Simple Screening Tool Spots Elderly Depression

A self-report survey was more accurate and took less time to complete than the widely used GDS screen.

BY HEIDI SPLETE
Senior Writer

WASHINGTON —A nine-item questionnaire of self-reported symptoms was more reliable and efficient than the widely used Geriatric Depression Scale and the Minimum Data Set 2.0 scale at assessing mood disorders in nursing home patients, according to a study in 71 facilities across eight states.

Accurate detection of mood disorders in the long-term care population remains a constant challenge, said Dr. Debra Saliba, a geriatrician at the University of California, Los Angeles, and director of the Borun Center for Gerontological Research there. She reported the results at the annual meeting of the American Geriatrics Society.

Identifying depression in nursing home patients is important, she emphasized, because the condition is associated with poor functional status; increased perception of pain; stress; suicide; and greater need for medical services.

"In fact, a disproportionate number of successful suicides [occurs] in people who are over the age of 65," Dr. Saliba said.

Treating depression can be effective in reducing poor outcomes in long-term care residents, but depression often goes unnoticed in this population.

Several screening tools for mood disorders are in use, but they haven't been compared with one another or with any validated psychiatric-assessment tool, Dr. Saliba said.

The new study compared the effectiveness of the nine-item Patient Health Questionnaire (PHQ-9), the Geriatric Depression Scale (GDS), Minimum Data Set version 2.0 (MDS 2.0) assessment by staff, and one of two validated tools for identifying mood disorders in a long-term care population.

The GDS was designed for older adults and has become a geriatric standard; this study used the newer version of the test, which is made up of 15 yes/no questions. But studies have suggested that the test may be overly influenced by somatic symptoms when individuals answer questions such as, "Have you stopped many of your activities and interests?" without being able to elaborate.

By contrast, PHQ-9 questions prompt open-ended responses to topics including sleep problems, bad feelings about oneself, and trouble with concentration. The tool may be administered either as a self-reported survey or as part of an interview. The MDS 2.0 observer-rated scale avoids an interview or self-report.

"Some people have said that the PHQ-9 is too symptom driven or too complicated," Dr. Saliba said, leading to questions of the survey's validity for assessing mood disorders in frail old people.

The investigators selected 418 nursing home residents scheduled to receive mandatory MDS 2.0 assessments. Nearly half the study participants were older than 85 years.

In addition to the MDS 2.0 assessment for each resident, one nurse administered the PHQ-9 and GDS, and a second nurse administered either the modified Schedule for Affective Disorders and Schizophrenia (mSADS) or the Cornell Scale for Depression. The Cornell tool was used for residents whose cognition was too low to allow assessment by mSADS, but both these tests are validated, "gold standard" tools, Dr. Saliba said.

About 80% of study participants were assessed by at least one of the screening tools as well as one of the validated tools. Overall, the GDS screen found 41% of residents with probable depression, PHQ-9 found 42%, and MDS 2.0 found 17%.

When the investigators used a measure of agreement adjusted for chance (kappa scores), the PHQ-9 had significantly higher agreement with the validated standard than either the GDS or the MDS 2.0 did. In fact, the MDS 2.0 assessment was less accurate than if the results had happened by chance, Dr. Saliba said.

"Contrary to the expectations of many, the PHQ-9 did not lead to more classification with depression," she said.

Not only was the PHQ-9 tool more accurate than the GDS screen, but it also took less time to complete: 4.9 minutes for the PHQ-9 vs. 11.4 minutes for the GDS.

A majority of the residents, including the large number with cognitive impairment, could complete the PHQ-9, Dr. Saliba said.

The findings suggest that standardized mood assessment of older adults could be performed more effectively with the PHQ-9 than with the GDS or MDS 2.0, although more research is needed to confirm the results.

"We hadn't expected it to be quite so favorable for PHQ-9," she said. "But it is often difficult for older adults to reduce their life experiences to yes or no questions." ■

Health Disparities Teased Out Between Elderly Blacks, Whites

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Several analyses of data from a longitudinal study of 3,075 elderly African American and white patients have helped identify some of the causes of health disparities between races in older adults, sometimes with surprising results.

Investigators presented their findings in a joint session at the annual meeting of the Gerontological Society of America. The results can inform the clinical care of older African Americans, several speakers said.

For example, depression was strongly associated with widespread bodily pain in African American men, but not in white men. Socioeconomic status played a big role in racial disparities in death rates. Lung function did not seem to influence racial differences seen in physical performance, contrary to expectations.

All of the studies analyzed data from the Health, Aging, and Body Composition (Health ABC) study of 3,075 well-functioning, community-dwelling adults aged 70-79 years at baseline in 1997-1998. The cohort was 42% African American and 48% female and resided in Memphis or Pittsburgh. They were followed with annual clinic visits and interim 6-month phone calls for the first 6 years.

Widespread pain was present in 8% of women regardless of race and in 3% of African American men and 4% of white men after investigations controlled for factors including osteoporosis, arthritis, and depression, reported Gregory H. Hicks, Ph.D., of the University of Delaware, Newark. He analyzed data on 2,423 patients in the Health ABC study who had appropriate records.

African Americans were significantly less likely than whites (28% vs. 53%) to report widespread pain, after accounting for the effects of demographics, socioeconomic status, psychosocial factors, health status, and biological factors.

Depressive symptoms increased the risk of widespread pain ninefold in African Americans, but did not significantly affect risk in whites. Feeling fearful quadrupled the odds for widespread pain in whites, but not for African Americans.

Osteoporosis was associated with a threefold increase in the risk of widespread pain in whites and an eightfold increase in African Americans. Arthritis was associated with a 10-fold increase in the risk of widespread pain in whites and a 13-fold increase in African Americans.

"So from a clinical perspective, it may be that addressing depression may be more important in African Americans, addressing fear may be more important in whites, and addressing osteoporosis is important in both" in order to manage widespread pain, Dr. Hicks said.

Drinking, smoking, and body mass index did not affect rates of widespread pain.

Roland J. Thorpe Jr., Ph.D., and his associates focused a separate analysis on 2,863 Health ABC patients with valid spirometry results in their records. African American patients performed worse on physical performance measures than did whites, but lung function did not explain this difference, said Dr. Thorpe of Johns Hopkins University, Baltimore.

In the African American group, 59% of women and 75% of men found it "very easy" to walk a quarter-mile in the clinic, compared with 75% of women and 82% of men in the white group. Normal gait was slower than 1 m/sec (predictive of mobility limitation) in 42% of women and 25% of men in the African American group and in 16% of women and 8% of men in the white group. A score of less than 2 (representing poor functional status) on a composite of physical activity tests was seen in 52% of women and 33% of men in the African American group, and in 31% of women and 17% of men among whites.

Spirometry results showed normal lung function in 54% of black women and 30% of black men, compared with 35% of white women and 35% of white men.

"Lung function had little bearing on differences in physical functioning" between races, Dr. Thorpe said. "This was contrary to our expectations." He speculated that other factors that might explain these disparities could include perceived discrimination, residential segregation, or other socioeconomic dimensions.

Annemarie Koster, Ph.D., and her associates at the National Institutes of Health, Bethesda, Md., studied data on 2,937 patients with 8 years of follow-up in the Health ABC study to look at mortality rates and causes. A previous report in 2003 found that age-adjusted all-cause death rates were 30% higher and life expectancy was 2 years shorter in African Americans, compared with whites.

After adjustment for demographic variables, African Americans had a 60% higher risk of mortality than did whites.

DR. KOSTER

In the current study, half of the African American patients and 25% of whites died during 8 years of follow-up.

After demographic variables were adjusted for, African Americans had a 60% higher risk of mortality. Socioeconomic factors explained about 60% of this difference, Dr. Koster said, and behavioral factors explained another 30% of the difference.

Factors assessed included education level, income, social support, smoking, body mass index, self-rated health, and having supplemental health insurance in addition to Medicare.

After adjusting for both demographics and socioeconomic status, African Americans still had a 25% higher risk of mortality, she said.

A 60% increased risk of death from coronary heart disease in blacks, compared with whites, resulted primarily from socioeconomic status, which accounted for 96% of the increase. Socioeconomic status explained nearly a third of a 75% increase in risk of death from cancer in blacks, and the lack of supplemental health insurance accounted for 18% of the cancer death risk increase, she added. ■