (Audit Commission, 2000).

Although a specific life event can trigger an episode of depression such as the death of a spouse or any other bereavement, it is often a combination of factors and life stresses that lead to clinical depression (Ruggles, 1998). The risk factors for depression can be categorised as external and internal (Table 1).

Depression often goes unreco gnised by older people themselves and those around them, such as family and health care professionals (Bagley et al, 2000; National Institute of Health, 1991). Both older people and professionals may believe that depression is inevitable in old age, with the result that the older person does not seek professional help and professionals may not see it as an area for therapeutic care (Waller and Hillam, 2000).

The detection of depression in older people can be complicated by the coexistence of multiple chronic illnesses. These chronic illnesses become the focus for care, and signs of depression may come to be viewed as understandable and normal and therefore not warranting attention, despite the evidence that the presence of depression adversely affects the older person’s physical recovery (Callahan et al, 1994). The belief that depressive symptoms are an understandable reaction to these losses and life changes is cited as one reason for the under-reporting (Bagley et al, 2000).

Moreover, for older people the stigma associated with having a mental illness may prevent individuals from being open about their feelings and symptoms. A focus on physical symptoms, rather than on how the person is feeling, is one feature of altered presentation (National Institute of Mental Health, 2001; Ryden et al, 1999).

**The best practice statement**

*Working With Older People Towards the Prevention and Early Detection of Depression* is split into four sections:

- Promoting nurses’ awareness of depression in the older person;
- Promoting positive mental health and well-being;
- Assessment and care planning;
- Education and training.

Each section consists of key points, followed by the detail of what constitutes best practice, how to achieve it, and how to demonstrate that it is being achieved. Reference to the evidence base is contained within the statement. We also included a short list of challenges because we wanted to acknowledge that certain aspects are not easily achieved, but on the other hand they are not impossible to achieve over time – and with a little creativity. The order of the sections does not reflect their importance. They all need to be addressed in order to achieve best practice.

The first section, promoting nurses’ awareness of depression, responds to findings suggesting that depression is an undetected and neglected area of care (Bagley et al, 2000). It sets out to alert nurses about depression in older people, and in so doing draws attention to the various risk factors specific to later life. In response to the finding that there is an increased risk of depression in care home residents (Audit Commission, 2000), the section focuses on the transition to a care home as an important area for nursing intervention.

| TABLE 2. GAINS AND LOSSES FOLLOWING TRANSITION TO A CARE FACILITY |
|-------------------------|-------------------------|
| **LOSSES**              | **GAINS**               |
| Role                   | Relief at no longer being alone |
| Lifestyle              | Relief from burden of meal preparation |
| Freedom                | Relief from worry about getting about in winter |
| Autonomy               | Relief from managing a household |
| Privacy – associated with group living | Feeling physically safe (Twasiew et al, 1996) |
| Home and personal belongings | Improved physical comforts and safety |
| Social contacts – friends, pets | Greater security and less loneliness and more stimulation than at home (Victor, 1992) |
| Control of daily living patterns – mealtimes | Residents and families often express an improvement or continuation of family ties following admission (Smith and Bengston, 1979) |
| Own space – this becomes limited to their own room and residents may share a room |
| New surroundings evoke loss of associated memories and may result in negative feelings |
| Change in identity (Willcocks et al, 1987) on giving up their home – no longer home owners or tenants but have become residents or patients |

**REFERENCES**


National Institute of Mental Health (2001) *Older Adults: Depression and Suicide Facts (NIH Publication No. 01-4593).* Bethesda, MD: NIMH.


The move from the community, hospital or other place of residence to a care home can be a traumatic life event (Rosswurm, 1983) and one of the greatest sources of fear and stress for older people (Louie, 2002). The move itself is unlikely to be the only trigger factor because when a person moves into residential care it is very likely that they have already experienced a number of other major life changes (National Institute of Mental Health, 2001; National Institute of Health, 1991).

Nursing staff have a key role to play in providing the appropriate psychological, spiritual, social, and physical support that can lead to improvement in quality of life for the older person and family (Hertzberg, 2001). Physical support might involve referral to specialist services for the correction of hearing and visual disabilities, both of which can hinder the individual and prevent them taking some control over their new situation (Tolson et al, 2002). The existence of written care guidance highlighting the effects of transition, the potential losses and gains, is one method of providing evidence that these are important areas for supportive care.

Section two, promoting positive mental health and well-being, focuses on types of supportive care that help to ease the transition and increase the older person’s feelings of independence and control. The move to a care home is likely to involve a mixture of gains and losses (Table 2). These may be exacerbated by the manner in which the transition to the care facility is made. A major aim of care is to minimise the perceived losses that the person may experience in moving into the care home.

A fully planned, coordinated and integrated approach to admission to the care home or continuing care facility is important. This includes provision of detailed information on the care facility, and ideally, a preadmission visit to meet staff and other residents. The emphasis is on supporting people through the transition. Practical steps include helping individuals to prepare for and anticipate the move, ensuring that they can see and hear to their best ability. This then puts older people in the best position for participating in planning their own care and maintaining some control over their new situation.

The third section addresses evidence around assessment and care planning. In view of the finding that depression often goes undetected, especially in care home residents, the use of a formal screening tool as part of the assessment for depression is strongly recommended in the research literature (Bagley et al, 2000; Ryden et al, 1999). Teresi et al (2001) found that use of screening tools by nursing staff improved their ability to recognise and report suspected cases of depression from approximately 32 to 50 per cent of cases. The
Geriatric Depression Scale-15 (GDS-15) (Sheikh and Yesavage, 1986) was chosen as the screening tool for use in the demonstration project. The GDS-15 is a short and well-validated tool that does not diagnose depression, but a particular score indicates that depression may be present. Nurses are well placed to use this tool because of their close relationship with clients. It is recommended that initial assessment for depression begins within 48 hours of admission and is completed within 14 days.

Proactive care planning focuses on the older people’s strengths and usual coping methods and daily living patterns. Relatives and other supporters are involved in planning care, if this is the wish of the individual. Other interventions such as enabling the older person to access advocacy services, providing psychosocial support, maintaining community links, and encouraging the person to engage in meaningful activities are recommended as they have been found to play a key role in the prevention of depression (National Institute of Health, 1991).

Finally, good practice in mental health care requires the expertise of a range of professionals other than nurses. The statement recommends that the registered nurse draws appropriately on or makes referrals to take advantage of the specialist knowledge and skills of other interdisciplinary team members (Bagley et al, 2000).

Section four addresses education and training. Bagley et al (2000) suggest that nurses are not well equipped to care for older people with depression. They found that there was little training on depression in older people for nursing staff working in care homes, with the result that depression was rarely identified, particularly in newly admitted residents. The section contains a list of topic areas, most of which have already been discussed, that are relevant to understanding, preventing, and detecting depression in older people.

**Conclusion**

Nurses are ideally placed to implement proactive strategies to prevent depression in older people, to promote early detection of symptoms, and to ensure access to effective treatment. Preventative strategies are based on an understanding of risk factors for depression in older people and an appreciation of how it feels to move from one’s home into a continuing care environment late in life.

This best practice statement has been developed as part of a national practice development initiative. It aims to demonstrate how nurses can work with older people and their families at times of critical change, providing support and preventing the normal responses to loss and grief from developing into clinical depression.

**REFERENCES**


