# Chapter 2

## LATE-LIFE DEPRESSION: SYSTEMATIC ASSESSMENT OF CARE NEEDS AS A BASIS FOR TREATMENT

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## Accessible summary

Systematic assessment of the care needs of older patients using the CANE contributes significantly to a targeted nursing anamnesis and diagnostic process. The Camberwell Assessment of Need for the Elderly appears to be a very suitable tool for structured and high quality of care.
Patients may benefit more from depression treatment when significant others of the patients (carers and staff) would be more sensitive to the unmet needs of depressed patients in different stages of their depression, and when treatment would be better targeted at these unmet needs.
Given the broad range of possible unmet needs, collaborative care arrangements should be established with home care, welfare and other organizations, to achieve adequate and efficient referrals to the responsible care providers.


## Abstract

Research shows that most of the variance in depression severity levels in late life can be explained by the unmet psychological needs of patients, more in particular the care needs of patients related with psychological distress. This case report describes the treatment of an 84-year-old patient suffering from depression. Her complaints faded upon the use of nursing interventions that were defined on the basis of a systematic assessment of her care needs with the Camberwell Assessment of Needs for the Elderly. The methodical attention to her needs for care and the interventions carried out led to the patient feeling acknowledged and to a diminished need for care and a better quality of life. Although there is no scientific evidence to date, a systematic assessment of care needs may well be a meaningful addition to the nursing diagnostic process. Moreover, alleviating distress in patients by fulfilling unmet care needs through tailored interventions can be seen as an essential element of an effective multidisciplinary depression treatment process.

## INTRODUCTION

Depression is a common disorder in later life. Studies show that 15% of all elderly people living at home and up to as much as 50% of all elderly people in nursing homes suffer from distinct depressive symptoms (1,2). Depression has considerable consequences for a person's well-being, daily functioning, service utilization and mortality (3–7). Although several studies indicate that depression is highly treatable in all age groups, late-life depression often remains undetected (8) or is ineffectively treated (9). One of the reasons for the poor recognition of depression is the stereotyped assumption that elderly people naturally tend to withdraw into themselves and become increasingly apathetic and gloomy. The patients themselves are often in denial (8). Accepting the situation as it is, depressed elderly patients show reluctance to undergo treatment, which can have a negative impact on the course and prognosis of late-life depression.

Existing guidelines on the treatment of late-life depression (10) focus strongly on the use of evidence-based diagnostics and interventions that have proven to contribute to a decrease in the symptoms of depression. Given the absence of hard scientific evidence regarding the effectiveness of interventions that target the consequences of depression on the daily functioning of older patients, much less attention has been paid to this type of intervention. The consequences of depression may or may not give rise to explicit care needs in older patients. In this regard, the care needs must be considered unmet if patients indicate that they do not receive the right care or the appropriate level of care (11). Care needs are met if a solution is found to the care difficulties experienced by patients.

Agreement with a patient about her actual care needs and how those needs can be met may be of consequence for the process of setting up an effective and tailored care program (12). Because the quantity of unmet care needs is a strong predictor of a lower quality of life and negative health perceptions, identifying met and unmet care needs is important (13).

Several studies have been conducted in which a quantitative examination was made of the care needs of patients suffering from various disorders/illnesses (11–18); however, the knowledge to date of the specific care needs of older depressed patients is still limited (12).

We have found no peer-reviewed studies addressing and evaluating the use of standardized care needs assessment instruments as part of the nursing anamnesis and diagnostic process. This present case report describes how the situation of a chronically depressed patient improved considerably after her met and unmet care needs were

systematically charted using the Camberwell Assessment of Needs for the Elderly (CANE), and after the resulting interventions, tailored to the patient's needs, were implemented.

‘I can't catch up with life anymore’; Mrs Brown sighed when asked what bothered her most about being depressed. That sentence is a pithy expression of what Mrs Brown felt to be her greatest problem. In September 2008, after having been treated in hospital for 8 months, the 84-year-old patient was referred to an outpatient mental health centre for the elderly. She was treated for chronic depression, but to the patient's great sorrow, the treatment did not produce the desired result. Mrs Brown's case history is impressive. Her complaints of depression began when she reached 60 years. Her family doctor prescribed the classic antidepressant, Clomipramine 150 mg/day, following which she went into full remission and stayed there for several years. The patient managed not only her own home, but also, after her daughter-in-law was diagnosed as terminally ill, that of her eldest son's family. Her son was running a farm and lived in the big farmhouse, while the patient and her husband lived next to the house in a lean-to. After her daughter-in-law's death in 1994, the patient went through a period of grief, which followed a pathological course. The patient felt empty and, as she put it, ‘the familiar colour of life’ had disappeared with her grief about the death of daughter-in-law. Once again, having taken the antidepressants prescribed by her family doctor, she went into remission for a prolonged period of time. Objectively, it appeared as if her condition was improving, but the patient herself was far from content. She continued to be in low spirits and felt unable to cope with her daily activities. When her husband died in 2005, her complaints exacerbated. She did not sleep well, felt gloomy and experienced unbearable stress levels. She dreaded each new day that came. She began to lean excessively on her two sons and three daughters, calling them several times a day – even at nights when she was unable to sleep – describing her fears and expressing her need for company. Especially, her son living next to her felt the burden. When her children tried to comfort her or, as the case may be, steered clear of her, the patient became reproachful, blaming them for ignoring her after she had done so much for them. The patient's behaviour clearly put pressure on the relationship with her children. The lack of recognition of her complaints made her feel lonely and desperate. Her suffering eventually resulted in an attempt to commit suicide by taking an overdose of drugs. Her son found her in time, however, and warned the family doctor. Via the emergency psychiatric service, she was admitted to the psychiatric ward of a general hospital where she received drug therapy (Cipramil, 20 mg/day) as well as interpersonal psychotherapy. At a later stage, reminiscence therapy techniques and relaxation exercises were added. The patient was discharged from hospital after 8 months, but indicated that she was still feeling depressed, stating that she was unable to enjoy life, that the colour had disappeared from her life and that she was constantly seeing herself as in a deadly boring black-and-white film. Her depression and loss of emotion were difficult to understand for her family. It seemed to her children as if she had

resumed her normal routines and could do everything she used to do before. But as much as her children tried to convince the patient that life was good, she continued to see it as colourless and pointless.

## REPORT

Mrs Brown's medical file shows that therapeutic interventions were targeted mainly at reducing symptoms. The patient continued to be depressed, however, albeit that the severity of her depression varied over time. The following psychiatric diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Revised Edition (DSM-IV TR) was made based on the clinical data collected (table 1):

| | | |
|---|---|---|
| Axis I | Clinical disorders (296.33) | Depressive disorder not otherwise specified |
| Axis II | Personality disorders | No diagnosis |
| Axis III | Physical disorders | Status after suicide attempt with benzodiazepines |
| Axis IV | Psychosocial and environmental problems | Problems with primary support group |
| Axis V | Global Assessment of Functioning (GAF) | Score of 50 |

Table 1. DSM-IV TR classification (19)

In conversations with the patient, she revealed that she was generally overcome by an overwhelming sense of discomfort. Attempting to specify her feelings, she indicated that ‘she always worried about everything’, but was unable to express the precise nature of those worries. She also despaired that she had lost control of her life and had no idea how to go on in life. However, she was unable to explain what aspects of life she would like to control.

Against this background, it was decided – in consultation with the patient – to first objectify the level of her depression using the Montgomery Åsberg Depression Rating Scale (MADRS; (20). The patients' MADRS score was 22/70, which indicates a moderate to severe depression. In consultation with the attending psychiatrist, the daily dose of antidepressant she had taken over a long period of time was gradually decreased and replaced with an initial dose of 20 mg Paroxetine per day. Furthermore, patients' needs for care were systematically assessed using the Dutch version of the Camberwell Assessment of Needs for the Elderly (CANE-NL). The CANE was designed as a comprehensive instrument to measure a broad range of needs of older people with mental health problems (17,21). With the CANE 24 potential needs of patients in the

social, medical, psychological and environmental domain can be assessed from a patient, carer or staff perspective.

The initial question for each CANE category is whether the patient experiences a specific need or problem and, if so, whether an adequate remedy or solution is provided to meet that need. The patient can answer the question with 'no need', 'met need' or 'unmet need'. The CANE has good psychometric properties (17,22,23). Tests have shown that the tool produces a valid and reliable picture of the care needs in patients with a severe psychiatric disorder (24). The CANE interview with Mrs Brown took about 25 min.

Both the MADRS and CANE were assessed in a 1-h screening session. When asked, Mrs Brown stated that the total session was not too aggravating for her.

| Need | Associated with | Intervention |
|---|---|---|
| Need for meaningful daytime activities | Feelings of boredom, long and empty days, loss of interest | Participation in day care programme at nursing home (Mon, Tue, Thu, Fri) |
| Need for company | Deteriorating relationship with the children, loneliness, sensory and affectional deprivation | See above<br>Psycho education to the patient and her children<br>Preparation, with the children, of a weekend visiting schedule |
| Need for support in times of psychological distress | Feelings of despair, loss of control in life, being unable "to catch up with life" | New antidepressant (SSRI[1])<br>2-weekly structural support visits by a specialist nurse to the patient's home to influence the patient's negative cognitions through behavioural therapy |
| Need for safety to prevent inadvertent self-harm | Fear of the consequences of a fall<br>Fear of being helpless | Installation of an alarm system with 15-minute response time (day and night)<br>Morning call by one of the children<br>Preventative removal of loose carpets and thresholds |
| Need for assistance with medication | Fear of forgetting medication or of taking the wrong dose | Pill box<br>Check on use at day care facility<br>Monitoring of efficacy by nurse under the supervision of a specialist nurse |

Table 2. Summary of needs for care, problem characteristics and interventions

[1] SSRI, selective serotonin reuptake inhibitor

The CANE analysis showed that Mrs Brown had unmet needs in the following categories: daytime activities, memory, medication, psychological distress, inadvertent self-harm and company (Table 2). The scores on these items formed the basis for a more detailed nursing anamnesis and the development of interventions to satisfy the patient's unmet care needs.

## INTERVENTIONS

Based on the needs for care thus established, several intervention options (see Table 1) were discussed with Mrs Brown following which the interventions were implemented with the patient's consent.

Mrs Brown's medication intake was structured by using a 24-by-7-medication management pillbox. Additionally, she received education about the importance of medication compliance and was carefully instructed how to use the pillbox in a safe way. It was agreed that nurses of the home care service who were also responsible for aid with daily personal care would monitor the daily use of medication.

The participation in the day-care program of the local nursing home was the most difficult part to implement. Initially, Mrs Brown showed a lot of resistance to leave her house. Psycho-education and the persuasive power of an acquaintance from her neighbourhood, who also visited the day-care program, made her willing to engage in a 2-week trial period. It was assumed that the day-care program would structure Mrs Brown's daily activities and moreover, it would extend her social network. To her children's relief, Mrs Brown responded positively; after the trial period she agreed to further participate in the program. For the weekends appointments were made concerning her children's visits. Previous negative experiences of the children were discussed in order to prevent them occurring again in the future. Especially, the ‘next-door son’ initially showed some reluctance. He reminded his brothers and sisters of the negative experiences he had with his mother in the past and emphasized the ‘mutual responsibility of all parties involved making it work this time’.

To make Mrs Brown feel more secure during the night, a personal alarm kit was installed. Pushing the alarm button would first alert her son. In case he would not respond within 5 minutes, the alarm signal would be automatically send to an operator who could alert one of the neighbours. Additional safety measures were taken in Mrs Brown's house. As part of a fall prevention plan, doorsteps and all loose mats were removed. Extra handrails were mounted in the bathroom. Special attention was paid to Mrs Brown's feelings of psychological distress. In a 2-weekly supportive counselling contact with a clinical nurse specialist in mental health care, expressions of Mrs Brown based on negative cognitions

were restructured into more positive responses by challenging the underlying irrational beliefs. Moreover, reminiscence techniques were used to discover positive memories and images as an alternative for the more negatively shaped thoughts Mrs Brown usually expressed.

## COURSE

After 3 months, the patient was accustomed to her new daily routine. A number of negative cognitions, such as the patient's belief that she could no longer catch up with life and her perception of being ignored and receiving only few visitors, were put into perspective, resulting, among other things, in a more relaxed relationship with her children. The patient also reported that her sense of being unable to control life had abated. She felt safer at home at times when she was without company and had not yet felt the need to push the alarm button. Her taking of the prescribed medication was going as planned and her feelings of despair had faded. The patient was satisfied with the level of social interconnection and her weekly day-care program. The children reported that their mother was becoming more actively involved in life again, taking a renewed interest in her environment and telling the children about events from her everyday life. After 6 months of treatment, the CANE and MADRS were administered to the patient again. The CANE scores showed that all unmet needs recorded before had transformed into met needs. In consultation with the patient, the number of home visits by the specialist mental health nurse was reduced to one 45-minutes visit every 6 weeks. Three months later, this frequency was reduced again to 45 minutes every quarter. The patient rejected an even further reduction, explaining that she did not want to plan ahead too far given her age. The purpose of the quarterly visits was to monitor the effects of the medication taken by the patient by observing her mood and functioning. Consultation with the patient's children resulted in the agreement that they could also contact the specialist nurse in between visits if the patient's complaints were to increase. According to the patient, this arrangement provided her with a sense of safety. She hoped that she would never again have to go through a period such as the one behind her now. All parties agreed that the MADRS and CANE measurements should be repeated on an annual basis. The patient currently scores 8/70 on the MADRS, which warrants the conclusion that she is in remission.

## CONCLUSION

The CANE produced a valuable basis for preparing a multidisciplinary treatment plan for an 84-year-old patient suffering from chronic depression. The case reported on above shows that a systematic assessment of the care needs of older patients using the CANE contributes significantly to a targeted nursing anamnesis and diagnostic process. In the present case, the analysis of the CANE results and the agreement obtained between the patient and her children about the perceived needs served as a useful basis for tailored care interventions.

The explicit discussion of her needs in combination with the individualized treatment plan led to Mrs Brown feeling acknowledged. Her passive and complaining attitude changed into a more active one, taking more responsibility for her own situation. It also changed the relationship between Mrs Brown and her children. The active approach enabled her children to experience their mother not as a nagging old woman but as an elderly person with a treatable condition and problems that were real and solvable. The acknowledgement and the positive attitude of her children that Mrs Brown felt proved to be the turning point in the treatment of her depression, marked by a significant decrease in her complaints. Although the results described in this case report do not provide hard scientific evidence for the effectiveness of a care needs assessment and the resulting tailored interventions, we illustrated the possible benefits of such an approach in the specific case of Mrs Brown.

The Camberwell Assessment of Need for the Elderly appeared to be a very suitable tool for structured and high quality of care. Moreover, we expect patients to benefit more from depression treatment when significant others of the patients (carers and staff) would be more sensitive to the unmet needs of depressed patients in different stages of their depression, and when treatment would be better targeted at these unmet needs. Given the broad range of possible unmet needs, collaborative care arrangements should be established with home care, welfare and other organizations, to achieve adequate and efficient referrals to the responsible care providers (25). However, more research is needed to obtain a sound scientific basis for the effectiveness of assessment-based interventions within a multidisciplinary treatment context.

## REFERENCES


1. Beekman AT, Kriegsman DM, Deeg DJ, van Tilburg W. The association of physical health and depressive symptoms in the older population: age and sex differences. Soc Psychiatry Psychiatr Epidemiol. 1995;30(1):32–8.

2. Jongenelis K, Pot AM, Eisses AMH, Beekman ATF, Kluiter H, Ribbe MW. Prevalence and risk indicators of depression in elderly nursing home patients: the AGED study. Journal of Affective Disorders. 2004; 83(2-3):135–42.

3. Ormel J, VonKorff M, Ustun TB, Pini S, Korten A, Oldehinkel T. Common mental disorders and disability across cultures: results from the WHO Collaborative Study on Psychological Problems in General Health Care. Jama. 1994;272(22):1741–8.

4. Badger TA. Depression, Physical Health Impairment and Service Use Among Older Adults. Public Health Nursing. 1998;15(2):136–45.

5. Beekman ATF, Penninx BWJH, Deeg DJH, de Beurs E, Geerling SW, van Tilburg W. The impact of depression on the well-being, disability and use of services in older adults: a longitudinal perspective. Acta Psychiatr Scand. 2002;105(1):20–7.

6. Fiske A, Wetherell JL, Gatz M. Depression in Older Adults. Annual Review of Clinical Psychology. 2009;5(1):363–89.

7. Meeks TW, Vahia IV, Lavretsky H, Kulkarni G, Jeste DV. A tune in “a minor” can “b major”: A review of epidemiology, illness course, and public health implications of subthreshold depression in older adults. Journal of Affective Disorders. 2011;129(1-3):126–42.

8. Licht-Strunk E, Van Marwijk HWJ, Hoekstra T, Twisk JWR, De Haan M, Beekman ATF. Outcome of depression in later life in primary care: longitudinal cohort study with three years follow-up. BMJ. 2009;338.

9. Beekman ATF, Geerlings SW, Deeg DJH, Smit JH, Schoevers RS, de Beurs E, et al. The natural history of late-life depression: a 6-year prospective study in the community. Archives of General Psychiatry. 2002;59(7):605.

10. Kok RM. GGZ-richtlijnen.nl: Addendum Ouderen bij de MDR Depressie : Steunende en structurele interventies [Internet]. Addendum Ouderen bij MDR Depressie. [cited 2014, November 26]. Retrieved from: http://www.ggzrichtlijnen.nl/richtlijn/item/pagina.php?id=684&richtlijn_id=62

11. Phelan M, Slade M, Thornicroft, et al. The Camberwell Assessment of Need: the validity and reliability of an intrument to assess the needs of people with severe mental illness. British Journal of Psychiatry. 1995;167:589–95.

12. Houtjes W, van Meijel B, Deeg DJH, Beekman ATF. Major depressive disorder in late life: A multifocus perspective on care needs. Aging & Mental Health. 2010; 14(7):874–80.

13. Wiersma D. Needs of people with severe mental illness. Acta Psychiatrica Scandinavica. 2006; 113: 115–9.

14. Brewin CR, Wing JK, Mangen SP, et al. Priciples and practice of measuring needs in the long-term mentally ill; The MRC needs for care assessment. Psychological Medicine. 1987;17:971–81.

15. Bebbington P, Marsden L, Brewin CR. The treatment of psychiatric disorder in the community: report from the Camberwell Needs for Care Survey. Journal of Mental Health. 1999;8(1):7–17.

16. Slade M, Phelan M, Thornicroft G. A comparison of needs assessed by staff and by an epidemiologically representative sample of patients with psychosis. Psychological Medicine. 1998;28(03):543–50.

17. Hancock GA, Reynolds T, Woods B, Thornicroft G, Orrell M. The needs of older people with mental health problems according to the user, the carer, and the staff. International Journal of Geriatric Psychiatry. September 2009;18(9):803–11.

18. Goossens PJ, Knoppert van der Klein EA, Kroon H, van Achterberg T. Self-reported care needs of outpatients with a bipolar disorder in the Netherlands. Journal of Psychiatric and Mental Health Nursing. 2007;14(6):549–57.

19. American Psychiatric Association. Diagnostic and Statistical Manual text revision (DSM-IV-TR. American Psychiatric Association; 2000.

20. Montgomery SA, Åsberg M. A new depression scale designed to be sensitive to change. The British journal of psychiatry. 1979;134(4):382–9.

21. Reynolds T, Thornicroft G, Abas M, Woods B, Hoe J, Leese M, et al. Camberwell Assessment of Need for the Elderly (CANE). British Journal of Psychiatry. 2000;176: 444–52.

22. Dröes RM, Van Hout HPJ, Van der Ploeg ES. Camberwell Assessment of Need for the Elderly (CANE). Revised version IV Nederlandse Vertaling VU Medisch Centrum, Amsterdam. 2004;

23. Hancock GA, Orrell MG. Introduction: Defining need. In: Hancock GA, Orrell M, editors. CANE: Camberwell Assessment of Need for the Elderly. London: Gaskell; 2004. p. 1–2.

24. Van der Roest HG, Meiland FJM, van Hout HPJ, Jonker C, Dröes R-M. Validity and reliability of the Dutch version of the Camberwell Assessment of Need for the Elderly in community-dwelling people with dementia. International Psychogeriatrics. 2008; 20(06): 1273.

25. Houtjes W, van Meijel B, Deeg DJH, Beekman ATF. Unmet needs of outpatients with late-life depression; a comparison of patient, staff and carer perceptions. Journal of affective disorders Journal of Affective Disorders. 2011;134:242-248