BEST PRACTICE

SPECIAL EDITION

Assessment and management of

Depression in Older Adults

bpac nz
better medicine

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PURPOSE AND INTRODUCTION

The purpose of this journal is to examine the assessment and management of depression in older adults. It is the final of three follow-up publications which supplement the Best Practice Journal, Special Edition: "Adult Depression", published in June 2009.

The "Evidence Based Practice Guideline for the Identification of Common Mental Disorders and Management of Depression in Primary Care" published in July 2008 by the New Zealand Guidelines Group, has formed the basis of this supplementary publication. It is intended as a resource for all primary care practitioners.

This publication is also a supporting information resource for the *bestpractice* Decision Support Module; "Management of Depression in Older Adults". This module is freely available to all New Zealand General Practices. Please contact *bestpractice* Decision Support for further information.

Note: The principles for the assessment and management of depression in older adults are the same as for all adults. The Best Practice Journal, Special Edition: "Adult Depression", published in June 2009, should be referred to for supplementary information and further details.

For further information and resources about the treatment of depression including the previously published Special Editions of Best Practice **Adult Depression, Depression in Young People and Depression in the Antenatal and Postnatal Periods** please visit our website:

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Key Points and recommendations

Diagnosis

- Depression in older people is often under-detected and untreated and should never be regarded as a normal consequence of ageing.
- Targeted screening for common mental disorders is indicated for older people in groups with high prevalence rates, including those:
  - In residential care
  - With a history of mental health disorder or suicide attempt
  - With multiple symptoms
  - With a recent significant life change, such as bereavement
  - With poor physical health
- An older person presenting with possible cognitive impairment should be assessed for both dementia and depression.
- Where there is a rapid change in cognitive status in an older person, medical assessment should exclude delirium.

Treatment

- Caring for the older person with depression can be a challenge due to the complexity of multiple co-morbidities. Shared decision making (with patient and carers/family) can facilitate the development of a patient specific care plan which evolves over time.
- Treat the underlying cause or problem (if present)
- Be positive, create hope and facilitate support
- Encourage lifestyle changes, exercise and social interaction
- Review current medicines use (including over-the-counter products) for the possibility that they may be causing or aggravating symptoms
- An older person with depression should be offered the same range of psychological therapies as other adults. Age should not be a barrier to specific therapies.
- Selective serotonin reuptake inhibitors (SSRIs) are generally suitable as the first line antidepressants for an older person. Consider the possibility of drug interactions in people taking other medicines.
- An older person prescribed an antidepressant should be monitored closely for adverse effects and increased risk of falls.

Causes and Diagnosis of Depression in Elderly People

Depression is common and under-recognised in older adults

Depression is common in older adults, although not as prevalent as in younger adults.[1] This may be partly due to under-recognition as the diagnosis of depression can be confounded by other disorders associated with ageing, or depression may be incorrectly accepted as a normal part of the ageing process.

It has been estimated that the 12 month prevalence of depressive disorders is approximately 2% for men and 5% for women, among adults aged over 65 years, living in the community in New Zealand.[2] Older people in residential care are at significantly higher risk of depression. One study in low-dependency care facilities in Australia reported a prevalence of depression of 18%, with only half of these residents receiving any intervention.[3]

Presentation and symptoms of depression may be different in older people

More than half of cases of depression in older people represent the first lifetime presentation. The symptoms of depression in an older adult can be subtly different to those in younger people. For example, older people are less likely to display affective symptoms, e.g. dysphoria, worthlessness and guilt, and more likely to show cognitive changes, somatic symptoms, e.g. sleep disturbance, agitation and general loss of interest.[1] These symptoms and their patterns of presentation can be attributed to other disorders and this often presents a challenge in differential diagnosis (see "Causes and risk factors").

Causes and risk factors of depression in older people

The fact that at least half of older adults who present with depression have no previous history, suggests that different pathological mechanisms may be involved compared to in those who have experienced depression earlier in life. **Late onset depression may be associated with age–related factors** such as specific co-morbid diseases, poor physical health, cognitive impairment and structural changes in the brain. Older people with depression who have experienced an episode earlier in life are more likely to have a family history of mental illness.[1]

Any **pathological differences** that exist do not have a bearing on the approach to treatment, which fundamentally follows a similar pathway as in younger adults. It is important to remember that a long life with no history of mental health disorder does not preclude or protect from the development of a first episode of depression in later life.

Psychological and social risk factors for depression in older adults are similar to those that increase vulnerability to depression in younger adults. For example, neurotic and ruminative personality traits, stressful life events, grief and loss, change in social status and reduced participation in enjoyable or physical activities may all increase the risk of depression. Bereavement over loss of a partner and reduced social/physical activities appear to be particularly strong risk factors in older people.

Co-morbidities and age related disorders increase the vulnerability to depression although it is not clear whether the pathological changes involved are actually causal for depression. The psychological or physical adjustment to a chronic illness may be a trigger for the onset of depression. Some conditions associated with depression include;

Cerebrovascular disease (e.g. stroke, vascular dementia) – depression is very common after a stroke (20–25% of patients) and all post-stroke patients should be screened for depression. Even a minor stroke or Transient Ischaemic Attack (TIA) can precipitate a severe bout of depression. A proportion of patients post stroke may develop bipolar like symptoms with elevated mood as well as depression.

Parkinson's Disease – often co-exists with depression, and depressive symptoms can sometimes be a prelude to the onset of Parkinson's disease.

Coronary Heart Disease – prevalence rates of depression in people with heart disease have been estimated at approximately 20–25%.[4]

Endocrine disorders (including diabetes, thyroid disease and adrenal insufficiency) – the prevalence of depressive symptoms in people with Type II diabetes has been reported at approximately 20%.[5]

Sleep disturbance – insomnia and sleep disturbance are recognised symptoms of depression, but among older adults insomnia also appears to be a risk factor for both the onset and persistence of depressive symptoms.[1] This association is an important consideration as the prevalence of insomnia increases with age, and also stresses the importance of managing insomnia when associated with depression.

Medicines can cause or aggravate depression

A number of medicines, which tend to be prescribed more in older adults, can cause or aggravate depressive symptoms.

These medicines include:

- Benzodiazepines, zopiclone and other central nervous system depressants
- Opioids prescribed for chronic pain syndromes
- Antipsychotics prescribed for agitation
- Beta-blockers, especially lipid soluble agents such as propranolol
- Corticosteroids (can cause a range of psychiatric reactions from psychosis to depression)
- Anticonvulsants, including gabapentin and carbamazepine, when used to treat pain syndromes
- NSAIDs – perhaps under-recognised, but most NSAIDs have been associated with depressive symptoms
- Antiparkinson agents, especially levodopa
- Histamine-2 receptor antagonists, such as ranitidine

Diagnosis can be challenging

The diagnosis of depression in older people is often overlooked as symptoms can be mistakenly attributed to normal "old age" or co-morbid conditions such as dementia

or delirium. When diagnosing and assessing depression in older adults, it is important to consider variations in the typical presentation and also the possibility of confounding co-morbidities.

Depression can present with similar symptoms to delirium and dementia. A schema of differential features is presented in Table 1.

Assessment of cognitive impairment is important

Memory impairment is common in elderly people and this may be due to normal age related forgetfulness, mild cognitive impairment or dementia

See “Having a senior moment?”, BPJ 23, Sep, 2009.

Depression is also a common cause of memory impairment but it is important to differentiate this from the early stages of dementia. Late onset depression is thought to be a risk factor for the development of dementia and the two conditions frequently co-exist.

An older adult presenting with possible cognitive impairment should be assessed for both depression and dementia using tools such as the GPCOG and the GDS, PHQ-9 or Kessler-10 (see “Screening and assessment tools”, Page 6). It may be difficult to use depression assessment tools in people with marked cognitive impairment.[7] If significant depressive symptoms are present in a person with cognitive impairment, a trial of antidepressant treatment should be considered. This could result in an improvement of cognitive function.

Table 1: Some differential features of the 3Ds; Delirium; Depression and Dementia (adapted from CCMSH, 2006).[6]

Feature	Delirium	Dementia	Depression
Onset	Usually sudden, often at twilight	Chronic and generally insidious	Often abrupt and coinciding with life changes
Duration	Hours to less than one month, rarely longer	Months to years	Months to years
Progression	Abrupt, fluctuating	Slow but even	Variable and uneven
Thinking	Disorganised, slow, incoherent	Scarcity of thought, poor judgment; words hard to find	Intact with themes of helplessness, generally negative
Memory	Impaired, sudden (immediate memory loss may be noticeable)*	Impaired	Selective or patchy
Sleep	Nocturnal confusion	Often disturbed; nocturnal wandering	Early morning wakening
Awareness	Reduced	Clear	Clear
Alertness	Fluctuates; lethargic or hypervigilant	Generally normal	Normal
Attention	Impaired, fluctuates	Generally normal	Minimal impairment but easily distracted

* Immediate memory – The ability to recall numbers, pictures or words immediately following presentation. People with immediate memory problems have difficulty learning new tasks because they cannot remember instructions. It relies on concentration and attention.

Where there is a rapid change in cognitive status in an older person, delirium should be excluded by clinical examination. Delirium is characterised by a sudden and fluctuating onset of confusion, change in cognition over a short period, disturbances in attention, disorganised thinking and a decline in level of consciousness.

Best Practice Tip:

In an older person with depressive symptoms consider:

- The 3Ds – delirium, depression and dementia
- A complete physical examination
- Adverse effects of medicines
- CBC and thyroid function tests
- Sodium, Creatinine, B12 and folate levels

Screening and assessment Tools for older people with depression

As with younger adults, psychosocial assessment tools can be used as an adjunct to clinical assessment. Targeted screening is particularly indicated for older adults in groups with high prevalence rates of mental disorders, such as those:[7]

- In residential care
- With multiple symptoms
- With a history of mental disorder or suicide attempt
- Who have experienced a recent significant loss
- With poor physical health

Where there is clinical concern, routine psychosocial assessment should also include questions that screen for anxiety disorders and substance abuse, particularly alcohol.[7] A low threshold for intervention is required where there is evidence of suicidal ideation in older people, as there is a high rate of completed suicide in this group, particularly in men aged 75 years and older.[7]

The same short, verbal screening questions used in younger adults can be used in older adults to identify concern and the need for further assessment (see opposite).

Further Assessment

The Geriatric Depression Scale was developed as a screening and assessment tool for depression in older adults. The original scale consisted of 30 questions but was considered too time consuming by some patients and staff to use in everyday practice. A shorter version (GDS-15 – Appendix 1) keeps the most discriminating questions and the validity is similar to the original form. The GDS-15 is a useful adjunct to diagnosis for depressive illness but does not take the place of a full clinical assessment.

The Patient Health Questionnaire for Depression (PHQ-9 - Appendix 2) is used extensively in younger adults and has also been validated in older people.

Both the GDS-15 and PHQ-9 give rating scores that can be used to assess the severity of depression and monitor the effects of treatment.

Other assessment tools include; Kessler-10 Psychological Distress Scale, GAD-7 for anxiety and AUDIT for alcohol misuse.

GPCOG - Assessment of Cognition

It is important to assess older people with any cognitive impairment, for the possibility of early dementia. The General Practitioner Assessment of Cognition (GPCOG) Test (Appendix 3) is a reliable, valid and efficient instrument to screen for dementia specifically in a primary care setting.[8] There are two components to GPCOG: a cognitive assessment conducted with the patient and an informant questionnaire (only considered necessary if the results of the cognitive section are equivocal, i.e. score 5–8 inclusive). It takes less than four minutes to administer the patient assessment and two minutes to interview the caregiver. The GPCOG performs at least as well as the standard screening tool, the Mini-Mental State Examination (MMSE), and unlike MMSE, GPCOG is not subject to copyright restrictions. Recent reviews of dementia screening tools for the primary care setting recommend the use of the GPCOG. Another study indicated that the GPCOG score is not influenced by the cultural and linguistic background of

a person making it an invaluable screening tool, especially in multicultural patient settings.[9]

All of these assessment tools are available in the *bestpractice* Decision Support depression module

Verbal screening tools

Verbal two to three question screening tools for common mental disorders.[7]

Questions for depression

- During the past month, have you been bothered by feeling down, depressed or hopeless?
- During the past month, have you been bothered by little interest or pleasure in doing things?

If **yes** to either question, ask Help question below

Question for anxiety

- During the past month have you been worrying a lot about everyday problems?

If **yes**, ask Help question below

Questions for alcohol and drug problems*

- Have you used drugs or drunk more than you meant to in the last year?
- Have you felt that you wanted to cut down on your drinking or drug use in the past year?

* These two questions have been shown to pick up about 80% of current drug and alcohol problems

Note: As the population ages, patients with a history of long-term cannabis use may present with dysphoria and depression.

If **yes** to either question, ask Help question below

The Help question

- Is this something that you would like help with?

Management of Depression in Older Adults

Older people respond well to treatments for depression. The management of depression in older people essentially follows the same step-wise pathway as in younger adults (See NZGG algorithms[7]) and chronological age should not be a barrier to specific therapies.[10] There is evidence to support the use of the same range of psychological therapies as in younger adults and if pharmacological management is required, an SSRI is also considered the first-line antidepressant.[10]

For further information see "Depression in elderly people", BPJ 11 (Feb, 2008).

Active support and liaison with other agencies

Successful management of depression depends largely on enabling the patient to be an active participant in the care process. A collaborative partnership between practitioner and patient is a consistent predictor of therapy outcomes for both pharmacological and psychological treatments.

Self-management includes exercise, activities (involving family/whanau and friends), advice on sleep hygiene, improving lifestyle and diet and avoiding alcohol.

Enjoyable social and intellectual activities, involving family and friends if possible, should be encouraged, such as; domestic leisure activities, walking, dancing, gardening, reading, music and social games. Voluntary organisations, support agencies and some care facilities may also offer services.

Exercise

The available evidence generally supports the benefits of exercise for older people with depression.[7] In most trials participants have been closely supervised undertaking relatively intense exercise programmes. Although this may not be possible in all community or care facility settings, it is generally accepted that exercise has beneficial effects in any age group. Exercise regimens need to be tailored to

the individual, taking in to account any physical or medical restrictions. Social exercises, such as walking groups or dancing combine the benefits of physical activity with social interaction.

Find out about local initiatives, for example access to discounted rates for group activities such as Tai Chi and swimming pool classes.

Psychological therapy

As with younger adults active management and psychological therapy should be considered in all older adults with depression.

A range of psychological therapies have been shown to be effective in older people with depression but it is unclear what type of therapy works best and if they are more effective if combined with antidepressants.[7]

Antidepressants

In moderate to severe depression, treatment with an antidepressant is an option but this should always be used in conjunction with non-pharmacological treatment such as active support and psychological therapy. As with any medicine prescribed for an older person, antidepressants need to be monitored carefully due to the increased risk of adverse reactions and drug interactions compounded by

Table 2: Comparative properties of SSRIs and similar agents

SSRI	Properties
Citalopram	Less drug interactions than other SSRIs due to minimal effect on hepatic CYP450 isoenezymes May cause less nausea than other SSRIs Short half-life –caution with discontinuation syndrome
Escitalopram	Similar to citalopram
Sertraline	Intermediate risk of drug interactions; somewhere between citalopram and fluoxetine/paroxetine Short half-life –caution with discontinuation syndrome
Fluoxetine	Significant number of important drug interactions due to hepatic enzyme inhibition Long half-life (one to two weeks) means slower reversal of adverse effects but discontinuation syndrome unlikely Requirement for longer washout period if switching to an alternative antidepressant Active metabolite (norfluoxetine) also inhibits hepatic enzymes
Paroxetine	Very short half-life –caution with discontinuation syndrome Significant number of important drug interaction due to hepatic enzyme inhibition. Tends to have more anticholinergic effects than other SSRIs so may be less suitable in older people
Other agents:	Refer to specific cautions in medicine datasheets
Venlafaxine, Mirtazapine	Venlafaxine can raise blood pressure and should be used with caution in people with significant cardiovascular disease Mirtazapine can cause weight gain

polypharmacy and medical co-morbidities. Poor adherence due to forgetfulness and confusion with multiple medicines therapy are also of concern.

In frail older people, antidepressants should generally be started at a lower dose than normal (e.g. half the normal adult doses) with gradual increases in dose.

An SSRI is first-line

An SSRI is considered to be the first choice antidepressant in an older person as they have similar effectiveness to tricyclic antidepressants (TCAs) and are better tolerated. There is no evidence that any one SSRI is better on the grounds of clinical effectiveness, but citalopram, escitalopram or sertraline may be preferred as they are generally better tolerated and are less likely to cause significant drug interactions than paroxetine or fluoxetine. For a comparison of the properties of individual SSRIs see Table 2.

Tricyclic antidepressants (TCAs)

Although not the preferred treatment for older adults with depression, TCAs may still be used if an SSRI is not tolerated or ineffective. Anticholinergic adverse effects may be poorly tolerated and are dose related. Treatment should be started with a low dose and titrated upwards gradually.

Nortriptyline is the preferred choice as it causes less postural hypotension, sedation and anticholinergic effects than the other TCAs.

Consider the potential for adverse effects and drug interactions

Older adults should be carefully monitored for the adverse effects of antidepressants, such as sedation, hypotension, anticholinergic effects, sleep disturbance and hyponatraemia (see sidebar "Antidepressant-induced hyponatraemia"). In general, older people appear to be more sensitive to adverse drug reactions and clinically significant drug interactions are more likely due to the increased prevalence of multiple drug therapy.

Antidepressants and the risk of falls

Depression is a risk factor for falling and people who do fall seem to be at increased risk of developing depression. Drug treatment is an independent risk factor for falls and overall, SSRIs are no safer than TCAs. The risk of falls and fractures with SSRIs is similar to that with TCAs.[11]

Antidepressants can contribute to the risk of a fall by a range of different mechanisms, including:

- Sedation and impaired reaction times
- Impaired balance
- Insomnia, alerting effects and deranged sleep patterns leading to daytime drowsiness and increased nocturia
- Orthostatic hypotension
- Cardiac rhythm and conduction disorders
- A tendency to cause movement disorders

Regularly monitor all older people started on an antidepressant for increased fall risk, e.g. sedation, change in sleep pattern, gait change.

Antidepressants and co-morbidities

Depression associated with co-morbid medical conditions increases with age and the possible effects of the antidepressant on concurrent disease has to be considered, and may influence the choice of medicine.

Cardiac disease: TCAs may cause or aggravate arrhythmias and hypotension, especially postural hypotension. SSRIs are generally safer. Venlafaxine needs to be used cautiously especially in people with hypertension.

Epilepsy: Most antidepressants lower seizure threshold. Ensure epilepsy is well controlled and use low doses with gradual titration.

Glaucoma: TCAs can precipitate acute narrow angle glaucoma. SSRIs are less likely to be a problem but paroxetine is less preferable due to its stronger anticholinergic effects.

Prostatic disease: TCAs may cause urinary obstruction in men with prostatic hypertrophy.

Parkinson's disease: SSRIs or TCAs can be used but individual response should be monitored closely. The risk of interaction between antidepressants and anti-Parkinson medicines is high. TCAs may be poorly tolerated and can aggravate constipation and postural hypotension. SSRIs may occasionally worsen extrapyramidal symptoms.

Depression with dementia

Depression often co-exists with dementia but can be difficult to differentiate and response to intervention is variable. However, depression in this sub-group should be treated in the same way as all older people with depression. Response to treatment should be closely monitored and the diagnosis reviewed if there is no improvement.[7] The potential for drug interactions, e.g. between antipsychotics and antidepressants, needs to be considered.

Antidepressant-induced hyponatraemia

There has been increasing awareness of the risk of hyponatraemia after starting antidepressants.[12] Many guidelines in primary and secondary care are now being updated to include monitoring advice.

Risk factors for antidepressant-induced hyponatraemia include; older age, low body weight, female gender, previous history of hyponatraemia, reduced renal function and concurrent intake of other hyponatraemic medicines, such as diuretics. Most reports have been linked to SSRIs but hyponatraemia can occur with any antidepressant including TCAs and newer drugs such as venlafaxine and mirtazapine.

Hyponatraemia due to antidepressants or thiazide diuretics usually occurs in the first four weeks of treatment. All patients taking antidepressants should be observed for signs of hyponatraemia (dizziness, nausea, lethargy, confusion, cramps and seizures). Monitoring recommendations vary slightly but a general consensus (especially for high risk patients) is as follows:

- Check baseline sodium level before starting the antidepressant
- Check sodium after two weeks and again after three months. Consider checking again after 12 months.
- Consider checking sodium after a dose increase of the antidepressant or addition of any other potentially hyponatraemic medicine, e.g. a diuretic
- If possible, avoid the combination of a diuretic and an antidepressant (particularly an SSRI) in people already at higher risk of hyponatraemia. Close monitoring is especially important in such patients.
- If a drop in sodium level is seen, but the patient does not have clinical symptoms of hyponatremia, it is still possible to remain on the antidepressant. Sodium levels need to be monitored more closely but they usually do not worsen and sometimes return to normal.

Prescribers should also be aware of other factors that may exacerbate or promote hyponatraemia in a person already taking an antidepressant or a diuretic. For example, fluid replacement (during acute gastrointestinal disturbance) with plain water instead of electrolyte solution may acutely aggravate hyponatraemia to dangerous levels.[13]

Further Resources

Ministry of Health Depression Web site.
www.depression.org.nz

Age Concern Information on depression
www.ageconcern.org.nz/health/healthy-mind/depression

Mental Health Foundation's pamphlet: "Late Life Depression"
www.ageconcern.org.nz/files/LateLifeDepression.pdf

Online Cognitive Behavioural Therapy
(appropriate for all ages if able to engage in eTherapy)
http://www.beatingtheblues.co.nz/

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Appendix 1

Geriatric Depression Scale (Shorter Version)[14]			
Choose the best answer for how you have felt over the **past week**:			
Yes	**No**		
◯	◯	**1.**	Are you basically satisfied with your life?
◯	◯	**2.**	Have you dropped many of your activities and interests?
◯	◯	**3.**	Do you feel that your life is empty?
◯	◯	**4.**	Do you often get bored?
◯	◯	**5.**	Are you in good spirits most of the time?
◯	◯	**6.**	Are you afraid that something bad is going to happen to you?
◯	◯	**7.**	Do you feel happy most of the time?
◯	◯	**8.**	Do you often feel helpless?
◯	◯	**9.**	Do you prefer to stay at home, rather than going out and doing new things?
◯	◯	**10.**	Do you feel you have more problems with memory than most?
◯	◯	**11.**	Do you think it is wonderful to be alive now?
◯	◯	**12.**	Do you feel pretty worthless the way you are now?
◯	◯	**13.**	Do you feel full of energy?
◯	◯	**14.**	Do you feel that your situation is hopeless?
◯	◯	**15.**	Do you think that most people are better off than you are?
☐		**TOTAL GDS**	

(GDS maximum score = 15)

0 – 4	normal, depending on age, education, complaints
5 – 8	mild
8 – 11	moderate
12 – 15	severe

Appendix 2

Patient health questionnaire (PHQ-9)

Patient health questionnaire for depression				
Over the last 2 weeks, how often have you been bothered by any of the following problems? For each question select the option that best describes the amount of time you felt that way.				
In the last 2 weeks	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

PHQ-9 provisional diagnosis

Scoring — add up answers to questions on PHQ-9

Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Total Score	Depression Severity
10–14	Mild
15–19	Moderate depression
≥ 20	Severe depression

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

GPCOG

Appendix 3

General Practitioner Assessment of Cognition – Patient Examination[8]

Unless specified, each question should be only asked once

1. **Name and address for subsequent recall**

   "I am going to give you a name and address. After I have said it I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: **John Brown, 42 West Street, Kensington**"

   (Say the info and allow the patient to repeat it up to 4 times to commit to memory. Do not score yet).

2. **Time orientation**

   What is the date?

   ◯ Correct ◯ Incorrect *Accept exact date only*

   1 point.

3. **Clock drawing (visuospatial functioning)** Use a page with a printed circle

   Please mark in all the numbers to indicate the hours of a clock. Correct spacing required

   ◯ Correct ◯ Incorrect *For a correct response the numbers 12,3,6 and 9 should be in the correct quadrants of the circle and other numbers should be approximately correctly placed.*

   1 point.

4. **Please mark in hands to show 10 minutes past 11 o'clock (11:10).**

   ◯ Correct ◯ Incorrect *For a correct response the hands should be pointing to the 11 and the 2, but do not penalise if the respondent fails to distinguish the long and short hands.*

   1 point.

5. **Information**

   Can you tell me something that happened in the news recently (in the past week) *1 point*

   ◯ Correct ◯ Incorrect *Respondents are not required to provide extensive details, as long as they demonstrate awareness of a recent news story.*

   If a general answer is given such as "war", "a lot of rain", ask for details. If unable to give details, the answer should be scored as incorrect.

   1 point.

6. **Recall**

   What was the name and address I asked you to remember?

   ◯ John *1 point each* Check each correct component – leave incorrect responses blank
   ◯ Brown
   ◯ 42
   ◯ West Street
   ◯ Kensington

Score: ☐

Score = 9	no cognitive impairment, interview not necessary
Score = 5 – 8	proceed to informant interview
Score = 0 – 4	cognitive impairment, interview not necessary

GPCOG

This informant questionnaire is only considered necessary if the results of the patient cognitive section are equivocal, i.e. score 5 – 8 inclusive).

The informant should know the patient well and will be asked to compare the patients current function with his/her performance a few years ago.

GPCOG Informant interview[8]					
	Ask the informant **"Compared to a few years ago"**				
1.	Does the patient have more trouble remembering things that have happened recently?	◯ Yes	◯ No	◯ Don't Know	
2.	Does he or she have more trouble recalling conversations a few days later?	◯ Yes	◯ No	◯ Don't Know	
3.	When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?	◯ Yes	◯ No	◯ Don't Know	
4.	Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?	◯ Yes	◯ No	◯ Don't Know	◯ Not applicable
5.	Is the patient less able to manage his or her medication independently?	◯ Yes	◯ No	◯ Don't Know	◯ Not applicable
6.	Does the patient need more assistance with transport (either private or public)?	◯ Yes	◯ No	◯ Don't Know	◯ Not applicable
Score:	*Score one point for each "no" answer*				

Score = 4–6 no cognitive impairment
Score = 0–3 cognitive impairment detected

Beating the Blues®

Online Cognitive Behavioural Therapy (CBT) programme for Depression and/or Anxiety

Effective and evidence-based

Beating the Blues® provides an effective and evidence-based treatment for depression and/or anxiety in primary care. Recommended by the National Institute for Health and Clinical Excellence (NICE), Beating the Blues® is used throughout the National Health Service in the UK. Beating the Blues® is now available in New Zealand, funded by the Ministry of Health. Free access to the online programme is managed by GPs, with accredited trainers offering training to practices in their area.

- Standardised delivery of psychological treatment
- Internet-based
- Patient friendly
- Eight 50 minute sessions
- GP progress reports and risk alerts generated

Beating the Blues® has been shown to be suitable for:

- Men or women with mild to moderate depression and/or anxiety*
- Patients with persistent subthreshold depression*
- Patients with acute or chronic depression and/or anxiety*
- Patients aged 18 or older*
- Patients with a wide variety of physical illnesses with depression and/or anxiety
- Patients able to read and write English at about nine year old to ten year old level
- Patients with access to a computer and broadband internet either at home or through a local community site e.g. Library
- Patient requires a valid email address

* Based on evidence from independent randomised control trials

Beating the Blues® is not suitable for:

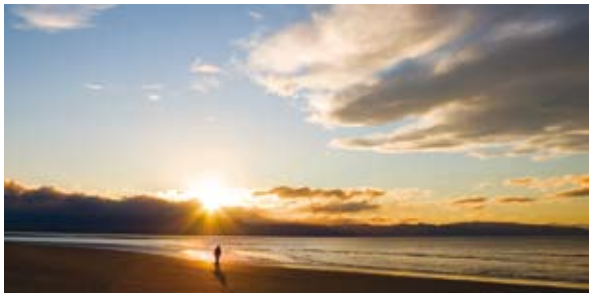
- Patients exhibiting active suicidal plans, although patients with low level suicidal thoughts can use the programme
- Patients in acute phase of psychosis or mania
- Patients in acute phase of drug or alcohol problem
- Patients with an organic mental health problem such as dementia

Benefits and outcomes:

- Immediate access to CBT for patients with depression and/or anxiety
- Evidence-based therapy with no known side effects
- Clinical outcomes achieved similar to those with face-to-face therapy
- Requires minimal clinical input – supports clinical oversight
- Higher patient satisfaction with treatment than with usual care

For more information visit
www.beatingtheblues.co.nz

The *bestpractice* Decision Support Depression suite provides up to date screening, assessment and management tools for the treatment of depression from antenatal through to older adults.



Depression & Adults

A logical and thorough resource to ensure effective screening and assessment of adults with depression. Leaving you more time to spend listening and engaging with your patients.

Depression & Young People

Using appropriate resources and assessment tools, this module gives management options reflecting a stepped care approach for this unique patient group. Red flags highlight the need for referral.

DEPRESSION *suite*

Depression & Older Adults

While there are many similarities between depression in older adults and the general adult population, this module concentrates on those differences that set older adults apart.

Antenatal & Postnatal **Depression**

This module focuses on the recognition and assessment of common mental disorders in the antenatal and postnatal period, and the management of depression in women during this period.

bestpractice
DECISION SUPPORT FOR HEALTH PROFESSIONALS

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