



Elder Depression Screening

Using the Geriatric Depression Scale

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This handout tells about elder screening using the Geriatric Depression Scale.

Why Conduct Depression Screening?

Depression is widespread among elderly persons, **affecting one in six patients treated in general medical practice and an even higher percentage of those in hospitals and nursing homes. Older people have the highest suicide rate** of any group, and many medical problems common to older people may be related to, or intensified by, a depressive disorder. Comparisons of people with suicidal ideation and people who attempt suicide has shown that, although older persons living in nursing homes are far less likely to attempt active suicide they have **high levels of suicidal ideation**.

More importantly, researchers are learning that **more elderly persons may die from indirect suicide than from direct suicidal behavior**. Indirect self-destructive behaviors are such things as **refusing to eat or refusing life-sustaining medications**. We know this is not an insignificant problem, though we don't yet have reliable estimates of the total numbers of people affected.

The **President's New Freedom Commission** on Mental Health emphasized training providers and laypersons about prevention factors among older adults, and both the Substance Abuse and Mental Health Services Administration (**SAMHSA**) **Technical Assistance Center** and the **National Suicide Prevention Strategy recommend universal screening strategies as a effective clinical and professional practices for older adults**. Universal prevention strategies offer the most hope for effecting significant reductions in late-life suicide rates (SAMHSA Older Americans TAC).

Data is increasingly showing us that, if professionals and lay persons can identify symptoms and see them for what they are, **we not only can modify risk factors for those persons who are high risk of using passive or active methods to promote premature death**, we can make great strides in **improving their quality** of life.

In fact, Oyama and colleagues (in 2004) evaluated the effectiveness of a universal screening program, focused on identifying depression and suicide risk among residential elderly and found a **73% reduction in suicide rates among older men and 76% among older women**, when symptoms were appropriately identified and interventions occurred.

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The GDS Overview

Recognition of the prevalence of depression among older people prompted development of the Geriatric Depression Scale (GDS) in 1986 to screen for depression in older adults. The screen is ideal in that it can be used in the community and acute and long-term care settings. The items may be answered *yes* or *no*, which is thought to be simpler than scales that use a five-category response set or other standard assessment scales. It is generally recommended as a routine part of a comprehensive geriatric assessment. One point is assigned to each answer and corresponds to a scoring

grid. The GDS: SF (Short Form) consists of 15 questions which **can be completed in less than seven minutes using yes or no** answers, making it much easier to administer, for the client and provider and it is **shorter than other assessment tools**

for the geriatric population which tend to have more questions and require detailed responses. The GDS: SF was modified from the original 30 item form, focusing on items with the highest correlation to depressive signs and symptoms, as noted in validation studies.

Recommendations for Administering the GDS

The GDS requires no formal training to administer since it is designed to assess older adults for depression, who are: ill or well, are easily fatigued, have a short attention span, or have mild to moderate, though not severe, cognitive impairment and **not designed to diagnose or treat depression**. To begin, introduce yourself to the patient stating, as an example: *"I'm going to ask you some questions about your mood and how you have felt over the past two weeks. Please answer with a yes or no"*. Explain that these are routine questions to assess the individual's feelings and mood related to current circumstances. Maintain good eye contact while speaking slowly and clearly. Reading the items to the resident is preferable.

Did You Know:

- The **fastest growing** segment of our population is **75 years of age or older**
- Persons in NFs are less likely to attempt suicide, but have **high levels of suicidal ideation (Schmidt et al. 1994)**. Many die from **indirect suicide**; self-destructive behaviors such as **refusing to eat** or **not taking life-sustaining medications (Thibault, 1999)**
- **Suicide is the 9th leading cause of death** in the U.S. **disproportionately** common among older adults, **age 65 and over** :
 - ⇒ Represent 13% of the U.S. population, yet nearly **one fifth of U.S. suicide**
 - ⇒ **Most deliberate and lethal attempts**
 - ⇒ More than half (**58%**) of older adults age **55** or older **interacted with a medical provider one month prior to committing suicide**
 - ⇒ Are **less likely to report suicidal thoughts** compared to younger adults
 - ⇒ Despite these statistics, **most suicide prevention programs focus on younger individuals**

One meta-analysis (In statistics, meta-analysis combines the results of several studies that address a set of related research hypotheses.) found:

- **3% to 26%** of older adults residing in community settings to have reported "clinically significant depressive symptoms", **10%** of older outpatients with medical conditions, and **16% to 30%** of older **nursing home residents**
- The prevalence of depression in patients with Alzheimer disease is **23% to 55%**, and one study found that patients with arthritis or heart disease are **18%** more likely to experience depression, with functional limitation as the strongest factor associated with depression. In older adults, somatic symptoms such as pain can mask signs and symptoms of depression resulting in under diagnosed depression that is otherwise treatable.
- A leading risk factor for **suicide** is **DEPRESSION**. In 2004 individuals **aged 65 and older** comprised 12% of the U.S. population, but **accounted for 16% of suicides**, or 14.3 of 100, 000 persons 65 or older, compared to 11 per 100, 000 in the general population of the U.S. The sub-group most likely to die by suicide was non-Hispanic white males 85 years and older, with a disturbingly high rate of **50 suicides per 100,000** within that age group. A 2004 study by Juurlink and colleagues found that older adults who died by suicide "were almost twice as likely to have visited a physician in the week before death" than were living control subjects.