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# Survey of Depression Reporting in Older Adults Admitted to Acute Hospitals

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**Date Published: March 2018**

**Publication number: CCQI1281**

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## Acknowledgements

We would like to thank the sites who volunteered to take part in the survey and the staff who took the time to collect and submit data. We are also grateful to Professor Alistair Burns and the NHS England team for their help in recruiting sites.

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# Executive Summary

## Background

People in the UK are living longer than ever before, with older people making an increasing proportion of our population. While this is a cause for celebration, the ageing of our population has major implications for our health systems. Increases in health expectancies are not keeping pace with gains in life expectancy and without significant improvements in public health and health care, the prevalence of long-term conditions affecting both physical and mental health will continue to grow as our population ages, resulting in growing demands for health and social care support (Government Office for Science, 2016).

Two-thirds of NHS beds are occupied by people aged 65 years or older and up to 60% of general hospital admissions in this age group will have or will develop a mental disorder during their admission. Depression is the most common mental health problem among older people, with a mean prevalence of 29% in acute hospital setting. When untreated, depression in old age can become

a chronic disorder that leads to poorer health outcomes, including increased rates of morbidity and mortality. However, despite a favourable response to treatment, depression remains largely undetected and untreated in older adults.

## Aim

We set out to undertake a survey of depression in older adults admitted to acute hospitals to understand current practice with regard to diagnosing and treatment in acute hospitals, and to make recommendations to support improvements in clinical practice in this area. To reach these objectives, we compared the current levels of recognition and treatment of depression as they emerged from the survey data against the best available evidence on the prevalence of this condition in older adults admitted to acute hospitals.

## Who should read this report

This report is primarily intended as a sector facing resource, to provide information for:

- People involved in providing care – professional staff, managers and Trust Boards working in general hospitals in England;

- People involved in commissioning care – NHS England, Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and clinical commissioning groups (CCGs);
- People who regulate care – including NHS Improvement, the Care Quality Commission, clinical audit and quality improvement professionals.
- People who lead on the education, training and workforce development of the health sector – Health Education England and the relevant Royal Colleges.

## Method

Twenty-nine acute hospital sites volunteered to take part in the survey between August 2017 and October 2017. Sites were asked to submit data on the diagnosis and treatment of depression in a sample of 30 consecutive inpatients aged 65 and over with an unplanned admission who were discharged from the hospital from 01 April 2017 onwards. They were also asked to complete a questionnaire on the organisation and delivery of mental health care in the hospital.

# Responses

Of the twenty-nine sites that volunteered to participate, 27 submitted eligible data for the survey, and the analysis was carried out on 766 service users from these sites.

# Key findings

## Diagnosis of depression

- The proportion of older people who had a diagnosis of depression recorded in their notes was less than half that expected (13% compared to 29%).
- Only one in a hundred older people in the survey had a new diagnosis of depression made during their admission to an acute hospital; the majority of older people with a diagnosis of depression were admitted to hospital with an existing diagnosis
- It is likely that some people may have had underlying depression which was not detected by the clinical teams providing their care. Thirty-seven (5%) older people had evidence of a discussion about mental health in their notes without a diagnosis of depression. Over half (22/37, 59%) may have had possible

symptoms of depression which do not appear to have been evaluated further.

## Communication

- The study highlights poor communication of the diagnosis of depression following an older person's discharge from hospital. For only half of older people with a diagnosis of depression in their records was this mentioned in discharge correspondence from acute trusts to primary care teams (50/98, 51%).

## Treatment

- When depression was recognised by the clinical team, it generally led to antidepressant treatment and/or referral to specialist mental health services. Eighty-seven percent of older people with a diagnosis of depression (85/98), including all (100%) of people with a new diagnosis of depression, received some form of treatment.
- Over one third of older people receiving medication for depression (48/131, 36%) did not have a depression diagnosis recorded in their notes.
- There was a significant reduction in the prescription of monoamine oxidase inhibitors (MAOIs). Prescriptions for this

group of drugs fell from 24% of those receiving medication prior to admission to 1% of those prescribed medication on discharge. Selective serotonin reuptake inhibitors (SSRIs) or Noradrenergic and specific serotonergic antidepressants (NASSAs) were prescribed instead.

- Most patients who were referred to specialist mental health services were referred to the in-hospital psychiatric/liaison team (35/38, 92%).

## Organisation

- Most sites had a specific team providing mental health liaison services for older people (18/19; 95%). Fifteen hospitals had an established pathway to refer older people with depression to mental health services.
- However, under 1/5 (3/19; 16%) of sites routinely used a standardised protocol or proforma to identify depression in older people.

# Recommendations

## Case identification and diagnosis

- **Acute hospital managers** should ensure their hospitals have mechanisms in place to routinely identify depression in older people for assessment and, where appropriate, recording alongside any other clinical problems on admission.

- **All acute hospital staff** caring for older people should consider the regular use of screening tools to help identify common symptoms associated with depression, particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment. The approach to screening and the tool selected should comply with the NICE Clinical Guideline on Depression in Adults: Recognition and Management (CG90). They may also wish to further establish the presence of depression and the need for referral to mental health services using diagnostic tools such as the Geriatric Depression Scale and/or as part of a 'Comprehensive Geriatric Assessment' or any similar holistic medical review.

## Access to mental health support during admission

- **Acute hospital managers** should ensure there is a clear referral pathway to mental health liaison services for older people who are admitted to hospital and suspected of having depression. This should facilitate specialist assessment, diagnosis and future care for emergency, urgent and routine referrals. The pathway should be informed by guidance on Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults issued by NHS England, NICE and the National Collaborating Centre for Mental Health (NCCMH).

- When designing a person's care package, **acute hospital staff**, and **liaison mental health services,** should consider the role of talking therapies, including via Improving Access to Psychological Therapies (IAPT) services, in supporting older people with a diagnosis of depression during and following their hospital stay. Some IAPT services have embedded teams within acute hospitals as part of the recent expansion of IAPT services.

## Medication review

- **Acute hospital staff** should take the opportunity of hospital

admission to ensure older people receive a structured medication review, particularly if a new medication is prescribed during the hospital stay. This medication review should be undertaken by a qualified professional – e.g. psychiatrists in the case of antidepressants – and take full account of the service user's preferences and personal circumstances, in line with the NICE Clinical Guideline on Medicines Optimisation (NG5).

## Record keeping and sharing

- **Clinical commissioning groups and all health and care providers** should take steps to ensure information about people with existing mental health problems, including medication, can be shared between primary care, acute hospitals and mental health services in order to assure quality and continuity of care upon arrival at A&E as well as upon admission to, and discharge from, hospital.

- Records should be updated by **acute hospital staff** following any relevant assessments, interventions and treatment for depression in hospital. These should be well-documented and included in discharge summaries.

## Education and training

- **Acute hospital managers** should ensure that all staff caring for older people are given basic training and education in the recognition and management (including referral processes) of depression in older people.

- **Health Education England**'s forthcoming Core Competency Framework on Older People's Mental Health should also provide key guidelines to help ensure acute hospital staff have consistent knowledge and skills in the recognition and management of depression in older people.

- **Liaison mental health teams** should consider their role in spreading expertise and upskilling non specialist staff in acute hospitals regarding depression in older people through education and training programmes. This will also help to ensure the appropriateness of referrals made to them by non-specialist staff. Wherever possible, mental health awareness training should be co-produced and co-delivered with people with lived experience.

## Research

- **National bodies** should explore with the **National Institute of Health Research (NIHR)** the possibility of undertaking further research on the prevalence, identification and treatment of depression among older people on acute hospital wards.

# Background

## Our changing demographics

People in the UK are living longer than ever before, with older people making an increasing proportion of our population. Between 2011 and 2026, the population aged 65-84 will have risen by 39% and those over 85 by 106% (Office for National Statistics, 2011). While this is a great cause for celebration, the ageing of our population has major implications for our health systems. Increases in health expectancies are not keeping pace with gains in life expectancy and without significant improvements in public health and health care, the prevalence of age-related long-term conditions affecting both physical and mental health will continue to grow as our population ages. This means our health and care systems must be geared to the needs of growing numbers of older people facing an increasingly complex set of needs. (Government Office for Science, 2016).

## Why look at depression in older people?

Depression affects around 22% of men and 28% of women over the age of 65, yet studies have estimated that 85% of older people with

depression receive no help at all from the NHS (Age UK, 2016, Royal College of Psychiatrists, 2009). Depression is the most common mental health problem among older people, with a mean prevalence of 29% in acute hospital settings (Goldberg et al., 2012, Health Survey for England, 2005; Cullum et al., 2006; Anderson et al., 2005). Depression in older adults is associated with disability, social isolation, self-reported poor general health and increased mortality from physical illnesses (The Kings Fund, 2008; Unutzer et al., 2000; Penninx et al., 1999; Burroughs et al., 2006). It is often expressed through physical complaints (somatisation) resulting in unnecessary physical health investigations. If left untreated, depression in older age can lead to high levels of morbidity and mortality, with important costs to health and care systems (Anderson, 2001).

Depression in later life can be treated successfully. However many older adults with depression do not receive appropriate treatment because their condition has historically been under-recognised across health and social care settings (Wilson et al., 2001; Karel et al., 2000; Scogin et al., 1994; Burroughs et al., 2006). This is due to a number of factors, including a lack of understanding of the presentations of depression in later life among healthcare

professionals, and a common assumption on the part of both practitioners and service users that mental health problems are an inevitable part of growing older and nothing can be done. This is known as "therapeutic nihilism" (Montano, 1999, NHS England & NHS Improvement, 2017). Other factors affecting diagnosis include barriers to accessing services and lack of collaborative care approaches between primary care and mental health specialists in the management of late-life depression (Age Concern, 2007; Burroughs et al., 2006).

## Older people's depression in acute settings

Two-thirds of NHS beds are occupied by people aged 65 years or older and up to 60% of general hospital admissions in this age group will have or will develop a mental disorder during their admission. Similarly, older adults account for about 80% of all hospital bed-days, and these include people with co-morbid physical and mental health problems. There is now clear evidence that poor physical health can lead to an increased risk of developing depression and vice versa (The Kings Fund, 2016). Given the high prevalence of both physical and mental health conditions in older people, it is important that acute hospitals take appropriate steps to identify and treat depression in older people upon admission, and

treat their mental health needs on a par with their physical health needs.

Collaborative care arrangements for people with co-morbid long-term physical conditions and depression are recommended by the National Institute for Health and Care Excellence (NICE), and liaison psychiatry services, in particular, within general hospitals can contribute substantially to improving the care people with mental health conditions receive when they are in hospital (Centre for Mental Health, 2012; NHS England 2016). Liaison psychiatry outpatient services provide a range of specialist mental health inputs aimed at improving the health outcomes of people with long-term physical health conditions, complicated by the presence of a mental health problem. As part of the Improving Access to Psychological Therapies (IAPT) programme, NHS England has provided new funding to 'early implementer' sites focussing on treating common mental health problems for people with long term conditions or medically unexplained symptoms (NHS England, 2016). Improvements in the identification, management and treatment of depression in hospital can significantly reduce the scale and cost of all of the poor health outcomes associated with low detection rates as well as making a positive impact on service users' quality of life.

## Aim of this study

We aimed to examine the recognition and treatment of depression in older adults aged 65 and above admitted to acute hospitals in England, to understand current practice with regard to diagnosing and treatment in acute hospitals and to make some initial recommendations to support service providers and clinicians to make practical improvements. To achieve this, we compared current levels of recognition and treatment of depression as recorded with a survey against the best available evidence on the prevalence of this condition in older adults in acute hospitals.

# Methodology

## Recruitment of hospital sites

All acute trusts in England were contacted via the National Audit of Dementia with details of the survey. Information was also circulated to liaison psychiatrists via the Royal College of Psychiatrists (RCPsych) College Centre for Quality Improvement (CCQI) Psychiatric Liaison Accreditation Network (PLAN) email discussion group. Clinical Networks were approached via NHS England and the RCPsych and asked to pass details to their networks. A copy of the information sheet that was provided can be found in Appendix 1.

## Development of the survey tool

An initial version of the survey tool was developed by the Depression Survey team to collect information on the recognition of depression in older people admitted to acute hospitals, and evidence on awareness of depression among the same group. There was input from a consultant geriatrician (the Clinical Advisor to the project) and two consultant psychiatrists. A copy of the tool and accompanying guidance can be found in Appendices 2-5.

## Sampling and data collection

Sites were asked to audit the discharge summaries and medical records of 30 consecutive service users aged 65 and over with an unplanned admission to an acute hospital who were discharged from 01 April 2017 onwards. To be eligible for inclusion, service users had to have been admitted to hospital for a minimum of one night to any type of ward. People with a diagnosis of dementia, slowly resolving delirium or other similar memory problems were excluded; people who died during the admission were also excluded. Sites were asked to complete a copy of the survey tool for each service user.

Data collection opened on 21 August 2017, with a deadline for online data submission of 13 October 2017. Data were submitted using the online data collection forms designed and hosted using Formic's Fusion software solution.

Sites were also asked to complete a questionnaire about the organisation and delivery of mental health care in the hospital (see Appendices 6-7). For more information on the methodology and its limitations, please refer to the section 'Limitations of the survey' at the end of this report.

## Data entry and analysis

All data were entered using Formic Fusion Survey Software via secure webpages. Data were downloaded and subsequently analysed using PASW Statistics 20/21 (SPSS).

## Data cleaning

Data cleaning was carried out in parallel to data submission during September and October 2017. A detailed process was followed to identify cases that did not meet the sampling criteria and to check for any duplication of data or unexpected values. Any suspected data errors were emailed back to sites for clarification. Amendments to the data were then made as necessary.

## Anonymisation and confidentiality

Formic Fusion abides by NHS security requirements and is ISO27001 certified and IGSoC Level 2 Compliant. The RCPsych has a bank level end-to-end SSL/Transport Layer Security with 128 bit encryption. The online data collection forms were password protected. Each site was provided with a username and password, also held by the Depression Survey team at the RCPsych.

Sites were asked to allocate codes to each eligible patient, which were used during data collection. It was stipulated that these should be independent codes that allowed the site to identify service users for the purposes of data cleaning, and should not identify people other than to those involved in data collection. The key to the patient codes was held by the site and was not known to the Depression Survey team.

# Results

## Participating sites

Twenty-nine sites registered to take part in the survey. Two sites did not sample according to the criteria so their data could not be included. Analysis was carried out on 766 eligible cases from 27 sites, which were spread fairly evenly across the country:

Midlands and East of England: 3

North of England: 14

South of England: 10

Six sites had 500 beds or less, 12 had between 501 and 1000 beds, and 7 had more than 1000 beds. Two sites did not report the number of beds.

Of the 19 sites which completed a questionnaire on the organisation and delivery of care, all but one (95%) had a specific team providing mental health liaison services for older people. Nearly two-thirds (63%) felt the need for liaison mental health service input was met, 26% did not, and 11% did not know.

Fifteen sites (79%) had an established pathway to refer a patient with depression to psychiatry/mental health services, which in 14 sites were based in the hospital. Only three sites (16%) routinely used a standardised protocol or proforma to help identify depression in older people. Nearly two-thirds of sites (12/19; 63%) used assessment tools to help identify depression in older people. The Geriatric Depression Scale was used by all of these sites. The majority of staff (60%) using assessment tools were acute hospital staff (non-mental health professionals); the others were mental health professionals.

For further detail about the organisation and delivery of mental health care at participating sites, see Appendix 8. Information about ward types and patient demographics is presented in Appendix 9. It should be noted that the analysis is not broken down by ward-type. Feedback from sites about their experience of participating in the survey is shown in Appendix 10.

# Recognition and awareness of depression

## Diagnosis of depression

Ninety-eight (13%) of the 766 patient records examined had a diagnosis of depression recorded in them when people were either

admitted or discharged from hospital (see Table 1).

This is below the expected prevalence of 29% (Goldberg et al., 2012, Health Survey for England, 2005; Cullum et al., 2006; Anderson et al., 2005). Ninety service users (12% of the total sample) had a diagnosis of depression recorded in their admission notes (an existing diagnosis) and only eight (1% of the total sample) had a diagnosis of depression made during the admission (a new diagnosis).

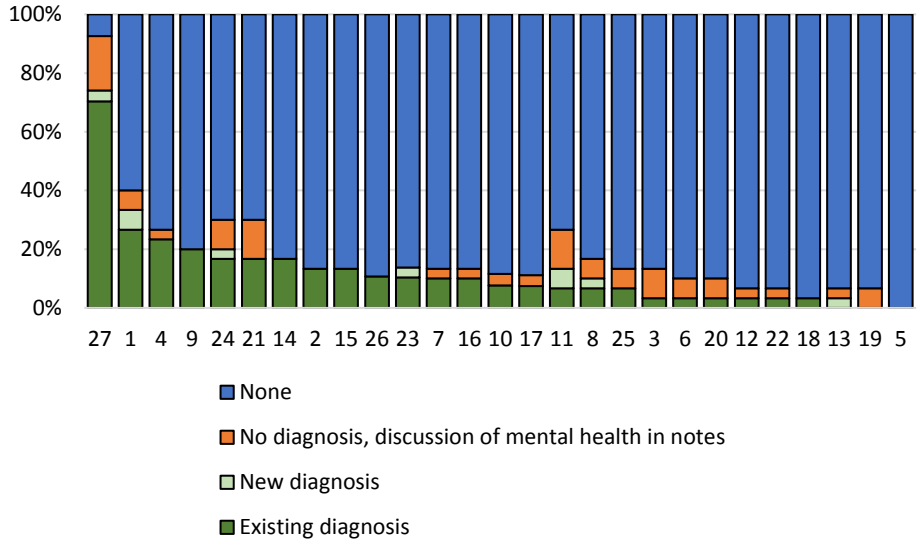
*Table 1: Diagnosis of depression (N=766)*

| | N | (%) |
|---|---|---|
| **Diagnosis of depression in admission notes (existing diagnosis)** | 90 | (12%) |
| **Diagnosis of depression during admission (new diagnosis)** | 8 | (1%) |
| **No diagnosis of depression** | 668 | (87%) |
| **Total service users** | 766 | (100%) |

Just over half of the people with either an existing or new diagnosis of depression (50/98; 51%) had this diagnosis recorded in their discharge correspondence to GPs. This suggests that a diagnosis of depression is being poorly communicated to GPs and primary care teams which may impact on service users' subsequent care and follow up.

## Trust-level variation in diagnosis of depression

*Figure 1: Individual trust variation in the percentage of service users diagnosed with depression (N=766)*




There was a large variability across the trusts with regard to the proportion of patients with a diagnosis of depression (new or existing) recorded in their notes. The ranged varied from 0% to 74% with the median being 10%. Seven sites had service users with a new diagnosis of depression recorded in their notes. The percentage ranged from 0% to 7%, with a median of 0%.

The percentage of service users with an existing diagnosis of depression recorded in their notes varied from 0% to 70%, the median being 8%. Three sites had no service users with an existing diagnosis of depression recorded in their notes.

The percentage of people with a discussion of mental health recorded in their notes varied from 0% to 19% with a median of 3%. Eight sites had no service users with a discussion of mental health recorded in their notes.

Notably, one site had a very high proportion of people with a diagnosis of depression recorded in their notes (74%). Nearly all of those with a diagnosis of depression at this hospital had the diagnosis made before their admission (an existing diagnosis). Whilst feedback from the site was that this might be explained by comprehensive staff training heightening community and hospital staff awareness of depression, it may also be explained by random variation within the context of the relatively small number of case records that each site examined.

## Depression and co-morbid mental health problems

Seventeen percent of the 98 service users with a diagnosis of depression had a co-morbid mental health diagnosis recorded in their discharge notes. Comorbidity with other mental health conditions was observed in 18% of people with an existing diagnosis of depression and in 13% of those with a new diagnosis of depression.

*Table 2: Breakdown of co-morbid mental health problems (N=17)*

| | New diagnosis of depression N (%) | Existing diagnosis of depression N (%) |
|---|---|---|
| **Psychosis, schizophrenia, F20** | 0 (0%) | 3 (18%) |
| **Alcohol excess, F10** | 0 (0%) | 2 (12%) |
| **Anxiety, F41** | 1 (6%) | 9 (53%) |
| **Bipolar affective disorder, F31.9** | 0 (0%) | 1 (6%) |
| **Emotionally unstable personality disorder, F60.3** | 0 (0%) | 1 (6%) |

Table 2 shows that anxiety accounted for over half (59%) of the co-morbid mental health problems whilst nearly one in five (18%) of people with a co-morbid mental health diagnosis suffered from psychosis and schizophrenia.

*Table 3: Depression and co-morbid anxiety (N=766)*

| | N | (%) | Total service users |
|---|---|---|---|
| **New diagnosis of depression and diagnosis of anxiety** | 1 | (13%) | 8 |
| **Existing diagnosis of depression and diagnosis of anxiety** | 9 | (10%) | 90 |
| **No diagnosis of depression and diagnosis of anxiety** | 4 | (1%) | 668 |

Ten percent of people with an existing diagnosis of depression also had a comorbid diagnosis of anxiety, compared to 1% of those with no diagnosis of depression.

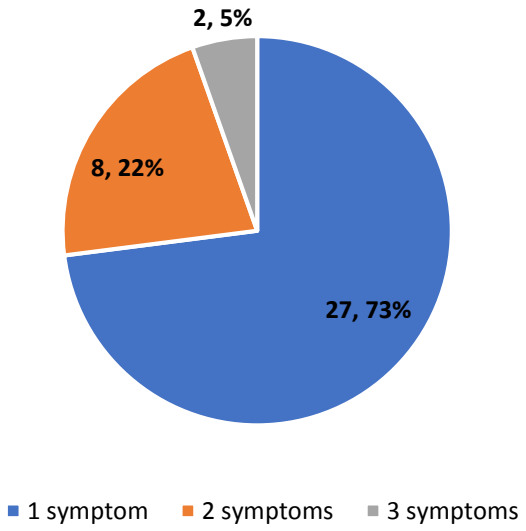
## Discussion of mental health in the notes

Thirty-seven (5%) people had evidence of a discussion about mental health in their notes but there was no diagnosis of depression recorded in their notes when they were admitted or discharged from hospital. There was deemed to have been a discussion of mental health in the notes if the person had any of the following symptoms: persistent sadness or low mood, poor concentration or indecisiveness, agitation or slowing of movements, loss of interests or pleasure, low self-confidence, suicidal thoughts

or acts, guilt or self-blame or other symptoms suggestive of depression (see Table 4 for a breakdown of other symptoms suggestive of depression).

As biological symptoms of depression, such as fatigue or low energy, poor or increased appetite or disturbed sleep, also occur in a number of conditions affecting physical health, these were not included in identifying this group. The majority (73%) of these older people who had evidence of a discussion about mental health in their notes had only one symptom of possible depression recorded in their notes (see Figure 2).

*Figure 2: Count of symptoms suggestive of depression (N=37)*



Fifteen (41%) of these 37 service users received treatment and were either prescribed medication or referred to specialist mental health services during admission (see Figure 5). It is therefore likely that these people did have a formal diagnosis of depression made prior to their admission and stay in the acute hospital, but that this was not properly recorded in their notes or had been poorly communicated by the various medical teams involved in their care.

The remaining 22 people who had evidence of a discussion of mental health in their notes (59%) may therefore have had possible symptoms of depression which do not appear to have been evaluated further.

## Types of mental health symptoms recorded in the notes

Table 4 shows the breakdown of symptoms discussed in the medical notes. More than one symptom could be chosen, therefore the percentages add up to more than 100%.

*Table 4: Breakdown of symptoms suggestive of depression chosen (N=37)*

| | N | (%) |
|---|---|---|
| **Persistent sadness or low mood** | 13 | (35%) |
| **Poor concentration of indecisiveness** | 3 | (8%) |
| **Agitation or slowing of movements** | 4 | (11%) |
| **Loss of interests or pleasure** | 4 | (11%) |
| **Low self-confidence** | 4 | (11%) |
| **Suicidal thoughts or acts** | 3 | (8%) |
| **Guilt or self-blame** | 0 | (0%) |
| **Other symptoms suggestive of depression** | 18 | (49%) |

Eighteen of the 37 (49%) individuals without a diagnosis of depression whose mental health symptoms were discussed in their notes had 'other symptoms suggestive of depression' (see Figure 3 for a breakdown). Over one third (35%) of these people, had symptoms of persistent sadness or low mood. Three service users (8%) had suicidal thoughts or acts recorded.

*Figure 3: Other symptoms suggestive of depression (N=18)*

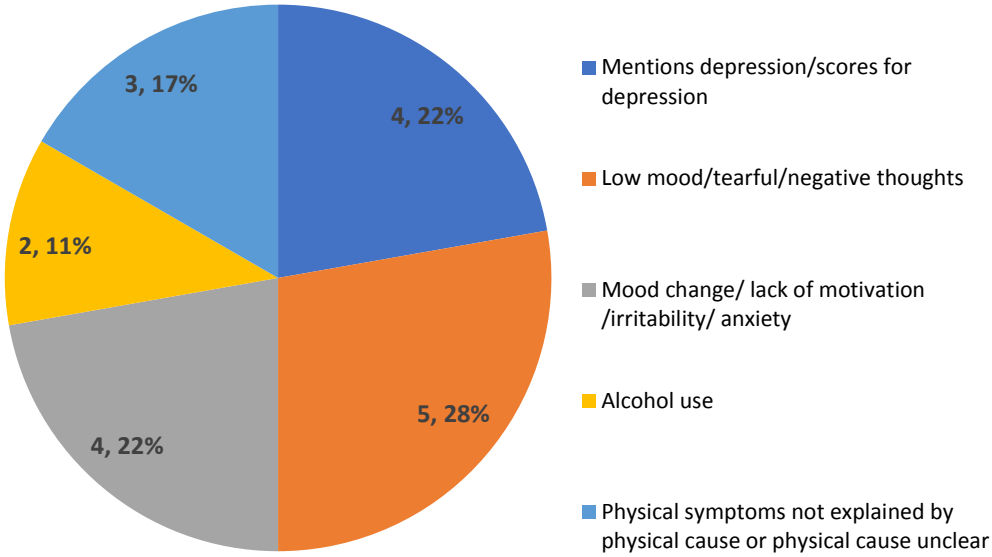
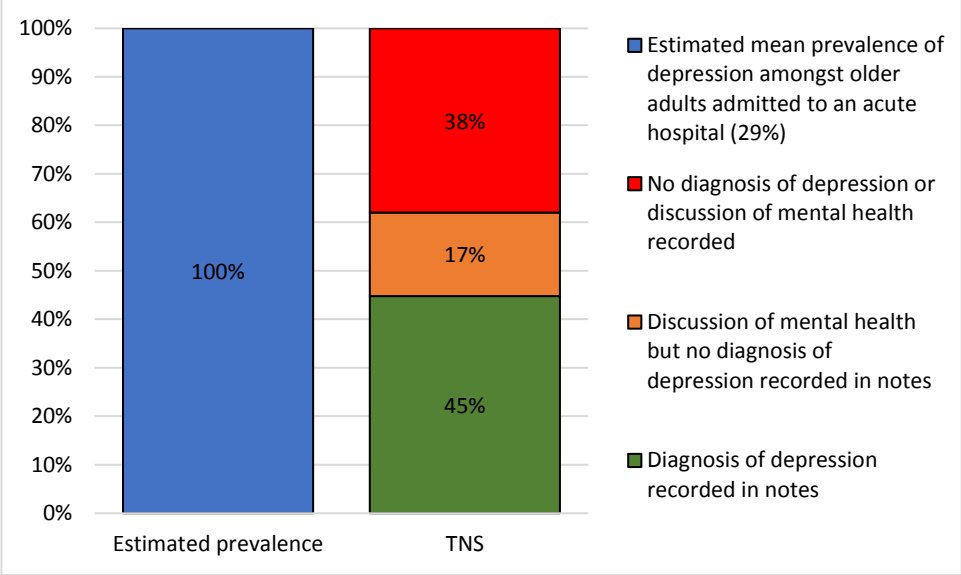



Figure 4 compares the recognition and awareness of depression found in the survey with the expected prevalence of depression among older adults admitted to an acute hospital (i.e. 29%, Goldberg et al., 2012, Health Survey for England, 2005; Cullum et al., 2006; Anderson et al., 2005). This shows that less than half (45%) of the estimated 29% of inpatients aged over 65 who are likely to have depression had this formally recorded in their case notes.

*Figure 4: Comparison of the recognition and awareness of depression found in the survey with the estimated mean prevalence of depression among older adults admitted to an acute hospital*




As shown in Figure 4, 11% of the sample (84 people) could be estimated to have depression that was not picked up in the hospital or other settings (e.g. primary care, community).

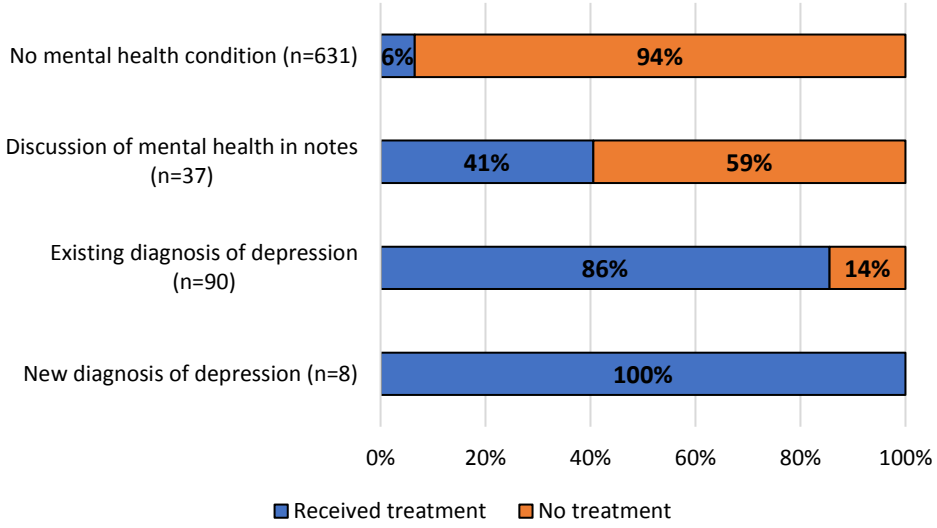
# Treatment

## Service users receiving any treatment

Treatment was deemed to have been received if antidepressant medication was being prescribed when the patient was admitted, or was prescribed on discharge or initiated as an inpatient, or if the patient was referred to specialist mental health services during their stay.

Eighty-five (87%) of the total number of service users with a new or existing diagnosis of depression recorded in their notes (*n*=98) received some form of treatment for their depression (see Figure 5).

*Figure 5: Service users receiving any treatment for depression (N=766)*



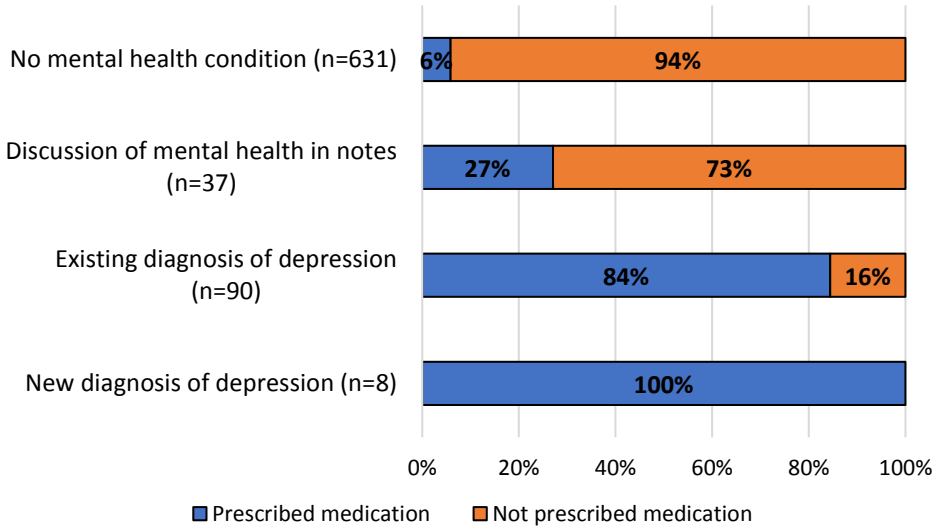

More than half (59%) of those with a discussion of mental health in their notes but no diagnosis of depression did not receive any form of treatment. Conversely, 41% received some form of treatment without a formal diagnosis.

It is notable that 6% of those with no mental health condition recorded in their notes received some form of treatment.

## Service users receiving treatment with medication at any point

Service users were considered to have received treatment with medication at any point if medication was prescribed prior to admission, on discharge, or if treatment with medication was initiated (including being altered) as an inpatient.

*Figure 6: Service users receiving treatment with medication at any point (N=766)*




Most people with a diagnosis of depression were prescribed medication, with all those with a new diagnosis (100%) and most of those with an existing diagnosis (84%) receiving treatment with medication at some point.

Of the 131 people prescribed medication at any point, more than one third (48 people, 36%) did not have a diagnosis of depression recorded in their notes or discharge correspondence. One possible explanation for this result could be that in addition to treatment for depression, certain antidepressants are sometimes prescribed as a primary treatment for chronic pain, anxiety disorders, and/or sleep disorders or insomnia.

## Service users already receiving antidepressants when admitted

*Table 5: Service users receiving antidepressants when admitted (N=766)*

| | N | (%) | Total service users |
|---|---|---|---|
| **New diagnosis of depression** | 0 | (0%) | 8 |
| **Existing diagnosis of depression** | 74 | (82%) | 90 |
| **Discussion of mental health in notes** | 8 | (22%) | 37 |
| **No mental health condition** | 37 | (6%) | 631 |

Most people (82%) with an existing diagnosis of depression were already receiving antidepressants when admitted to hospital.

Nearly a quarter (22%) of people with a discussion of mental health recorded in their notes were receiving antidepressants when admitted. Thirty-seven people (6%) had no mental health condition recorded in their notes but were receiving antidepressants prior to admission. Table 6 shows the type of medication prescribed. More than one type of medication could be chosen, so percentages add up to more than 100%.

*Table 6: Type of medication prescribed to service users when admitted (N=766)*

| | **Existing diagnosis** | **Discussion in notes** | **No condition** |
|---|---|---|---|
| | **N (%)** | **N (%)** | **N (%)** |
| **SSRI** | 21 (23%) | 5 (14%) | 15 (2%) |
| **SNRI** | 5 (6%) | 0 (0%) | 1 (0%) |
| **TCA** | 8 (9%) | 0 (0%) | 1 (0%) |
| **MAOI** | 18 (20%) | 1 (3%) | 9 (1%) |
| **Mood stabiliser** | 4 (4%) | 0 (0%) | 2 (0%) |
| **NASSA** | 0 (0%) | 0 (0%) | 1 (0%) |
| **Reversible MAOI** | 22 (24%) | 2 (5%) | 10 (2%) |
| **Other** | 2 (2%) | 1 (3%) | 0 (0%) |
| **Total service users** | 90 | 37 | 631 |

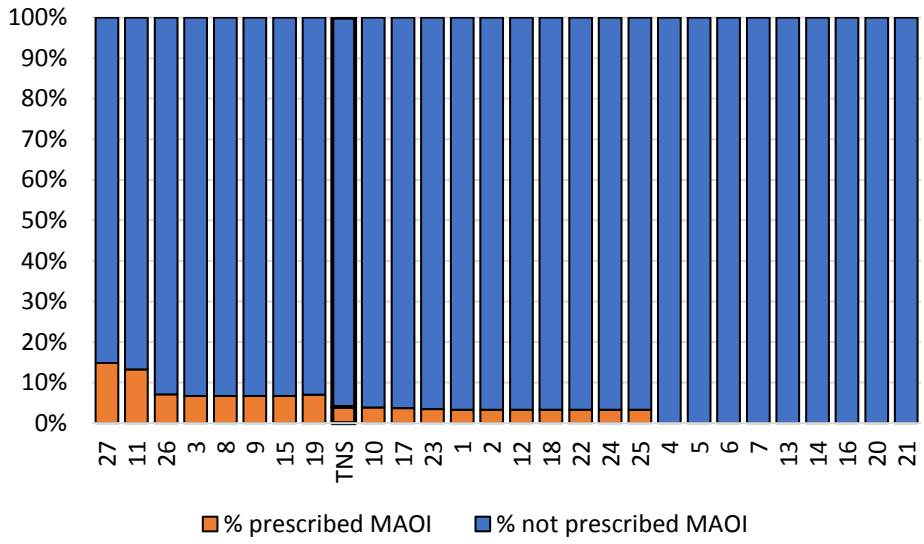
SSRI - selective serotonin reuptake inhibitors; SNRI - serotonin and noradrenaline reuptake inhibitors; TCA – tricyclics; TCA related – tricyclic related drugs; MAOI - monoamine oxidase inhibitors; NASSA - Noradrenergic and specific serotonergic antidepressant; Reversible MAOI – Reversible monoamine oxidase inhibitors; Other - other antidepressants

No one had been prescribed TCA-related antidepressants prior to being admitted and none of the service users with a new diagnosis of depression were being prescribed antidepressants prior to being admitted.

Most people who were receiving medication prior to admission (*n*=119) had been prescribed an SSRI (34%). Twenty-nine percent of people in this group had been prescribed a reversible MAOI, with nearly a quarter of them (24%) prescribed a MAOI. Figure 7 shows individual trust variation in the percentage of people who had been prescribed a MAOI before they were admitted.

## Trust-level variation in prescription of MAOIs prior to admission

*Figure 7: Individual trust variation in the percentage of service users being prescribed a MAOI prior to admission (N=766)*




The percentage of people being prescribed a MAOI before they were admitted ranged from 0% to 15% with a total national sample (TNS) average of 4%. In nine sites, no one had been prescribed MAOIs prior to admission.

## Treatment with medication initiated during hospital stay

Most people with a new diagnosis of depression (88%) had treatment with medication initiated during their hospital stay (see Table 7).

*Table 7: Treatment with medication initiated during hospital stay (N=766)*

| | N | (%) | Total service users |
|---|---|---|---|
| **New diagnosis of depression** | 7 | (88%) | 8 |
| **Existing diagnosis of depression** | 7 | (8%) | 90 |
| **Discussion of mental health in notes** | 3 | (8%) | 37 |
| **No mental health condition** | 1 | (0%) | 631 |

A similar proportion of those with a discussion of mental health in their notes (8%) had treatment with medication initiated (including altered) during their hospital stay.

Table 8 shows the type of medication prescribed. More than one type of medication could be chosen, so percentages add up to more than 100%.

*Table 8: Type of medication prescribed during hospital stay (N=766)*

| | New diagnosis N (%) | Existing diagnosis N (%) | Discussion in notes N (%) | No condition N (%) |
|---|---|---|---|---|
| **SSRI** | 3 (38%) | 2 (2%) | 3 (8%) | 0 (0%) |
| **NASSA** | 5 (63%) | 5 (6%) | 0 (0%) | 1 (0%) |
| **Total service users** | 8 | 90 | 37 | 631 |

SSRI - selective serotonin reuptake inhibitors; SNRI - serotonin and noradrenaline reuptake inhibitors; TCA – tricyclics; TCA related – tricyclic related drugs; MAOI - monoamine oxidase inhibitors; NASSA - Noradrenergic and specific serotonergic antidepressant; Reversible MAOI – Reversible monoamine oxidase inhibitors; Other - other antidepressants

No treatment with SNRI, TCA, TCA related, MAOI, mood stabiliser, reversible MAOI or another antidepressant was initiated during the hospital stay.

Over half of patients (61%) with a diagnosis of depression whose treatment with medication was initiated during their stay (*n*=18) were prescribed a NASSA antidepressant. The remaining 44% were prescribed an SSRI.

## Service users prescribed antidepressants on discharge

Nearly nine tenths of service users (88%) with a new diagnosis of depression were prescribed medication on discharge (this is all those for whom treatment with medication was initiated during their stay) (see Table 9).

*Table 9: Service users prescribed medication on discharge (N=766)*

| | N (%) | Total service users |
|---|---|---|
| **New diagnosis of depression** | 7 (88%) | 8 |
| **Existing diagnosis of depression** | 69 (77%) | 90 |
| **Discussion of mental health in notes** | 8 (22%) | 37 |
| **No mental health condition** | 35 (5%) | 631 |

Over three quarters (77%) of those with an existing diagnosis of depression were prescribed medication on discharge. This is a small reduction from the 74 people (82%) who had a prescription prior to admission, suggesting that treatment with antidepressants was thought to be appropriate for the majority of these people. However, under one quarter (23%) were referred to specialist mental health services during their hospital stay (see Table 11).

## Type of medication prescribed on discharge

Table 10 shows the type of medication prescribed on discharge. More than one medication could be chosen, so the percentages may add up to more than 100%.

*Table 10: Type of medication prescribed on discharge (N=766)*

| | New diagnosis N (%) | Existing diagnosis N (%) | Discussion in notes N (%) | No condition N (%) |
|---|---|---|---|---|
| **SSRI** | 4 (50%) | 33 (37%) | 6 (16%) | 23 (4%) |
| **SNRI** | 0 (0%) | 6 (7%) | 0 (0%) | 3 (0%) |
| **TCA** | 0 (0%) | 5 (6%) | 0 (0%) | 1 (0%) |
| **TCA related** | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) |
| **MAOI** | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) |
| **Mood stabiliser** | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) |
| **NASSA** | 3 (38%) | 26 (29%) | 2 (5%) | 10 (2%) |
| **Other** | 0 (0%) | 2 (2%) | 0 (0%) | 0 (0%) |
| **Total service users** | 8 | 90 | 37 | 631 |

SSRI - selective serotonin reuptake inhibitors; SNRI - serotonin and noradrenaline reuptake inhibitors; TCA – tricyclics; TCA related – tricyclic related drugs; MAOI - monoamine oxidase inhibitors; NASSA - Noradrenergic and specific serotonergic antidepressant; Reversible MAOI – Reversible monoamine oxidase inhibitors; Other - other antidepressants

None of the service users was prescribed a reversible MAOI on discharge. Nearly nine tenths (89%) of people prescribed medication on discharge (*n*=119) were prescribed an SSRI (55%) or NASSA (34%) class of antidepressant. One person (1%) was prescribed a MAOI. Nearly one fifth of people (16%) received prescriptions for other classes of antidepressant, these were mainly people with an existing diagnosis.

Comparing the types of medication prescribed prior to admission and on discharge, there is a significant reduction in the prescription of MAOIs. Of those people receiving medication when admitted, nearly one quarter (24%) were being prescribed a MAOI; at discharge MAOIs were prescribed to only 1% of those prescribed a medication. It seems that prescriptions of this class of antidepressant are being replaced by SSRIs and NASSAs. There was an increase in the prescription of SSRIs from 34% of people prescribed medication prior to admission to 55% on discharge. There was an increase in the prescription of NASSAs from 1% of people prescribed medication when admitted to 34% on discharge.

NICE guidelines on depression (CG90) advise that when an antidepressant is prescribed it should usually be an SSRI. SSRIs should be the first class of antidepressant prescribed. If there is no

adequate response, a second SSRI should be tried, before a different class of antidepressant is prescribed. The guidance suggests that MAOIs should normally be prescribed by specialist mental health professionals. Specific guidance for prescribing antidepressants for older people is to prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics and carefully monitor for side effects.

The shift from the prescription of MAOIs to SSRI and NASSA antidepressants suggests compliance with national guidance. Figures 8 and 9 show the individual trust variation in the percentage of people prescribed a NASSA or SSRI on discharge.

## Trust-level variation in the prescription of medication on discharge

The percentage of people being prescribed a NASSA on discharge varied from 0% to 20% with a TNS average of 5% (see Figure 8). In eight sites, no one had been prescribed NASSAs on discharge.

*Figure 8: Trust-level variation in the percentage of service users being prescribed a NASSA on discharge (N=766)*

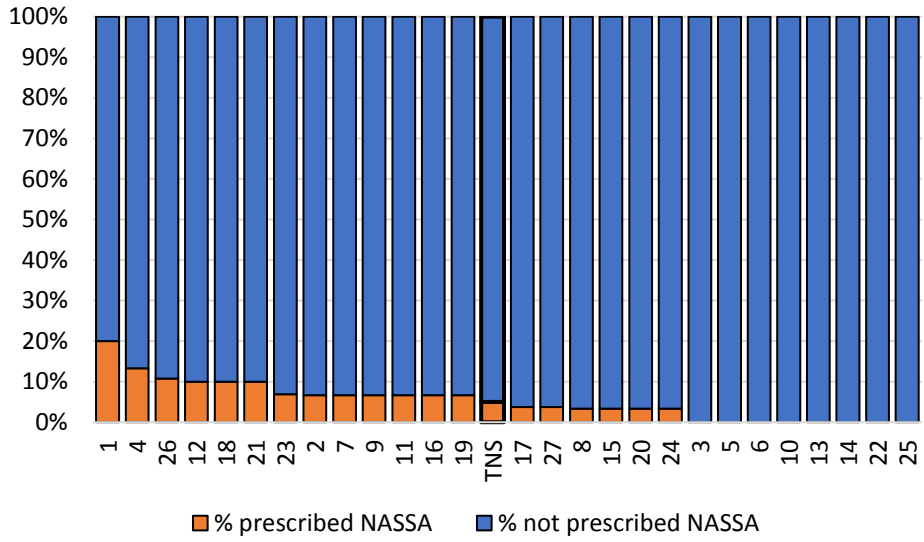
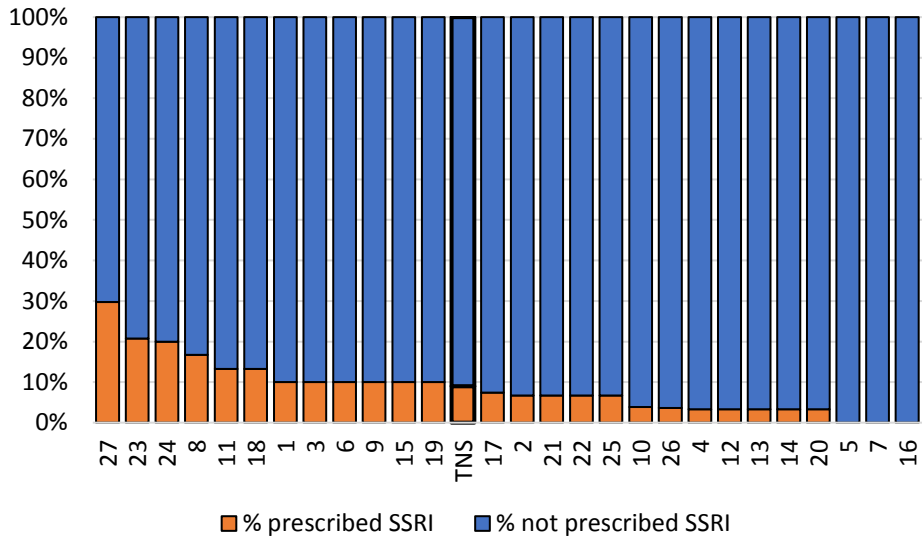


*Figure 9: Trust-level variation in the percentage of service users being prescribed an SSRI on discharge (N=766)*




The percentage of people being prescribed an SSRI on discharge varied from 0% to 30% with a TNS average of 9%. In three sites, no one was prescribed SSRIs on discharge.

## Referral to mental health specialist services during admission

*Table 11: Referral to specialist services during admission (N=766)*

| | N | (%) | Total service users |
|---|---|---|---|
| **New diagnosis of depression** | 6 | (75%) | 8 |
| **Existing diagnosis of depression** | 21 | (23%) | 90 |
| **Discussion of mental health in notes** | 7 | (19%) | 37 |
| **No mental health condition** | 4 | (1%) | 631 |

Fewer service users with a new diagnosis of depression were referred to specialist mental health services during their stay than received treatment with medication at any point (75% compared to 100%).

Around one fifth of those with an existing diagnosis of depression and those with a discussion of mental health in their notes (23% and 19% respectively) were referred to specialist mental health services during admission.

## Types of referral made

Table 12 shows the types of referral made. More than one referral could be chosen, so percentages add up to more than 100%.

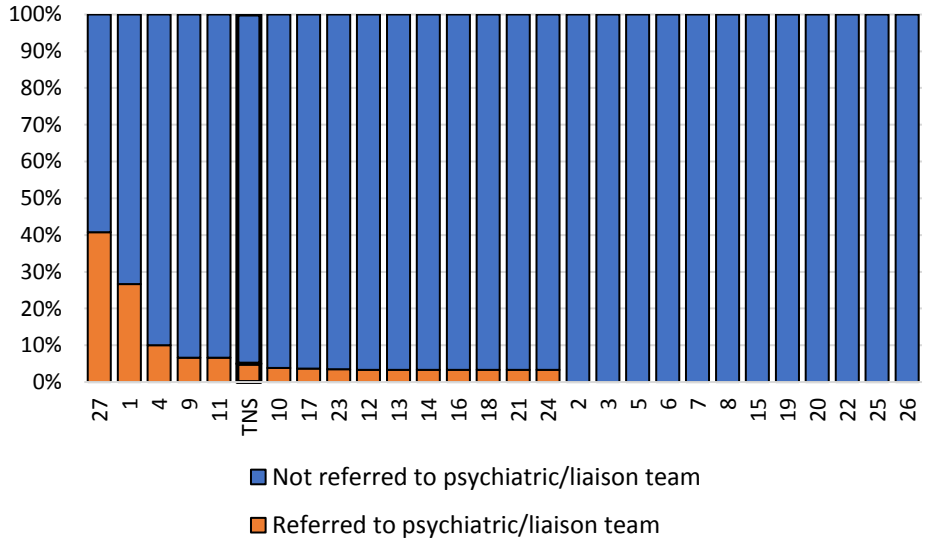
*Table 12: Type of referral made to specialist mental health services (N=766)*

| | New diagnosis N (%) | Existing diagnosis N (%) | Discussion in notes N (%) | No condition N (%) |
|---|---|---|---|---|
| **Psychiatric/ liaison team** | 6 (75%) | 21 (23%) | 5 (14%) | 3 (0%) |
| **Community Mental Health Team** | 0 (0%) | 1 (1%) | 1 (3%) | 0 (0%) |
| **Psychiatrist** | 3 (38%) | 5 (5%) | 1 (3%) | 1 (0%) |
| **Mental Health nurse** | 1 (13%) | 6 (7%) | 0 (0%) | 0 (0%) |
| **Psychologist** | 0 (0%) | 0 (0%) | 0 (0%) | 1 (0%) |
| **Counsellor/ talking therapist** | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) |
| **Total service users** | 8 | 90 | 37 | 631 |

No referrals were made to a mental health social worker. Most of those who were referred to specialist mental health services were referred to the psychiatric/liaison team. All those with a diagnosis of depression who were referred to a specialist mental health service were referred to the psychiatric/liaison team.

However, overall less than a quarter (23%) of people with an existing diagnosis were referred to the psychiatric/liaison team.

*Figure 10: Trust-level variation in the percentage of service users referred to psychiatric/liaison teams during admission (N=766)*




The percentage of service users referred to a psychiatric/liaison team varied from 0% to 41% with a TNS average of 5%. In 12 sites, no one was referred to a psychiatric/liaison team.

Results from the questionnaire on the organisation and delivery of mental health care in the hospital can be found in Appendix 8.

## Reasons for referral

Table 13 shows the breakdown of reasons for referral to specialist mental health services. These are taken from the free text responses and grouped into categories.

*Table 13: Reasons for referral (N=766)*

| | New diagnosis N (%) | Existing diagnosis N (%) | Discussion in notes N (%) | No condition N (%) |
|---|---|---|---|---|
| **Psychosis/ delusions/ hallucinations** | 0 (0%) | 4 (4%) | 0 (0%) | 1 (0%) |
| **Self-harm/ suicidal intent** | 1 (13%) | 4 (4%) | 2 (5%) | 0 (0%) |
| **Anxiety/ agitation** | 0 (0%) | 2 (2%) | 0 (0%) | 0 (0%) |
| **Assessment of mood/change in mood/low mood** | 5 (63%) | 6 (7%) | 4 (11%) | 0 (0%) |
| **Confusion** | 0 (0%) | 1 (1%) | 0 (0%) | 0 (0%) |
| **Mental health review/advice regarding mental capacity assessment** | 0 (0%) | 2 (2%) | 0 (0%) | 0 (0%) |
| **Medication advice or review** | 0 (0%) | 1 (1%) | 0 (0%) | 2 (0%) |
| **No stated reason** | 0 (0%) | 1 (1%) | 1 (3%) | 1 (0%) |
| **Total service users** | 8 | 90 | 37 | 631 |

Over one third (39%) of people referred to specialist services (*n*=38) were referred for assessment of mood/change in mood/low mood. Nearly one fifth (18%) were referred for self-harm/suicidal intent.

Table 14 shows the breakdown of reasons of referral for each profession. These are taken from the free text responses and grouped into categories. Percentages are given from the number of referrals made to each profession.

*Table 14: Reasons for referrals to each specialist service*

| | 1 N (%) | 2 N (%) | 3 N (%) | 4 N (%) | 5 N (%) | 6 N (%) |
|---|---|---|---|---|---|---|
| **Psychosis/ delusions/ hallucinations** | 5 (14%) | 0 (0%) | 2 (20%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Self-harm/ suicidal** | 7 (20%) | 1 (50%) | 2 (20%) | 2 (29%) | 0 (0%) | 1 (100%) |
| **Anxiety/ agitation** | 2 (6%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Assessment of mood/change in mood/low mood** | 13 (37%) | 1 (50%) | 5 (50%) | 4 (57%) | 0 (0%) | 0 (0%) |
| **Confusion** | 1 (3%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Mental health review/advice regarding mental capacity assessment** | 2 (6%) | 0 (0%) | 1 (10%) | 1 (14%) | 0 (0%) | 0 (0%) |
| **Medication advice or review** | 3 (9%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **No stated referral reason** | 2 (6%) | 0 (0%) | 0 (0%) | 0 (0%) | 1 (100%) | 0 (0%) |
| **Total service users** | 35 | 2 | 10 | 7 | 1 | 1 |

1= Psychiatric/liaison team
2= Community Mental Health Team
3= Psychiatrist
4= Mental Health nurse
5= Psychologist
6= Counsellor/talking therapist

## Drug treatment and referral to specialist services

Table 15 shows that three quarters (75%) of service users with a new diagnosis of depression received drug treatment at any point and were referred to specialist services during admission. Over one fifth (22%) of those with an existing diagnosis received the same.

*Table 15: Drug treatment (at any point) and referral to specialist mental health services during admission (N=766)*

| | N | (%) | Total service users |
|---|---|---|---|
| **New diagnosis of depression** | 6 | (75%) | 8 |
| **Existing diagnosis of depression** | 20 | (22%) | 90 |
| **Discussion of mental health in notes** | 2 | (5%) | 37 |
| **No mental health condition** | 0 | (0%) | 631 |

Just 5% of those with a discussion of mental health in their notes, and no one without a mental health condition, received both treatment at any point and were referred to specialist services during admission.

# Conclusion

Results of this survey show that levels of depression noted in the records of people aged over 65 are lower than what would be expected given what we know about the high prevalence of this condition among older adults treated on acute hospital wards. Our findings suggest that record keeping is not capturing all those with depression. However, more importantly, depression in some older adults may be going undetected. In most instances where depression was recorded during the hospital stay, this was because people already had a diagnosis of depression prior to admission; instances of people having this diagnosis made whilst in hospital were rare, which may reflect the transient nature of their visit to and stay in hospital, or their presentation, the prioritisation of physical health treatment, or a lack of confidence or expertise among staff. A diagnosis of depression was not systematically recorded in discharge notes, thereby suggesting that depression is not being well communicated by acute staff to GPs and primary care teams when people leave hospital, which may impact on their future care.

Among other things, this locality-based, practical investigation

confirms previous research findings that depression in older people remains under-diagnosed and under-treated in acute hospitals, and that more steps need to be taken to ensure routine identification of mental health issues in those settings, in line with national guidelines. We are proposing a set of recommendations below to help the sector make improvements in clinical practice and to ensure that opportunities are taken to provide more older people with the mental health support they need.

# Recommendations

## Case identification and diagnosis

- **Acute hospital managers** should ensure their hospitals have mechanisms in place to routinely identify depression in older people for assessment and, where appropriate, recording alongside any other clinical problems on admission.

- **All acute hospital staff** caring for older people should consider the regular use of screening tools to help identify common symptoms associated with depression, particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment. The approach to screening and the tool selected should comply with the NICE Clinical Guideline on Depression in Adults: Recognition and Management (CG90). They may also wish to further establish the presence of depression and the need for referral to mental health services using diagnostic tools such as the Geriatric Depression Scale and/or as part of a 'Comprehensive Geriatric Assessment' or any similar holistic medical review.

## Access to mental health support during admission

- **Acute hospital managers** should ensure there is a clear referral pathway to mental health liaison services for older people who are admitted to hospital and suspected of having depression. This should facilitate specialist assessment, diagnosis and future care for emergency, urgent and routine referrals. The pathway should be informed by guidance on Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults issued by NHS England, NICE and the National Collaborating Centre for Mental Health (NCCMH).

- When designing a person's care package, **acute hospital staff**, and **liaison mental health services,** should consider the role of talking therapies, including via Improving Access to Psychological Therapies (IAPT) services, in supporting older people with a diagnosis of depression during and following their hospital stay. Some IAPT services have embedded teams within acute hospitals as part of the recent expansion of IAPT services.

## Medication review

- **Acute hospital staff** should take the opportunity of hospital

admission to ensure older people receive a structured medication review, particularly if a new medication is prescribed during the hospital stay. This medication review should be undertaken by a qualified professional – e.g. psychiatrists in the case of antidepressants – and take full account of the service user's preferences and personal circumstances, in line with the NICE Clinical Guideline on Medicines Optimisation (NG5).

## Record keeping and sharing

- **Clinical commissioning groups and all health and care providers** should take steps to ensure information about people with existing mental health problems, including medication, can be shared between primary care, acute hospitals and mental health services in order to assure quality and continuity of care upon arrival at A&E as well as upon admission to, and discharge from, hospital.

- Records should be updated by **acute hospital staff** following any relevant assessments, interventions and treatment for depression in hospital. These should be well-documented and included in discharge summaries.

## Education and training

- **Acute hospital managers** should ensure that all staff caring for older people are given basic training and education in the recognition and management (including referral processes) of depression in older people.

- **Health Education England**'s forthcoming Core Competency Framework on Older People's Mental Health should also provide key guidelines to help ensure acute hospital staff have consistent knowledge and skills in the recognition and management of depression in older people.

- **Liaison mental health teams** should consider their role in spreading expertise and upskilling non specialist staff in acute hospitals regarding depression in older people through education and training programmes. This will also help to ensure the appropriateness of referrals made to them by non-specialist staff. Wherever possible, mental health awareness training should be co-produced and co-delivered with people with lived experience.

## Research

- **National bodies** should explore with the **National Institute of Health Research (NIHR)** the possibility of undertaking further research on the prevalence, identification and treatment of depression among older people on acute hospital wards.

# Limitations of the survey

## Sampling criteria

- Over one third of people (35%) in the survey had a stay of 1 - 2 days which may have been too short a time in which to evaluate the possibility of depression.

## Questions asked

- The questions regarding medication were designed to identify people prescribed medication for depression only. However, sites reported it was sometimes difficult to determine whether medication was prescribed for depression or not as the reason was not specified in the notes. It is possible that some medication prescribed for other reasons, for example chronic pain, was mistakenly included.
- The questions about referrals to specialist mental health services only covered the period during the hospital stay. People may have been receiving treatment in the community, or have been referred post-discharge.

## Data availability

- Sites commented that data was not always available, for example regular medication was not documented during the admission, or that they had difficulty accessing notes. This may have affected the data collected.

## Selection of study sites

- Hospital that took part in the survey were self-selecting. While the 27 hospitals that took part varied in size and came from different parts of the country, we do not know the extent to which these findings are representative of practice at hospitals that did not take part in the survey.

## Sample size

- The sample size of patients was relatively small so we do not know the extent to which these findings are representative.

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# Appendix 1: Information sheet

## Survey of depression reporting in older adults (DepSurv) - Information Sheet

The Royal College of Psychiatrists has been commissioned by NHS England to carry out a survey of depression reporting in older adults (DepSurv).

Depression is an illness that can often go unrecognised or untreated particularly in older adults, due to therapeutic nihilism – that is, the expectation on the part of both practitioners and patients that nothing can be done[1]. However, it is expected that at least a quarter of older adults admitted to an acute hospital will have depression.

DepSurv will use audit methods to collect retrospective data from a sample of inpatients admitted to acute hospitals in order to compare levels of recognition and treatment of this condition.

### Participation

We are looking for **10-15 acute hospital sites** across England to participate in the survey. All hospital wards will be included in the sample.

### What is involved?

Sites will be asked to audit the records of 30 consecutive patients aged 65 and over with an unplanned admission, discharged from 01 April 2017 onwards. The information should be extracted primarily from the discharge notes as well as medical records where necessary. Please note that any patients with a diagnosis of dementia, slowly resolving delirium or other similar memory problems should be excluded.

Information collected will include:

- Depression diagnosis (ICD-10 code)
- Other mental health comorbidity (e.g. anxiety disorder or obsessive compulsive disorder)
- Prescription of medication for depression (e.g. antidepressants)
- Other indication of symptoms suggestive of depression recorded in the notes (e.g. emotional lability, distress, withdrawal, sleeping problems, anorexia)
- Referral to mental health practitioner or mental health liaison service

## Timescales

Data collection will take place from August until mid-October 2017. Findings will be reported in November 2017.

We don't anticipate that data collection will take participants more than 2 days of clinical time, and the findings may help highlight areas for future consideration or development.

## Why participate?

All participating hospitals will be thanked personally by NHS England for their contribution to this important work. This is an opportunity to be involved in real change and the vanguard for improving depression services, in terms of both access and treatment. Participating hospitals will be invited to provide feedback on the data collection process and the utility of data collected in the survey to influence the developing work.

You will also be able to benchmark your own data against the performance of the total sample (please note that all data published in the report will be non-identifiable).

## Contact us

If you are interested to take part or would like to find out more about the survey, please complete the registration form, or email DepSurv@rcpsych.ac.uk.

## Appendix 2: Data collection tool

# Survey of depression reporting in older adults (DepSurv)

### Data Collection Form

Please complete this survey for each patient. Guidance on completion of the survey is available here. For additional support please contact the DepSurv team on depsurv@rcpsych.ac.uk; 020 3701 2716.

Please submit data online by **Friday 13 October 2017**.

Patient identifier:

*This is the code or number allocated to the patient for the purposes of the survey. Please see the guidance for more details.*

Name of data collector / clinician:

Job title of data collector / clinician:

Email address of data collector / clinician:

## PATIENT INFORMATION

**Date of admission:**

DD / MM / YYYY

**Date of discharge:**

DD / MM / YYYY

**Age of the patient** NNN

*This is the age of the patient in whole years at discharge. To calculate age using date of birth, you can use this website:*
*http://www.mathcats.com/explore/age/calculator.html*

**Gender**

- Male ☐
- Female ☐
- Other ☐

**Ward type:**

*Please choose the specialty of the ward the patient spent most time on.*

- ☐ Cardiac
- ☐ Critical care
- ☐ Care of the elderly
- ☐ General medical
- ☐ Nephrology
- ☐ Neurology
- ☐ Oncology
- ☐ Respiratory
- ☐ Stroke
- ☐ Other Medical
- ☐ General Surgery
- ☐ Gynaecology
- ☐ Orthopaedics
- ☐ Other

**If Other, please specify:**

**Ethnicity**

| **White** | **Black or Black British** | **Asian or Asian British** | **Mixed** | **Other ethnic groups** |
|---|---|---|---|---|
| ☐ British | ☐ African | ☐ Bangladeshi | ☐ Asian & white | ☐ Chinese |
| ☐ Irish | ☐ Caribbean | ☐ Indian | ☐ Black African & white | ☐ Any other ethnic background |
| ☐ Any other white background | ☐ Any other black background | ☐ Pakistani | ☐ Black Caribbean & white | ☐ Not documented |
| | | ☐ Any other Asian background | ☐ Any other mixed background | |

## DEPRESSION DIAGNOSIS

Q1a **Was a diagnosis of depression recorded when this patient was discharged from hospital?**

*Please obtain this information from the discharge notes. Please see the guidance for more details.*

Yes ☐

No ☐

Q1b **Was the patient known to have depression before they were admitted to hospital?**

*Please obtain this information from the admission notes. Please see the guidance for more details.*

Yes ☐

No ☐

Q2a **Was a diagnosis of any other co-morbid mental health problem(s) (e.g anxiety disorder or obsessive compulsive disorder) recorded when this patient was discharged from hospital?**

*Please obtain this information from the discharge notes. Patients with a diagnosis of dementia, slowly resolving delirium or other similar memory problems should not be included in the sample. Please see the guidance for more details.*

Yes ☐

No ☐

Q2b **If Yes, please give details. Please include the ICD-10 code if this is available:**

| |
|---|
| |

Q3 **If the patient has not been diagnosed with depression, have any of the following symptoms suggestive of depression been noted during this admission?**

*Please check the medical notes to find this information. Please ensure a clinician has reviewed the notes if three or more boxes have been ticked. Please see the guidance for more details.*

| | | | |
|---|---|---|---|
| Persistent sadness or low mood | ☐ | Loss of interests or pleasure | ☐ |
| Fatigue or low energy | ☐ | Disturbed sleep | ☐ |
| Poor concentration or indecisiveness | ☐ | Low self-confidence | ☐ |
| Poor or increased appetite | ☐ | Suicidal thoughts or acts | ☐ |
| Agitation or slowing of movements | ☐ | Guilt or self-blame | ☐ |
| Other symptoms suggestive of depression | ☐ | None of these | ☐ |

**If you have ticked 'Other symptoms suggestive of depression', please give more details:**

| |
|---|
| |

## TREATMENT

### Q4a **Was the patient being prescribed medication for depression when they were admitted?**

*Please check the admission notes and medication records ('drug charts') to find this information. Please note that some drugs (ie. Amitriptyline) can be prescribed for other conditions (e.g. chronic pain). Please ONLY include medication prescribed for depression. Please see the guidance for more details.*

Yes ☐

No ☐ If no, please continue to the next page

### Q4b **If yes, please choose the medication:**

*The generic drug name is given together with the brand name(s) in brackets. Please see the guidance notes for more information.*

- ☐ Agomelatine (Valdoxan)
- ☐ Amitriptyline (Triptizol)
- ☐ Amitriptyline and Perphenazine (Triptafen)
- ☐ Citalopram (Cipramil)
- ☐ Clomipramine (Anafranil)
- ☐ Dosulepin (Prothiaden)
- ☐ Doxepin (Sinepin)
- ☐ Duloxetine (Cymbalta, Yentreve)
- ☐ Escitalopram (Cipralex)
- ☐ Fluxetine (Prozac, Prozep, Oxactin)
- ☐ Fluvoxamine (Faverin)
- ☐ Imipramine (Tofranil)
- ☐ Isocarboxazid
- ☐ Lamotrigine (Lamictal)
- ☐ Lithium (Priadel)
- ☐ Lofepramine (Gamanil, Lomont)
- ☐ Mianserin
- ☐ Mirtazapine (Zispin)
- ☐ Moclobemide (Manerix)
- ☐ Notriptyline (Allegron)
- ☐ Paroxetine (Seroxat)
- ☐ Phenelzine (Nardil)
- ☐ Reboxetine (Edronax)
- ☐ Setraline (Lustral)
- ☐ Tranylcypromine (Parnate)
- ☐ Trazodone (Molipaxin)
- ☐ Trimipramine (Surmontil)
- ☐ Venlafaxine (Efexor XL, Depefex XL, Foraven XL, Politid XL, Sunveniz XL, Tonpular XL, Venaxx XL, Venadex XL, Venlalic, Viepax
- ☐ Vortioxetine (Brintellix)

Q5a **Was the patient prescribed medication for depression when they were discharged?**

*Please obtain this information from the discharge notes and medication records ('drug charts'). Please note that some drugs (ie. Amitriptyline) can be prescribed for other conditions. Please ONLY include medication prescribed for depression. Please see the guidance for more details.*

Yes ☐

No ☐ If no, please continue to the next page

Q5b **If yes, please choose the medication:**

*The generic drug name is given together with the brand name(s) in brackets. Please see the guidance notes for more information.*

- ☐ Agomelatine (Valdoxan)
- ☐ Amitriptyline (Triptizol)
- ☐ Amitriptyline and Perphenazine (Triptafen)
- ☐ Citalopram (Cipramil)
- ☐ Clomipramine (Anafranil)
- ☐ Dosulepin (Prothiaden)
- ☐ Doxepin (Sinepin)
- ☐ Duloxetine (Cymbalta, Yentreve)
- ☐ Escitalopram (Cipralex)
- ☐ Fluxetine (Prozac, Prozep, Oxactin)
- ☐ Fluvoxamine (Faverin)
- ☐ Imipramine (Tofranil)
- ☐ Isocarboxazid
- ☐ Lamotrigine (Lamictal)
- ☐ Lithium (Priadel)
- ☐ Lofepramine (Gamanil, Lomont)
- ☐ Mianserin
- ☐ Mirtazapine (Zispin)
- ☐ Moclobemide (Manerix)
- ☐ Notriptyline (Allegron)
- ☐ Paroxetine (Seroxat)
- ☐ Phenelzine (Nardil)
- ☐ Reboxetine (Edronax)
- ☐ Setraline (Lustral)
- ☐ Tranylcypromine (Parnate)
- ☐ Trazodone (Molipaxin)
- ☐ Trimipramine (Surmontil)
- ☐ Venlafaxine (Efexor XL, Depefex XL, Foraven XL, Politid XL, Sunveniz XL, Tonpular XL, Venaxx XL, Venadex XL, Venlalic, Viepax
- ☐ Vortioxetine (Brintellix)

Q6a **Was treatment with medication for depression initiated during their hospital stay?**

*Please check the medical notes, medication records ('drug charts') and discharge notes to find this information. Please note that some drugs (ie. Amitriptyline) can be prescribed for other conditions. Please ONLY include medication prescribed for depression. Please see the guidance for more details.*

Yes ☐

No ☐ If no, please continue to the next page

Q6b **If yes, please choose the medication:**

*The generic drug name is given together with the brand name(s) in brackets. Please see the guidance notes for more information.*

- ☐ Agomelatine (Valdoxan)
- ☐ Amitriptyline (Triptizol)
- ☐ Amitriptyline and Perphenazine (Triptafen)
- ☐ Citalopram (Cipramil)
- ☐ Clomipramine (Anafranil)
- ☐ Dosulepin (Prothiaden)
- ☐ Doxepin (Sinepin)
- ☐ Duloxetine (Cymbalta, Yentreve)
- ☐ Escitalopram (Cipralex)
- ☐ Fluxetine (Prozac, Prozep, Oxactin)
- ☐ Fluvoxamine (Faverin)
- ☐ Imipramine (Tofranil)
- ☐ Isocarboxazid
- ☐ Lamotrigine (Lamictal)
- ☐ Lithium (Priadel)
- ☐ Lofepramine (Gamanil, Lomont)
- ☐ Mianserin
- ☐ Mirtazapine (Zispin)
- ☐ Moclobemide (Manerix)
- ☐ Notriptyline (Allegron)
- ☐ Paroxetine (Seroxat)
- ☐ Phenelzine (Nardil)
- ☐ Reboxetine (Edronax)
- ☐ Setraline (Lustral)
- ☐ Tranylcypromine (Parnate)
- ☐ Trazodone (Molipaxin)
- ☐ Trimipramine (Surmontil)
- ☐ Venlafaxine (Efexor XL, Depefex XL, Foraven XL, Politid XL, Sunveniz XL, Tonpular XL, Venaxx XL, Venadex XL, Venlalic, Viepax
- ☐ Vortioxetine (Brintellix)

Q7a **At any point during the admission, was the patient referred to any of the following services or mental health professionals (please tick all that apply):**

*Please check the medical and discharge notes to find this information.*

| Services | | Mental health professionals | |
|---|---|---|---|
| Psychiatric / mental health liaison team | ☐ | Psychiatrist | ☐ |
| | | Mental health nurse | ☐ |
| Community mental health team | ☐ | Mental health social worker | ☐ |
| | | Psychologist | ☐ |
| | | Counsellor/ talking therapist | ☐ |

No ☐

Q7b **If referred, was there a stated reason for referral?**

Yes ☐

No ☐

Q7c **If yes, please specify:**

| |
|---|
| |

Thank you for completing the survey for this patient

**Please ensure that data is submitted online by Friday 13 October 2017**.

If you have any questions, please contact the DepSurv team on depsurv@rcpsych.ac.uk; 020 3701 2716.

# Appendix 3: Data collection guidance

**Survey of depression reporting in older adults**

**Data collection guidance**

## General guidance

Sites should audit the records of 30 consecutive patients aged 65 and over with an unplanned admission, discharged from 01 April 2017 onwards. All hospital wards will be included in the sample but please note that any patients with a diagnosis of dementia, slowly resolving delirium or other similar memory problems should be excluded. Patients must have been admitted for a minimum of one night.

Please complete a copy of the survey for each patient.

## Question routing

Some questions on the survey form are routed, depending on previous answers. Questions routed out will automatically be greyed and thus not answerable on the online form. When submitting data online you will be prompted to return and answer any questions that are missed, unless questions are routed out.

## Using the online data system

Guidance on using the online data system has been provided as a separate document.

## Deadline for data submission

Data collection opens 21 August 2017 and closes 13 October 2017. Please note that this deadline is final, and no data can be accepted after this date.

## Contact

If you have any questions, please contact the DepSurv team on depsurv@rcpsych.ac.uk; 020 3701 2716.

## DATA COLLECTION FORM

Patient identifier: This is the code or number allocated to the patient for the purposes of the survey. It is intended to ensure the patient's anonymity, so please do not use the NHS number or any other identifying details such as birthday.

Data collector: Please enter the name, job title and email address of the data collector or clinician in case we need to contact you with any data cleaning queries.

## PATIENT INFORMATION

Date of admission: please enter the date of the patient's admission to hospital in the format dd/mm/yyyy.

Date of discharge: please enter the date of the patient's discharge from hospital in the format dd/mm/yyyy. Please note that it must be on or after 01/04/2017, and not later than 21/08/2017.

Age of the patient: This is the age of the patient in whole years at discharge. To calculate age using date of birth, you can use this website:
http://www.mathcats.com/explore/age/calculator.html

Please note that the patient must be 65 years or over at discharge.

Gender: Please enter the patient's self-identified gender.

Ward type: Please choose the specialty of the ward the patient spent most time on. If the ward type is not specified, please choose 'other' and provide details in the box below.

Ethnicity: Please enter the patient's ethnicity as documented in the notes. Please note that there is a 'Not documented' option in the column 'Other ethnic groups'.

## DEPRESSION DIAGNOSIS

Q1a: Please see if a diagnosis of depression was recorded in the discharge notes.

Q1b: Please see if a diagnosis of depression was recorded in the admission notes.

Q2a: Please see if there was a diagnosis of a co-morbid mental health problem noted in the discharge notes. Please note that patients with a diagnosis of dementia, slowly resolving delirium or other similar memory problems should not be included in the sample.

Q2b: If a diagnosis was recorded, please provide further details, including the ICD-10 code if this is available.

Q3: You will only be asked to answer question 3 if you answered 'no' to question 1a. If this question is greyed out, please continue to the next page.

Please check the medical notes to find information for this question. Some of these symptoms may be linked to a medical problem rather than depression. If 3 or more boxes are checked, please ensure a clinician has reviewed the patient notes for this question and feels that the symptoms chosen are suggestive of depression in this patient.

## TREATMENT

Questions 4 – 6 ask about medication for depression prescribed to this patient. Please note that some drugs can be prescribed for other conditions e.g. Amitriptyline is prescribed for chronic pain. Please ONLY include medication prescribed for depression. If a drug has been prescribed for other reasons, please do not include it when answering these questions.

Q4a: Please check the admission notes and medication records ('drug charts') to find this information.

Q4b: The list of medications has been ordered alphabetically by the generic drug names and includes brand names in brackets. This list has also been provided as an appendix to this guidance.

Q5a: Please obtain this information from the discharge notes and medication records ('drug charts').

Q5b: The list of medications has been ordered alphabetically by the generic drug names but includes brand names in brackets. This list has also been provided as an appendix to this guidance.

Q6a: Please check the medical notes, medication records ('drug charts') and discharge notes to find this information.

Q6b: The list of medications has been ordered alphabetically by the generic drug names but includes brand names in brackets. This list has also been provided as an appendix to this guidance.

Q7a: Please check the medical and discharge notes to find this information. If it is not specified in the discharge summary, there may be a referral form to a mental health professional or team, or it may be a handwritten request in the notes.

# Appendix 4: Appendix to data collection guidance

**Survey of depression reporting in older adults**

**Data collection guidance appendix**

## List of medications

| Generic name | Brand name (s) | Type of medication* |
|---|---|---|
| | | |
| Agomelatine | Valdoxan | Other |
| Amitriptyline | Tryptizol | TCA |
| Amitriptyline and Perphenazine | Triptafen | Other |
| Citalopram | Cipramil | SSRI |
| Clomipramine | Anafranil | TCA |
| Dosulepin | Prothiaden | TCA |
| Doxepin | Sinepin | TCA |
| Duloxetine | Cymbalta, Yentreve | SNRI |
| Escitalopram | Cipralex | SSRI |
| Fluoxetine | Prozac, Prozep, Oxactin | SSRI |
| Fluvoxamine | Faverin | SSRI |
| Imipramine | Tofranil | TCA |
| Isocarboxazid | - | MAOI |
| Lamotrigine | Lamictal | Mood stabiliser |
| Lithium | Priadel | Mood stabliser |

| | | |
|---|---|---|
| Lofepramine | Gamanil, Lomont | TCA |
| Mianserin | - | TCA-related |
| Mirtazapine | Zispin | NASSA |
| Moclobemide | Manerix | Reversible MAOI |
| Nortriptyline | Allegron | TCA |
| Paroxetine | Seroxat | SSRI |
| Phenelzine | Nardil | MAOI |
| Reboxetine | Edronax | Other |
| Sertraline | Lustral | SSRI |
| Tranylcypromine | Parnate | MAOI |
| Trazodone | Molipaxin | TCA-related |
| Trimipramine | Surmontil | TCA |
| Venlafaxine | Efexor XL, Depefex XL, Foraven XL, Politid XL, Sunveniz XL, Tonpular XL, Venaxx XL, Venadex XL, Venlalic, ViePax | SNRI |
| Vortioxetine | Brintellix | Other |

*Types of antidepressants:

SSRI - selective serotonin reuptake inhibitors
SNRI - serotonin and noradrenaline reuptake inhibitors
TCA – tricyclics
TCA related – tricyclic related drugs
MAOI - monoamine oxidase inhibitors
Other - other antidepressants

## Appendix 5: Guidance for online data submission

# Survey of depression reporting in older adults

# Data submission guidance

### About this guidance

This guidance is provided to help your hospital submit data online for the survey of depression reporting in older adults.

### Data collection

Data collection will open online on 21 August 2017 and will close on 13 October 2017. Please note that this deadline is final, and no data can be accepted after this date.

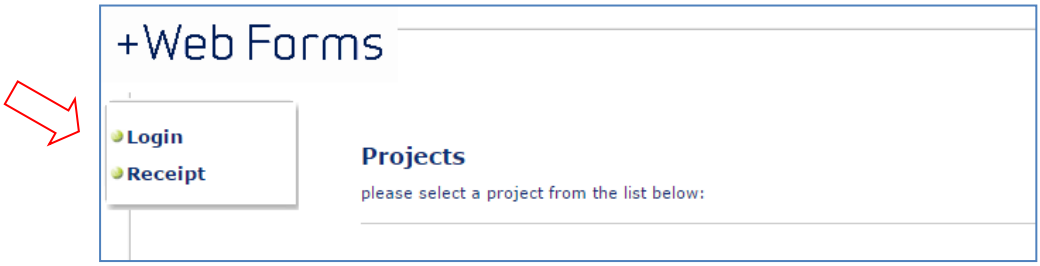
### Access to the online data form

The online data form can be accessed at http://rcop.formic.com/. A username and password has been sent to the contacts registered for your trust (please note that passwords are case sensitive).

Your username is unique to your organisation and enables us to link the data submitted to your hospital.

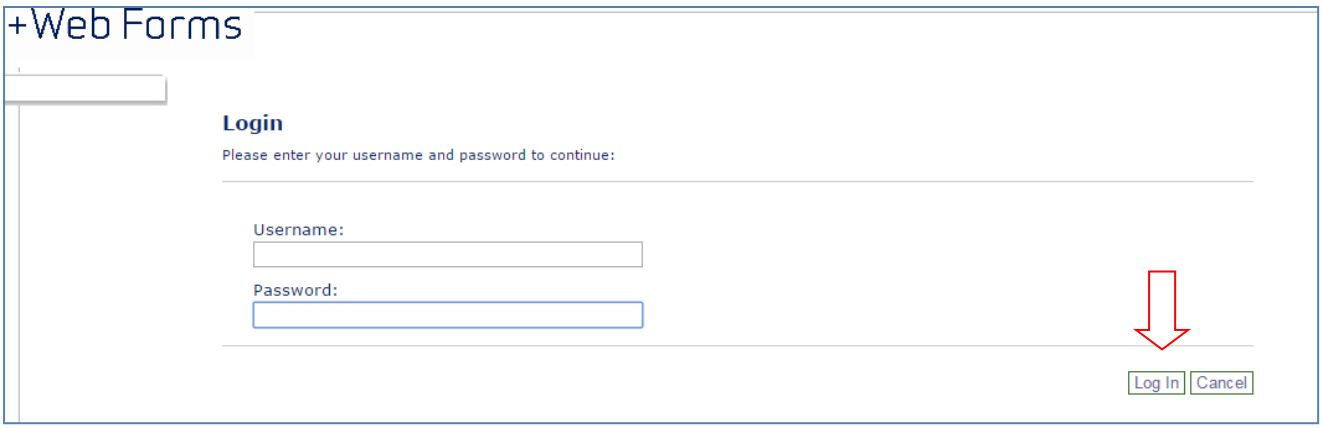
**How to access the data collection form online**

- The link for the online data collection form is: http://rcop.formic.com

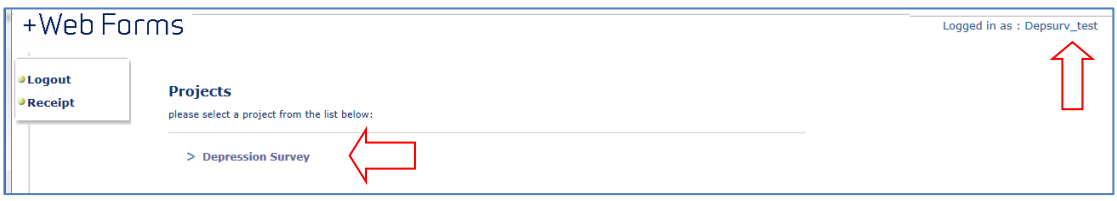



- Click 'Login' at the left hand side of the screen.
- This leads you to the Login page where you need to enter your username and password. These details have been emailed to the contacts registered for your organisation. Enter your username and password (passwords are case-sensitive).

- Click on the 'Log In' button located in the bottom right hand corner of the screen.

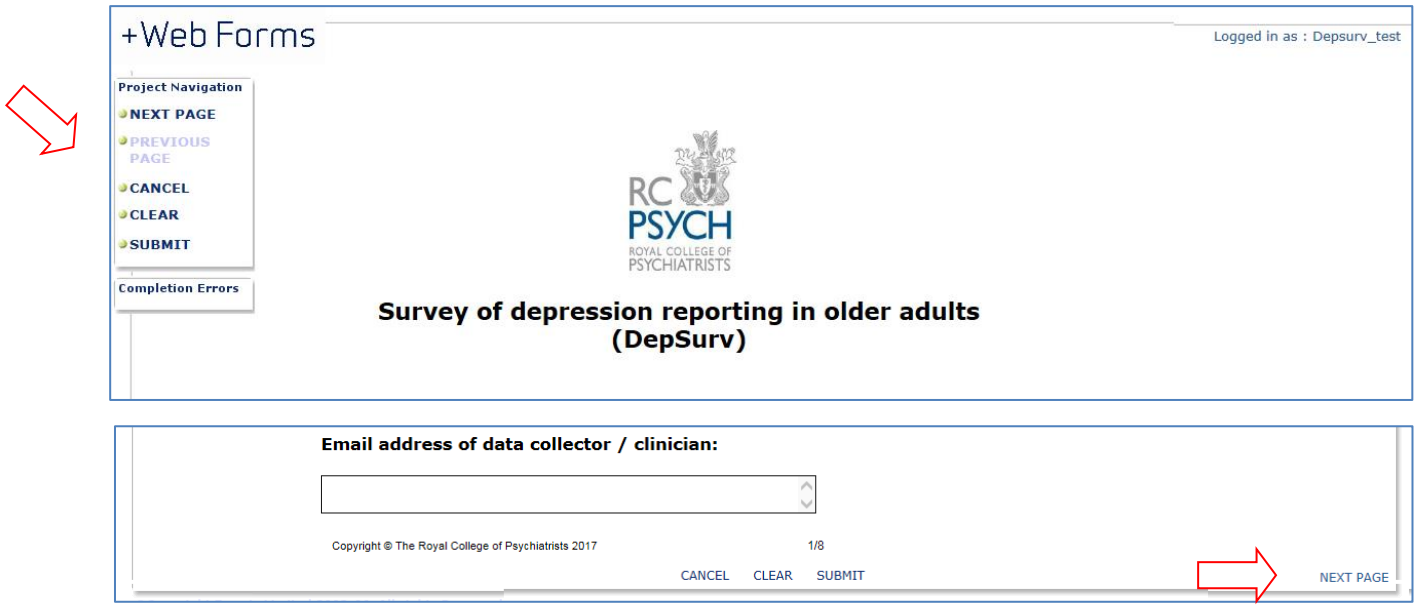



- This takes you to the Projects page where the link to the online data entry form '**Depression Survey'** is available. Your Trust/ organisation name is displayed in the top right hand corner. Clicking on the survey link takes you to the online data collection form.



## Navigational tools

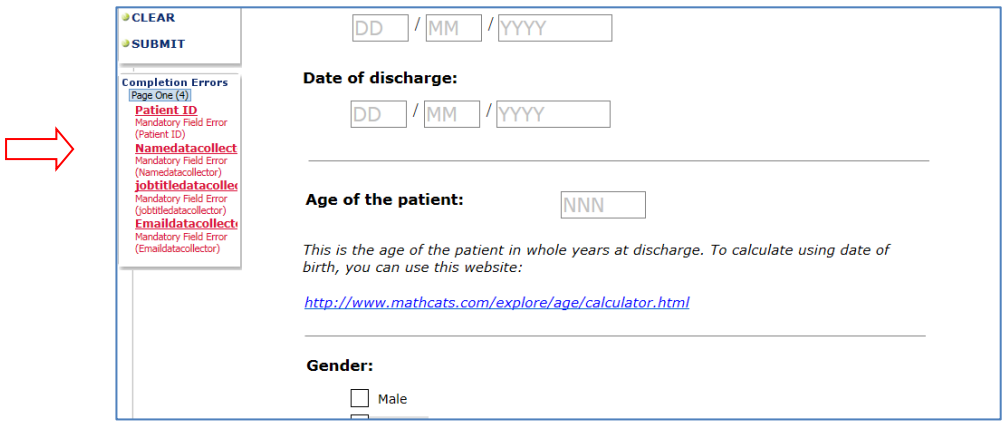
- Links to help you navigate through the form are available at the top left hand corner of the survey and at the bottom of the page.




- The navigational tools include options to go to the 'previous page', 'next page' or to 'cancel', 'clear', 'save', and 'submit' your data.

- Clicking 'cancel' takes you back to the 'Projects' page. Please note that clicking 'clear' **deletes all the information you have completed on the form**, not just on that specific page. The 'save' option enables you to save partially completed forms for completion at a later date.

- Data missed or completed inaccurately on the form will be displayed in the 'Completion Errors' box. Details include the page where the error(s) are, and what the error for that particular question is. To return to the question simply click on the link in the box.

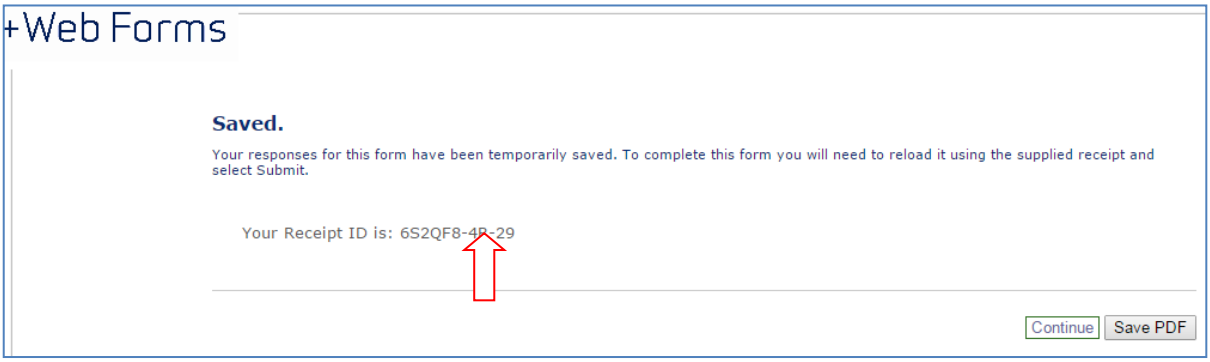



- Please note that there is no autosave function. Partially completed forms must be saved and accessed again using the receipt number (please see instructions for how to access a partially completed form below).

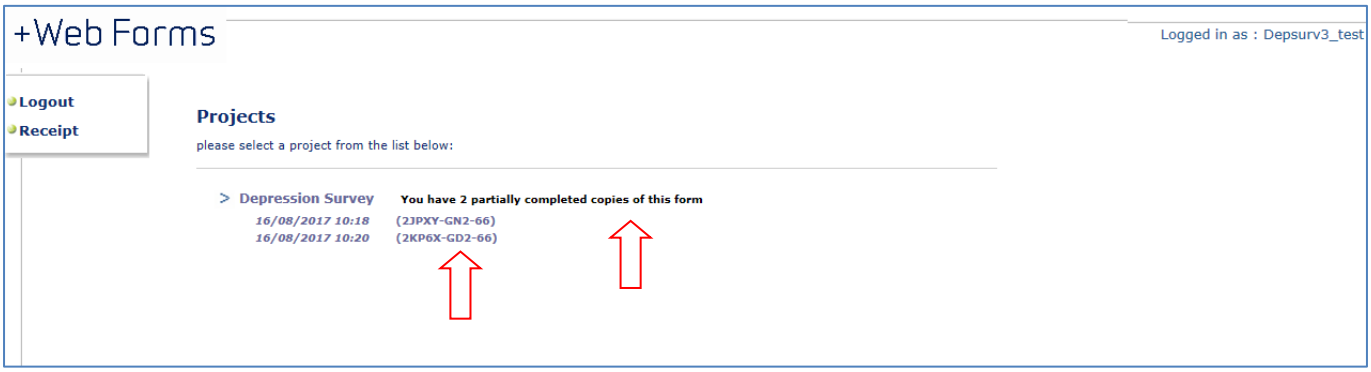
- Forms will time out automatically after 20 minutes. If you require extra time, please ensure that you have saved the form.

**How to access a partially completed form**

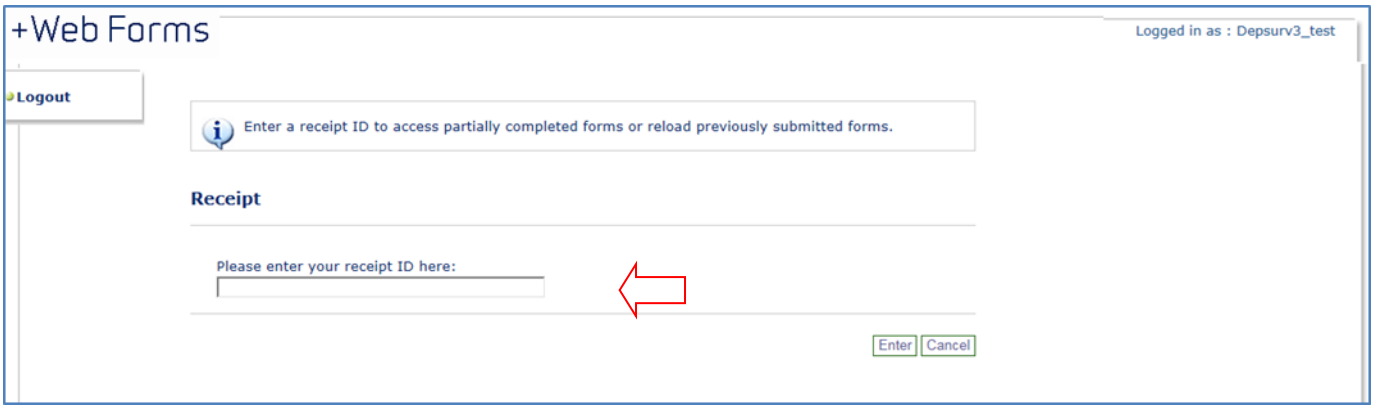
- A receipt number will be generated for each form you save for completion later. Please ensure that you save a copy of this receipt number if you wish to go back to your form.




- To access incompleted forms, navigate back to the Projects page and click on the message "You have partially completed copies of this form". A list of saved forms will appear showing the date and time it was last saved. To access a form, click on the receipt number:



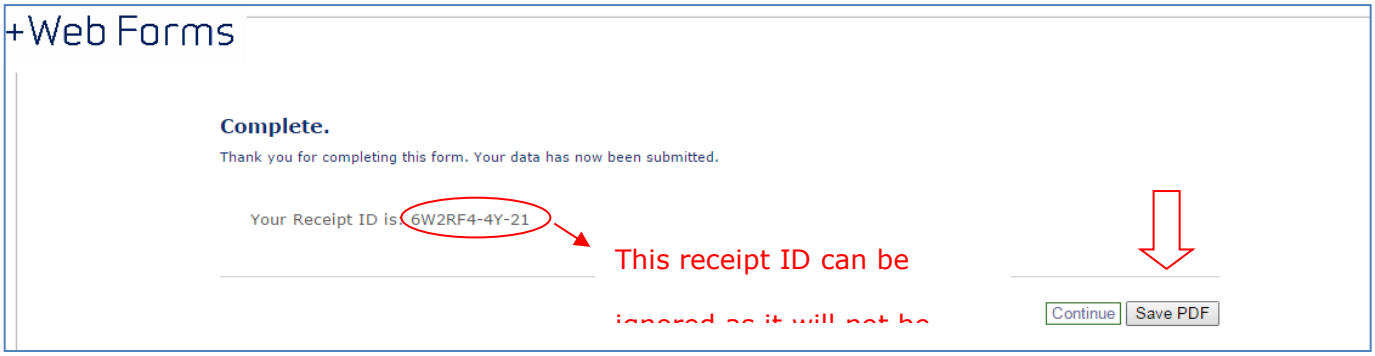

- You can also search for a specific form using the receipt number. To do this return to the Projects page, click on Receipt in the left hand menu and enter the receipt ID.




**Saving a submitted form as a pdf**

- After submitting a form you will be taken to the 'Complete' page which will display a thank you message.

- On this screen, you can save your submitted form as a PDF. This is located in the bottom right corner of the page. Clicking on 'continue' will take you back to the Projects page where you can submit data for another patient.




- Please note that you will not be able to edit forms once they have been submitted. Please contact us if you need to make any changes to data that have been submitted.

**Contact information for the DepSurv team**

- For queries about online data submission please email the DepSurv team: Depsurv@rcpsych.ac.uk
-
- Beatrice Tooke T: 020 3701 2716

  E: beatrice.tooke@rcpsych.ac.uk

## Appendix 6: Organisational checklist and survey feedback form


### Survey of depression reporting in older adults

### (DepSurv)

#### Feedback questionnaire

Please complete **one copy** of this questionnaire for your site. If you have any questions, please contact the DepSurv team on depsurv@rcpsych.ac.uk; 020 3701 2695.
Please submit data online by **Friday 3 November 2017**.

Name of person completing questionnaire:

Job title of person completing questionnaire:

Email address of person completing questionnaire:

## MINI ORGANISATIONAL CHECK

Please note that questions 1 – 5 are mandatory and must be submitted. You can choose whether to answer questions in the subsequent general feedback section

Q1a **Is there a specific team which provides mental health liaison services for older people in your hospital?**

*Please see the guidance for more details.*

Yes ☐

No ☐

Don't know ☐

**Please use this box if you wish to make any comments**

Q1b **If Yes, do you know the average number of WTE Consultant Psychiatrists in the team?**

*Please see the guidance for more details.*

Yes ☐ If yes, please specify ☐☐

No ☐

Q2a **In what clinical situations would you feel it beneficial to obtain the opinion of a psychiatrist from a mental health liaison service to help you manage older adult patients?**

*Please give details of the clinical problems and what support you would like.*

Q2b **Overall, do you feel the need of your older patients for input from liaison mental health services is currently being met?**

Yes ☐

No ☐

Don't know ☐

Q3a **Is there an established pathway in your hospital to refer a patient with depression (or other mental health condition) to psychiatry/mental health?**

Yes ☐

No ☐

Q3b **If Yes, are those mental health services based in the hospital or in the community?**

In the hospital ☐

In the community ☐

Q4a **Does your hospital routinely use a standardised protocol or proforma to help identify depression in older people?**

Yes ☐

No ☐

Q4b **If Yes, please specify.**

Q5a **Does your hospital use any assessment tools (e.g. Geriatric Depression Scale) to help identify depression in older people?**

Yes ☐

No ☐ Please go to page 6

Q5b **Please indicate the assessment tools used below. (Please tick all that apply)**

| | Used routinely | Used when depression suspected |
|---|---|---|
| Beck Depression Inventory (BDI) | ☐ | ☐ |
| Hamilton Rating Scale for Depression (HAM-D) | ☐ | ☐ |
| Hospital Anxiety and Depression Scale (HADS) | ☐ | ☐ |
| Patient Health Questionnaire (PHQ) | ☐ | ☐ |
| The Geriatric Depression Scale (GDS) | ☐ | ☐ |
| Zung Self Rating Depression Scale (ZSDS) | ☐ | ☐ |
| Other | ☐ | ☐ |

**If Other, please specify.**

Q5c **Which health professionals use these tools? (Please tick all that apply)**

| | |
|---|---|
| **Medical Professionals** | |
| Consultant | ☐ |
| Staff grade / associate specialist | ☐ |
| Junior doctor | ☐ |
| Hospital practitioner / clinical assistant | ☐ |
| Nurse | ☐ |
| Nursing support staff | ☐ |
| **Mental Health Professionals** | |
| Psychiatrist | ☐ |
| Staff grade / associate specialist in Psychiatry | ☐ |
| Junior doctor in Psychiatry | ☐ |
| Mental health nurse | ☐ |
| Mental health social worker | ☐ |
| Psychologist | ☐ |
| Counsellor/talking therapist | ☐ |
| Other(s) | ☐ |

**If Other(s), please specify.**

Q5d **In which departments are the tools used? (Please tick all that apply)**

| | |
|---|---|
| ☐ Cardiology | ☐ General Surgery |
| ☐ Critical care | ☐ Gynaecology |
| ☐ Care of the elderly | ☐ Orthopaedics |
| ☐ Gastroenterology | ☐ Accident and Emergency |
| ☐ Nephrology | ☐ Occupational therapy |
| ☐ Neurology | ☐ Urology |
| ☐ Oncology | ☐ Other(s) |

**If Other(s), please specify:**

## GENERAL FEEDBACK

Please note that questions 6 – 14 are not mandatory and you can submit the form at any time

Q6 **How did you hear about the survey? (Please tick all that apply)**

| | | | |
|---|---|---|---|
| Depression survey team | ☐ | SCN | ☐ |
| National Audit of Dementia mail out | ☐ | NHS England | ☐ |
| Psychiatric Liaison Accreditation Network | ☐ | Other | ☐ |
| Clinical advisor (Dr Oliver Corrado) | ☐ | | |

**If Other, please specify:**

Q7 **Why did your hospital choose to take part? (Please tick all that apply)**

| | |
|---|---|
| Particular interest in the topic on the part of one or more staff | ☐ |
| Hospital is looking to improve performance in this area | ☐ |
| Interested to benchmark our performance against that of other sites | ☐ |
| Other | ☐ |

**If Other, please specify:**

Q8a **Do you think the information collected will be useful to the hospital?**

Yes ☐

No ☐

Q8b **Please give details.**

| |
|---|
| |

Q9 **Was the data easy to collect?**

*Please indicate on a scale of 1 – 5 where 1 is very easy and 5 is very difficult.*

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Q10a **Did the guidance documents provide the information you needed?**

Yes ☐

No ☐

Q10b **If No, please specify:**

| |
|---|
| |

Q11a **Did you find the online data collection form easy to navigate?**

Yes ☐

No ☐

Q11b **If No, please specify:**

| |
|---|
| |

Q12a **Was information about the survey communicated clearly?**

Yes ☐

No ☐

Q12b **If No, please specify:**

| |
|---|
| |

Q13a **Did you feel you had adequate support from the DepSurv team?**

Yes ☐

No ☐

Q13b **If No, please specify:**

| |
|---|
| |

Q14 **Any other comments or suggestions**

Thank you for completing the feedback questionnaire

**Please submit this form by Friday 3 November 2017**.

If you have any questions, please contact the DepSurv team on depsurv@rcpsych.ac.uk; 020 3701 2695.

# Appendix 7: Guidance for organisational checklist and survey feedback form

**Survey of depression reporting in older adults**
**Feedback questionnaire guidance**

**General guidance**
Please complete a single copy of this questionnaire. Please note that only the first five questions in the mini organisational check are mandatory, you can choose whether to answer questions 6 – 14 in the general feedback section. Once you have answered questions 1 – 5 you can submit the form at any time.

**Question routing**
Some questions on the survey form are routed, depending on previous answers. Questions routed out will automatically be greyed and thus not answerable on the online form. When submitting data online you will be prompted to return and answer any questions that are missed, unless questions are routed out.

**Using the online data system**
Guidance on using the online data system has been provided as a separate document.

**Deadline for data submission**
Data collection opens 11 October 2017 and closes 3 November 2017. Please note that this deadline is final, and no data can be accepted after this date.

**Contact**
If you have any questions, please contact the DepSurv team on depsurv@rcpsych.ac.uk; 020 3701 2695 /2716.

**DATA COLLECTION FORM**

Questionnaire respondent: Please enter the name, job title and email address of the questionnaire respondent in case we need to contact you with any queries about the data.

## MINI ORGANISTIONAL CHECK

Q1a: A psychiatric liaison team works in general hospitals, for example in the emergency department or in-patient wards.

They provide psychiatric assessment and treatment to those patients who may be experiencing distress whilst in hospital and provide a valuable interface between mental and physical health.

The liaison team can work with any patient in the hospital who requires psychological help to manage their condition. Liaison teams differ from one hospital to another. Some liaison teams work with children, some work with adults of working age (18-65 years old) and others work with older people (over 65 years old). There are also teams that work with all age groups.

Please answer this question regarding mental health liaison services for adults aged 65 and over.

Liaison Teams are managed by the Community/ Mental Health/ Partnerships Trust and not the Acute Trust and so it might not always be easy to find the answer to this question. If you are unsure, your Trust's Medical or Operations Director and the Clinical Director or General Manager for Acute Medicine should be able to help.

Please use the comment box if you would like to provide any further details (please note that you do not have to provide any comments if you do not wish to).

Q1b: WTE means Whole Time Equivalent. If you know the answer, please provide the average number of WTE Consultant Psychiatrists in the team. Please choose ‘no’ if you don’t know the answer to this question.

## GENERAL FEEDBACK

Please note that the questions in this section are not mandatory, and you can submit the questionnaire at any time.

# Appendix 8: Organisation and delivery of mental health care at participating sites

## Response rate

An organisational checklist (see Appendix 7) was distributed to all sites. Responses were received from 19 (70%) of them.

## Liaison support

*Table 16: Sites with a specific team providing mental health liaison services for older people (N=19)*

| | N | (%) |
|---|---|---|
| **Sites with team** | 18 | (95%) |
| **Sites without team** | 1 | (5%) |

*Table 17: Free text responses on the specific team providing mental health liaison services*

| | N |
|---|---|
| **Dedicated older person's mental health team operating as part of the liaison psychiatry service.** | 1 |
| **1.5 Consultants and 1.6 Nurses in Hours, with AMH covering out of hours for ED and AMU.** | 1 |
| **Psychiatric Liaison Team** | 1 |
| **we currently have a separate old age psychiatry service but the local mental health trust plan to merge the old age and general adult services** | 1 |
| **24 - 7 service available** | 1 |
| **.8 older peoples position not filled** | 1 |
| **.8 working age consultant** | 1 |
| **The mental health team has some staff who have a specific interest in older people** | 1 |
| **Currently all service is via CPN's (1WTE) on site they will link to community based consultants as needed** | 1 |
| **RAID team is the liaison team for mental health but not exclusively to old age adults** | 1 |

*Table 18: Average number of WTE Consultant Psychiatrists in the team providing mental health liaison services for older people (N=14)**

| | N |
|---|---|
| **Range** | 0 - 4 |
| **Mean** | 1.05 |

*Four sites were unable to answer the question about the average number of WTE Consultant Psychiatrists

*Table 19: Need of older patients for input from liaison mental health services currently being met (N=19)*

| | N | (%) |
|---|---|---|
| **Need being met** | 12 | (63%) |
| **Need not being met** | 5 | (26%) |
| **Don't know** | 2 | (11%) |

From the 19 sites, 43 statements were given indicating clinical situations where the opinion of a psychiatrist from a mental health liaison service would be of benefit in the management of older adult patients. These are broken down into themes in Table 26 below. Percentages are given from the total number of statements.

*Table 20: Clinical situations when it would be beneficial to obtain the opinion of a psychiatrist from a mental health liaison service to help manage older adult patients (N=43)*

| | N | (%) |
|---|---|---|
| **Assessment, Diagnosis and treatment** | 11 | (26%) |
| **Patients with psychosis** | 5 | (12%) |
| **Patients with psychosis and/or depression** | 5 | (12%) |
| **Prescribing/medication advice** | 3 | (7%) |
| **Planning- risk assessments** | 1 | (2%) |
| **Patients with complex behaviour** | 5 | (12%) |
| **General advice and support** | 4 | (9%) |
| **Information sharing** | 1 | (2%) |
| **Patients with severe illness (needing ECT)** | 1 | (2%) |
| **Advice with discharge** | 2 | (5%) |
| **Advice on admission** | 1 | (2%) |

## Pathways and assessment tools

Fifteen sites (79%) had an established pathway to refer a patient with depression (or other mental health condition) to psychiatry/ mental health services. Table 21 shows where these were based.

*Table 21: Location of referral pathway to psychiatry/mental health services for patients with depression (or other mental health condition) (N=15)*

| | N | (%) |
|---|---|---|
| **Pathway based in community** | 1 | (7%) |
| **Pathway based in hospital** | 14 | (93%) |
| **Total sites** | 15 | (100%) |

*Table 22: Sites routinely using a standardised protocol or proforma to identify depression in older people (N=19)*

| | N | (%) |
|---|---|---|
| **Routine use of standardised protocol/ proforma** | 3 | (16%) |

Of the three sites that used a standardised protocol or proforma, one used the GDS assessment tool, one the PHQ-9 Geriatric depression scale, and in one the GDS was used as standard in the stroke service but not elsewhere in the Trust.

## Assessment tools

Nearly two-thirds of sites (63%) used assessment tools to help identify depression in older people. Table 23 shows the breakdown of assessment tools used. More than one tool could be chosen, therefore the percentages add up to more than 100%.

*Table 23: Breakdown of assessment tools used (N=12)*

| | Used routinely N (%) | Used when depression suspected N (%) |
|---|---|---|
| **Beck Depression Inventory** | 0 (0%) | 1 (8%) |
| **Hamilton Rating Scale for Depression** | 0 (0%) | 0 (0%) |
| **Hospital Anxiety and Depression Scale** | 1 (8%) | 7 (58%) |
| **The Geriatric Depression Scale** | 2 (17%) | 10 (83%) |
| **Patient Health Questionnaire** | 1 (8%) | 0 (0%) |
| **Zung Self Rating Depression Scale** | 0 (0%) | 0 (0%) |
| **Other** | 0 (0%) | 3 (25%) |

The other assessment tools noted were the GP2Qs, and the PHQ sometimes used in stroke rehab.

Over half the staff (60%) using the tools were acute hospital staff (non-mental health professionals); the others were mental health professionals. The breakdown of staff using these tools are shown in Tables 24 and 25 below. More than one type of staff could be chosen. Percentages are given from the total number of acute hospital staff (non-mental health professionals) (*n*=38) or mental health professionals (*n*=25).

*Table 24: Acute hospital staff (non-mental health professionals) using assessment tools (N=38)*

| | N (%) |
|---|---|
| **Consultant** | 9 (24%) |
| **Staff grade/associate specialist** | 8 (21%) |
| **Junior doctor** | 11 (29%) |
| **Hospital practitioner / clinical assistant** | 4 (11%) |
| **Nurse** | 4 (11%) |
| **Nursing support staff** | 2 (5%) |

*Table 25: Mental health professionals using assessment tools (N=25)*

| | N (%) |
|---|---|
| **Psychiatrist** | 4 (16%) |
| **Staff grade/associate specialist in Psychiatry** | 2 (8%) |
| **Junior doctor in Psychiatry** | 7 (28%) |
| **Mental health social worker** | 0 (0%) |
| **Mental health nurse** | 11 (44%) |
| **Psychologist** | 1 (4%) |
| **Counsellor/talking therapist** | 0 (0%) |

In addition to this, one hospital noted that a nurse practitioner used the assessment tools, and another hospital noted the tools would be used by a support worker.

*Table 26: Department where assessment tools are used (N=26)*

| | N (%) |
|---|---|
| **Cardiology** | 2 (8%) |
| **General Surgery** | 1 (4%) |
| **Critical care** | 0 (0%) |
| **Gynecology** | 0 (0%) |
| **Care of the elderly** | 9 (35%) |
| **Orthopedics** | 3 (12%) |
| **Gastroenterology** | 1 (4%) |
| **Accident and Emergency** | 1 (4%) |
| **Nephrology** | 0 (0%) |
| **Occupational therapy** | 1 (4%) |
| **Neurology** | 1 (4%) |
| **Urology** | 0 (0%) |
| **Oncology** | 0 (0%) |
| **Other** | 7 (27%) |

## Appendix 9: Ward types and patient demographics

### Ward type

*Table 27: Ward type where the patient spent most time (N=766)*

| Ward | N | (%) |
|---|---|---|
| **Cardiac** | 73 | (10%) |
| **Critical care** | 3 | (0%) |
| **Care of the elderly** | 141 | (18%) |
| **General medical** | 155 | (20%) |
| **Nephrology** | 14 | (2%) |
| **Neurology** | 4 | (1%) |
| **Oncology** | 12 | (2%) |
| **Respiratory** | 51 | (7%) |
| **Stroke** | 34 | (4%) |
| **Other medical** | 44 | (6%) |
| **General surgery** | 111 | (14%) |
| **Gynaecology** | 3 | (0%) |
| **Orthopaedics** | 30 | (4%) |
| **Other** | 91 | (12%) |

## Breakdown of 'Other' wards

*Table 28: Breakdown of Other Wards (N=91)*

| Ward | N | (%) |
|---|---|---|
| **Emergency department/A&E/ Acute Medical Unit/medical admissions ward** | 23 | (25%) |
| **Gastroenterology/hepatology/ hepatobiliary and pancreatic surgery** | 17 | (19%) |
| **Urology/Urology and hepatobiliary surgery** | 16 | (18%) |
| **ENT** | 9 | (10%) |
| **Neurosurgery** | 7 | (8%) |
| **Vascular/vascular surgery** | 6 | (7%) |
| **Plastic surgery/maxillo-facial** | 4 | (4%) |
| **Cardiology/Cardiothoracics/ Cardiothoracic surgery** | 3 | (3%) |
| **Theatre** | 2 | (2%) |
| **Gynae-oncological surgery** | 1 | (1%) |
| **Infectious Disease** | 1 | (1%) |
| **Opthalmology** | 1 | (1%) |
| **STAR Ward - step down** | 1 | (1%) |

## Patient age groups

*Table 29: Age groups (N=766)*

| Age Range | N | (%) |
|---|---|---|
| **65-80** | 464 | (61%) |
| **81-100** | 302 | (39%) |

*Table 30: Range and mean of patient age (N=766)*

| | Age |
|---|---|
| **Range** | 65-99 |
| **Mean** | 79 |

## Gender

*Table 31: Gender of patients (N=766)*

| Gender | N | (%) |
|---|---|---|
| **Male** | 351 | (46%) |
| **Female** | 414 | (54%) |
| **Other** | 1 | (0%) |

## Ethnicity

*Table 32: Ethnicity of patients (N=766)*

| Ethnicity | N | (%) |
|---|---|---|
| **White** | 643 | (84%) |
| **Black or Black British** | 6 | (1%) |
| **Asian or Asian British** | 19 | (2%) |
| **Mixed** | 2 | (0%) |
| **Other ethnic groups** | 96 | (13%) |

## Length of stay

*Table 33: Length of stay of patients (N=766)*

| Length of stay (in days) | N | (%) |
|---|---|---|
| **1-10** | 588 | (77%) |
| **11-20** | 107 | (14%) |
| **21-30** | 38 | (5%) |
| **31-40** | 10 | (1%) |
| **41-50** | 4 | (1%) |
| **51-60** | 3 | (0%) |
| **61-70** | 6 | (1%) |
| **71-80** | 1 | (0%) |
| **81-90** | 2 | (0%) |
| **>90** | 7 | (1%) |

# Appendix 10: Feedback from sites about their experience of taking part in the survey

## Response rate

Participating sites were asked to give feedback on their experience of taking part in the survey. Responses were received from 17 (63%) of them.

## How sites heard about the survey

Table 27 shows how sites heard about the Depression Survey. More than one response could be chosen, so the percentages add up to more than 100%.

*Table 34: How sites heard about the Depression Survey (N=17)*

| | N | (%) |
|---|---|---|
| **Depression Survey team** | 6 | (35%) |
| **National Audit of Dementia mail out** | 9 | (53%) |
| **Psychiatric Liaison Accreditation Network** | 0 | (0%) |
| **Clinical advisor** | 4 | (24%) |
| **Clinical Network** | 0 | (0%) |
| **NHS England** | 1 | (6%) |
| **Other** | 3 | (18%) |

Sites who chose 'Other' had heard about the survey through the NW British geriatric society mailing list and through the CCQI's Director, Professor Mike Crawford.

## Why sites took part

Table 28 shows why sites chose to take part. More than one response could be chosen, so the percentages add up to more than 100%.

*Table 35: Why sites chose to take part (N=17)*

| | N | (%) |
|---|---|---|
| **Particular interest in the topic on the part of one or more staff** | 12 | (71%) |
| **Hospital is looking to improve performance in this area** | 6 | (35%) |
| **Interested to benchmark our performance against that of other sites** | 7 | (41%) |
| **Other** | 3 | (18%) |

Fourteen sites (74%) thought the information collected would be useful for their hospital.

## Views on how useful the results will be

*Table 36: Free text responses on how useful the results will be*

| | N |
|---|---|
| **I am hopeful the data will reflect whether depression is routinely screened for in older patients who present to trusts as part of their holistic care.** | 1 |
| **Not sure. I suspect will show very poor interaction with mental health issues. I'm not sure that the audit is detailed enough to tease out the underlying issues though.** | 1 |
| **From this hospital wide sample a lot of patients were relatively short stay and in areas outside of elderly medicine admitted for reasonably well defined acute issues, so it felt like they were all very similar.** | 1 |
| **Too many patients in the audit were 1 day stays for eg rectal bleeding or pacemaker insertion where I don't believe routine screen for depression is practical and they don't stay long enough to determine any problems like this** | 1 |
| **To inform quality of service offered and develop services further** | 1 |
| **It will be useful to benchmark and also estimate what extra input from liaison psychiatry may be required if an unmet need identified** | 1 |
| **It was a lot of work for little gain. We looked at 40 sets of notes to get 30 patients because 10 were excluded. Only one of those patients had evidence of significant** | 1 |

| | |
|---|---|
| **depression requiring intervention during their admission.** | |

| | **N** |
|---|---|
| **To identify current status to use for comparisons and future audits** | 1 |
| **Maybe, but a full report from all the participating hospitals will be of more interest. We need to consider whether a screening tool should be used more widely.** | 1 |
| **Because it has highlighted how little regard we show to depression** | 1 |
| **Very few of the patients had depression. If the survey had been limited to medical admissions/geriatric admissions I think we would have had more useful information** | 1 |
| **It highlights that depression is not routinely being screened for.** | 1 |

## Other comments and suggestions

*Table 37: Free text responses on other comments and suggestions*

| | N |
|---|---|
| **It felt a shame that patients with cognitive impairment were not included as many of the excluded patients I had come across had superimposed and complex depression. Also given the inclusion criteria a lot of the patients did not or have any signs of depression so audit would only have focused on whether there was adequate screening. In future audits it may be useful to ask data collectors whether a patient was formally screened for depression as part of their admission. As a large teaching hospital I am surprised that there was fewer patient with depression identified from my audit as it did not reflect my clinical area (Frailty unit) so perhaps the volume of older patients that are admitted are a large number and they are being admitted to areas that do not screen.** | 1 |
| **We have half a consultant but it won't let me put that! The collection tool was easy but it was v difficult to get the right notes sent to me, could only include a really small proportion of those selected by the audit department** | 1 |
| **I would advise auditing patients with longer stays -say over 72 hours or else minor admissions will be the bulk. Could consider for purposes of audit patients with loss over a week. Not many under Geriatricians. Could take older group eg over 75 as that is mainly considered "elderly" now. Mostly my data didn't include anyone** | 1 |

| | N |
|---|---|
| **admitted with a prior history of depression or on medication which implies they were rel fit younger patients without significant comorbidities generally.** | |
| **Excluding those patients who had delirium or dementia has probably led to gross under-reporting of prevalence of depression. Delirium and dementia are quite well recognized in our Trust and it is possible to also diagnose and suspect co-existing depression** | 1 |
| **Timescale for completion was rather short.** | 1 |
| **some patients take antidepressants for other reasons eg orthostatic hypotension but there was no way to explain this in the survey looking at medical admissions would be more useful for us as the numbers were very low** | 1 |
| **For patients with a short stay, unless depression was major part of cause for admission, depression was not addressed. For longer stay patients, if they did not respond as expected depression could be considered. Looking for hints of depression was a tedious task as it required reading all entries of very long admissions in full. It was a useful exercise for me to understand how we can miss things we do not look for.** | 1 |