Depression is a serious and widespread condition in aging services settings, affecting as many as one of three seniors. This disorder is often undiagnosed or under-treated across the spectrum of care, which may result in prolonged recovery time from illness, exacerbated drug side effects, worsening cognitive impairment and even suicide attempts. To improve clinical outcomes and limit related financial losses, organizations should implement a comprehensive depression management program that focuses on enhancing residents’ and clients’ quality of life, promptly recognizing depressive symptoms, and providing multifaceted and individualized treatment.

This edition of CareFully Speaking® is intended to help aging services providers establish and maintain a thorough, well-coordinated system for the prevention, screening and management of depressive disorders. The self-assessment tool on page 5 can aid organizations seeking to evaluate their existing policies and procedures or develop a new depression management program.

INITIAL STRATEGIES

Successful depression management begins with a concerted effort by leadership to foster awareness of the problem among staff, residents and family members, and to institute appropriate preventive, diagnostic and treatment protocols. The following preparatory strategies can help create a strong foundation for a depression management program:

Appoint an interdisciplinary mental health assessment team. Composition varies, but such teams typically include a physician, nurse, certified nurse assistant, pharmacist, social worker and Minimum Data Set (MDS) coordinator. Members have primary responsibility for diagnosing and managing depressive disorders, coordinating referrals and measuring compliance with quality care indicators.

Adopt and implement evidence-based practice guidelines. A number of organizations – including the Agency for Healthcare Research and Quality, the American Medical Directors Association and the American Psychiatric Association – have compiled clinical

practice guidelines for managing depression. The depression management team should be assigned the tasks of selecting guidelines and translating the recommendations into organization-specific policies and procedures. (To assess and compare available guidelines, visit the National Guideline Clearinghouse at http://www.guideline.gov/ or the American Association for Geriatric Psychiatry at http://www.aagponline.org.)

Train staff to detect signs of depression. Studies show the importance of providing direct care staff with ongoing training in the detection, treatment and observation of depression.\(^2\) Classes and resources should cover a variety of topics, such as

- depression screening and assessment parameters,
  as well as guidelines for managing the condition
- documentation requirements, including target symptoms and their frequency
- environmental factors contributing to depression, such as restricted access units
- goals of treatment, including relieving symptoms and preventing regression of the resident’s/client’s mental health and overall condition

For best results, adapt depression management training sessions to the discipline – e.g., nursing, rehabilitation therapy, social work, dietary – and learning level of participants, and allow them to ask questions of a clinical expert. (The Iowa Geriatric Education Center offers a CD-based depression management training program for nurses, which includes patient simulations, video presentations and workplace exercises. It is available at http://www.healthcare.uiowa.edu/igecc-e-learning/depression-training/Default.asp.)

Broach the subject of depression early in the placement and admissions process. By scheduling discussions between depression management team members and prospective residents/clients, administrators can help disseminate vital information about mental health issues while learning about incoming residents’ needs.

Incorporate a depression screen into referral agreements with other healthcare organizations and agencies. This is another effective way to obtain information about the care requirements of residents/clients prior to admission, and to assess whether these requirements can be fully and safely satisfied by the facility.

Promote meaningful social and private experiences. Encourage residents and clients to participate in pleasurable recreational and creative activities that bolster a sense of belonging and self-esteem.

Personalize living spaces. Resident-selected decor, warm lighting and aromatherapy can create a more congenial and homelike environment, helping to reduce the feelings of stress and alienation associated with sustained depression.

SCREENING PROCEDURES
Depression is frequently mistaken for other physical or psychological ailments. To protect against allegations of missed or delayed diagnosis, screen residents and clients for depression upon admission and readmission, prior to the MDS assessment and following any change in condition. An effective screening process includes the following components, among others:

Select an effective screening tool. Depression screening instruments should be of proven scientific validity, easy to administer and document, and reliant on both questioning and direct observation. For individuals who do not have symptoms of dementia, the Geriatric Depression Scale or GDS (http://www.stanford.edu/~yesavage/GDS.html) may be most appropriate, as it relies heavily on self-reported symptoms. Residents and clients with cognitive deficits often respond well to the Cornell Scale for Depression in Dementia (http://www.michigan.gov/documents/mdch/bhs_CPG_Depression_Appendix_2_206523_7.pdf). Other tools, such as the Hamilton Rating Scale for Depression (http://healthnet.umassmed.edu/mhealth/HAMD.pdf), may be used in conjunction with visual analog scales to screen residents and clients who are unable to communicate verbally.

Check for predisposing conditions. As depression can be triggered or exacerbated by a range of factors, the screening criteria should include the following predisposing conditions or events:

- chronic illness, such as dementia, stroke, cancer, myocardial infarction, chronic obstructive pulmonary disorder or Parkinson’s disease
- functional disability due to aging, medical conditions that impair mobility or general poor health
- longstanding pain or digestive problems that do not respond well to medication

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- use of depressogenic medications, such as steroids, narcotics, sedatives, antihypertensives, beta-blockers or immunosuppressants
- chemical imbalances due to thyroid or other endocrine and metabolic disorders
- alcoholism or other substance abuse problems
- low self-sufficiency or recent decline in capabilities
- frequent isolation or lack of social support
- recent loss or major change, e.g., new residential setting, retirement, or death of spouse, friend or pet

Identify at-risk individuals and conduct further clinical assessment.

Residents or clients with any of the above risk factors should be evaluated by behavioral health professionals for the following symptoms, among others:
- significant weight loss or gain
- appetite change
- decreased interest in former pleasures
- increased irritability, anxiety or restlessness
- frequent crying
- chronic fatigue or loss of energy
- sleep disturbance
- psychomotor slowing
- diminished concentration
- feelings of guilt or worthlessness
- suicidal thoughts

Document these symptoms in terms of onset, frequency, pattern and duration, as well as their effects on mood, behavior and general functioning.

TREATMENT

With early detection and carefully calibrated intervention, depression in the elderly is often reversible. Generally, referral for psychiatric or neurological evaluation is required for severe depression, which is signaled by a GDS score of 11 or greater, or the presence of five or more depressive symptoms. Community- and institution-based services – such as psychotherapy, counseling, geropsychiatric nursing care and social work intervention – are often appropriate for less severe cases. The following treatment strategies are effective for managing all levels of depression:

- adopt a coordinated, multidisciplinary approach tailored to individual needs. Therapeutic measures to manage depression range from traditional pharmaceutical and behavioral therapy to more innovative forms of group, individual and family counseling. Case management and care/service planning are essential to coordinate the overall approach, create an ongoing clinical record and achieve the following treatment goals:
  - identify and minimize suicide risk
  - monitor nutrition, elimination, sleep patterns and comfort levels
  - enhance physical functioning and well-being
  - maximize positive social interaction
  - meet spiritual and cultural needs
  - address stigma associated with mental illness
  - ensure regular reassessment (i.e., two to four weeks following admission, after readmission and at least every six months thereafter)

- offer a variety of individual therapy and support group options. Psychosocial therapy, when offered in conjunction with other forms of care, can help accelerate recovery. Such techniques as supportive listening, reminiscence therapy, expression of feelings and adaptive coping can help residents and clients regain emotional well-being and reintegrate into community life. Some residents/clients and their families respond favorably to support groups, while others benefit more from individual or family counseling sessions. (For more information about depression recovery and a toolkit of resident/client educational materials, visit the Geriatric Mental Health Foundation at http://www.gmhfonline.org/gmhf/news/news_story.asp?id=16.)

- recognize the risks of polypharmacy. Treating residents/clients with antidepressant medications should be considered only after non-pharmacological interventions have proven ineffective, or if there is documented evidence of sustained depressive disorder. To minimize the dangers of polypharmacy, all current prescriptions and over-the-counter remedies and supplements should be reviewed periodically for their potential to interact with each other or worsen depressive symptomatology. Discontinuing certain drugs or gradually altering their dosage and/or dosing schedule may be indicated.
New antidepressants should be prescribed in low doses with an eight-to-twelve week incremental dosage adjustment window, in order to assess treatment effects. If multiple depressive symptoms are present on examination, those that cause the greatest distress should be targeted first. (For a reference guide to antidepressant medications commonly prescribed to the elderly, along with a list of drugs to avoid, see the American Geriatrics Society's Geriatrics at Your Fingertips™, which is available for purchase at https://fulfillment.frycomm.com/ags/gayf/order_form.asp.)

Implement a quality improvement process. The quality improvement program should continually measure the effect of depression management efforts on resident/client outcomes. This involves monitoring the screening, assessment and treatment phases of the program, guided by the following key questions:

- Are appropriate screening tools available for residents/clients of varying cognitive and communication abilities?
- Are signs of depression promptly assessed, addressed and conveyed to families and clinicians?
- Are treatment decisions based upon clinically accepted guidelines, and is the medical rationale thoroughly documented?
- Is medication managed carefully to prevent adverse side effects and interactions?
- Is the effectiveness of treatment carefully measured, and are different modalities compared and selected based on resident/client response?
- Are suicide risk screening tools and suicide prevention guidelines in place, and are they consistently implemented?
- Are there formal protocols for documenting worsening symptoms and notifying designated personnel of the need for re-evaluation?

While sadness may be part of life, deep and sustained depression is not a normal aspect of the aging process. By promptly recognizing and addressing symptoms, aging services organizations can help alleviate suffering on the part of residents and clients, improve their overall quality of life, and reduce both treatment costs and liability exposures.
### Depression Management Program Self-assessment Tool

The following series of questions is designed to aid organizations in evaluating the effectiveness of their existing depression management program or creating a new program.

<table>
<thead>
<tr>
<th>REQUIREMENT</th>
<th>PRESENT (YES/NO)</th>
<th>ACTION REQUIRED</th>
<th>FOLLOW-UP PLAN</th>
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<tbody>
<tr>
<td><strong>PROGRAM MISSION</strong></td>
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<td>1. Has the organization articulated its philosophy regarding the treatment of depression in a comprehensive management plan addressing these primary goals?</td>
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<td>- prompt assessment and diagnosis of the condition&lt;br&gt;- application of evidence-based clinical guidelines&lt;br&gt;- optimization of the quality of life&lt;br&gt;- reduction of suicide risk</td>
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<td>2. Does the written program include requirements for screening, assessment, reassessment and ongoing monitoring of the condition?</td>
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<td>3. Does the program support family participation in the treatment process, and are residents/clients and families apprised of treatment options?</td>
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<td>4. Is there a multidisciplinary team dedicated to the diagnosis and treatment of depression in residents/clients?</td>
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<td>5. Are both processes and outcomes monitored by the organization’s quality improvement program?</td>
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<td><strong>EDUCATION AND PREVENTION</strong></td>
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<td>1. Are staff members oriented to the basic principles of depression management at time of hiring?</td>
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<td>2. Are ongoing education and training sessions offered to staff on screening, assessment and monitoring of depressive disorders, as well as assessment of suicide risk and suicide monitoring?</td>
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<td>3. Is a designated professional available to answer staff members’ questions concerning the clinical management of depression?</td>
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<td>4. Are there community outreach activities to educate prospective residents/clients and families on depression and its management?</td>
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<td>5. Does the organization attempt to minimize depression by emphasizing individual choice and autonomy?</td>
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<td>6. Are social/recreational activities designed to be pleasurable, meaningful and creative?</td>
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<td>7. Are public and private spaces light, cheerful and inviting?</td>
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<td>REQUIREMENT</td>
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<td><strong>SCREENING</strong></td>
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<td>1. Does the referral protocol require mandatory screening of residents/clients for the presence of depressive symptoms prior to their admission?</td>
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<tr>
<td>2. Are residents/clients screened for depression using the Geriatric Depression Scale or other scientifically tested tool?</td>
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</table>
| 3. Does the screening tool address conditions that predispose the elderly to depression, including the following?  
  - chronic illness  
  - functional disability  
  - longstanding pain  
  - use of depressogenic medications  
  - chemical imbalances due to metabolic disorders  
  - alcoholism or other substance abuse problems  
  - low self-sufficiency  
  - social isolation or lack of social support  
  - recent loss or crisis  
  - recent change in residential setting |                 |                |               |
| 4. Does the written policy specify who is responsible for performing screening activities? |                 |                |               |
| 5. Are residents/clients screened at admission and readmission, upon Minimum Data Set assessment and with any change in condition? |                 |                |               |
| 6. Does the written policy require a comprehensive medical examination if the following conditions (among others) are present?  
  - weight loss or gain  
  - appetite change  
  - decreased interest in pleasures  
  - irritability or anxiety  
  - frequent crying  
  - fatigue/loss of energy  
  - sleep disturbance  
  - psychomotor slowing  
  - diminished concentration  
  - feelings of worthlessness  
  - suicidal thoughts |                 |                |               |
| **ASSESSMENT AND TREATMENT**                                               |                 |                |               |
| 1. Does written policy set forth documentation requirements for depression assessment and treatment, including the following?  
  - primary symptoms  
  - frequency of symptoms  
  - behavioral disturbances  
  - physical signs  
  - aggravating factors  
  - alleviating factors  
  - cyclical features affecting appetite, emotions and physical functioning  
  - current treatment and medications  
  - response to treatment |                 |                |               |
<p>| 2. Is there a protocol for discussing depression evaluation results with residents/clients and family members? |                 |                |               |
| 3. Does written policy stipulate when to refer residents/clients to a mental health professional? |                 |                |               |
| 4. Are direct caregivers promptly informed of the need to implement suicide prevention precautions? |                 |                |               |
| 5. Are agreements in place to facilitate transfer of residents/clients whose suicide risk cannot be safely managed? |                 |                |               |</p>
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<td><strong>CARE PLANNING</strong></td>
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<td>1. Is the depression management team responsible for communicating all assessment findings to the resident’s/client’s primary physician, as well as to other members of the treatment team?</td>
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<td>2. Are care planning goals mutually determined by the depression management team, care team, residents/clients and family members?</td>
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<td>3. Are residents/clients and family members apprised of therapy goals, medication adjustments and side effects, and the overall treatment plan?</td>
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<td>4. Do resident/client care plans include non-pharmacological approaches to depression management (i.e., psychosocial and adjunctive therapies)?</td>
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<td>5. Is there a multidisciplinary process to alleviate the dangers of polypharmacy when medication is used to treat depression?</td>
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<td>6. Are care plans updated based upon resident/client response to medications and other therapeutic interventions?</td>
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<td>7. Do care plans include an automatic date for medical reassessment?</td>
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<td>8. Is the effectiveness of pharmacological and non-pharmacological therapies regularly reassessed?</td>
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<td>9. Is suicide risk re-evaluated whenever the care plan is reviewed?</td>
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<td><strong>MONITORING</strong></td>
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<td>1. Are staff members trained to recognize both verbal and nonverbal signs of depression?</td>
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<td>2. Does written policy specify how frequently residents/clients should undergo comprehensive reassessment for depressive symptoms?</td>
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<td>3. Do all reassessments include a review of symptoms and medication effectiveness?</td>
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<td>4. Are all monitoring results documented in the resident’s/client’s healthcare record?</td>
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<td>5. Is there a protocol to expedite review of care in the event of worsening symptoms?</td>
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<td>6. Is there a procedure for measuring resident/client and family satisfaction with the depression management process?</td>
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<td>7. Are quality improvement findings documented and reported through established committees?</td>
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RESOURCES
Organizations:
- American Association for Geriatric Psychiatry (AAGP), at www.aagponline.org
- American Geriatrics Society (AGS), at www.americangeriatrics.org
- Depression and Bipolar Support Alliance (DBSA), at www.dbssalliance.org
- Geriatric Mental Health Foundation (GMHF), at www.gmhfonline.org/gmhf/
- International Foundation for Research and Education on Depression (iFred), at www.depression.org
- Mental Health America (MHA), at www.mhonline.org
- National Institute of Mental Health (NIMH), at www.nimh.nih.gov

References: