Complete Summary

GUIDELINE TITLE

Detection of depression in the cognitively intact older adult.

BIBLIOGRAPHIC SOURCE(S)

Piven MLS. Detection of depression in the cognitively intact older adult. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2005 May. 33 p. [79 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Piven MLS. Detection of depression in the cognitively intact older adult evidence-based protocol. In: Titler MG, editor(s). Series on evidence-based practice for older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 1998. 25 p.

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SCOPE

DISEASE/CONDITION(S)

Depression including the following diagnoses: major depression, subsyndromal depression (also known as subclinical depression or minor depressive disorder), dysthymia, adjustment disorder with depression, depression due to a medical condition, and depression with anxiety

GUIDELINE CATEGORY

Diagnosis
Evaluation
Risk Assessment
Screening

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Psychiatry

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physicians
Social Workers

GUIDELINE OBJECTIVE(S)

To improve detection of depression in medically compromised, cognitively intact, older adults

TARGET POPULATION

Medically compromised, cognitively intact, older adults

INTERVENTIONS AND PRACTICES CONSIDERED

1. Risk assessment for depression
2. Evaluation of patient for cognitive impairment
    - Screening tools recommended for administration: Mini Mental State Exam (MMSE) and Short form of Geriatric Depression Scale (SGDS)
3. Monitoring of patient's mood, sleep, and appetite
4. Health screening
5. Suicide prevention

MAJOR OUTCOMES CONSIDERED

- Quality of life
- Length of hospitalization
- Use of health care services
- Mortality (i.e., suicide rates)
- Treatment compliance
- Functional status
- Caregiver burden
- Depression level
- Mood equilibrium

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The grading schema used to make recommendations in this evidence-based practice guideline is:

A. Evidence from well-designed meta-analysis
B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment)
C. Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results
D. Evidence from expert opinion or multiple case reports

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Experts in the subject of the proposed guideline are selected by the Research Translation and Dissemination Core to examine available research and write the guideline. Authors are given guidelines for performance of the systematic review of the evidence and in critiquing and weighing the strength of evidence.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline was reviewed by experts knowledgeable of research on the detection of depression in the cognitively intact older adult and development of guidelines. The reviewers suggested additional evidence for selected actions, inclusion of some additional practice recommendations, and changes in the guideline presentation to enhance its clinical utility.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (A-D) are defined at the end of the "Major Recommendations" field.

Individuals at Risk for Depression

The following characteristics increase the risk for major depression: (American Psychiatric Association [APA], 2000. Evidence Grade = B).

- A prior episode of major depression
- A family history for depressive disorders
- A personal history of prior suicide attempts
- Being female
- Recent loss of a spouse
- Medical co-morbidity (See Table 2 in the original guideline document)
- Lack of social supports
- Stressful life events, such as death of a loved one, divorce
- Current alcohol or substance abuse

Older individuals are at increased risk for depression because they frequently exhibit several of these risk factors simultaneously. In addition, caregivers of persons with dementia are extremely vulnerable to depression secondary to the burden of caregiving. Prevalence rates, ranging from 30 to 83% (Baumgarten et al., 1992; Cohen & Eisdorfer, 1988; Drinka, Smith, & Drinka, 1987; Gallagher et al., 1989; Kiecolt-Glaser et al., 1991; Schulz & Martire, 2004) are consistently reported in the literature. Elderly persons caring for their grandchildren are also at higher risk for depression (Burton, 1992; Fuller-Thomson & Minkler, 2000; Minkler et al., 1997). Major depression is one of the most prevalent conditions occurring concurrently with post-traumatic stress disorder (PTSD) (O'Donnell, Creamer, & Pattison, 2004) and increases the risk for suicidal behavior (Oquendo et al., 2005).

Assessment Criteria

Any individual over age 60, who is identified as at risk according to the factors listed earlier (e.g., caregiver, socially isolated, bereaved, physically ill), should be evaluated for depression (APA, 2000. Evidence Grade = B).

In practice, detection of depression in the older adult is a complex process and there are many factors which may interfere with detection. According to Rouchell and colleagues (Rouchell, Pounds, & Tierney, 2002), reasons for the under-diagnosis and under-treatment of depression in medically ill patients include the following:

- Emphasis on somatic rather than cognitive and mood complaints
- Reluctance to stigmatize patient with psychiatric diagnosis
- Mild or nonspecific symptoms of depression
- Fear of antidepressant side effects
- Mistaken notion that reactive depressions are not pathological (e.g., "She should be depressed; she has cancer.")
- Time limitations in primary care
- Inadequate training in psychiatry among primary care providers

Attitudes are difficult to change and time limitations will continue to be a limiting factor so detection methods must be quick. Training and education of health care staff can improve detection rates and health care outcomes.

Detection of depression is further hampered by the way depressive symptoms are manifested in the elderly. Whereas sad mood is a prominent feature of depression in younger persons, it isn't always a symptom in older adults (Kane, Ouslander, & Abrass, 2004). In contrast to younger persons, presentation of depression in older adults may be characterized by the following:

- Complaints of somatic (physical) symptoms, rather than psychological symptoms
- Denial of feeling sad
- Apathy and withdrawal are common.
- Feelings of guilt are less common.
- Feelings of loss of self-esteem are prominent.
- Inability to concentrate, impairment of memory, and other cognitive function is common.

Description of Practice

The following assessment is a simple, but effective practice that can be widely used to screen for the presence of clinically significant depressive symptoms. This is a screening process, not a diagnostic process. Positive screens should be followed with a diagnostic evaluation by a physician or nurse practitioner.

1. Assess for cognitive impairment using the Mini Mental State Exam (MMSE) (See Appendix A-1 in the original guideline document). If the patient scores 23 or above (normal cognitive function), administer the Short form of the Geriatric Depression Scale (SGDS) (See Appendix A-2 in the original guideline document).

   If the patient scores below 23 on the MMSE, establish whether this is an acute change in mental status (see Research Translation and Dissemination Core [RTDC] guideline for "Acute Confusion/Delirium" by Rapp, 1998) or typical mental status for this individual (Folstein, Folstein, & McHugh, 1975. Evidence Grade = B). (For non-acute and/or progressive mental status changes and associated agitated behaviors please refer to the RTDC guideline "Non-pharmacologic Management of Agitated Behaviors in Persons with Alzheimer Disease and Other Dementing Conditions" by McGonigal-Kenny & Schutte [2004]). The Cornell Scale for Depression in Dementia (Alexopoulos, Abrams, & Young, 1988) and the Apparent Emotions Rating scale (Ryden et al., 1998) are available to assess depression among cognitively impaired older adults.

2. The suggested cutoff score for SGDS is 6 (Eisdorfer, Rovner, & Whitehouse, 2001; Sheikh & Yesavage, 1986; Evidence Grade = B), therefore, if the patient scores 6 or greater on the SGDS, notify the primary health care provider (i.e., physician and/or geriatric/psychiatric mental health nurse practitioner) of the patient's increased risk for major depression and the need for further evaluation, treatment, and referral.
3. If the patient scores below 6 on the SGDS, monitor the patient's mood (document decreased speech, irritability, or tearfulness), sleep, (document for difficulty falling asleep, frequent awakenings, and early morning awakening), and appetite (document poor appetite, weight loss, poor wound healing). If symptoms continue, repeat the MMSE and SGDS every week or more frequently if necessary. Patients who score below 6 (subsyndromal) depression are at high risk for developing major depression. If early treatment is not elected, these patients should be followed closely for the development of major depression (Williams et al., 1995). Their discharge plan should include recommendations for monitoring depression levels in the community or other health care settings.

Nursing Interventions

The Nursing Interventions Classification (NIC) is a comprehensive, standardized classification of interventions that nurses perform. The Classification includes the interventions that nurses do on behalf of patients, both independent and collaborative interventions, both direct and indirect care. An intervention is any treatment, based upon clinical judgment and knowledge, that a nurse performs to enhance patient/client outcomes. NIC can be used in all settings (from acute care intensive care units, to home care, to hospice, to primary care)

and all specialties (from critical care to ambulatory care and long term care) (Dochterman & Bulecheck, 2004).

Please refer to the original guideline document for the Nursing Interventions Classification.

Priority Interventions

These are the obvious interventions associated with the guideline. They were selected because they provide a good match with the focus of the guideline.

Health Screening -- Detecting health risks or problems by means of history, examination, and other procedures

Suicide Prevention -- Reducing risk of self-inflicted harm with intent to end life

Definitions:

Evidence Grading

A. Evidence from well-designed meta-analysis
B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment)
C. Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results
D. Evidence from expert opinion or multiple case reports

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved ability to identify vulnerable older adults
- Improved quality of life

- Decreased length of hospitalization
- Decreased inappropriate and costly use of health care services
- Increased adherence with treatment regimens
- Enhanced functional status of patient

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This evidence-based practice protocol is a general guideline. Patient care continues to require individualization based on patient needs and requests.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The "Evaluation of Process and Outcomes" section and the appendices of the original document contain a complete description of implementation strategies.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Resources
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (revised 2005 May)

GUIDELINE DEVELOPER(S)

University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core - Academic Institution

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GUIDELINE COMMITTEE

University of Iowa Gerontological Nursing Interventions Research Center Research Development and Dissemination Core

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available from the University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core, 4118 Westlawn, Iowa City, IA 52242. For more information, please see the University of Iowa Gerontological Nursing Interventions Research Center Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The original guideline document and its appendices include a number of implementation tools, including screening tools, outcome and process indicators, staff competency material, and other forms.

PATIENT RESOURCES

Not stated

NGC STATUS

This summary was completed by ECRI on March 1, 1999. The information was verified by the guideline developer on May 5, 1999. This NGC summary was updated by ECRI on November 14, 2005. The updated information was verified by the guideline developer on November 21, 2005.

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