



*Nursing Home Quality Initiative*

# FAST FACTS: DEPRESSION *Overview*

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**PREVALENCE**

- Approximately 300,000 (20%) of the 1.5 million older adults residing in nursing homes in the United States have symptoms of depression.
- Clinically significant depression in nursing homes ranges from 24-50%
- The rates of new cases of depression in nursing homes are striking-13% of residents develop a new episode of major depression over a one-year period and another 18% develop new depressive symptoms.

**DEFINITION**

Depression is a serious medical illness that disrupts a person’s mood, behavior, thought processes, and physical health. It should not be mistaken for the passing feelings of unhappiness that everyone experiences, and is not a normal consequence of age. Some of the symptoms of depression are:

1. Sleep Disturbance
2. Psychomotor retardation or agitation
3. Appetite disturbance (decreased or increased) or weight loss or gain
4. Concentration difficulties
5. Loss of energy, fatigue, tiredness
6. Depressed mood
7. Diminished or lost interest in activities
8. Guilt or feelings of worthlessness
9. Suicidal ideation or thoughts of death

Seniors often exhibit different symptoms when experiencing depression and should be carefully monitored for changes in their usual habits which can signal depression.

**BARRIERS TO PREVENTION/TREATMENT**

The following are common barriers to adequate recognition and/or treatment of depression in the geriatric population:

- Social stigma associated with mental illness prevents acknowledging depression and seeking treatment
- Family members available as support to resident may be limited or unavailable
- Clinician, resident and family mistaken belief that depression is a natural consequence of old age
- Confusion of symptoms with co-morbid physical conditions or medications used
- Staff time spent ruling out other possible diagnoses
- Lack of trained providers



**BARRIERS TO PREVENTION/TREATMENT (CONT.)**

- Fragmented and limited availability of mental health services in long-term care setting
- Limited reimbursement for mental health care
- Use of suboptimal treatment dosages; choice of medications restricted by formularies
- View of depression medications as “chemical restraints”

**FURTHER READING AND WEB RESOURCES**

A more detailed overview of depression can be obtained by contacting your state Quality Improvement Organization (QIO). Visit [http://www.ahqa.org/pub/connections/162\\_694\\_2450.cfm](http://www.ahqa.org/pub/connections/162_694_2450.cfm) for contact information for your state QIO.

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More depression resources available at: <http://www.psychologynet.org/major.html> Last accessed 9/1/2004.



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# FAST FACTS: DEPRESSION Screening

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**WHAT IS SCREENING?**

A question or test to determine if a person may or may not need further evaluation for a problem or condition. If the result of the screening is positive, it should trigger a comprehensive evaluation of a resident's problem or condition. If the result is negative, the facility should conduct periodic re-screening.

**WHY SCREEN FOR DEPRESSION?**

Depression remains substantially under diagnosed and under treated in nursing home residents. Suggested strategies to improve diagnosis and management of depression among residents have included:

- Educational interventions with nursing home staff to improve staff knowledge
- Quarterly administration of the Minimum Data Set (MDS) assessment instrument.

While the MDS may be useful for identifying residents that demonstrate certain symptoms consistent with depression, it is not effective alone as a screening instrument. The Resident Assessment Protocols (RAPs) are problem-oriented frameworks for additional assessment based on problem identification items. The RAP guidelines provide guidance on how to synthesize screening and assessment information within a comprehensive evaluation.

**SCREENING TOOLS**

A multitude of screening instruments are available to screen for depression:

- The Geriatric Depression Scale (GDS)
- Hamilton Depression Scale - not specific for geriatrics
- Beck Depression Inventory - not specific for geriatrics
- Zung Scale - not specific for geriatrics

In screening for depression in nursing home residents, a two-step approach is often utilized to increase sensitivity and specificity.

1. A Mini-Mental State Exam (MMSE) is usually administered first to assess cognitive function.
2. Residents with a MMSE of 15 or greater are then screened with the GDS. The GDS may be used with healthy, medically ill, and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.
3. For those residents who screen positive with the GDS, a formal diagnostic evaluation is indicated in order to determine whether clinical depression is present.



**SCREENING  
TOOLS (CONT.)**

4. Residents with a MMSE less than 15 should be screened with a tool appropriate for their degree of cognitive impairment (i.e. Cornell Scale for Depression in Dementia or CSDD).

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**FURTHER  
READING AND  
WEB  
RESOURCES**

A more detailed overview of depression can be obtained by contacting your state Quality Improvement Organization. Visit:

[http://www.ahqa.org/pub/connections/162\\_694\\_2450.cfm](http://www.ahqa.org/pub/connections/162_694_2450.cfm)

for contact information for your state QIO.

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# FAST FACTS: DEPRESSION *Evaluation*

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**FACILITY  
COMMITMENT**

Evaluation of depression requires a system-wide interdisciplinary approach starting with facility leadership.

Important components of facility commitment are:

- Standardize collaborative and interdisciplinary approaches to manage depression
- Establish format or policy/procedure for identification and management of depression
- Create processes for screening, evaluating, and monitoring care of the depressed resident
- Individualize care plans for treatment of depression
- Institute pharmacological and non-pharmacological therapies to manage depression
- Provide strategies to educate staff across multiple levels on the care of the depressed elderly.

**EVALUATION OF  
DEPRESSION**

Once depression has been identified by an appropriate screening method (i.e. Geriatric Depression Scale), a thorough interdisciplinary evaluation should occur. An interdisciplinary evaluation of depression should include:

- History of Symptoms
  - a) when symptoms started
  - b) how long they last
  - c) how severe they are
  - d) prior history
- Physical examination and medication review to rule out physical and pharmacologic causes
- Current/previous treatment and effects of treatment
- Substance abuse and suicide risk assessment
- Mental status examination (i.e. Mini-Mental State Examination if not completed during screening)

The AMDA Clinical Practice Guidelines for Depression identify signs and symptoms suggestive of depression that is seen in long-term care residents. These include somatic complaints, particularly pain. Other symptoms include:

- Increased or excessive utilization of health services/resources
- Decreased socialization or attendance at activities
- Apathy or “model patient” behavior
- Combative or resistant behavior



**EVALUATION OF DEPRESSION (CONT.)**

- Delusions
- Paranoia
- Sleep disorders
- Poor appetite or weight loss

**RISK FACTORS**

People in the later stages of life may experience stressful events or changes that put them at higher risk for developing depression. Some of these risk factors are:

- Change in environment or new admission
- Personal or family history of depression or mood disorders
- New stressful losses, including loss of autonomy, loss of privacy, loss of functional status, loss of family member or friend
- History of attempted suicide
- History of psychiatric hospitalization
- Alcohol or substance abuse
- Medical diagnoses such as Alzheimer's disease, Parkinson's disease, certain stroke syndromes, cardiovascular disease and cancer
- Certain medications such as carbidopa/levodopa, beta-adrenergic antagonists, clonidine, benzodiazepines, barbiturates, anticonvulsants and H2 blockers

**FURTHER READING AND WEB RESOURCES**

A more detailed review of evaluation of depression can be obtained by contacting your state Quality Improvement Organization. Visit [http://www.ahqa.org/pub/connections/162\\_694\\_2450.cfm](http://www.ahqa.org/pub/connections/162_694_2450.cfm) for contact information for your state QIO.

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