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Evidence-Based Guideline Detection of Depression in Older Adults with Dementia

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INTRODUCTION

Depression and dementia are the two most frequent psychiatric syndromes in the older adult population. Depression in older adults with and without dementia often goes unrecognized and untreated (Charney et al., 2003; Kales, Chen, Blow, Welsh, Mellow, 2005). Estimates of the prevalence of depression in older adults with dementia vary widely (Alexopoulos, Abrams, 1991; Wragg, Jeste, 1989), which is attributed to differences in sampling, diagnostic criteria used to identify depression, and the way it is assessed (Alexopoulos, Abrams, 1991; McCabe et al., 2006). Depression in older adults is not simply due to aging; medical conditions increase the likelihood of depression (Alexopoulos, 2000).

Despite expert recommendations (Alexopoulos et al., 2001) and increased availability of a range of depression treatment options (e.g., medication, psychotherapy, combination therapy, and ECT), depression remains a significant public health problem for older adults (Surgeon General Healthy People 2010). Detection is the first essential step to improving depression care for patients with dementia.

Major depression is a syndrome characterized by a number of signs and symptoms. According to the DSM-IV TR (American Psychiatric Association, 2000), at least five symptoms must be present for a diagnosis of major depression to be made (see Definitions of Key terms). In a study conducted in a nursing home, 25% of residents screened positive for major depression (Gruber-Baldini et al., 2005). This is close to the prevalence rate of major depression reported for persons with Alzheimer's disease (Alexopoulos, Abrams, 1991 [15%–20%]; Lyketsos et al., 1997 [22%]; Wragg, Jeste, 1989 [10%–20%]). In recognition that many demented patients

experience clinically significant depression that may not meet full criteria for major depression, Olin et al. (2002b) have proposed new provisional diagnostic criteria for depression of Alzheimer disease. Diagnostic criteria include fewer symptoms of depression (three symptoms versus five symptoms required for major depression). In addition, symptoms need to be present for a shorter period of time due to the fluctuating nature of depression in persons with dementia (Abrams, Alexopoulos, 1994; Jost, Grossberg, 1996). However, research studies are still needed to validate these new depression criteria (Charney et al., 2003).

Depression screening in persons with dementia is hindered at times by the patient's inability to self-report symptoms and tendency to underestimate degree of depression, and discrepant caregiver reports (Teri, Wagner, 1991). The assessment of depression in dementia is complicated by the considerable overlap in its clinical presentation with that of dementia.

PURPOSE

The purpose of this evidence-based guideline is to improve detection of depression in older adults with dementia. This guideline may be used by physicians, advanced practice nurses, registered nurses, licensed practical nurses, and social workers across a variety of settings including inpatient and outpatient, long-term care, assisted living, and home care.

INDIVIDUALS/PATIENTS AT RISK FOR DEPRESSION

The following characteristics increase the risk of major depression (APA, 2000).

- A prior episode of major depression
- Severe psychosocial events (stressors), such as death of a loved one, marital separation, divorce
- Chronic general medical conditions
- Substance dependence issues
- A family history of depressive disorders
- Being female
- Loss of independent functioning (Rovner, Ganguli, 1998)
- Acutely disabling conditions (e.g., stroke, MI) (Alexopoulos et al., 1997; Lesprance, Frasure-Smith, Talajic, 1996)
- Physical disability (Bruce, Seeman, Merrill, Blazer, 1994)

ASSESSMENT CRITERIA

Any individual over age 60 should be screened for depression periodically. The AGS recommends depression screening two to four weeks after admission to a nursing home and then repeated screening at least every six months after admission. In all nursing homes, residents should be screened at least every six months (AGS & AAGP, 2003; Snowden et al., 2003).

DESCRIPTION OF THE PRACTICE

The following assessment is a three-step procedure that can be used across health care settings to screen for the presence of depressive symptoms. This is a screening guideline, not a diagnostic process. Positive screens should be followed with a diagnostic evaluation by a skilled health care provider.

Implementation of the evidence-based guideline requires administration of the Mini-Mental State Exam (MMSE) (Folstein, Folstein, McHugh, 1975), and either the Geriatric Depression Scale Short Form (SGDS) (Sheik, Yesavage, 1986) or the Cornell Scale for Depression in Dementia (CSDD) (Alexopoulos, Abrams, Young, Shamoian, 1988) depending on level of cognitive functioning. The Mini-Mental State Exam is a widely used cognitive functioning assessment that screens for dementia. Its short, ten-minute administration allows the administrator to quickly screen for cognitive deficits.

The Geriatric Depression Scale (GDS) is a depression screening tool that takes about five minutes to administer and has been validated for community-dwelling, hospitalized, and institutionalized older adults (Koenig, Meador, Cohen, Blazer, 1988; Leshner, Berryhill, 1994; Sheik, Yesavage, 1986). The Cornell Scale for Depression in Dementia is a depression severity tool that can also be utilized for screening. The tool has been validated to rate depressive symptomatology over the entire range of cognitive impairment (Alexopoulos et al., 1988).

In order to implement this guideline, we first suggest that a series of five patients be assessed by the user with the supervision of a mental health expert (Cohen, Hyland, Kimhy, 2003; Schnelle, Wood, Schnelle, Simmons, 2001; Teresi, Abrams, Holmes, Ramirez, Eimicke, 2001).

Step 1: MMSE (Mini Mental State Exam; Folstein et al., 1975): Assess for cognitive impairment using the Mini-Mental State Exam (MMSE)

If the patient scores 24 or above, you may need to refer to the RTDC guideline *Detection of Depression in the Cognitively Intact Older Adult* (Piven, 2005).

If the patient scores below 24 on the MMSE, establish whether this reflects an acute change in mental status or rather the patient's baseline cognitive function or expected progressive mental status changes associated with Alzheimer's disease and other forms of dementia. An acute change in cognition requires immediate medical attention.

If score reflects baseline cognitive function or expected progressive mental status changes, continue with Step 2.

Step 2: Depression Screen

Depression screening can be conducted at various periods during a standard assessment. Particularly good opportunities present themselves after assessment of functional status, the experience of pain, or use of coping strategies.

If the patient scores 15 to 23 on the MMSE, administer the Short Form of the Geriatric Depression Scale (SGDS) (McCabe et al., 2006; Leshner, Berryhill, 1994; Sheik, Yesavage, 1986).

If the patient scores below 15 on the MMSE, administer the Cornell Scale for Depression in Dementia (CSDD) (Alexopoulos et al., 1988).

Because many patients with dementia may be unable to reliably report emotional symptoms, the CSDD derives information from interviews with both the patient and an informant. This approach is consistent with the DSM-IV TR (APA, 2000) where all sources of information are used as necessary to make a clinical judgment. Research has confirmed the value of informant reports of symptoms of depression when assessing older adult patients (McAvay, Bruce, Raue, Brown, 2004). The informant should be a close family member or other individual who knows and has frequent contact with the patient (e.g., nurse, social worker, home health aide) (Alexopoulos, 2002).

Step 3: Referral Referral of positive screens

For SGDS scores of 6 or greater, notify primary health care provider of immediate need for further evaluation, treatment, or referral for clinically significant depression (i.e., probable or definite major depression).

For CSDD scores of 11 or greater, notify primary health care provider of immediate need for further evaluation, treatment, or referral for clinically significant depression (i.e., probable or definite major depression).

Procedure for negative screens

For SGDS scores below 6, reassess individual in one month if clinically indicated. If not, perform screening process in six months.

For CSDD scores below 11, reassess individual in one month if clinically indicated. If not, perform screening process in six months.

Outcome Indicators

Outcome indicators are those expected to change or improve from consistent use of the guideline. The major outcome indicators that should be monitored over time are:

Increasing percentage of patients receiving a mental health referral for depression (Callahan et al., 2006).

Increasing recognition of depression symptoms in patients with dementia (Cohen et al., 2003).

Improved detection, treatment, and course of depression in normal practice (Eisses et al., 2005)

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FIGURE 1.
ALGORITHM FOR DETECTION OF DEPRESSION IN OLDER ADULTS WITH
DEMENTIA POPULATION

TABLE 1

DEFINITION OF KEY TERMS

ALZHEIMER'S DISEASE – A cortical degenerative disease. Essential features include: memory impairment, impairment in at least one other cognitive domain (e.g., language and visual-spatial skills), and significant disturbance in work or social functioning resulting from cognitive deficits (Small, 2000).

ANHEDONIA – A pervasive loss of interest or ability to experience pleasure in normally enjoyable activities.

ANTIDEPRESSANT MEDICATION – A class of medication that is used to treat depression by restoring the balance of neurotransmitters in the brain.

APATHY – A loss of motivation manifesting itself in behaviors such as diminished initiation, poor persistence, lowered interest, indifference, low social engagement, blunted emotional response, and lack of insight (Landes, Sperry, Strauss, Geldmacher, 2001).

DEMENTIA – Multiple cognitive deficits that include impairment in memory and at least one other cognitive disturbance (i.e., aphasia, agnosia, or a disturbance in executive functioning) whose severity impairs social or occupational functioning. The course is characterized by gradual onset and continuing cognitive decline. (APA, 2000).

DEPRESSED MOOD – A pervasive feeling of sadness.

DIMINISHED INTEREST IN ACTIVITIES – See Anhedonia.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2000: Fourth Edition, Text Revision) – A manual of diagnostic criteria that is commonly used by mental health professionals to assign specific psychiatric diagnoses; it is also integrated into the ICD-10.

MDD (Major Depressive Disorder) – According to DSM-IV, MDD is a clinical syndrome that includes five (or more) of the following symptoms that have been present during the same two week period and represent a change from previous functioning (APA, 2000); *at least one* of the symptoms must be DEPRESSED MOOD *or* ANHEDONIA *and*

Significant weight loss or gain (e.g., a change of more than 5% of body weight in a month or decrease or increase in appetite nearly every day)

Insomnia or hypersomnia nearly every day

Psychomotor agitation or retardation nearly every day

Fatigue or loss of energy nearly every day

Feelings of worthlessness or excessive or inappropriate guilt nearly every day

Diminished ability to think or concentrate or indecisiveness, nearly every day

Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide

PSYCHOTHERAPY – A psychological method of treating mental or emotional disorders based on the patient therapist relationship.

PSYCHOTROPIC MEDICATIONS – Pharmacological agents used to treat psychiatric disorders.

SOCIAL ISOLATION – Withdrawal from social contacts and customary activities (Olin, Katz, Meyers, Schneider, Lebowitz, 2002a).

STIGMA – A mark of disgrace; a stain or reproach, as on one's reputation.