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Caring for Depressed Elderly in the Emergency Department: Establishing Links Between Sub-Acute, Primary, and Community Care

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Caring for Depressed Elderly in the Emergency Department: Establishing Links Between Sub-Acute, Primary, and Community Care

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Elderly patients presenting to St. Vincent's Health Emergency Department (ED) constitute approximately one third of presentations. A significant proportion of these involve preexisting conditions including depression that, within elderly patients, is associated with social isolation, physical and mental health problems, and barriers to accessing community services. It is also often overlooked as a clinical diagnosis among the elderly. This study aimed to assess the efficacy of a brief depression screening tool and examine the change over time in quality of life and social factors for elderly patients who present to ED. Patients aged 65 years and over were screened for depression using a short form of the Geriatric Depression Scale (GDS-15). Participants were randomized into control (usual care) and intervention (an assertive outreach community management program) groups and

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assessed in relation to depression, quality of life, and social support/functioning at recruitment and 6 weeks post discharge. Approximately one in four participants experienced mild to moderate depression that was related to medical factors and associated reduced mobility. This study suggests that an assertive outreach program, with the inclusion of community intervention and links to social supports and services, could improve the management of depression in the elderly and associated health outcomes.

KEYWORDS *multidisciplinary intervention, elderly depression management, community resources, social support*

INTRODUCTION

Elderly patients presenting to St. Vincent's Emergency Department (ED) constitute approximately one third of all presentations. This situation is common to metropolitan hospitals in Victoria, Australia and internationally, with those aged 65 and over disproportionately represented. Specifically, while this age group currently comprise 13% of the population in Australia, they account for 33% of hospital admissions and 20% of ED presentations (Emergency Demand Coordination Group, 2001). In addition, approximately 15.2% of overall growth in demand on EDs within Australia stems from individuals within this age group (Emergency Demand Coordination Group, 2001). Further, the number of individuals aged 60 and over within Victoria is projected to increase from 1 million (19% of the population) in 2010 to 1.4 million (23%) in 2020 and 2.4 million (29%) in 2050 (Department of Planning and Community Development, 2010). The aging nature of our population emphasizes the importance of examining the aetiology of ED admissions among the elderly and the patient experience of these presentations to ensure both positive health outcomes and a reduction in the associated public health burden.

A significant proportion of elderly presentations to ED involve exacerbations or episodes of underlying or preexisting conditions. In older adults, depression specifically is known to cause significant distress and disability, which exacerbates, and is often exacerbated by, existing medical conditions (Frazer, Christensen, & Griffiths, 2005). However, depression in the elderly is often characterized by different symptomatology from that seen in younger adults. Specifically, depressed mood may be less commonly reported by health care professionals and the presentation of somatic symptoms, including a loss of appetite, lack of energy, irritability, sleeplessness, rumination, and physical pain may be more prominent (Frazer et al., 2005). Within the cohort of patients aged over 65, depression has significant implications for psychosocial health and well-being and is associated with social

isolation, carer stress, and barriers to effective access of community resources (Achterberg et al., 2003; Ell, 2006; Fessman & Lester, 2000; VanItallie, 2005). Not surprisingly, depression in the elderly is also associated with increased health service use, medical costs, and general health burden (Ell, 2006). However, it is also often considered to be a normal response to aging, physical deterioration, and other life events including the loss of loved ones (Birrer & Vemuri, 2004; Frazer et al., 2005). Accordingly, depression is often overlooked as a clinical diagnosis and, as a result, elderly patients may not receive optimal treatment during, or following, hospital admissions for depressive episodes (Ell, 2006; Koenig et al., 1992; Raj, 2004; VanItallie, 2005). For these reasons, recent research has investigated the efficacy of current treatment and management strategies for depression in the elderly in both primary health and community settings.

International literature suggests that the appropriate management of depression in the elderly, who present at the ED with complex care needs, should involve an integrated approach across a continuum of care from presentation to follow up with telephone tracking and supported linkages established between primary care and community services (Aminzadeh & Dalziel, 2002). Specifically, research has investigated the involvement of general practitioners, geriatricians, and allied health in appropriate care of the elderly, in conjunction with carers who are commonly the main source of support for these patients (Jeon, 2004). Research has focused specifically on integrating internal liaison with effective networking within the patient's community to improve long-term outcomes (Spillane et al., 1997). These studies have assessed the use of screening, geriatric and psychiatric assessment, education, the promotion of self-care (Hendriksen & Harrison, 2001), rehabilitation services and counseling (Lee, Ross, & Tracy, 2001), referral to appropriate community services (Aminzadeh & Dalziel, 2002) and community-carer linkages (Jeon, 2004). Such research shows that collaborative, holistic care is effective in improving outcomes for elderly patients with depression (Birrer & Vemuri, 2004; Frazer et al., 2005; Jeon, 2004; McGarry, Hegarty, & Gunn, 2005; Raj, 2004).

In response to the increasing recognition of this best practice care for elderly patients who present with depressive episodes, St. Vincent's Health in Melbourne undertook a recent analysis of elderly patients presenting to the ED. The findings indicate that the majority of individuals live alone (44%) with many more living with a primary carer (29%) (Joubert, Vale, Brock, & Braddy, 2005). However, minimal attention was paid to carer liaison or the linkages between primary health and community services. In response to this discrepancy, and given international literature supporting continuums of care for the elderly, St. Vincent's Health has implemented three integrated care programs under the Victorian Hospital Demand Management Strategy to develop alternative treatment plans for elderly individuals whose conditions are chronic or complex and who present frequently to ED. These

programs are of specific relevance to the elderly as their main purpose is to increase linkages with, and the use of, primary health and community services in instances where presentation at ED could be prevented or care more appropriately provided elsewhere. These programs are: ALERT (Assessing, Liaison and Early Referral Team), HiT (Holding it Together), and TRAAC (Treating the elderly in the right place: Facilitating appropriate community care). The directive of both the ALERT and HiT programs stipulates the importance of risk management, screening, early discharge planning for ED patients, and case management for patients who have complex care needs. The major objectives are to: screen for high-risk patients at all stages of care; coordinate a central referral process for sub-acute care; ensure early communication with relevant community agencies and programs; follow up with patients who are at risk of unplanned readmissions; ensure community supports are in place prior to discharge; centralize and improve timeliness of the referral process; and avoid unnecessary duplication of services. By contrast, the TRAAC program provides rapid assessment response and short-term case management for older people living in the community or in residential care settings. This service aims to prevent unnecessary ED presentations by offering alternative options where appropriate, through building linkages with community-based services. Rather than establishing another service structure, this model seeks to enhance existing services within the community. These three projects have cut across professional and skill boundaries and focus on an integrated systems approach to service delivery. However, there are no screening tools or management guidelines for patients who present with depressive symptomatology within the protocols of these programs.

This study sought to evaluate the patient experience and the resulting change over time in reported depression, quality of life, and social support factors for patients who present to ED and receive intervention in accordance with the ALERT, HiT, and TRACC programs, by comparison with those who receive usual care. The objective of this study was to improve the identification of, and response to, depression in elderly patients, aged over 65 years, who present with complex care needs, to improve health outcomes. The specific aims of this project were twofold. The first was to implement and assess the efficacy of a brief screening assessment for depression into existing protocols in the three integrated care programs at St. Vincent's Health and assess the efficacy of this assessment compared to standardized measures. The second aim was to develop a protocol for the identification and management of depression in elderly patients based on assertive outreach programs, linking patients and carers into existing integrated care programs at St. Vincent's Health and with primary and community care resources. This project was undertaken with the vision of contributing to the evidence base for best practice care with elderly patients presenting to ED and the identification and management of depression in this population.

METHODOLOGY

Participants

The study was conducted at St. Vincent's Health, an acute health care facility, in Melbourne, Australia. The participants for this study included male and female patients aged 65 years and over who presented to the ED between March 2005 and August 2005. The inclusion criteria for participation were extensive due to the sensitive nature of screening for depression in elderly patients who present to an ED. To qualify for inclusion, patients had to be English speaking, have a nominated general practitioner (GP) in the local community, and have no known psychiatric history and no identified medical issues that would hinder participation. Over the 6-month period, a total of 771 participants aged 65 and over presented to St. Vincent's Health ED. Of these, 363 (47.08%) identified as non-English speaking and 126 (16.34%) did not have a nominated local GP, 118 (15.30%) had an identified psychiatric history, and 99 (12.84%) reported medical problems that excluded them from participating including profound deafness, dysphasia, and cognitive impairment. Therefore, in total, within this 6-month period, 66 patients were determined eligible for participation in this study. The mean age of these participants was 76.63 years ($SD = 7.32$) and 71% were female.

Procedure

All 771 patients who presented during this time were screened during Phase 1 for depressive symptomatology using a brief version of the Geriatric Depression Screening (GDS-15) tool. This allowed for the evaluation of the efficacy of this tool in screening for depression in this patient cohort.

During Phase 2, the sample was refined based on the exclusion criteria described above and the remaining 66 patients were fully screened for depression using the 15-item form of the GDS-15 tool (Sheikh & Yesavage, 1986). The aim of this was to assess the efficacy and accuracy of the initial screen in the identification of depression. Using this full screen, a total of 15 patients scored positively and the remaining 51 patients screened negatively. Of the 15 patients who screened positively for depression, 7 refused to consent to participate in ongoing research. This reflects complexities inherent to conducting research with elderly patients demonstrating depression. During Phase 2, all participants who screened positively and consented to ongoing participation were randomized into control ($n = 4$) and intervention groups ($n = 4$). The characteristics of these participants are presented in Table 1. Both groups then completed measures designed to assess depression (GDS-15), quality of life (Manchester Short Assessment of Quality of Life), social support and social functioning (Person-In-Environment Classification System and Medical Outcome Study

Social Support Scale), and patient experience using a semi-structured interview. These measures are described below. Following the completion of these measures, the control group received usual care. The intervention group received a comprehensive, integrated management plan in accordance with the ALERT, HiT, and TRACC programs. This involved assessment outcome reports, patient education about depression in a one-on-one session with a social worker at St. Vincent's Health, emotional support, and counseling utilizing a problem-solving framework. Contact was also made with the participant's GP who received assessment outcome reports and links were established to community agencies for the provision of ongoing monitoring and support.

During Phase 3, participants in both the intervention and control groups were followed up with at 6 weeks post discharge from the ED. This follow up was conducted via phone to examine between-group differences in depression, quality of life, social support and social functioning, and patient satisfaction as examined in Phase 2.

TABLE 1 Profile of Intervention and Control Groups

Intervention group
Case 1: 68-year-old Italian male with congestive heart failure and renal failure
Case 2: 72-year-old Italian male, with cardiomyopathy and diabetes
Case 3: 67-year-old German female with sciatica and diabetes
Case 4: 66-year-old Australian female, with renal failure and diabetes
Control group
Case 1: 79-year-old Italian female with chest pain
Case 2: 70-year-old Egyptian female with abdomen pain
Case 3: 65-year-old Greek female with chest pain
Case 4: 83-year-old Australian female with limb pain

Measures

BRIEF GERIATRIC DEPRESSION SCREENING TOOL

This tool was used during Phase 1 to screen elderly ED patients who had depressive symptoms. It was adapted from the GDS-15 and consisted of four questions. A score of two or more was indicative of depression.

GERIATRIC DEPRESSION SCALE (GDS-15)

This measure has been used and validated extensively in past research to examine depressive symptomatology, present during the past week, in older patient populations and in primary and community health settings (Friedman, Heisel, & Delavan 2005; Pomeroy, Clark, & Philp, 2001; Rinaldi et al., 2003; Scogin & Shah, 2006; Sutcliffe et al., 2000; VanItallie, 2005; Watson & Pignone, 2003). It contains 15 questions (Sheikh & Yesavage, 1986) and evidence

of acceptable but moderate internal consistency and reliability has been found with the Cronbach's alpha coefficient for the total scale previously reported as 0.75 (Friedman et al., 2005). Construct validity for the assessment of depressed mood has also been determined (Friedman et al., 2005). Participant scores of 0–4 are considered within the range of normal function, dependant on age, education, and complaints; a score of 5–8 indicates mild depression, 9–11 indicates moderate depression, and 12–15 indicates severe depression. Within this study, participants who scored at or above a score of five were categorized as a positive screen, whereas those who scored below five were categorized as a negative screen.

MANCHESTER SHORT ASSESSMENT OF QUALITY OF LIFE (MANSA)

Quality of life was examined using the MANSA scale (Priebe, Huxley, Knight, & Evans, 1999). This scale consists of 16 items comprising 4 objective questions and 12 subjective questions examining satisfaction with life, job, financial situation, friendships, leisure activities, accommodation, personal safety, people, sex life, family, physical health, and mental health. Participant responses are reported on a 7-point Likert scale. A higher score, calculated as the mean scores of these scales, is indicative of a better reported quality of life. Cronbach's alpha for ratings using this measure has been reported at 0.74 and it has been found to be comparable to the Lancashire Quality of Life Profile (Priebe et al., 1999).

PERSON-IN-ENVIRONMENT (PIE) CLASSIFICATION SYSTEM

The PIE classification system (Karls & Wandrei, 1994) is widely field-tested and determines social functioning in four domains: role functioning, the environment, mental health, and physical health. It has good reliability and validity and assesses social functioning using a systemic model. The PIE was used in this study to examine the contribution of social functioning to depressive symptomatology, quality of life, representation rates at ED, and the use of primary care and community resources (Karls & Wandrei, 1994; Karls, Lowery, Mattaini, & Wandrei, 1997).

MEDICAL OUTCOME STUDY (MOS) SOCIAL SUPPORT SURVEY

The MOS social support survey allows for the examination of medical events and other stressors by assessing the availability of perceived social support in four categories including emotional/informational, tangible, affectionate, and positive social interaction (Sherbourne & Stewart, 1991). This self-administered scale uses a five-category Likert response for each of 19 items. Scores range from 0 (none of the time) to 5 (all of the time) and a higher score indicates greater social support. High internal consistency

and reliability have been reported for this measure with Cronbach's alpha coefficients reported as 0.97 for the total social support scale (Sherbourne & Stewart, 1991).

PATIENT SATISFACTION AND EXPERIENCE QUESTIONNAIRE

A semi-structured questionnaire was used to examine the needs of patients, their perceptions of the ED experience, the lived experience of depression, social supports and functioning, practical considerations including accommodation, transportation and financial concerns, and satisfaction with the health care service.

Data Analysis

Trends in quantitative results were examined as data could not be statistically compared due to a small sample size and the associated lack of power. Qualitative results ascertained from the semi-structured interview were analyzed using thematic analysis based on the framework of Grounded Theory (Liamputtong & Ezzy, 2005). Two independent raters, who were blind to the aims of the study, examined and coded qualitative data based on the identification of recurrent words, phrases, patterns, and themes. These categories were further refined to enable the formation of sub-categories as defined by similar coding (Morse & Field, 1995). Inter-rater agreement was established by comparing the coding of data and creation of sub-categories between raters. Analyses were refined until agreement was reached about all major coding categories and subcategories.

RESULTS

During Phase 1, a total of 771 patients participated in this study. Based on exclusion criteria, 66 patients were then fully screened for depression. Of these, 15 patients screened positively and the 8 who provided informed consent were randomized into intervention ($n = 4$) and control ($n = 4$) groups.

Depression

The overall mean score for depression screening during Phase 1 ($n = 66$), was 0.90 ($SD = 1.08$) (Figure 1). After randomization of the patients who screened positively and consented to ongoing participation, the mean screening score for the intervention group was 2.75 ($SD = 0.43$) and the mean score for the control group was 2.00 ($SD = 0.00$).

By comparison, the overall mean score for the GDS-15 ($n = 66$) was 3.13 ($SD = 2.56$) (Figure 2) with 22.72% experiencing mild to moderate

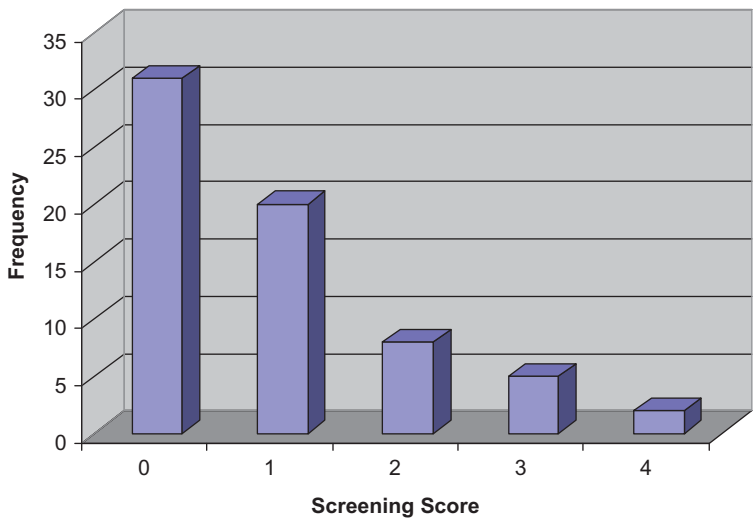


FIGURE 1 Spread of depression screening scores for patients assessed at Phase 1 who proceeded to Phase 2 ($N = 66$) (color figure available online).

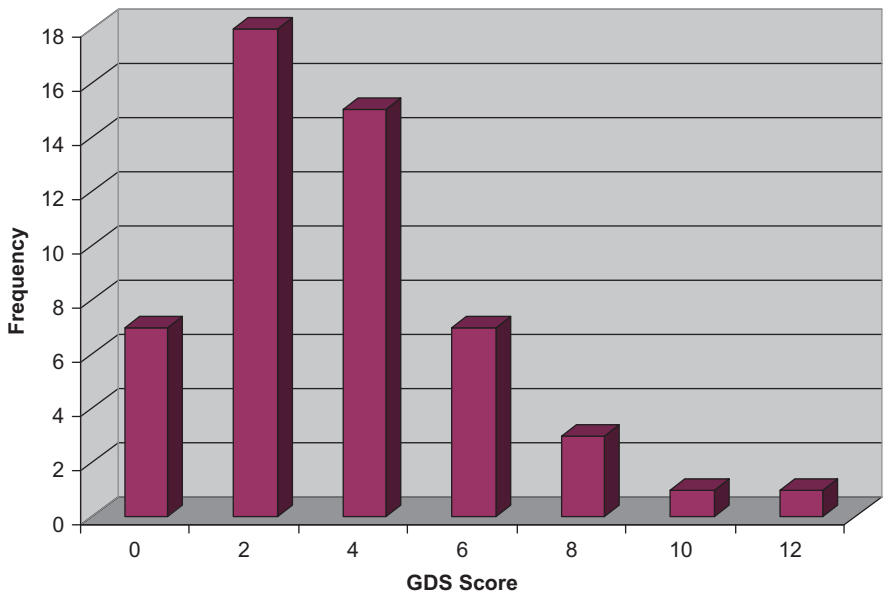


FIGURE 2 Spread of GDS-15 depression scores for patients assessed during Phase 2 (color figure available online).

depression. After randomization of the patients who screened positively and consented to ongoing participation, the mean GDS-15 score for the intervention group was 7.75 ($SD = 3.30$) and the mean score for the control group was 5.50 ($SD = 2.65$). The differences between GDS-15 scores at presentation and 6-weeks post discharge indicate fairly stable averages for

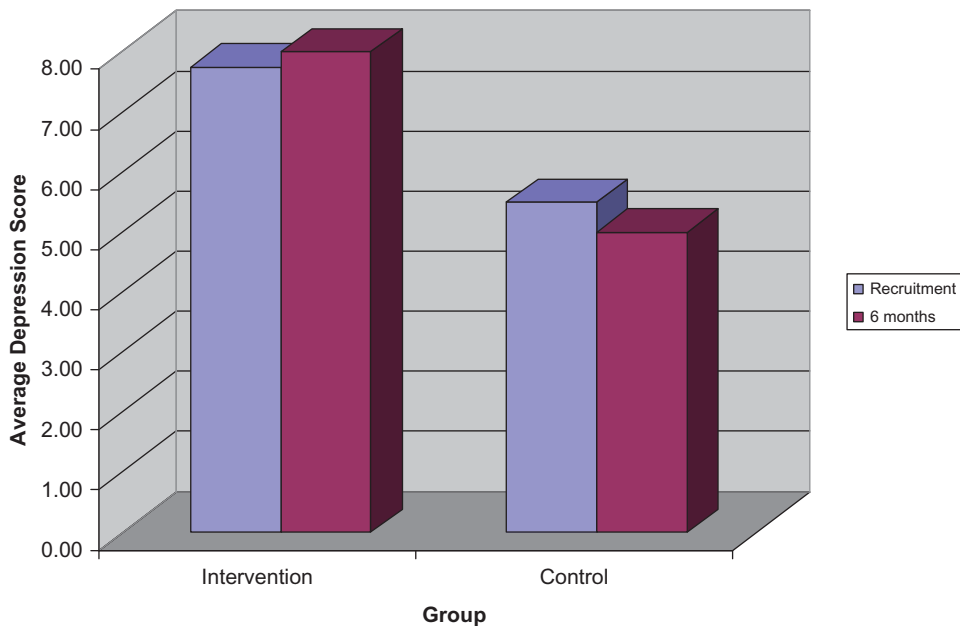


FIGURE 3 Change in mean GDS-15 score between recruitment and testing 6 months post discharge for control and intervention groups (color figure available online).

both groups with a slight reduction in the average depression score observed over time for the control group and a slight increase for the intervention group (Figure 3).

Quality of Life, Social Support, and Social Functioning

Trends in quantitative results compared at recruitment and 6-weeks post discharge (Figure 4) indicate that quality of life scores remained consistent for both groups, with a slight decrease observed for the intervention group. Social support and positive social interaction declined for the control group and improved for the intervention group. Emotional support increased slightly for the control group and remained relatively stable for the intervention group whereas affectionate social support improved for both groups. Overall social functioning, as examined with the PIE classification system, appeared stable for the control group but improved for the intervention group over time.

Thematic Analysis: Recurring Themes

PSYCHOLOGICAL FUNCTIONING

Overall, those who scored positively on the depression scale expressed mild to moderate depression. Thematic analyses of the semi-structured interview

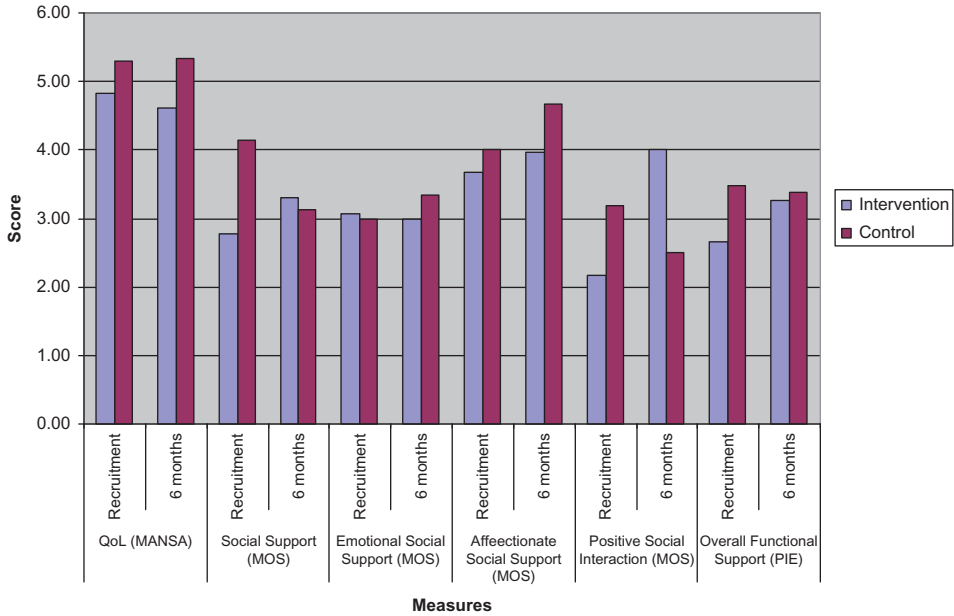


FIGURE 4 Quality of life (QoL), social support measures, and functional support scores at recruitment and 6 weeks post discharge for control and intervention groups and the measures used for examination (color figure available online).

indicate that participants reported multiple medical problems and frustration, primarily related to decreased mobility, as the most significant causes for depressed mood, rather than psychological dysfunction. In relation to reduced mobility, being unable to do what they would normally be able to do, and prefer to do, was cited as the main reason for this frustration, noting that they would lead normal happy lives if they were mobile. In terms of participants' perception of their mood, they described their feelings as "flat," "down," "/ "weak," and "very bad" but never used the words "sad" or "depressed." In addition, no participants expressed a fear of dying in this study, appearing instead to adopt an attitude of acceptance about the fact that when their time comes, it comes, although this was not perceived as giving up, but rather acceptance by participants. However, mixed feelings of worthlessness and hopelessness were reported with 62.5% reporting not feeling worthless but the same percentage (62.5%) reported feeling that their situation was hopeless.

SOCIAL FUNCTIONING

Mixed reports of good and poor social supports from family and friends resulted from this study. Those who lived alone tended to have less social supports available to them in the community and were more isolated.

Overall, social supports appeared to be important in the management of depression, although socializing outside the family was perceived as less important to participants' general well-being. Specifically, they noted great joy in talking about their grandchildren.

PRACTICAL FACTORS

In general, all participants enjoyed being retired and reported high satisfaction with their accommodation. They also reported frequent use of public transport, including buses, trams, and taxis and no reported problems relating to service accessibility. However, the majority of participants noted dissatisfaction with their financial situation; with the common comments being that "it's hard to make ends meet" and that "the pension doesn't go very far." No problems in accessing health services were reported and health care staff were generally rated as "wonderful," although a minority expressed a preference for the private health system over the public system.

DISCUSSION

Depression is increasingly recognized as an important issue in the elderly who present to ED, particularly in those with complex physical health and social problems. This study aimed to examine depression in patients aged over 65 years presenting to the ED at St. Vincent's Health in Melbourne; to examine the efficacy of a screening tool for the identification of depression and a protocol for the management of depression utilizing linkages between primary care and community care. The objective of this research was to contribute to the knowledge base about appropriate care of elderly patients who present with complex needs and depression, and to improve health outcomes for these patients. The significance of this research is supported by Hight, Luscombe, Davenport, Burns, and Hickie (2006) who assert that although depression is commonly recognized as a mental health problem, it is not yet considered a major general health problem throughout Australia. This is despite evidence to illustrate the increasing public health burden of depression in the elderly, particularly within the context of an aging Australian population.

The results of this study indicate that the mean scores for the brief screening tool and GDS-15 were comparable, with no clinical depression evident in the majority of patients but approximately one in four patients (22.72%) experiencing mild to moderate depression. This suggests that a brief screening for depression is appropriate in the context of ED presentation within the elderly. The majority of patients, encouragingly, did not feel worthless, but did report that their situation felt hopeless. According to patient reports, lowered mood was most significantly attributed to the

presence of multiple medical problems and associated decreased mobility. Although quantitative results in this study have to be interpreted with caution due to the relatively small sample size obtained, differences in depression scores between recruitment and 6 months indicate relatively stable scores for both the control and intervention groups. This may support patient reports that depression may largely reflect factors related to medical circumstance and functionality, an assertion that is supported by Travis, Lyness, Shields, King, and Cox (2004) who found that depressive symptoms were significantly associated with functional impairment and disability. It may therefore be hypothesized that as, over time, functionality increases or worsens in elderly patients, depression similarly changes. This requires further investigation in future research.

Like previous studies, this research also showed that the elderly will often not talk about symptoms of sadness and depression but will rather talk about 'feeling weak', or 'very bad'. These terms may often disguise depression by making feelings of sadness appear to relate to persistent physical complaints and health issues, rather than psychological dysfunction. This is likely to exacerbate poor recognition and management of depression in elderly patients (Ell, 2006; Koenig et al., 1992; Raj, 2004; VanItallie, 2005) and suggests that the use of patient education about depression, as integrated into the three integrated care management approaches (ALERT, HiT, and TRACC) at St. Vincent's Health, is essential to engender change in the perception and discussion of depression among the elderly to ensure early intervention and appropriate management.

Within this study, the intervention group demonstrated the most notable trends in increased social support and functioning between recruitment and 6-weeks post discharge in areas of social support and positive social interaction and social functioning, with the control group experiencing a reduction in scores over time or no change. Emotional support was the only aspect of social functioning that appeared to increase for the control group although this remained stable for the intervention group. The experience of affectionate social support improved for both groups. As iterated above, these results have not been statistically compared and therefore must be interpreted with caution. However, within this study, the qualitative reports of patients confirmed the significance of social support to the management of depression, particularly in relation to support received from family members. This is supported by Jeon (2004) who illustrates that family caregivers play an essential role in the care of elderly patients, particularly those engaged primarily in community-based care. The improvement trends in several areas of social support and functioning over time for the intervention group illustrates the importance of integrated care approaches for the management of depression not only incorporating patient education about depression but also promoting family and community linkages to ensure adequate social support, consistency in care, and the promotion of positive health outcomes for these patients.

The emergency health care environment can present challenges in responding to the elderly with depression as it is a high-stress, high-volume environment. Yet, it provides a window of opportunity. The use of screening tools for depression in elderly patients and the provision of integrated care teams, such as those within the ALERT, HiT, and TRACC programs at St. Vincent's Health, provide the opportunity for assessing and responding to patients screening positively for depression within this environment. This facilitates appropriate follow-up medical care with the general practitioner and supports the isolated elderly person with limited mobility to access community resources and services. This is supported by research that demonstrates that EDs in Australia are appropriate settings for the detection of mental health problems as the prevalence is high and patients may not present elsewhere (Kinner et al., 2005; Scogin & Shah, 2006; VanItallie, 2005). This research also stresses the importance of appropriate screening, assessment, and referral processes to ensure adequate support within emergency health to facilitate consistent patient assessment and ensure appropriate, ongoing patient care.

There are limitations inherent to the nature of this study. These primarily relate to complex factors related to the assessment of elderly patients who present to ED, particularly those with depression. Within this particular study, although 771 patients were initially screened for depression and 66 were fully assessed, the rate of consent for the participation in ongoing research was significantly reduced with a final sample of 8 participants. As discussed, this significantly reduced the power of this study, particularly related to the use of quantitative measures. However, the corresponding use of both quantitative and qualitative measures in this study ensured that the results obtained holistically reflect the experience of the sample recruited, despite this reduced power. Significant factors that contributed to the reduced number of participants recruited for this study included previous psychiatric history and complex medical needs. This is an area that requires future research to ensure that the identification of depression in primary care settings for such patients is accurate and timely.

It was anticipated that the findings of this research would contribute to knowledge about the psychosocial and cultural factors that may contribute to the presentation of depression in this patient cohort and about the role and function of practitioners in the management of depression. It was also anticipated that this research would illuminate the key outcome indicators that are significant in directing the most appropriate management of depression in elderly patients while taking into consideration the needs of the patient, co-morbid health conditions, and the role of community services. Most significantly, it was hoped that this research would improve care and health outcomes for elderly patients. Through the indication of the importance of patient education and depression, physical mobility and functioning, and social support, this research suggests that the use of integrated care

approaches to the management of depression in the elderly who present to ED is essential. This is necessary to improve health outcomes within this patient population and work to reduce the high associated public health burden.

Stemming from this research is the recommendation of the need for a controlled study, with adequate power, into the efficacy of integrated care approaches to the management of depression in elderly patients presenting to ED; especially those with multiple medical problems who are socially isolated and, or, financially vulnerable. This intervention may involve the four screening questions for depression and Geriatric Depression Scale as part of routine protocols for integrated care services, in combination with an immediate treatment response and referral to a general practitioner in the community for further management. The importance of concurrent linkage and telephone follow up to facilitate and reduce barriers to community social supports and where possible, engagement of the carer in this process, cannot be underestimated.

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