# Navigating Depression:

## A roadmap for health professionals and patients

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# DHS guidelines (Victoria)

- Depression identified as one of the nine risk areas for functional decline in older persons in policy “Improving Care for Older Person”
- Functional decline defined as a reduced ability to perform tasks of everyday living due to a decrement in physical and/or cognitive functioning
- Minimising Functional Decline guidelines on depression include:
    - Depression under-recognised in elderly pop.
    - Recommend screening for depression
    - Recommend increasing health care workers knowledge and skills in recognising and managing depression

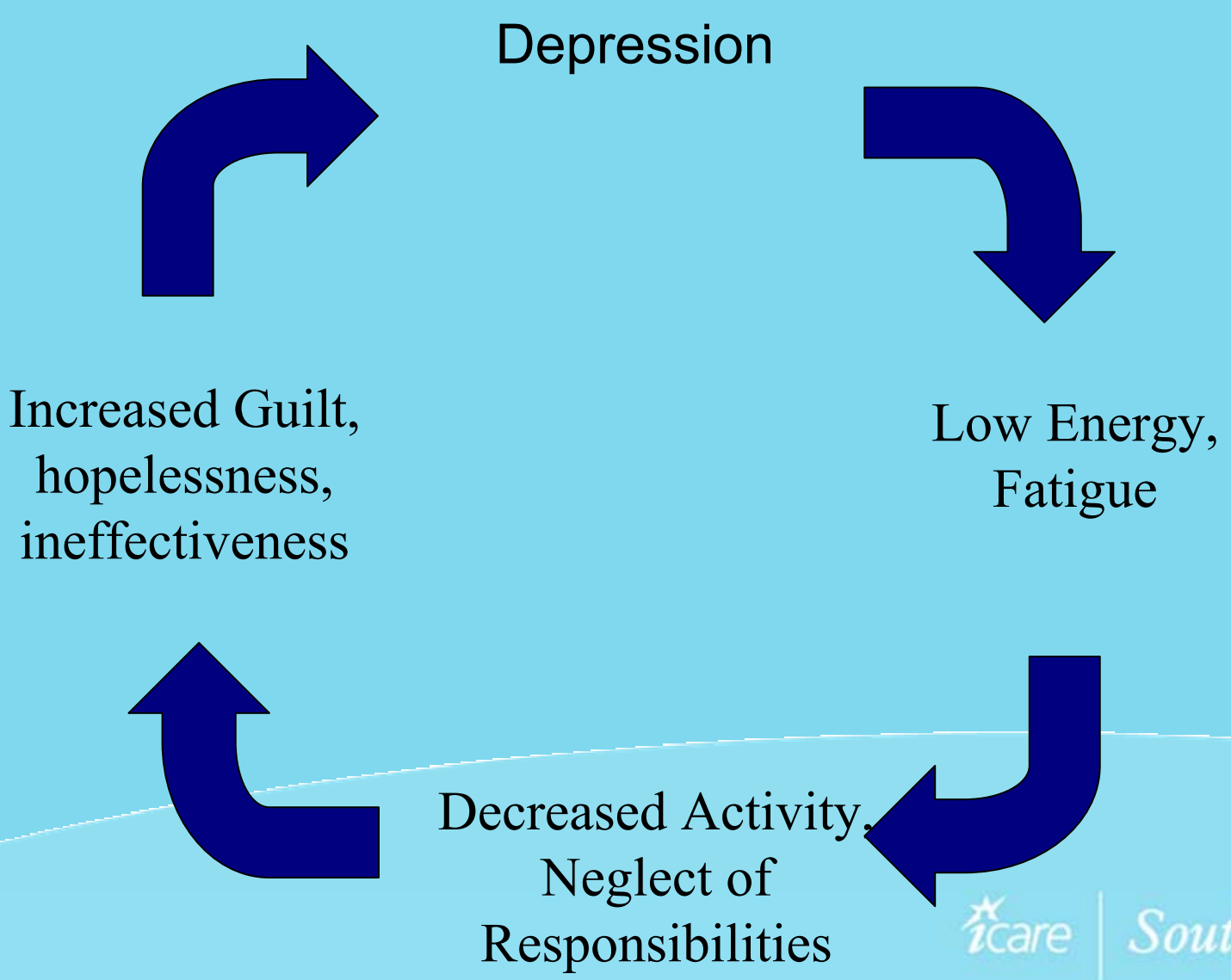
# Clinical Depression: definition

- Depression is a multifaceted syndrome, comprising a constellation of affective, cognitive, somatic and physiological symptoms in varying degrees from mild to severe.
- Different level of severity requires a different approach to treatment.
- It is **not** general sadness, or bereavement, which is better categorised as adjustment (e.g. tears ≠ depression).
- Key features that distinguish sadness from depression (e.g. Hopelessness, guilt, worthlessness, disturbed sleep and diet, withdrawal from life).

# Geriatric Depression: How is it different?

- Older people commonly deny being depressed, and tend to focus on physical and somatic complaints
- Presence of co-morbidities, acute and chronic illness, can tend to mask depressive symptoms
- Behaviour is not recognised as necessarily depressive eg: being irritable, demanding, difficult or over-quiet, withdrawn and unwilling to talk
- Emotional states can be highly variable in this population due to varied physical condition and negative life events.
- Literature suggest rates of depression up to 50% in hospitalised or residential settings for the elderly.

# The Vicious Cycle of Depression

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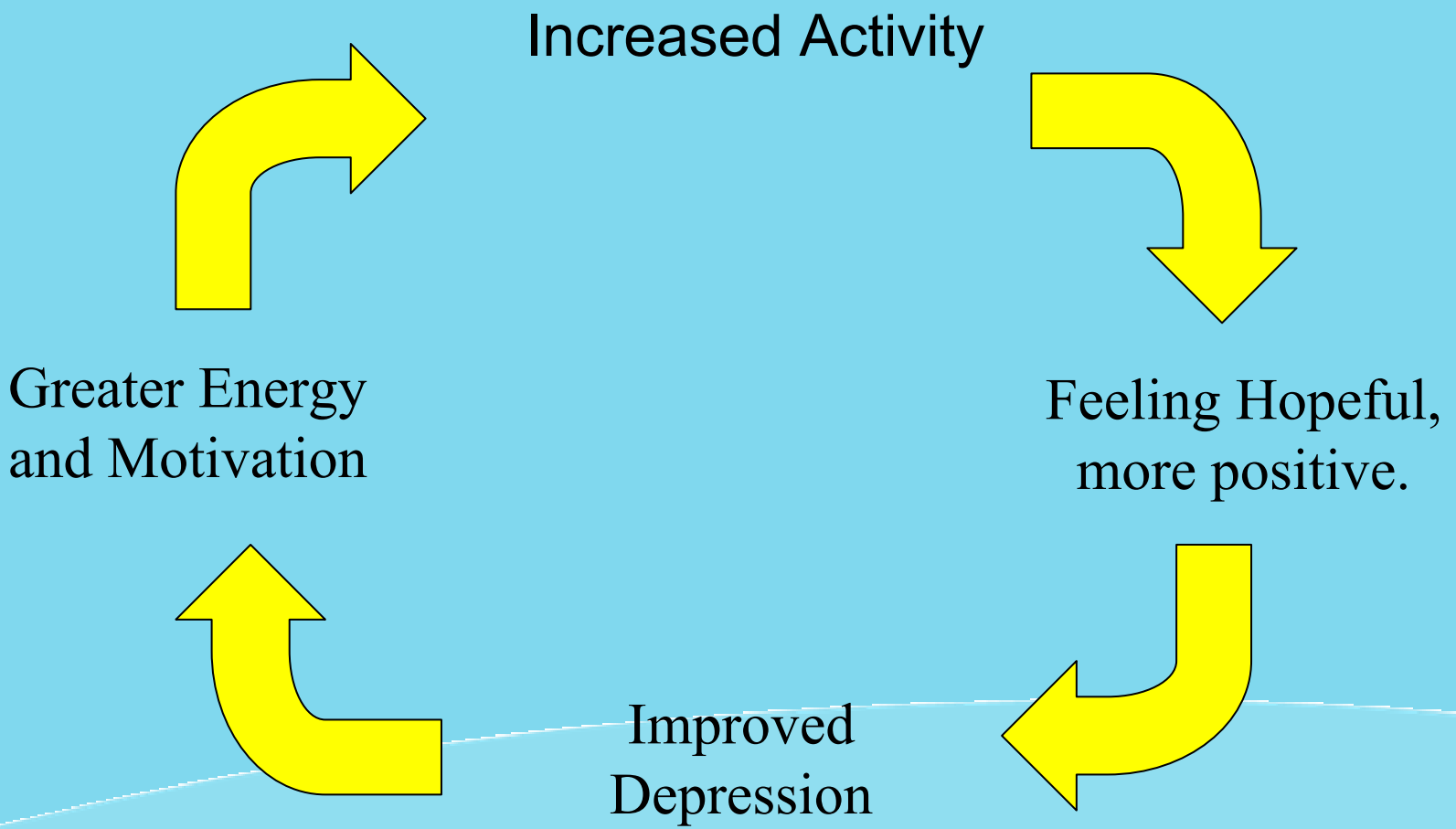
# Reversing This Cycle



# Clinical project for depression

- Phase 1: screening and staff education
  (Aug – Dec 2005)
- Phase 2: treatment and management
  (May 2006 – July 2007)

# Phase 1: Design

- Clinical protocol established on 3 aged rehab and GEM wards at Kingston Centre
- All admitted patients screened for depression, subsequent to cognition screen by medical staff.
- Those reaching criterion referred to clinical psychology for treatment planning and intervention
- Staff education sessions provided by clinical psychologist

# Phase 1: screening

- 236 patients admitted to 3 aged care/GEM wards at Kingston Centre in Sept-Nov 2005. Of those, 137 screened for cognition (MMSE) and depression (GDS-Geriatric Depression Scale).
- The prevalence rate of depression was 33%. This was consistent across the three wards.
- Depression was at significantly higher levels than 2004 psychology referral rates suggested.
- More in-patients with depression referred to psychology in 3 months of project than ever before.

# Rates of Depression by Diagnosis

| | Total | Depressed | Non Depressed | Prevalence of Depression |
|---|---|---|---|---|
| Other Fractures | 26 | 11 | 15 | 42% |
| Parkinson's Disease | 13 | 5 | 8 | 38% |
| Fractured Hip | 25 | 8 | 17 | 32% |
| Other Medical | 44 | 13 | 31 | 29% |
| Stroke | 14 | 4 | 10 | 28.5% |
| Post Surgery | 9 | 2 | 7 | 22% |
| Recurrent Falls | 8 | 1 | 7 | 12.5% |

# Phase 1: Staff Education

| | PRE Low | *POST Low* | PRE Satis | *POST Satis* | PRE High | *POST High* | PRE Very High | *POST Very High* |
|---|---|---|---|---|---|---|---|---|
| Q1. Level of confidence in dealing with depression | 24% | ***8%*** | 62% | *60%* | 11% | ***24%*** | 3% | *8%* |
| Q2. Level of comfort in dealing with depression | 21% | ***4%*** | 65% | *72%* | 7% | ***16%*** | 7% | *8%* |
| Q3. Level of organisational support when dealing with depression | 43% | ***20%*** | 54% | *40%* | 3% | ***40%*** | Nil | *Nil* |
| Q4. Level of job satisfaction when dealing with depression | 17% | ***4%*** | 73% | *68%* | 10% | ***20%*** | Nil | *Nil* |
| Q5. To what level has this information seminar increased your awareness of depressive symptoms? | N/A | Nil | N/A | **36%** | N/A | **48%** | N/A | 8% |
| Q6. To what level has this education session provided you with extra skills in managing depressive symptoms in our patients? | N/A | 4% | N/A | **44%** | N/A | **48%** | N/A | 4% |

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# Phase 2 Design

- Treatment and prevention approach
- As with Phase 1, screening was entry point into study
- For those depressed, individual psychological treatment provided by clinical psychologists
- In parallel, activity program was run for all patients on the wards.  Although patients with depression were not excluded, the aim was to enhance mood from a preventative focus.

# Afternoon Activity/Treatment Program

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **WEEK 1** | Mind/Body Balance (Ψ) | Reminiscence | Newspaper Group | Wellbeing (Ψ) | Games | Movie Session | Movie Session |
| | | "Up & Go" | Walking Group | | Coffee Group | | |
| | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **WEEK 2** | Coffee Group | Bingo | Newspaper Group | Behavioural Activation (Ψ) | Walking Group | Movie Session | Movie Session |
| | | | "Up & Go" | | | | |

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# Phase 2: results

- 26 patients were recruited to the study over 6 months from 2 sub-acute rehabilitation wards. This low number reflected poor completion rate of admission screening.  (Based on phase 1, it was anticipated that a minimum of 50 patients would be recruited ).
- Of the total 26 patients enrolled in the study, 21 gained a diagnosis of a Major Depressive Episode, whilst five were diagnosed with a Minor Depressive Illness.
- Length of stay ranged from 21 to 92 days.

# Phase 2 key results

- For the 14 patients who were screened on admission and discharge, there was a statistically significant improvement in their mood ($t=3.673$, $p<.01$).
- There was a significant improvement in admission and discharge Barthel ($N=24$) scores ($t=-3.175$, $p<.01$)
- An observation of parallel improvement in functional ability and mood.

# Types of Depression by Diagnosis

| Admission Diagnosis | Total Number | Minor Depression | Major Depression | % of depressed group |
|---|---|---|---|---|
| Parkinson's Disease | 10 | 3 | 7 | 38.5% |
| Fracture | 10 | 1 | 9 | 38.5% |
| COAD | 1 | 1 | | 4% |
| Cancer | 2 | | 2 | 7% |
| Stroke | 1 | | 1 | 4% |
| Shingles | 1 | | 1 | 4% |
| Multiple Myeloma | 1 | | 1 | 4% |
| TOTAL | 26 | 5 | 21 | 100% |

# Activity program patient evaluation

| | Very Low | Low | Satis | High | Very high |
|---|---|---|---|---|---|
| How comfortable did you feel coming along and participating? | | | 38.5% | 46.2% | 15.4% |
| How much did you enjoy the group ? | | | 28.8% | 44.2% | 26.9% |
| How satisfying was the activity? | | | 46.2% | 32.7% | 21.2% |
| How would you rate your level of confidence with the activity ? | | 7.7% | 34.6% | 36.5% | 15.4% |
| How well equipped do you think the hospital is regarding activity options? | 1.9% | 3.8% | 36.5% | 28.8% | 17.3% |

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# Discussion points

- Crucial to ensure patients are identified as depressed on admission
- Mood can be treated effectively during a sub-acute in-patient admission
- Treatment by interdisciplinary team ideal for targeting multiple avenues for improvement in mood (i.e. medication; psychotherapy; rehab program)
- If engaged in rehab program, functional status more likely to improve, and mood
- Increased profile, which increased staff awareness of clinical psychologist's role and of depression
- More women than men, who attended the activity program, filled in evaluation forms. Language was a barrier to participating in the activity groups.

# Recommendations

- Clinical psychologist required to provide individual treatment for depression
- Dedicated 5 day a week clinical psychologist to oversee admission screening and treatment process
- Structure and regular ward based activity effective for prevention and treatment. Consider gender and cultural differences.
- Institute individual patient timetables to increase self-determination and independence (i.e. client-centred approach).
- Annual staff education program as quality requirement
- Sustainability of any new clinical initiative, particularly in the psychosocial domain, requires high level organisational support and ongoing systems of accountability

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