Depression: to screen or not to screen?

There are few more difficult diagnoses to make than depression in sick older patients in a general hospital. There is no diagnostic test and confounding physical symptoms, the sheer fact of being ill in the inhospitable and frightening environment of a hospital away from home, possibly for weeks, and still facing an uncertain recovery makes interpretation of symptoms very difficult. When does a miserable and frightening experience become a mental disorder? But, we know that depression in this situation is common and adversely affects outcome, and so its presence matters. The association of depression with physical illness is strong, and multimorbidity is the norm that has implications for research and medical education [1]. In a general hospital, the prevalence of depression in older people may be as high as 20–30% (2–3 times higher than in the community) depending on the diagnostic criteria used. The number of older people with depression is increasing quickly as the population ages [2], and depression is predicted to become the highest global cause of Disability Adjusted Life Years by 2030 [3].

To screen for depression in this hospitalised population would involve large numbers of patients, and any screening instrument would need to be easy and quick to administer with good sensitivity and specificity if it is to identify those in need of treatment yet not produce large numbers of false-positive cases that would require a longer diagnostic assessment. Furthermore, there needs to be sufficient evidence that treating depression would improve outcome. The paper by Baillon et al. [4] investigates an elderly medical population using a two-stage procedure supplementing the two screening questions recommended by NICE [5] with the 15-item Geriatric Depression scale (GDS). The diagnostic gold standard was the ICD-10 criteria for depression excluding those who scored <24 on the Mini Mental State Examination. Twenty-two per cent met the ICD-10 criteria for depression.

Biological symptoms of depression in a physically ill population are particularly difficult to interpret and both NICE questions and the GDS purposefully avoid them as much as possible which usually improves specificity but at a loss of sensitivity. The GDS is the most validated screening instrument for depression in the hospitalised elderly population.

The primary purpose of a good screening instrument is not to miss cases. On this level, the report by Baillon et al. found that answering positively to just one of the NICE questions was very effective with a sensitivity of 100% but at the expense of poor specificity with only 50% of screen positive cases meeting the criteria for depression. As the authors say this would produce large numbers of non-depressed people who would then require a thorough psychiatric assessment. The essential effect of adding the GDS was to reduce this false-positive rate by about two-thirds, but the numbers are small.

The authors recognise that their opportunistic method may not have produced a representative sample. Certainly, the sample size is small. The method also picked people at different points in their admission, and even if we thought this screening process was useful, we would not know when it should be applied, other than opportunistically. This is important as the point of admission would not be appropriate for this population of physically ill people and being screened negative at some point would not preclude depression developing later. Intermittent delirium, which can produce depressive symptoms indistinguishable from depression including suicidal thoughts [6], and excluding those performing poorly on cognitive tests when both depression and prolonged hospitalisation can do this, further complicates the position. Consequently, the opportunistic application of these screens would depend on the clinical team already suspecting the possibility that a patient was depressed. They would already need to have an understanding of the core features of depression. If they had that knowledge, then why would they need a screening instrument?

Any older person presenting with self-harm or expressing thoughts of self-harm or an admission clearly due to a primary mental health problem should automatically have a psychiatric assessment regardless of screening results. Older people only account for around 2% of self-harm presenting to general hospitals, but it is always serious and depression is the major cause of suicide. The risk of completed suicide after self-harm increases with age such that a person over age 60 years is 67 times more likely to commit suicide in the 12 months following self-harm than older people in the general community with males over 75 being at highest risk [7].

There is no doubt that pharmacological and psychological treatments for depression work just as well for older people as young [8], but the prognosis in this hospitalised, often complex, population may not be as good. At this point in time, there is conflicting opinion for the effectiveness of systematic detection and treatment of elderly depressed people in a general hospital. Mortality rate is often high and maintaining treatment in this group of patients can be difficult [9]. Most controlled antidepressant studies exclude those with physical illness [10], and we cannot assume this hospitalised elderly population is the same as those included in these trials. Antidepressants are not without their problems in older people [11]. We also need to know more about the nature of depression with different medical co-morbidities and whether this heterogeneity alters the treatment approach [12]. There is a very important research...
agenda here that needs to be tackled. Improving the outcome for these depressed older people does not only have implications for well-being but also for physical recovery and utilisation of healthcare resources.

While the value or practicality of population screening is doubtful, perhaps, we should just concentrate on education programmes that enable ward teams to recognise the key features of depression in this population and to then have easy access to liaison psychiatry teams competent in assessing older people’s mental health. Reliance on quick tests, which in any case still need to be interpreted, rather than applying informed clinical knowledge and skill, and talking to patients, may be counterproductive and produce poor clinical practice. This condition is sufficiently common for it to be a routine part of training for all general hospital clinicians.

Key points

• The value and practicality of routine screening for depression in older hospital inpatients are doubtful.
• We should concentrate on education programmes that enable ward teams to recognise the key features of depression in this population and to then have easy access to liaison psychiatry teams competent in assessing older people’s mental health.
• Reliance on quick tests, rather than applying informed clinical knowledge and skill and talking to patients, may be counterproductive and produce poor clinical practice.
• Depression is sufficiently common for it to be a routine part of training for all general hospital clinicians.

References