Section 10

Mood CAP

Problem

Mood disorders (for example, depression, sadness, and anxiety) are common problems for adults in the community and in institutional settings. Depression is often underdiagnosed and undertreated. Where symptom rates are low, underdiagnosing must be considered. Left untreated, mood disorders are disabling and associated with high mortality, functional decline, and unnecessary suffering by the person, family, and caregivers. This CAP focuses on identifying depression, with a pre-existing diagnosis or a depressed mood state that requires attention and possible diagnosis.

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Overall Goals of Care

- Identify and address any immediate threats to the person's, or other's, safety that is posed by the mood state.
- Identify and treat any underlying conditions that may have caused or contributed to the mood state.
- Implement a treatment for the mood problem.
- Monitor for response to treatment or adverse effects of treatment.

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Mood CAP Trigger

There are three levels to the Mood CAP trigger. The triggers are based on the person's Depression Rating Scale (DRS). Note that while other items in the interRAI assessment may assist with further evaluation, the DRS is the best indicator of a potential or actual problem with depression.

TRIGGER RULES FOR THE MOOD CAP

- First, calculate the DRS by adding the person's code response for the following items. In the interRAI suite each item is first recoded such that 0 = 0, 1, 2 = 1, and 3 = 2, creating a scale ranging from 0 to 14.
  - Person made negative statements
  - Persistent anger with self or others
  - Expressions of what appear to be unrealistic fears
  - Repetitive health complaints
  - Repetitive anxious complaints or concerns
  - Sad, pained, or worried facial expressions
  - Crying, tearfulness

In most computer applications, the DRS will already have been programmed into the system.

- Second, assign the person to a trigger level as follows:

TRIGGERED — HIGH RISK: DRS SCORE OF 3 OR HIGHER

This group includes about 20% of persons in long-term care facilities, 25% of home care recipients, and 5% of older adults living independently in the community. In a long-term care facility setting, about 42% of the persons triggered into this group will improve over a 90-day period. The rate of improvement in home care tends to be about the same.

TRIGGERED — MEDIUM RISK: DRS SCORE OF 1 OR 2

This group includes about 30% of persons in long-term care facilities, 25% of home care recipients, and 5% of older adults living independently in the community. In a long-term care facility setting, about 25% of the persons triggered into this group will improve over a 90-day period. The rate of improvement for home care recipients is the same, about 25%.

NOT TRIGGERED — DRS SCORE OF 0

This group includes about 50% of persons in long-term care facilities, 50% of home care recipients, and 90% of older adults living independently in the community.

Mood CAP Guidelines

Overview of the Approach to the Person with a Mood Disorder

- **Initial assessment and stabilization.** There is a spectrum of severity of mood disorders, ranging from mild to life threatening. One primary objective of the initial assessment is to determine whether a person has symptoms of a severe mood disorder that place him or her or others at risk for harm. Clinicians must be able to identify when a person is at risk or poses an imminent risk to others and communicate these findings to the appropriate mental health professionals so that interventions to maintain safety can be implemented immediately.
- **Determination of the nature of the mood disorder.** There are many possible precipitants to the development of mood disorder symptoms, including psychosocial stressors (such as personal loss), relapse of an underlying mental health problem, a medication side effect, or an active medical condition. It is not uncommon for a person to have more than one precipitant. Selection of the appropriate treatment relies heavily on the assessment of factors contributing to the mood problem.
- **Treatment and monitoring.** There are many possible treatments appropriate to the wide range of mood disorders. The person who receives treatment must be monitored, as treatment (for example, dose of a medication) may need to be adjusted depending on the person's response.

Initial Assessment Observations

Is the person at risk for self-harm?

- Inquire about suicidal thoughts (that is, "suicidal ideation") and actions:
  - Has the person made a suicide plan?
  - Has the person attempted suicide in the past?
  - Has the person taken any risky actions such as stockpiling pills, saying good-bye to family, giving away possessions, or writing a note?
  - Has the person intentionally harmed or tried to harm him- or herself?
  - Has the person been refusing to eat or drink? Has the person experienced recent anorexia or weight loss? [See Dehydration CAP and Undernutrition CAP.]
  - Has the person been refusing medication or other therapies?
  - Observe for impaired judgment or safety awareness (for example, a person with depression can experience a sense of hopelessness and helplessness, which in turn can have a negative impact on judgment and decisions that he or she makes).

Is the person at risk for harming others?

- Observe for increased anger, mood lability, or agitation.
- Inquire if the person feels threatened by others or has thoughts of harming someone else (for example, a person with a mood problem may have delusional thinking, including paranoia).
- Check for weapons (for example, firearms) and objects that could be used as weapons (for example, dinnerware, sharp pencils, or scissors).

Characterize the full spectrum of symptoms of the mood disorder.

- Assess for subjective symptoms of a mood problem by asking the person whether he or she feels depressed. Note that even persons with dementia often can reply adequately when asked.
  - Person reports feeling sad or an absence of pleasurable moments in life.
  - Person reports having no interest in usual activities or complains of feeling too tired to participate. The person may report increased difficulty concentrating on customary activities.
  - Person describes feelings of worthlessness or guilt (for example, a person may complain of feeling like he or she has become a burden to the family).
  - Person reports diminished appetite or a change in sleep habits.
- Observe for the following objective signs of a mood problem:
  - Person displays increased tearfulness or sadness.
  - Sleep disturbance: either difficulty sleeping or increased sleep. Consider keeping a sleep log to accurately track sleep habits.
  - Person's activity level appears low.

- Person eats poorly and loses weight [see Undernutrition CAP] or eats more than usual.

- Signs and symptoms of mania or hypomania should also be explored for persons who trigger the Mood CAP. This information can assist with the clinical management of the disorder, as it will assist in identifying a depressed mood related to a bipolar disorder. Review for a history of the following indicators:
  - Racing thoughts or euphoria
  - Increased irritability
  - Frequent mood changes
  - Pressured speech
  - Flight of ideas
  - Marked decrease in the need for sleep
  - Agitation or hyperactivity
- Attempt to quantify how long the subjective and objective changes have been present.

Inquire whether family or friends of the person have observed a change in mood.

Determination of the Cause of the Mood Disorder

Review the person's medications for drug(s) or regimen(s) that can be associated with mood changes. Large numbers of prescribed or over-the-counter medications can cause mood changes. Request that a pharmacist or physician review the person's full drug regimen. This assessment should focus on (1) whether any drug could be causing or exacerbating the mood disorder; and (2) whether the antidepressant drug prescribed is at a therapeutic dosage for a significant period of time.

- Any new medication(s), or frequency or drug dosage change? Review the length of time from change to onset of symptoms. [See Appropriate Medications CAP.]
- Any specific medication that may be associated with a mood problem? For example, some medications in the following categories have been associated with mood problems:
  - Corticosteroids
  - Cardiac medications
  - Anticholinergics
  - Anticonvulsants
  - Glaucoma medications
  - Antibiotics
  - Chemotherapeutic agents
  - Narcotics
  - Antipsychotics

- Other drugs, such as interferon and some over-the-counter medications

- Cessation of a medication (for example, corticosteroids or antidepressant medications) may be associated with a mood problem.

New medications are regularly appearing on the market, and some herbal remedies can positively or negatively affect mood.

Is the development of a mood problem associated with a change in the person's medical condition? Check for the presence of

- **Delirium —** This can mimic depression but may be able to be distinguished from depression by the presence of fluctuating levels of consciousness and new or worsening cognitive impairment. [See Delirium CAP.]

- **Infection —** Examine the person for signs of infection including fever, foul-smelling cloudy urine, or purulent sputum.

- **Pain** is often associated with depression, and in these cases assessing and managing both has to be considered. [See Pain CAP.]

- **Other examples of medical conditions** associated with mood problems include thyroid abnormalities, dehydration, metabolic disorders, recent CVA (stroke), dementia, and cancer. [See Cognitive Loss CAP.]

- Consider consulting a physician to diagnose and treat the medical condition.

Is the development of a mood problem associated with any psychosocial changes?

- Any recent change in environment (for example, moving from the life-long home to an apartment in a senior housing complex or into a long-term care facility)?

- Any recent change in relationships (for example, illness or loss of a relative or a friend, or a relative moving out of town)?

- Any recent change in health perception (for example, perception of being seriously ill)?

- Any clinical or functional change that may affect the person's dignity (for example, new or worsening incontinence, communication decline)?

What has been the course of the mood problem?

- Has the change in mood been abrupt or gradual? Mood disorders rarely develop overnight, and a sudden onset may be a clue to an acute medical illness or delirium.

- Has the mood change been constant or has the person's mood fluctuated between extremes?

Does the person have a history of a mood problem?

- Is there a record of a mood disorder or treatment of one in the past?

- Was treatment for a mood disorder changed or discontinued recently?

To what extent do symptoms of anxiety co-occur with the mood disturbance?

- Although distinct disorders, there is the possibility of occurrence of both mood and anxiety disorders.

Treatment and Monitoring

Response to treatment:

- Continue to monitor safety.
  - Monitor for the presence of suicidal feelings. Thoughts of suicide should always be taken seriously. In some persons with depression, the suicide risk may increase during the early treatment phase when the person's energy is restored.
  - Consider referral to a mental health professional.
  - Continue to monitor for signs of dehydration and assess nutritional status.
- Monitor mood state.
  - Is the mood responding to treatment as anticipated?
  - Are there signs that the person may be developing a different mood problem? For example, a person with bipolar disorder may cycle into a manic episode when treated for depression.
- Monitor for the onset of treatment side effects.
  - Anticholinergic side effects (for example, delirium, severe constipation, dry mouth, urinary retention, and blurred vision).
  - New sleep disturbance (insomnia, sudden need for less sleep, or daytime drowsiness).
  - Postural hypotension or gait unsteadiness.
  - Confusion (for example, persons treated with electroconvulsive therapy for a mood disorder may experience transient confusion after treatments).

Need for education about the mood disorder and its treatment:

- What are the person's expectations about psychotherapy or counseling?
- What are the person's concerns about the effects and side effects of psychotropic medication? [See Appropriate Medications CAP.]
- What are the person's expectations about the course of recovery? For example, a person may be unaware that several weeks of treatment with an antidepressant medication may be required before symptoms improve.
- Is the person aware that his or her treatment will require ongoing evaluation, titration of drug dosages, and sometimes a change to different medications in order to achieve adequate dosing, optimal treatment effects, and minimal side effects?
- Is the person aware of the need for a maintenance treatment to prevent relapse of the mood problem?

- If the person is receiving home care or lives in an assisted living facility, is he or she aware of community resources to obtain additional information on mood disorders?

Make sure the team, the person, and the family are aware of the planned length of the treatment, the time frame needed for the treatment to be effective, and the potential adverse effects to watch for. [See Appropriate Medications CAP.]

Additional Resources

Alexopoulos GS, Bruce ML, Hull J, Sirey JA, Kakuma T. 1999. Clinical determinants of suicidal ideation and behavior in geriatric depression. *Archives of General Psychiatry* (November). **Note:** This article reports the results of a study to determine risk factors for suicide in the elderly and provides a brief review of the epidemiology of suicide in the elderly.

Block SD. 2000. Assessing and managing depression in the terminally ill person. *Annals of Internal Medicine* (1 February). **Note:** This article, prepared for the End-of-Life Care Consensus Panel of the American College of Physicians — American Society of Internal Medicine, reviews the challenges encountered in the diagnosis and treatment of grief and depression in the terminally ill person. Case examples are used to illustrate points.

Burrows AB, Morris JN, Simon SE, Hirdes JP, Phillips C. 2002. Development of a minimum data set–based depression rating scale for use in nursing homes. *Age and Aging* 29: 165–72.

Satlin A, Murphy KM. 1997. Depression. In Morris JN, Lipsitz LA, Murphy KM, Belleville-Taylor P, eds. *Quality care in the nursing home*. St. Louis, MO: Mosby. **Note:** This chapter provides an overview of the risk factors, presenting signs and symptoms, and treatment options for depression in the elderly. Particular attention is given to the relationship between dementia and depression.

Clinical Practice Guidelines

American Psychiatric Association (APA). 1994. Practice guideline for the treatment of patients with bipolar disorder. *American Journal of Psychiatry* (December). **Note:** This guideline uses an approach similar to the depression guideline for the assessment and management of bipolar disorder.

American Psychiatric Association (APA). 2000. Practice guideline for the treatment of patients with major depressive disorder (revision). *American Journal of Psychiatry* (April). **Note:** This guideline provides a detailed general overview of the clinical characteristics of major depression and the treatment options. Flowcharts are used to assist with decision making. These guidelines are also available at the APA Web site: www.psych.org (click on "Clinical Resources" and then click on "Practice Guidelines"). This site includes Patient and Family Guides, which would also be useful in training nursing assistants.

Depression in primary care: Detection and diagnosis. 1993. Vol. 1: Detection and Diagnosis Clinical Practice Guideline #5. AHCPR Publication # 93-0550 (April). (Available online at www.nlm.nih.gov)

Diagnosis and treatment of depression in late life. 1991. NIH Consensus Statement. (November 4-6). 9(3):1–27. (Available on line at www.nlm.nih.gov).

Lebowitz BD, Pearson JL, Schneider LS, et al. 1997. Diagnosis and treatment of depression in late life: Consensus statement update. *JAMA* 278(14): 1186–90. (Available online at www.nlm.nih.gov)

Piven MLS. 1998. Detection of depression in the cognitively intact older adult (research-based protocol). University of Iowa Gerontological Nursing

Interventions Research Center, Research Dissemination Core 10. www.nursing.uiowa.edu

Treatment of major depression. 1993. Vol. 2: Treatment of major depression. Clinical Practice Guideline #5. AHCPR Publication #93-0551 (April).

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