

DEPRESSION CARE GUIDE

Note the number of symptoms, onset, frequency/patterns, duration, changes in normal mood, behaviour and functioning.
(Symptoms must be present pervasively for longer than two weeks to indicate a possible depression.)

SYMPTOMS

- ❖ Depressed or irritable mood, frequent crying.
- ❖ Loss of interest, pleasure (family, friends, hobbies, sex).
- ❖ Weight loss or gain (especially loss).
- ❖ Sleep disturbance (especially insomnia)
- ❖ Fatigue, loss of energy.
- ❖ Psychomotor change.
- ❖ Diminished concentration.
- ❖ Feelings of worthlessness and guilt.
- ❖ Suicidal thoughts or attempts, hopelessness.

RISK FACTORS

- ❖ Psychosis e.g. delusional/paranoid thoughts, hallucinations.
- ❖ History of depression, current substance abuse (especially alcohol), previous coping style.
- ❖ Recent losses or crises e.g. death of spouse, friend, pet, retirement, anniversary dates, move to another residence or nursing home, changes in physical health status, relationships or roles.
- ❖ In elderly persons, frequent somatic (physical) complaints may actually represent an underlying depression.
- ❖ Chronic pain.
- ❖ Diseases: e.g. respiratory, cardiac, stroke, cancer.

ASSESSMENT

- ❖ Obtain/review medical history and physical/neurological examination.
- ❖ Assess for depressogenic medications (e.g. steroids, narcotics, sedatives/hypnotics, benzodiazepines, antihypertensives, histamine-2 antagonists, beta-blockers, antipsychotics, immunosuppressives, cytotoxic agents).
- ❖ Assess for related systemic and metabolic processes (e.g. infection, anaemia, hypothyroidism or hyperthyroidism, hyponatraemia, hypercalcaemia, hypoglycaemia, congestive heart failure and kidney failure).
- ❖ Assess for cognitive dysfunction.
- ❖ Assess level of functional disability.
- ❖ Do a Geriatric Depression Screen – short form (next page). For those with cognitive impairment use the Cornell Scale for Depression in Dementia (next page)
- ❖ **Refer to Mental Health professionals, such as Mental Health Services for Older Adults if assessment indicates depression.**

INTERVENTIONS

- ❖ Institute safety precautions for suicide risk as per institutional policy (ensure continuous surveillance of resident while obtaining an emergency psychiatric evaluation and disposition).
- ❖ Remove or control risk factors: consult with GP to avoid/remove/change medications that can worsen depression; work with GP to correct/treat physical/metabolic/systemic medical issues.
- ❖ Monitor and promote nutrition, elimination, sleep/rest patterns, physical comfort (especially pain control).
- ❖ Enhance physical function e.g. structure regular exercise/activity; refer to physical, occupational, recreational therapies; develop a daily activity schedule.
- ❖ Enhance social support e.g. identify/mobilise a support person e.g. family, confidant, friends, facility resources, support groups, resident visitors; ascertain need for spiritual support and contact appropriate clergy.
- ❖ Maximise autonomy/personal control/self efficacy e.g. include patient in active participation in making daily schedules and setting short term goals.
- ❖ Identify and reinforce strengths and capabilities.
- ❖ Structure and encourage daily participation in relaxation therapies, pleasant activities (conduct a pleasant activity inventory) and music therapy.
- ❖ Monitor and document responses to medication and other therapies; re-administer depression screening tool.
- ❖ Provide practical assistance; assist with problem solving.
- ❖ Provide emotional support e.g. empathic, supportive listening, encourage expression of feelings and hope instillation, support adaptive coping and encourage pleasant reminiscences.
- ❖ Provide information about the physical illness and treatment(s) and about depression e.g. that depression is common, treatable and not the person's fault.
- ❖ Ensure mental health community linkup; consider psychiatric, nursing home care intervention.

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

- | | |
|---|-----------------|
| 1. Are you basically satisfied with your life? | YES / NO |
| 2. Have you dropped many of your activities and interests? | YES / NO |
| 3. Do you feel that your life is empty? | YES / NO |
| 4. Do you often get bored? | YES / NO |
| 5. Are you in good spirits most of the time? | YES / NO |
| 6. Are you afraid that something bad is going to happen to you? | YES / NO |
| 7. Do you feel happy most of the time? | YES / NO |
| 8. Do you often feel helpless? | YES / NO |
| 9. Do you prefer to stay at home, rather than going out and doing new things? | YES / NO |
| 10. Do you feel you have more problems with memory than most? | YES / NO |
| 11. Do you think it is wonderful to be alive now? | YES / NO |
| 12. Do you feel pretty worthless the way you are now? | YES / NO |
| 13. Do you feel full of energy? | YES / NO |
| 14. Do you feel that your situation is hopeless? | YES / NO |
| 15. Do you think that most people are better off than you are? | YES / NO |

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression and warrants follow-up comprehensive assessment.

A score > 10 points is almost always indicative of depression.

Anxiety can be a symptom of depression

Anxiety is an arousal state. People experience anxiety in different ways, but the following three elements are considered to be common symptoms:

1. A conscious feeling of fear and danger without the ability to identify immediate objective threats that could account for these feelings;
2. A pattern of physiological arousal and bodily distress that may include miscellaneous physical changes and complaints, such as heart palpitations, faintness, feeling of suffocation, breathlessness, diarrhoea, nausea or vomiting; and
3. A disruption or disorganisation of effective problem-solving and mental control, including difficulty in thinking clearly and coping effectively with environmental demands.

DEPRESSION SCREENING

CORNELL SCALE FOR DEPRESSION IN DEMENTIA

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

SCORING SYSTEM

A = unable to evaluate 0 = absent 1 = mild to intermittent 2 = severe

SCORE GREATER THAN 12 = Probably Depression

A. MOOD-RELATED SIGNS	A	0	1	2
1. Anxiety; anxious expression, rumination, worrying	A	0	1	2
2. Sadness; sad expression, sad voice, tearfulness	A	0	1	2
3. Lack of reaction to pleasant events	A	0	1	2
4. Irritability; annoyed, short tempered	A	0	1	2
B. BEHAVIORAL DISTURBANCE	A	0	1	2
5. Agitation; restlessness, hand wringing, hair pulling	A	0	1	2
6. Retardation; slow movements, slow speech, slow reactions	A	0	1	2
7. Multiple physical complaints (<i>score 0 if GI symptoms only</i>)	A	0	1	2
8. Loss of interest; less involved in usual activities (<i>score 0 only if change occurred acutely, i.e., in less than one month</i>)	A	0	1	2
C. PHYSICAL SIGNS	A	0	1	2
9. Appetite loss; eating less than usual	A	0	1	2
10. Weight loss (<i>score 2 if greater than 5 pounds in one month</i>)	A	0	1	2
11. Lack of energy; fatigues easily, unable to sustain activities	A	0	1	2
D. CYCLIC FUNCTIONS	A	0	1	2
12. Diurnal variation of mood; symptoms worse in the morning	A	0	1	2
13. Difficulty falling asleep; later than usual for this individual	A	0	1	2
14. Multiple awakenings during sleep	A	0	1	2
15. Early morning awakening; earlier than usual for this individual	A	0	1	2
E. IDEATIONAL DISTURBANCE	A	0	1	2
16. Suicidal; feels life is not worth living	A	0	1	2
17. Poor self-esteem; self-blame, self-depreciation, feelings of failure	A	0	1	2
18. Pessimism; anticipation of the worst	A	0	1	2
19. Mood congruent delusions; delusions of poverty, illness or loss	A	0	1	2