Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2020

Promoting the Recognition of Depression in the Geriatric Population

Rose L. Hodge
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

 Part of the Nursing Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Rose Hodge

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mattie Burton, Committee Chairperson, Nursing Faculty
Dr. Anita Manns, Committee Member, Nursing Faculty
Dr. Mary Catherine Garner, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2019

Abstract

Promoting the Recognition of Depression in the Geriatric Population

by

Rose Lee Hodge

MSN, Walden University, 2013

BSHA, Florida International University, 2002

DNP Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

December 2019

Abstract

Depression is a chronic condition that has both physical and mental consequences, complicating the elderly's health status and interfering with daily functioning. Depression is not a normal part of aging and the elderly frequently seek mental health care in outpatient clinical settings where there is need for effective screening and prompt recognition leading to decreased morbidity and mortality. It is critical for psychiatric care settings to provide the most effective screening tools for recognizing depression as quickly as possible. This Doctoral Nursing Project quality improvement (QI) evaluation project resulted from observation of lack of a tool for recognizing depression in a vulnerable population in a mental health clinic. The purpose of this project was to evaluate a QI initiative aimed at promoting recognition of depression in the elderly population (age 55 to 65) by use of the Geriatric Depression Scale in the clinic. The guiding practice-focused statement is: Adoption of the Geriatric Depression Scale will promote recognition and treatment of depression in the elderly population (age 55 to 65) presenting to a clinic. The QI strategies used the Plan-Do-Study-Act model and the diffusion of innovation theory which guided the development, implementation, and process of evaluation throughout the project. Once the screening tool was in place, recognition of need for further diagnostics went from 15% pre-implementation to 29%. Chi square analysis proved this to be significant improvement in recognizing depression despite a small population and a restricted time frame indicated by the N value of 143 = 3.624 being close to the critical value of 3.84. Future studies with expanded time frames and larger populations are recommended. The QI project is expected to create positive social change that can prove beneficial on a larger scale to other mental health clinics and providers who aim to diagnose and treat depression in the elderly population in a timely manner.

Promoting the Recognizing of Depression in the Geriatric Population

by

Rose Lee Hodge

MSN, Walden University, 2013

BSHA, Florida International University, 2002

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

December 2019

Acknowledgments

I give thanks to God daily for keeping me throughout this process. I thank God for my children Taunja Cummings and, Vernon Hodge, who continued to encourage me even when I waivered in doing so for myself. They stood close in the time when it was hard with health issues and feelings of discouragement. Thanks to Christene Johnson who continued to encourage me along the way. In this journey, I met health care providers who made an impact and supported me, like Dr. Marjorie Gillespie Johnson, ARNP and Loraine Hay, Mental Health counselor. The family is important when you need that extra push.

Thanks to all the family of educational friends along the way, and the wonderful professors and counselors at Walden, although we never met face to face but you continued to encourage through each course. The love was real!

I especially thank all the professors who make Walden the excellent school it is. I want to give an extra special thanks to my chair, Dr. Mattie Burton, who labored with me now for a few years as I slowly worked through this process, as she has done with all students, she is phenomenal.

Table of Contents

Section 1: Nature of the Project

Introduction

Depression is a mental illness that has become a major issue in the United States in both older and younger populations (Center for Disease Control and Prevention, 2017). It is a leading cause of the increase of suicide rates in America (*City of Milwaukee Report*, 2007). The increase in the elderly population may be influenced by the empty nest syndrome and by economic changes (Martin, Neighbors, & Griffith, 2013). Depression is one of the conditions most commonly associated with suicide in older adults, but it is widely underrecognized and undertreated (*City of Milwaukee Report*, 2007). According to the *City of Milwaukee Report* (2007), studies show that many older adults who die by suicide—up to 75%—visited a physician within a month before death. The suicide rate in the United States was 33% in 2017; it rose from 10.5 per 100,000 to 14 per 100,000 (MediciNet, 2019; WebMd, 2019). One of the major contributing factors for depression in this group is the presence of other chronic conditions. In the geriatric population, 80% have at least one chronic health condition, and 50% have two or more (Center for Disease Control, 2017). Depression (2017) affects more than 6.5 million of the 35 million Americans aged 65 or older. Most people in this stage of life with depression have been experiencing episodes of the illness during much of their lives without being diagnosed. Others may experience a first onset in late life—even in their 80s and 90s. Depression in older people is closely associated with dependency and disability and causes great distress for the individual and the family. Current information points to the urgency of improving detection and treatment of depression to reduce suicide risk among older adults. Early recognition before late life onset will help to decrease the effects of depression.

The treatment of depression is moving away from the primary-care and general medical setting as advanced practice nurses assume new roles as mental health specialist practitioners (Naegle, 2011). The advent of more advanced mental health nurse practitioners makes treatment more available to adults. The increased need for early identification of signs and symptoms of depression through an effective screening tool is essential. The use of the GDS provides the advantages of early recognition, early treatment, and improvement in patient outcomes.

The mental health setting of focus, Total Family Health Center, did not until recently use a method of identifying depression in the elderly to expedite effective treatment and thus lessen potential complications of risky behaviors such as drug , alcohol usage, and suicide. Early recognition of depression among the elderly greatly impacts prompt and effective treatment and decreases the complications. Staff accepted the principle that completion of the GDS on the initial visit, given as a part of the admission assessment, would provide immediate recognition of depression and yield subsequent treatment. When an elderly patient presented with psychiatric symptoms, an initial assessment of depression was ruled out or confirmed, followed by the formal diagnosis and treatment plan. Recognition of a problem directs the course of treatment that reduces ongoing suffering. The psychiatric clinic implemented the GDS screening tool, and this QI project ended in an evaluation that showed an increase in the number of patients diagnosed with the tool from 15% to 29% resulting from use of the GDS tool in diagnosing depression in adults 55 to 65 years of age. This QI evaluation could lead to its introduction to other clinics, and thus could lead to the recognition and treatment of depression among adults ages 55 to 65.

Problem Statement

In the psychiatric clinic where the project was conducted, there was a lack of initial screening tools for recognizing depression in the elderly population. This created the potential for misdiagnosis, the administration of incorrect medication, and prolonged lack of care. While depression may be a common late life occurrence, affecting nearly 5 million of 31 million Americans aged 65 and older, it is treatable and damages reversible when treated promptly with appropriate treatment (Hildebrandt, 2011). It is important to implement strategies that lead to prompt recognition and effective treatment to lessen complications of depression in the middle stage of adult hood. If depression is left untreated, it can lead to physical, cognitive, and social impairment along with medical illnesses, increased use of the health care system, and suicide (Wible, 2017). Depression is a common cause of disability that can, in short, lead to reduced quality of life (Steffens, et al., 2000).

Depression among the elderly is an established fact through research studies (Steffens et al., 2009; Barua et al., 2011). Growing older is a natural part of life, but depression is not a normal part of aging. However, the adult population, aged 55 and older, is at increased risk for depression-related changes in life, both psychologically and physiologically (Martin, 2016; Mental Health Foundation, 2018). Depression is not a state of having the blues related to loss or change; it is a true and treatable medical condition (Centers for Disease Control and Prevention [CDC], 2013). There are criteria for determining the existence of depression (Diagnostic and Statistical Manual of Mental Disorders, 2013). Elderly populations have at least one to two chronic health conditions that increase risk for depression. Another significant factor is the mis-diagnosing and undertreatment of this population**.**

Implementation of a depression screening instrument on the patient's initial contact with the clinic guides effective recognition and implementation of care. Screening scales are valuable tools that help providers recognize early disorders and implement treatment. The long-term effects of mental illness are well known, and the average mental health patient's life is reduced by 10 years (Johnson, 2016). Psychiatric outpatient clinics are growing in relation to the growing need of mental health care, and more patients are seeking mental health care on an outpatient basis (Johnson, 2016). Screening is essential in both clinics and psychiatric home health care , and the time is critical for determining the severity of depression across this population (Marc, Raue, & Bruce, 2008). The diversity of outpatient care such as clinics, private psychiatric offices and psychiatric home health care requires instruments that minimize the amount of time required to screen for basic data, leading to a diagnosis of depression.

An evaluation of the effectiveness of the GDS tool in promotion and recognition at the initial intake in the clinical setting was needed for prompt diagnosis and treatment. The geriatric population is very susceptible to psychiatric disorders. The most common psychiatric disorder among the elderly is depression (CDC, 2008; World Health Organization, 2017). According to the Administration for Community Living (Johnson, 2016), there are 46.2 million people, age 65 and older in the United States; theyrepresent 14.5% of the U. S. population. This population increased from 36.6 million in 2005 to 47.8 in 2015, and is projected to double to 98 million in 2060 (CDC, 2016). In the census report, *An Aging Nation: The Older Population in the United States* (Ortman, Velkoff, & Hogan, 2015) the authors project that between 2012 and 2050 the United States will experience a considerable growth, which will include 83.7 million of older adults ages 65 and over. On the global level, He, Goodking, and Kowal (2016) projected that the

world population would reach an increase of 236 million by 2025. World-wide, projected growth is 1.6 billion. These trends among the aged are expected to outpace younger growth over the next 35 years. The older adult population represents a substantial portion of the healthcare industry. Out-patient care is now providing more accessibility to mental health patients, therefore this project becomes important to quality improvement in these settings. The DNP role is one of leadership in healthcare, indicated through the assessment of a need: the recognition of a need followed by evaluation of the implementation of a tool aimed at improving behavioral care for a target population via a clinical intervention is a clear leadership role. As the DNP practitioner who recognizes a lack in the application of an appropriate geriatric assessment tool, helping to develop mental health clinic QI strategies occurs through evaluation of an implementation process**.**

Purpose Statement

The purpose of this study was evaluation of the effectiveness of using the GDS during the initial medical and social history assessment of patients at a mental health clinic. The lack of a method to consistently evaluate the potential problem of depression in a patient, which is life-changing for the older population, places them at risk for potential complications due to lack of initial treatment.

The practice guiding question was as follow: Will adoption of the GDS by the outpatient clinic setting promote recognition and treatment of depression in the elderly population? This doctoral project addressed the recent implementation of the GDS in a mental health clinic for recognizing depression in a special population. This project addressed this gap in practice at one particular clinic, but if shown to be beneficial, it also provided the potential for implementation

in other settings. The GDS served as an instrument for providers to plan treatments that would address depression on initial visits and, if diagnosed [OK?], would implement plans that would help prevent future complications.

Nature of the Doctoral Project

As a part of this project the psychiatric clinic under study implemented a screening tool, called the GDS short version, which was used with first-time clients ranging in age from 55 to 65. Prior research in its use in the primary care setting showed that it was effective in use for screening for depression in patients with various cognitive impairments (Glorighian, 2016; Paradela, Lourenco & Veras, 2005; Decosta & Bray, 2013). Results showed validity of 81% sensitivity, and 71% specificity (Paradela, Lourenco & Veras, 2005). Having been tested in primary care with positive results supported the implementation for QI investigation in the psychiatric clinical setting.

The GDS short version was selected based on its validity and its acceptability: it does not add time constraints, changes in staff, or increase financial resources for implementation. When the GDS is used as part of the initial assessment process, it can be followed by a more in-depth assessment based on the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), to validate a diagnosis. However, appropriate treatment can be initiated by the provider based on a strong protocol for a diagnosis of depression after careful patient evaluation and review of the GDS assessment .

The collected evidence was analyzed for effectiveness in identifying depression on first contact with the patient. The facility had no specific assessment tool in place for this geriatric population being evaluated for psychiatric care daily. According to the project protocol, first-

time patients were given the screening tool and assisted with completion as needed. Completion was necessary prior to the initial evaluation by the PMHN or RN, patients were assisted by the medical assistant or secretary if needed. The psychiatric practitioner or psychiatric nurse would assist as part of the new patient initial intake process if required. All assessment forms were evaluated for completion including the final decision by the practitioner in terms of diagnosis. Data were collected from clients' charts who were new patients, in the age range of 55 to 65 for a 30-day time frame prior to implementation of the GDS. Subsequent charts following the same criteria were evaluated for depression diagnosis after implementation of the GDS by the PMHN and RNs for a 30-day span. The analysis of the cumulative values from each time frame was completed to determine whether the use of the GDS improved the recognition of depression in this population. Recognition aids in prompt initiation of treatment, which lessens or eliminates the possible side effects of this condition.

The GDS is a self-report tool that measures depression in older adults using a "Yes/No question format on their initial visit to a clinic (see Appendix A). It was first created as a 30-item instrument. Later, it was decreased to a 15-item instrument and thus reduced the time frame and patients' frustration (Yesavage, et al, 1982). It has been tested and used extensively in evaluation of the elderly for depression (Yesavage, et al, 1982). A score of 0–9 is considered normal, 10–19 indicates mild depression and 20–30 indicates severe depression. It has been demonstrated to have a 92% sensitivity and 89% specificity when evaluated against diagnostic criteria [citation needed]. The validity and reliability of the tool have been supported through both clinical practice and research (Sheikh & Yesavage, 1986). It is not a substitute for the thorough diagnostic interview by mental health professionals. The GDS shorter version maintains

questions with high correlation for recognizing depressive symptoms in previous validation studies (Sheikh & Yesavage, 1986). The completion time ranges from 5–10 minutes.

The psychiatric team consisted of the Advanced Registered Nurse Practitioners (ARNPs), psychiatric nurses, and therapist at the site. The GDS was completed by new patients at the point of initial contact in the clinic. The score sheet developed for the chart review included: total number of patients evaluated and the number diagnosed with depression. The success of the tool in screening for depression in the elderly addressed the gap in practice in the clinical setting. Prompt and effective treatment will lessen the life-changing complications that lead to morbidity and comorbidity in this population. Depression in the elderly is not readily confirmed and often missed (Naegle, 2011). treatment is frequently delayed or not implemented at all (Naegle, 2011). The goal of this QI project evaluation was to bring about a social change in the mental health clinic. Social change seeks to improve human conditions and promote a more positive future through research (Walden, 2018). It comes from increased awareness and QI evaluations that bring about knowledge of a better method (U. S. Department of Health and Human services, 2011). QI involves consistency within systems along with the continuous actions of using the strategy that has been put in place that leads to improvement in health services for the health of the targeted population. The success of this QI plan supports the value of its effectiveness and serves as the impetus for positive social change in the psychiatric clinic. Social change can broaden to other psychiatric clinical areas in the community as a result of the success of this evaluation project.

Significance

All stakeholders (primarily patients, but also psychiatrists, mental health advanced nurse practitioners, home care nurses, and therapists) benefit from the use of an effective tool in planning and implementing care for the target population. Depression in the geriatric population is growing and nurses need to know how to readily screen for signs and symptoms (Naegle, 2011). Stakeholders in both outpatient clinics and psychiatric home care, where geriatric patients are treated, can benefit from the evidence of effective early identification of geriatric depression. What follows the implementation of this project could be a safe and effective plan of care that decreases mortality and morbidity among the elderly.

This QI strategy was the start of a change that can lead to continuous improvement in the care of the elderly seeking mental health care. Other clinical practices treating geriatric patients on a continuous basis can adopt this strategy for positive change in their settings. Geriatric patients are usually seen by primary care providers first, who could also adopt this tool for early recognition of depression, and then follow with referral to psychiatric care. Patient safety can be maintained, and functioning improved through recognition of symptoms and treatment that decrease the incidence of suicidal thoughts and psychosis (Harvath & McKenzie, 2012). According to Harvath and McKenzie (2012), depression is often underrecognized, underdiagnosed and undertreated. They suggest that all at-risk groups should be assessed and that a depression screening tool should be used. They recommend the GDS short form because it takes a little as 5 minutes to complete and has been validated extensively (Harvath & McKenzie, 2012). The GDS also includes fewer somatic items that lessen the potential? confusion with physical illness (Harvath & McKenzie, 2012). This project sought to establish nursing standards

of practice within the mental health clinic for the promotion and recognition of depression in the geriatric client.

Summary

Depression in the elderly is not a natural part of aging; in fact, it is a growing health concern. Late-life depression has devastating consequences associated with increased risk of morbidity and suicide. There is a need for nurses in leadership to recognize symptoms early and to be instrumental in planning appropriate care. There is a need for implementation of tools to screen the geriatric population more carefully. The gap in practice in the outpatient clinical setting was evident, but changeable through leadership projects that addressed the problem. Depression is often not recognized at all, or misdiagnosed in the geriatric population, which leads to failure to administer or proper treatment. The DNP student was in a pivotal position to implement strategies that promote positive change in the outpatient mental health care setting for the targeted population.

Section 2 addresses the local background, concepts, theories and roles of the staff and DNP student in the evaluation of the use of the GDS screening tool for depression in the elderly population.

Section 2: Background and Context

Introduction

The lack of adequate screening in the psychiatric clinic impacts patient care related to failure to recognize depression in its initial stages. Failure to recognize depression in the elderly population seeking mental health care poses the potential for misdiagnosing in the medical setting as nurses assume new roles as mental health specialist practitioners (Naegle, 2011). The treatment of depression is moving away from primary care and the outpatient clinical settings are becoming more of the focus of treatment. In the psychiatric clinic, there was a demand for tools leading to prompt, effective recognition of depression, and thus to treatment, in order to lessen the potential for complications in the elderly population. The practice-focused question for this project was as follows: Does the adoption of the GDS within the outpatient clinic setting promote recognition and treatment of depression in the elderly population?

The purpose of this project was to evaluate the effectiveness of the GDS as a screening tool for recognizing depression in the elderly and thus leading to immediate intervention. The geriatric population constitutes a substantial portion of the health care services and the lack of proper care will place a burden on health care providers when the geriatric patient needs are not met. The expected outcome of this study was improved functioning and quality of life for the geriatric patient with a diagnosis of depression.

Concepts, Models, and Theories

Depression can have both physical and mental consequences that complicate the elderly's health status (WebMD, 2019) Mortality rates are higher among the elderly who suffer with depression (University of Washington, 2008). The elderly is more prone to experience

hopelessness and loneliness which leads to suicidal attempts (American Psychological Association, 2019). Recognizing depression in people ages 55 and older could prompt immediate interventions and aggressive treatment of symptoms resulting in a decrease in complications from depression in this population. The adoption of the GDS within the outpatient setting provided the means for recognizing depression in elderly patients leading to early treatment.

The QI strategy used in this project was the Plan-Do-Study-Act (PDSA) model and was underpinned by the diffusion of innovation theory. The PDSA strategy gradually helped in the development of this new initiative, while producing improvement as needed. The rapid-cycle aspect of PDSA began with piloting a single new process, followed by examining the results and responding to what was learned by problem-solving (effectiveness, adoption, implementation, and maintenance). In this project PDSA guided the practical application of evaluating the clinic's environmental change in adopting the intervention.

The diffusion of innovation theory complemented this project through the use of its style of communication or communication channels used to introduce the process to a group, its steps in the group making decisions, and the social context or the forces by individuals or a group that affect change (Swanson-Fisher, 2004). Use of this theory involved three processes: presentation of the new element, acceptance of the new intervention, and integration of the accepted intervention into the clinical practice (Dearing, 2009). When referring to innovation, there are five elements of a new or substitute clinical behavior that influence adoption or diffusion: *relative advantage, compatibility, complexity, trialability,* and *observability* (Swanson-Fisher, 2004). Relative advantage is the degree to which an innovation is accepted as better than what was previously used. Compatibility is the degree to which the new is considered comparable

with the existing methods and the needs of those adopting the innovation. Complexity is the measure of the difficulty of the new measure. Trialability is the degree of which the innovation can be trialed and modified, that also allows the clinician time to explore implementation and acceptability and the potential outcomes. Observability is the degree of visibility to others, and more visibility stimulates discussion that leads to acceptance. The social context of the clinic was considered, as change in the clinical behavior led to a need to modify the system for monitoring and maintenance. The five steps that were applied in the decision-making process included knowledge shared about the project and the team members understanding the goals of change; the owner/administrator being persuaded on the advantages of the implementation and engagement in activities leading to adoption; the intervention was incorporated into the daily activity of the clinic, and the team followed up with reinforcement about the intervention decision through discussion and comparison.

Relevance to Nursing Practice

One of the most frequent psychiatric disorders diagnosed in the geriatric population is depression which often goes unrecognized and untreated (Brown, Raue, Halperi, Adams, & Titler, 2009). Depression cannot be simply attributed to aging because medical conditions can contribute to depression. Expert recommendations have been made in regard to screening and treatment, but geriatric depression remains a major public health problem. If the problem is to be resolved, there must first be an address of proper screening in all settings common to care of the geriatric patient, inclusive of those with mental health care requirements. The first essential step is proper screening for detection of the problem. Screening for depression with present comorbidities makes the process more difficult and increases the need for more research towards

better instruments to address recognition despite other underlying disorders. Recognizing the gap in evidence-based practice related to screening, this DNP project established the use of the tool in the psychiatric setting with the possible goal of use in similar private settings. The need for evidenced-based guidelines for detection of depression has been addressed, and screening has been identified as a major criterion (Brown et al., 2009).

This project addresses the gap in practice related to screening in psychiatric clinics of the geriatric patient for depression. This QI evaluation project assisted in bridging a practice gap by a growing set of providers, called psychiatric mental health care advanced practitioners who provide mental health care to a growing geriatric population seeking mental health care in outpatient clinics.

Local Background and Context

Depression among the elderly is a growing health concern creating a large burden on the health care industry. The elderly population is increasingly seeking treatment from outpatient providers. As more geriatric patients seek psychiatric care in the clinical settings, the need for an effective screening tool becomes essential. The GDS which was developed for the elderly is used because other depression scales used in the general population my not work well with the geriatric population (O'Connor, Rossom, & Henninger, 2016). The GDS was selected as effective for the geriatric population in the outpatient clinic related to its simplicity of the yes/no format while adequately indicating the presence of depression (O'Connor, Rossom, & Henninger, 2016). At the clinic of study, patients come from the northern end of Miami, as well as the Southern and central areas of Fort Lauderdale, and are either referrals or independent seekers of psychiatric health care. The providers are licensed in the state of Florida to administer

psychiatric health care as they meet the license and/or educational requirements of the department of education and the Florida Board of Nursing. The mission of the clinic is to administer quality health care to all participants enrolled.

Psychiatric health care is provision of health care services for the acutely and chronically ill patient with mental health disorders. It includes diagnosing and treating people with mental disorders, and the prevention of mental disorders through the application of psychosocial and behavioral science skills. The provider interviews, counsels, and applies psychosocial and behavioral science skills (Lvbijaro, 2008). Primary health care services can be in an integrated setting where other services are being provided, often providing less attention to patients who seek mental health care. Stand-alone psychiatric centers provide primary care to patients seeking mental health services.

Role of DNP Student

My relationship to the DNP project is that of a professional registered nurse with an interest in care of individuals with mental health conditions. I chose the psychiatric setting as my DNP practicum site and have spent one year in the clinical setting as a student and I continue to volunteer to learn more of the range of care presented in this setting. I had no relationship to the clinic other than acquiring experience in psychiatric health care as part of my educational pursuit. Observation of the practice setting allowed me to see the need for changes in areas of psychiatric care, in collaboration with the Advanced Practice mental health nurse.

My motivation comes from seeing the need for behavioral health management across the life span. Seeing the gap in practice related to screening of geriatrics motivated this project. Any

potential for bias may be related to the fact that my social arena is in the group, as I am in the age range being focused on.

Role of the Project Team

The project team was selected based on their functional roles within the clinic as it relates to having initial contact and provision of care for the focus population of patient ages 55 to 65 that are first time clients within the facility during this project. The team consisted of the office manager, administrative secretarial staff, psychiatric nurses, mental health therapists and advanced nurse practitioners. The GDS form was presented to the patient of the targeted age group by the secretary with their intake package, followed by review by the nurse or practitioner who starts the initial assessment. The form was reviewed for completion, assistance given for completion, and questions answered for the patient at that time. The psychiatric nurses and practitioners reviewed their forms and evaluated results based on the designated scales from which they make decisions to assess more thoroughly and recommend treatment. The practitioners have a tool to assist with recognition of depression leading to the development of a prompt treatment plans.

The purpose and the process of the evaluation of the effectiveness of the tool was discussed with the team members, with request for feedback on needed changes for future use. Other than the administrative secretaries who delivered the forms, all users and evaluators were qualified health care providers. The nurses were registered nurses with a minimum bachelor's degree in nursing or psychotherapy. The mental health therapists were counselors with social work backgrounds and mental health experience in individual and group therapy. The ARNPs were licensed in the state of Florida with specialization in mental health therapy. The role of the

team was implementation and assessing for the tool usefulness in promotion of recognition of depression in the geriatric population.

Summary

Recognizing the gap in evidence-based practice related to depression screening, this DNP evaluation project aimed to establish the effectiveness of the GDS tool in the psychiatric setting. The need for evidenced-based guidelines for detection of depression was addressed, and screening was identified as a major criterion for addressing the problem. Screening impacts the efficiency of psychiatric care through prompt recognition and delivery of effective care for prevention of complications. Screening tools can be implemented to decrease the subjectivity that is common to psychiatric care. Failure to implement a screening tool for early recognition of depression in the elderly population seeking mental health care poses the potential for mis-diagnosing and delayed treatment plans (Naegle, 2011). There is an increase in use of outpatient psychiatric clinical settings where there will be responsibility for using every strategic method of assuring accurate and prompt treatment for a population that has a high level of comorbidity already. The practice-focus question for this project was: Will the adoption of the GDS within the outpatient clinic setting promote recognition and treatment of depression in the elderly population? The PDSA and diffusion of innovation theory served to underpin the study.

Section 3: Collection and Analysis of Evidence

Introduction

A healthcare provider's ability to identify potential problems is critical to developing an effective plan of care. Part of the identification process includes the use of screening tools in the initial assessment of a patient. The more accurate the assessment, the more strategic the plan of

0 care can be for giving the patient the best care possible and the opportunity for improved quality in life. gap in practice is evident through the absence of the use of a screening tool to ensure prompt care to the elderly, who are at great risk for depression.

Depression is a major health issue in the United States (Steffens, et al, 2009). Florida is a major area of migration for the elderly due to its warm climate (Jacobs, 2016). Many elders come to South Florida to live almost half of the year there, migrating back home to the north when the weather is warmer (Jacobs, 2016). The elderly population has an increasing rate of depression),that is .expected to escalate (Naegle, 2011) The organization where the project took place accepted the identification of a gap in practice, and implemented the GDS in an effort to correct the practice standards for treating depression and ensuring treatment in this vulnerable population. The project evaluated the outcome of that endeavor.

The GDS is a self-report measure of depression in adults where the patient responds to questions in a Yes/No question format in their initial assessment. The GDS was first created as a 30-item instrument, but developers have decreased the number of questions reducing the time and frustration of completion (Yesavage et al., 1982). It has been tested and used extensively with the older population. Scores of 0–9 are considered normal, 10–19 indicate mild depression and 20–30 indicate severe depression. It has been shown to have 92% sensitivity and 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. According to Prakash, Gupta, Singh, and Nagarajarao, (2009), the sensitivity of the GDS was 100% and specificity 94%. Their report confirmed that brief screenings such as the GDS helped in identification and diagnosis of depression in medical settings. It is not a substitute for the thorough diagnostic interview by

mental health professionals, but a screening tool to assist in the prompt recognition and appropriate treatment of elderly depression. The GDS shorter version with 15 items selectively taken from the long version, have questions with high correlation with depressive symptoms in previous validation studies (Sheikh & Yesavage, 1986). The completion time ranges between 5–10 minutes. The GDS short form is considered effective in recognizing depression in this population.

Practice-Focused Question

Only recently has the local organization, the outpatient psychiatric clinic, realized a need to screen for depression in the growing elderly population. This project sought to evaluate the outcomes of that endeavor to documentation of the effectiveness of the chosen screening tool, the GDS. Therefore, the practice-focused question guiding this project was as follows: Will the adoption of the GDS within the outpatient clinic setting promote recognition and treatment of depression in the elderly population?

Sources of Evidence

The psychiatric care providers collected evidence exclusively from review of records for 30 days as designated at the initiation of the project, but prior to use of the GDS tool. Post implementation of the GDS, the clinic team collected data for 30 days after IRB approval. The QI project involved retrospective and prospective review of medical records of geriatric clients between the ages of 55 to 65 seen at the clinic. All patient assessments were performed by the psychiatric practitioners or staff at the clinic. The data was then analyzed and blinded for identification purposes. Records of the patients within the age range dating back to prior implementation of the GDS tool were evaluated for promotion of recognition of depression,

followed by a review of records of clients seen after IRB approval for gathering of data for 30 days. Collection of the results was related to gender, and ages, and diagnosing of depression by the practitioner using the GDS tool as an assessment in recognizing the signs and symptoms of depression. All information collected was held in strict confidentiality and remained in the custody of clinical staff. The chief officer of the clinic signed in agreement for the project (Appendix A). Collection of the results of the initial implementation tool were used to provide evidence of effectively addressing the gap in the clinical practice.

Protections

This project respected the rights and welfare of human participants. QI activities are data-driven and involve human participants, and whether the activity is human subjects research or not, it is vital that it was executed in a manner that is ethical and respects the rights and welfare of the human participants (Gliklich & Dreyer, 2014). This project was a QI evaluation of the implementation of the GDS by the mental health staff who was in full acceptance and compliance with the project requirement. No identifiers of staff or patients were used in compiling the analysis. The staff included three mental health nurse practitioners, one psychiatric nurse and clerical staff. The QI evaluation project involved the evaluation of a process where data is collected before and after the facility's implementation of a tool. During the collection of data, no patients' identifiers were used, and there was no direct patient contact as data is being retrieved. The numerical input was related only to the number of cases, how many males versus female, ages, and the impact of the form in assisting the practitioners in promoting recognition of depression in the geriatric population. The project was directed according to the standards of

Walden University's policy for protection of human rights, governed by Walden University IRB Board.

Analysis and Synthesis

Screening improves recognition, treatment and clinical outcomes in health care (Pignone, Gaynes, Rushton, Burchell, Orleans, Mulrow, & Lohr, 2013). The QI evaluation project was an analysis of the data obtained from a review of charts of selected patients for 30-day periods prior to and after the implementation of the GDS. The staff accepted use of the GDS at an assigned period pending final reviews after IRB approval. No chart exclusion was made related to sexual orientation, cultures, races, religion, or economic considerations. The exclusion was a prior diagnosis or history of depression, but not another psychiatric diagnosis even if made by a prior psychiatrist or psychiatric mental health practitioner. The QI evaluation was used to determine the results of the use of the GDS tool in identifying depression in the elderly population.

Summary

The gap in practice relating to recognition of depression in the elderly population ages 55-65 was addressed in this project. The practice focused question was: Does the adoption of the GDS in the psychiatric clinical setting improve the recognition of depression in the elderly? This project aimed at evaluation of the outcomes of a QI evaluation project implemented by the clinic to improve care of elderly patients. Data was collected with respect for protection of participants identity. All guidelines expressed in the beginning of the project were followed by the team. All data collected was submitted and evaluated for outcome of implementation of the project. According to facility and university standards.

Section 4: Findings and Recommendations

Introduction

The aim of this QI evaluation project was to promote recognition of depression in the elderly population ages 55 to 65 in a psychiatric clinic. This took place in a psychiatric clinic that provides care across the life span, inclusive of elderly patients. A problem was identified within the clinical setting that there was lack of use of an assessment tool to assist the practitioners in recognizing on initial contact the signs or symptoms of depression in the elderly population. The practice focused question was: Will the adoption of the GDS promote recognition of depression in the elderly population ages 55 to 65. This project's hope was to establish that use of the GDS tool promotes recognition of depression in this special population leading to prompt treatment, thus decreasing the possible complications that could result if recognition is prolonged or even missed.

After orientation and agreement of the staff and director to the project, comparative data were requested by the DNP student for a 30-day period prior to use of the GDS to validate a comparison of improvement. The psychiatric staff was instructed to gather the results for a 30-day period on all new patients between the age of 55 to 65 on initial contact with diagnosis of depression even if another psychiatric condition existed prior to use of the GDS, followed by continued use awaiting the approval of IRB for the project. to facilitate comparison. The 30-day period of post-GDS implementation data was gathered on all new geriatric patients seen after IRB approval for collection of data. The clinic continued to use the GDS with all elderly patients after implementation, which allowed familiarization and proficiency with the tool. Post-approval data on patients were collected 30 days after IRB approval. No chart exclusions were made with

respect to sexual orientation, culture, race, religion, or economics. Patients with a prior diagnosis or history of depression were excluded from the study, but not another psychiatric diagnosis, even if made by a prior psychiatrist or psychiatric mental health practitioner was permitted Staff gathered de-identified data and submitted it to me, the DNP student overseeing the project for analysis.

The data consisted of the number of patients seen on initial contact, gender, and the number of patients diagnosed with depression. Data were analyzed using a two-sample, chi square analysis, which compares the difference between the two independent groups. This project analysis compared the difference in number of patients identified with depression between the two groups.

Findings and Implications

The sample size of the population reviewed prior to implementation of the GDS was 64, while the data collected on sample size for the patients after implementation of the GDS was 79. The number of patients diagnosed in the group evaluated prior to administration was 10, equaling 15.6%. Of the post-GDS implementation group, 29.1% were diagnosed with depression. In consideration of the time frame and group size, the findings were enough to indicate the positive outcome from the use of the GDS. The population and the time frame were adequate to establish effectiveness in use of the tool (Wong, & Sullivan, 2016).

Findings indicated that the demographics for the 30-day, pre-GDS implementation period included 64 patients between the ages of 55 to 65 years. Of these, 45 were females and 19 were males. The evaluation was done to screen for diagnosis of depression in new geriatric patients at

this clinic site who had no prior diagnosis for depression, although they may have had diagnosis of other psychiatric conditions.

Following IRB approval in March of 2019, data collection ran for 30 days, from March 13 to April 16, 2019. The data reported by staff showed 79 patients between the ages of 55 to 65 were seen at the mental health clinic. The breakdown consisted of 50 females and 29 males. All patients were initial clinic admissions seeking psychiatric evaluation for various symptoms. The GDS had been in use by the clinic on a continuous basis from the time of evaluation of the first group till the time frame of reviewing its effectiveness after implementation. The group of patients included in the evaluation after implementation was 79 with 23 subsequently diagnosed with major depressive disorders.

Implementation of the GDS did, in fact, increase the number of patients diagnosed with depression. Although results are from a small sample size, findings indicate the positive outcome of the use of the GDS. Further, the fidelity is high as the team has a high commitment to the use of the tool. In addition, when considering the small population, the time frame of use of the GDS extended well beyond a year making it a critical factor in showing a possible consistent change over time (Adomavicius, Kwon, & Zhang, 2010). The question of prematurity in evaluation is low related to time frame of project discussion, implementation and the permission for implementation of evaluation. The results are therefore predictable of a positive change when compared to the narrow window of review of only 30 days. The sampling is sufficient to predict adequate data for recommendation.

The data received from the clinic were of two types, the first being the number of patients seen, and the second was the number of patients diagnosed. The first variable was the number of

patients seen (pre and post-GDS), broken down by gender. The second categorical variable was the number of patients diagnosed with depression. These were counts for those when the GDS was not implemented (pre) as well as for after the GDS was implemented (post). Therefore, in order to determine if the GDS increased, the number of patients diagnosed, an evaluation of those seen against those diagnosed in each group. This was appropriate since the data received were counts rather than averages. When examining the diagnostic data presented by the clinic the results indicated an improvement in the number of clients diagnosed overall after the implementation of the GDS.

In health care, we develop patterns within our practices that often need to be evaluated against improvement in technology, and better theories of evidence-based practice, and all-around changes in communities (U. S. Department of Health and Human Services Health Resources and Services Administration, 2011). Positive change cannot occur without education of the deliverers and evaluators of any strategic QI plans. Social change is a framework that helps to develop leadership as health care providers follow the models of social change. The DNP student can cultivate change through implementation of a QI evaluation that employs strategies leading to improvement in patient outcomes in health care (Kurowski, Schondelmeyer, Brown, Dandoy, Hanke & Cooley, 2015)

The smallest improvement in a system's outcomes outweighs failure to produce positive change. As the instrument is continually used and its necessity realized as a daily part of the assessment process, there will be greater efficiency in usage and improved health care management for depression, especially for this special population. The implementation of the GDS in the mental health clinic will continue to provide improvement in the assessment by the

mental health care providers. As the clinic continues to benefit from the use of the GDS, recognition of symptoms of depression improves, implementation of effective treatment can begin early. Complications of depression left untreated will be lessened, care will improve within the psych clinic, and this positive outcome can be shared with other clinics in the community through workshops, and seminars, and one to one communication among leaders and providers. As the quality of life improves in, a healthier community evolves, and these communities can bring about changes in adjacent communities through seminars. Eventually better treatment globally leads to better health care systems around the world. The psychiatric health care system improves with use of assessment tools where evaluations are documented with proven tool of accuracy.

Recommendations

Solutions to the gap in practice include acceptance and implementation of the GDS assessment tool. The continued use of the GDS promotes recognition and prompt implementation of treatment on a consistent basis in the mental health clinic. Consistent use of the assessment tool decreases possible complications. Closure of the gap was made through acceptance and continued use leading to ongoing improvement in patient care and decrease in potential complications for this population.

The providers and staff were responsible for making sure that the tool was given to each patient within the age group of 55-65 regardless of race, culture, economic, or education status on initial admission to clinic for evaluation. Practitioners and nurses were responsible for reviewing the tool with the patients for completion, making diagnosis based on their findings, and making treatment recommendation as needed according to findings on each patient. The team reviewed and collected data on all patients and determined who received diagnosis of depression being assisted by recognition through the use of the tool.

Strengths and Limitations of the Project

The strengths of the project were the acceptance after introduction, eagerness and willingness of the team, their feedback indicating understanding of the purpose and use, and readiness for implementation of the tool by the team. The ease of orientation within the team of when and how to implement the tool to prevent added work issues and provider delays in care, and knowledge by team of documentation system for data input and retrieval was a great strength.

The limitations were the study group sizes and time frames of observation pre and post project implementation. The limitation, however, did not diminish the observation of improvement within the implementation group as indicated.

Section 5: Dissemination Plan

Dissemination will include discussion of recognition of a gap in practice, defining the problem with the Chief Officer, then further explanation with staff and practitioners and nurses. Collection and results based on university policy will be reviewed. The tool was the Geriatric Depression Scale, designed for recognizing symptoms of depression in the elderly population. The population of this study was geriatric patents ages 55 to 65. The venue was a psychiatric private clinic where patients are seen across the lifespan for behavioral problems including drug abuse. The benefit of this evaluation project in the psychiatric clinic comes through dissemination of the results of the project to the providers showing positive outcome. The providers will see the accomplishment and can develop plans to review again the usage over a longer time period. The DNP level of leadership serves the broader nursing profession by becoming an instrument of dissemination of results of this QI evaluation through seminars, workshops, and publication.

All providers of psychiatric mental health care can benefit from knowledge of this QI evaluation. Attending seminars or workshops such as the Florida Psychiatric Nurses Association for my region and state, of which I am a member, is an excellent presentation opportunity. In these meetings psychiatrist, nurse practitioners from the regional area attend. Seeking opportunities to publish results can also help to disseminate the results to a broader range of psychiatric health care providers.

Analysis of Self

As DNP student and practitioner of nursing care and education, growth has occurred since the initiation of this program and my quality evaluation project. Insight into scholarly

expectations has improved beyond expectations. The project allowed me to increase my depth of assessment, and ability to identify valuable needs for change within a specialty healthcare environment in this case a psychiatric clinic. I grew to appreciate the value of tools to assist the practitioner and not serve as an enemy to work time frames. While assessment tools will never take the place of the in-depth review, they help the practitioner to focus on potential dangers quickly which prevent patient suffering. Long term goals will include the use of available instruments to help me focus and revaluate appropriately for the benefit of the patient.

The challenges on this scholarly journey have been lack of specific skills related to writing requirements that greatly delayed the time frame for completion of the project. Challenges at the end included interruptions within the facility itself. My Chair provided the solutions needed and I took my time once I had comfort level to complete the project. My insight or after thought is to know what is totally required for such a journey before the travel. I would weigh all options of research or projects more carefully and make sure there is meaningful use involved as it makes a project easy to implement. It is most beneficial to choose a project that will bring the greatest benefit to the greatest population for the greatest impact in nursing care.

Summary

This QI evaluation project involving the implementation of the GDS assessment tool designed to close a gap in practice related to the promotion of recognition of depression in the elderly population ages 55-65. The clinical site was a clinic where patients across the life span are seen starting at ages six to the oldest elderly. The targeted population of this study was 55 to 65. The question was whether implementing the GDS would promote recognition of depression in this group. While the population and the time frame of observation was limited, small

improvement was seen. In conclusion, the practice focused question was answered as to the usefulness of the tool. The project's evaluation of the outcomes of the QI project shows improvement in recognition of depression in this population, even when small.

References

Adomavicius, G., Kwon, Y.O, Zhang, J. (2010). *Impact of data characteristics on Recommender systems performance gediminas*. Department of Information and Decision Sciences, Carlson School of Management, University of Minnesota Retrieved from

Barua, A., Kar, N., Ghosh, M., & Basilio, M. (2011). Prevalence of depressive disorders in the elderly. *Annals of Saudi Medicine*, *31*(6), 620. doi:10.4103/0256-4947.87100

Brown, E., Raue, P., Halperi, K., Adams, M. & Titler, G. (2009). *Evidenced-based guidelines detection of depression in older adults with dementia*. Retrieved from https://www.ncbi.nlm.nib.gov

Centers for Disease Control and Prevention and National Association of Chronic Disease Directors (2008). *The state of mental health and aging in america issue brief 1: what do the data tell us?* Atlanta, GA: National Association of Chronic Disease Directors. Retrieved from www.cdc.gov

Centers for Disease Control and Prevention (2013). *CDC finds suicide rates among middle-aged adults increased form 1999-2010.* Retrieved from http://www.cdc.gov

Centers for Disease Control and Prevention (2016). *Promoting health for older adults*. Retrieved From https://www.cdc.gov/chronic disease/resources/publications/factsheets

Centers for Disease Control and Prevention (2017). *Depression is not a normal part of growing older/healthy aging. R*etrieved from https://www.cdc.gov/aging/mentalhealth/depression.htm

City of Milwaukee (2007). *Older adults: depression and suicide facts.* (Fact sheet).

Retrieved from https://city.milwaukee.gov/ImageLibrary/User/jkamme/EAP/Info-Library/MentalHealth_OlderAdultsDepres.pdf

Dearing, J. W. (2009). Applying diffusion of innovation theory to intervention development. *Research on Social Work Practice*, *19*(5), 503-518. doi:10.1177/1049731509335569

Gliklich, R., Dreyer, N.A. (2014) *Protecting data: confidentiality and legal concerns of provider, manufacturer, and health provider*. Retrieved from https://www.ncbi.nlm.nih.gov

Harvath, T. & McKenzie, G. L. (2012). Nursing standard of practice: protocol: depression in older adults. Retrieved from https://consultgeri.org

He W., Goodking D., & Kowal P. (2016). An aging world 2015 international population reports. Retrieved from https://census.gov/content/dam/census/library publication/2016.

Hildebrandt, S. (2011). *Depression can damage the brain*. Retrieved from Science Nordic. Com.

Holtz, E. (2012). Power of consistency: five rules. Retrieved from https://www.inc.com/eric-holtzclaw/consistency-power-success-rules.html

Johnson, S. R. (2016). *Addressing behavioral health to improve all health*. Retrieved from https://www.modernhealthcare.com/reports/behavioral-health

Kurowski, E. M., Schondelmeyer, A., Brown, C., Dandoy, C.E., Hanke, S. J., & Cooley, H. L. (2015). *A practical guide to conducting quality improvement in the health care setting*. Retrieved from https://link.springer.com/article/10.1007/s40746-0150027-3

Lvbijaro, G. O. (2008). Mental health in family medicine: a new opportunity. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777552

Marc, L. G., Raue, P. J., & Bruce, M. L. (2008). Screening, performance of the 15-Item geriatric depression scale in a diverse elderly home care population. *The American Journal of Geriatric Psychiatry, 16*(11), 914-921. doi:10.1097/jgp.0b013e318186bd67.

Martin, B. (2016). What are the risk factors for depression? Retrieved from https: psychcentral.com

Martin, L. A., Neighbors, H. W., & Griffith, D. M. (2013). The experience of symptoms of depression in men vs women. *JAMA Psychiatry*, *70*(10), 1100. doi:10.1001/jamapsychiatry.2013.1985

MediciNet (2019). *Suicide Rate Rose 33% Between 1999 and 2017*. Retrieved from https://www.medicinenet.com/script/main/art.asp/222414

Mental Health foundation (2018). Physical health and mental health. www.mentalhealth.org

Naegle, M. (2011). Detecting and screening for depression in older adults. *American Nurse Today*, *6*(11), 18-20.

O'Connor E., Rossom R C., & Henninger M. (2016). Screening for depression in adults: an updated systematic evidence review for the U.S. preventive task force. Retrieved from https://www.ncbi.nlm.nih.gov

Ortman J. M., Velkoff A., & Hogan H. (2014). An aging nation: the older population in the united states. Retrieved from https:www.census.gov./prod/2014pubs/p25-1140.pdf

Paradela, E. M., Lourenco, R. A., & Veras, RP. (2005). Validation of geriatric depression scale in a general outpatient clinic. *Rev Saude Publica. 39*(6). Retrieved from

doi.org/10.1590/s0034-8910200500600008

Pignone, M., Gaynes, B. N., P.H.; Rushton, J. L., Burchell, C.M., Orleans, T. C., Mulrow, C. D., & Lohr, K. N. (2013). Screening for depression in adults. Retrieved from https://www.ahrq.gov/professionals/cliniciansproviders/resources/depression/depsum1.html

Prakash, O., Gupta, L. N., Singh, V. B., & Nagarajarao, G. (2009). Applicability of 15-item Geriatric Depression Scale to detect depression in elderly medical outpatients. *Asian Journal of Psychiatry*, *2*(2), 63-65. doi: 10.1016/j.ajp. 2009.04.005

Sheikh, J. & Yesavage, J.A. (1986) *Geriatric depression scale (GDS): recent evidence and development of a shorter version*. *Clinical Gerontology, 5,* 165-173. https://doi.org/10.1300/J018v05n01_09

Steffens, D. C., Fisher, G. G., Langa, K. M., Potter, G. G., & Plassman, B. L. (2009). Prevalence of depression among older Americans: The aging, demographics and memory study. *International Psychogeriatrics*, *21*(05), 879. doi:10.1017/s1041610209990044

Steffens, D. C., Skoog, I., Norton, M.C., Hart, A.D., Tschanz, J.T., Plassman, B.L., Wyse, B.W., Welsh-Bohmer K.A., & Breitner, J.C.S. (2000). Prevalence of depression and its treatment in an elderly population. Retrieved from http://jamanetwork.com

Swanson-Fisher, R. W. (2004). Diffusion of innovation theory for clinical change. Medical Journal of Australia. Retrieved from https://www.mja.com/journal

University of Washington (2008). Depression linked to high death rates from all cases among elderly with diabetes. Retrieved from www.sciencedaily.com

U. S. Department of Health and Human Services Health Resources and Services Administration (2011). *Quality improvement*. Retrieved from https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf

Walden University (2017). Walden 2020: A vision for social change report. Retrieved https://www.waldenu.edu/-/media/Walden/files/about-walden/walden-university-2017-social-change-report-final-v-2.pdf

WebMD. U.S. (2019). *Suicide Rate Rose 33% Between 1999 and 2017.* Retrieved from https://www.webmd.com/mental-health/news/20190620/us-suicide-rate-rose-33-between- 1999-and-2017

Wible, P.L. (2017). Doctors and depression: suffering in silence. Retrieved from https://www.medscape.com/viewarticle/879379

World Health Organization (2017a). *Depression*. Retrieved from http://www.who.int/medical

World Health Organization (2017b). *Mental health folder adults: fact sheet*. Retrieved from www.who.int/medcentre/factsheet

Yesavage, J. A., Brink, T., Rose, T. L., Lum, O., Huang, V., Adey, M., & Leirer, V. O. (1982). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17*(1), 37-49. doi:10.1016/0022-3956(82)900334

Appendix A: Geriatric Depression Scale (short form)

Tools may be copied without permission

Instructions:

Circle the answer that best describes how you felt over the past week.

1. Are you basically satisfied with your life? yes no

2. Have you dropped many of your activities and interests? yes no

3. Do you feel that your life is empty? yes no

4. Do you often get bored? yes no

5. Are you in good spirits most of the time? yes no

6. Are you afraid that something bad is going to happen to you? yes no

7. Do you feel happy most of the time? yes no

8. Do you often feel helpless? yes no

9. Do you prefer to stay at home, rather than going out and doing things? yes no

10. Do you feel that you have more problems with memory than most? yes no

11. Do you think it is wonderful to be alive now? yes no

12. Do you feel worthless the way you are now? yes no

13. Do you feel full of energy? yes no

14. Do you feel that your situation is hopeless? yes no

15. Do you think that most people are better off than you are? yes no

Total Score _____

Geriatric Depression Scale (GDS) Scoring Instructions

Instructions:

Score 1 point for each bolded answer. A score of 5 or more suggests depression.

1. Are you basically satisfied with your life? yes no

2. Have you dropped many of your activities and interests? yes no

3. Do you feel that your life is empty? yes no

4. Do you often get bored? yes no

5. Are you in good spirits most of the time? yes no

6. Are you afraid that something bad is going to happen to you? yes no

7. Do you feel happy most of the time? yes no

8. Do you often feel helpless? yes no

9. Do you prefer to stay at home, rather than going out and doing things? yes no

10. Do you feel that you have more problems with memory than most? yes no

11. Do you think it is wonderful to be alive now? yes no

12. Do you feel worthless the way you are now? yes no

13. Do you feel full of energy? yes no

14. Do you feel that your situation is hopeless? yes no

15. Do you think that most people are better off than you are? yes no

A score of > 5 suggests depression Total Score _____