MOOD Research Project

November 2000

Development of Checklist to Detect Older People at Risk of Depression

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1. Background

MOOD is a voluntary organisation based in the west of West Lothian offering support to older people and carers facing the problems of depression and other mental health problems. Its principal activity is to identify people over the age of sixty who have, or are at risk of, developing depression or mental health problems, and to devise a range of resources to support them and their carers. This is achieved by effectively using existing resources and structures, developing new initiatives, and collaborating with other voluntary and statutory agencies to promote joint working. A further aim of the project is to raise the level of public awareness of the problems experienced by older people with mental health difficulties.

To further the objectives of MOOD, in January 2000 the management committee made the decision to undertake a research project, to develop a method of detecting older people who are at risk of developing depression to enable the Project Leader to develop and target resources more effectively.

Research has indicated the important role that staff who are in regular contact with older people can play in identifying changes in mood or behaviour. However, there is also evidence that primary care and social care staff often fail to identify mental health problems experienced by older people. This is clearly an important issue for MOOD to address in seeking to identify needs and develop and provide supports.

The aim of the research therefore was to develop a tool or process to be used by a variety of workers in a range of settings in the community to identify that an individual is at risk of developing depression or other mental health problems. An important element of the tool or process being developed was that it would be accessible to people not trained in mental health and who do not work in clinical settings. The intention was not to create a diagnostic tool, but to produce a means for those in contact with older people to identify the warning signs that would alert them that the older person may need support and help to prevent their mental health deteriorating.

The Scottish Development Centre for Mental Health (SDC) supported this project, in terms of offering research support and advice. The SDC is a not-for-profit Scottish based organisation dedicated to the continuing development and improvement of mental health services in Scotland, which works in close collaboration with the key stakeholders involved in the planning, purchase, delivery and receipt of mental health services. The SDC is part of the Institute for Applied Health and Social Policy, Kings College London.

2. Aims and Objectives

Aim

The overall aim of the research project was to develop a method of detecting an older person at risk of developing depression to enable the Project Leader to develop and target resources more effectively.

Objectives

1. To identify from the literature and from local workers the factors that are likely to make an older person vulnerable to depression or mental health problems

2. To design and pilot a tool for the early identification of individuals who are at risk of developing depression

3. To ascertain the value of the tool in practice (using the pilot) as a means of identifying needs and of stimulating referrals to MOOD and other resources

4. To assess how the tool can best be introduced to and used by workers in a variety of settings

3. Research Methods

A. Literature review

The aim of the literature review was to set the context for the research, and to identify the key issues in relation to depression and other mental health problems in older people. The literature review explored the following:

- Definitions of depression
- Manifestations of depression
- Prevalence and detection of depression in older people
- Factors associated with the onset of depression (mainly in a social and environmental context)
- Measures and screening instruments

Medline and Cinahl databases were used; most of the relevant literature that came up was duplicated across the two databases, with a few exceptions. Follow-up references obtained from publications were identified through the primary search. The MOOD website was also an important source for locating information. Full details of the search strategy can be found in the Literature Review (full version), available from MOOD.

It was beyond the scope of the review to consider specific interventions to treat depression or support people with depression.

B. Focus groups

The aim of focus groups was to find out from older people and those working with them on a regular basis (in a range of settings) the factors and signs they were aware of in relation to depression and other mental health problems in older people. Six focus groups were held throughout May and June 2000 with the following:

- Older people in a local club (n=9)
- Older people attending a day care centre (n=10)
- Staff working in home care (n=8)
- Staff working in day care (n=3)
- Staff working in primary care (included district nurses, health visitors and GP) (n=4)
- Staff working in very sheltered housing (n=4)

To help frame the discussion, two vignettes were presented at the outset of these groups. These were based on real life cases of older people with depressive symptoms (all names and some details were changed). Focus group participants were encouraged to think around the factors associated with depression onset in these people, before moving on to talk about experiences from their own work or experience.

Focus Group Vignettes

Mrs Campbell

Mrs Campbell is 75 years old and has been widowed for nearly four years. Since her husband died she has been living with her daughter. She attends day hospital twice a week, this is the only time she gets out apart from her daughter taking her our in the car. She has not has a holiday since her husband died. She had a recent fall so needed a hip replacement operation and takes pain killers. She was recently diagnosed with lung cancer and has been undergoing treatment. Her grandsons are also suffering from poor health.

Mrs Campbell now attends a small group comprising of women who meet every week. A bus picks her up from the house to take her. As she is the most physically fit she makes the tea and does the dishes. The group has got to know each other well and have formed friendships. They talk openly about the way they are feeling in the group and support and encourage each other. Her daughter is getting some respite.

Mr.Mc.Cue.

Mr. Mc.Cue was a businessman who owned his own shop and retired at the age of 70. He is now 86 and has an active mind. Mr. Mc.Cue has a long history of hospital admissions for a depressive illness and he continues to lack confidence and experience low mood. Both he and his wife are frail and suffer from poor mobility due to arthritis. This restricts their ability to leave the house although Mr. Mc.Cue does attend Day Centre one day each week and a local lunch club twice weekly.

Throughout his life Mr.Mc.Cue was a keen golfer and misses not being able to play now. When he was referred to the MOOD project he expressed a desire to attend our bowling group as he had watched tournaments on television and had always wanted to try the sport. Mr.Mc.Cue attended the group from November 1999 until the summer of 2000 when he became physically unable to cope with the walking and bending necessary to participate.

A bowling group for frailer men started in September 2000 and he joined this and he continues to attend the group, which meets indoors in a local community education centre. Mr.Mc.Cue looks forward to his weekly bowling session and his wife confirms that he derives much pleasure from the activity and the camaraderie amongst the participants.

The completed Beck scale score showed an improvement of 10 points over a ten month period.

C. Collation of data from MOOD

Data from MOOD referral questionnaires was collated to explore common themes and patterns.

D. Brainstorming, testing and consensus reaching

Material from the literature review, focus groups and MOOD referrals formed the basis for this session.

A brainstorming session took place between the researchers and sub-group members to identify both relevant points to be incorporated into the instrument and to arrive at ideas about the type of format and presentation that would be

useful. A first draft was assembled by the researcher, which was refined during discussions and circulated to the research sub-group for comment and feedback. Comments from this exercise were incorporated into the instrument which was then circulated to people who had participated in the focus groups, and expressed an interest in continuing their involvement with the project. They were asked to consider the relevance and appropriateness of the instrument for the range of individuals they have contact with in their work capacity.

On this basis the instrument was in a continual process of refinement. A final version was agreed upon by the researchers and sub-group, and accompanying information in the form of procedure guidelines, record sheets and MOOD information was developed.

E. Piloting

Piloting took place over a four week period in July and August 2000. Managers of pilot sites were met with and supplied with forms, procedure guidelines, record sheets and MOOD information. Contact was made with all those participating during this stage of work (with the exception of home care staff).

The following pilot sites participated:

- Two day care centres
- Ten home care workers identified by Social Work Department
- One sheltered housing unit
- One very sheltered housing unit
- Two medical practices

On completion of the pilot phase, managers, supervisors or wardens were met with to discuss issues arising from the pilot stage e.g. how useful they felt the instrument was, staff's thoughts on usage, any problems encountered.

Piloting procedure

Staff were to familiarise themselves with the forms. If they felt a client was at risk of or showing signs of depression, they were to complete a form and discuss the situation with their manager or supervisor (exception is sheltered housing warden who had the responsibility to make this decision). If their manager or supervisor agreed, s/he approached the client to discuss the situation and ask if they would like the support of MOOD. Information about MOOD was available to be shared. If the client expressed an interest in MOOD, MOOD continued this process when notified. Staff involved in the piloting exercise were to complete referral forms throughout this process.

4. Findings

A. Literature review

A summary of the literature is provided here. A full version is available from MOOD.

The aim of the literature review was to set the context for the research, and to identify the key issues in relation to depression and other mental health problems in older people. Factors in relation to definitions of depression, manifestations, prevalence and detection in older people, social, environmental and psycho-social risk factors and currents methods for measuring and screening depression are discussed.

Depression has been defined in a range of ways but is best viewed as a spectrum disorder from significant distress to minor depression or depressive symptoms. Quality of life, life satisfaction and levels of morale or motivation are also closely related to depression. Because of the lack of a precise definition, it is a challenge to measure and accurately diagnose depression in older people. Apart from somatic signs, symptoms of depression include apathy, social withdrawal, loss of motivation or interest in usual activities and behavioural changes. People experience depression in different ways so it is important to be aware that not everyone will have the same 'symptoms' or show the same signs[1].

Depression and age are not correlates although there is evidence that depression or depressive symptoms increase with increasing age[2]. Prevalence rates vary considerably depending on the way depression is conceptualised, the sample studied and methods and measures used. Community studies in the UK have reported rates of depression among older people of between 11% and 16%[3]. There is substantial evidence that depression in older people regularly goes undetected or untreated for any of the following reasons: it is considered part of the normal ageing process by some; primary care professionals feel they have the inability to control the causes; insufficient training for those working with older people to deal with it; feelings of stigma or embarrassment thereby masking or hiding the condition[4].

People in receipt of home care have been shown to have a significantly higher prevalence of depression compared to the rest of the population (27% compared to 14%)[5]. It may be that the home care population with a high proportion of very elderly, as well as high levels of disability and social isolation, are particularly vulnerable to depressive symptoms. A high prevalence of depression in sheltered housing residents has been reported. This may be associated with factors such as admission involves a person losing their own home which may precipitate depression; the death of a spouse may require the person to move to sheltered housing which involves the person coming to terms with the loss and moving to a new environment[6]. People living in residential and nursing homes are also at greater risk of depression[7].

In terms of ‘risk factors’ for depression in older people, there is an association between socio-economic status and depression risk or onset. These are general risk factors for all age groups and apply also to older people. In examining mental health data across deprivation categories (using NHS data) people assigned to deprivation categories 6 and 7 (the most ‘deprived’) have higher prevalence and contact rates for depression[8]. Similarly there is an inverse relationship between depression and level of income[9]. Studies have found women to be at higher risk than men, although men are more at risk of suicide than women. Marriage conferred protection against depression for men whilst placing women at greater risk relative to never married women[10].

An association between physical health variables and depression in old age is well established. Some conditions such as stroke, Parkinson’s disease and Alzheimer’s disease hold clear risks, and depression can be a side effect of certain medications[11]. In multi-variate analyses, illness and disability have consistently been found to be among the strongest predictors of depression in older people: in the Gospel Oak Study (community survey of all residents over 65 in an electoral district of London) 78% of older people with depression would not be depressed if the risk factor for disability was removed[12]. However, the relationship between physical health, disability and depression is complex, with both social and psychological dimensions. Depression can, for instance, be a reaction to the impairment associated with being ill leading to pain, loss of mobility and impact on social functioning.

Levels of social support and social capital are associated with depression in older people. In the area of mental health, social support is usually associated with the hypothesis that it provides a buffer against the effects of ‘life circumstances’[13]. It is suggested that it is mobilisation of support in the face of a life event that is crucial to the onset of depression, and people are less likely to relapse after an episode of depression if they had good levels of social support. However, in the Gospel Oak Study there was stronger evidence for a direct association between lack of social support and depression than the buffer theory[14]. Social capital applies at the community rather than individual level. It has been argued that a community with high social capital is associated with positive health outcomes. This has implications for people living in communities where social capital is low (for example communities experiencing socio-economic disadvantage, de-industrialisation), with implications that they are at greater risk of poorer health, including poorer mental health[15].

Other factors associated with depression in older people include the impact of loneliness, loss, and specific or chronic life stresses. Loneliness is more common among those living alone, among those lacking supportive neighbours or contact with friends and among those upset about a relationship with a child. Desolation and the loss of intimate relationships have been seen as more powerful predictors of loneliness rather than isolation[16]. The loss of someone close (for example partner, spouse, friend, pet) can lead to loneliness and frequently leads to depression or depressive symptoms, particularly in the short-term. ‘Loss’ can also refer to loss of role, such as ‘wife’, ‘’partner’, ‘homemaker’ or ‘breadwinner’.

Most of the factors identified do not work in isolation to one another. The factors associated with depression risk and onset are inter-related and complex, and depend also on the characteristics of the individual (e.g. personality, coping capacity, locus of control).

Many instruments and screening measures are currently in use such as The Geriatric Depression Scale[18], the Beck Inventory[19] and SelfCARE(D)[20]. Other quality of life measures such as the Life Satisfaction Index and Social Support Scale have strong similarities to depression scales. However, many older people are still not receiving the appropriate support or treatment for depressive illness and other related mental health problems. It has been suggested that the use of short screening instruments is one way to remedy this situation. People working with older people in the community, such as home care workers, day care staff and community nurses, are in a good position to detect the signs because they see people in a natural environment on a regular basis. With the appropriate training and tools they could perform a useful screening and surveillance service.

Key factors contributing to the onset of depression in older people

The **death** of a spouse or partner, family member, friend, neighbour or pet

Loss of health, fitness, mobility or the ability to do things done previously, such as driving, shopping, gardening or getting out

Changes to circumstances such as living arrangements, benefits, amount of money coming in, caring for someone

Recent **major event** such as illness, family concerns, house break-in, theft

Changes in relation to availability, frequency and satisfaction with support from **friends, family and neighbours**

Stroke, Parkinson’s disease, Alzheimer’s disease

B. Focus groups themes

The main themes arising from the focus groups are presented. There was a great deal of consensus between groups on most issues.

Factors contributing to depression onset in older people

Key themes from focus groups

Changes to circumstances
e.g. Moving away from own things, not in own home

Changes in relation to social support/interaction
e.g. tied to the house, agoraphobia, not getting out, loneliness, no company
Importance of relationships – children, friends, neighbours
Suggestion that friends and neighbours more important than family (re. sympathy)
Little contact with other people
Lacking company
Boredom

Physical health
Physical health important, especially if housebound
Poor physical health – more dependent, more afraid, less confidence

Bereavement/loss
Loss or role and independence
Death of husband
Missing company previously had

Traumatic event
Such as a death, major illness, house break-in

Other factors
Lack of fresh air
Little to look forward to
Financial worries
Not feeling useful

Manifestations of depression in older people

Key themes from focus groups

Behavioural
Letting self go
Loss of interest in life – can't be bothered
Loss of interest in personal care – neglect hygiene
Loss of interest in home – dirty dishes, fridge smelling
Changes to normal behaviours – not wanting to go out, get the messages
Smoking and/or drinking more than usual
Lacking confidence
Argumentative
Withdrawn
Quiet

Physical
Appetite changes, eating more or less or not at all
Complaining of aches and pains
Sleeping more or less
Having no energy

Emotional
Holding things inside
Mood changes/swings
Temper and aggression – flinging things about
Weepy - Finding someone having a wee greet

Cognitive
Getting confused
Forgetfulness
Vagueness
Negative thoughts such as 'life's not worth living'
Not concentrating
Paranoid

Relationships/social interaction
Not mixing or participating
Loss of interest in things which were previously enjoyable e.g. gardening, shopping, going out for a cup of tea, normal conversation
Not wanting people to visit
Being lonely
Moaning about people around them

C. Collation of data from MOOD referrals

Data was collated from MOOD referral questionnaires (n=27) to examine current patterns of referral and reasons given.

ISSUE	YES (%)	NO (%)
Other people living in house?	41	59
Contact with hospital services, social work, church groups etc?	85	15
Relatives, neighbours, friends visit?	92	8
Ability to manage house/garden as wished?	31	69
Problems with sight/hearing/making self understood?	50	50
Medical condition present?	65	35
Difficulties getting out of house/using transport?	52	48
Recent major life event?	56	44
Changes in weight or appetite?	57	43
Receiving medication?	85	15
Sleep as well as used to?	55	45
Manage to get out of the house?	78	22
Problems with drinking, smoking, taking drugs?	4	96
Difficulty remembering things?	58	42
Sometimes feel angry or depressed?	93	7

Key issues:

- Over 50% live alone
- 69% are not able to manage the house or garden as they would like to.
- Half have sensory impairment or communication problems
- The majority have a medical condition present (65%) or are receiving medication (85%)
- Over half have experienced a recent major life event.

Process of checklist development

1. Literature review, focus group data, MOOD referral questionnaire data – key themes established

2. ‘Brainstorming’ session between researchers and sub-committee member decided relevant areas to include in instrument, including ideas for design and format

3. Draft checklist developed and refined via feedback and comments from sub-group and focus group participants

4. Final checklist developed and designed with accompanying forms (information, instructions and record sheet)

D. Pilot results

The following table illustrates the numbers of referrals and non-referrals in each pilot site.

Pilot site	Referral – agreed by client	Referral – declined by client	Non-referral – showed no signs	Non-referral – showed signs but not referred	*TOTALS*
DAY CARE	1	0	132	2	135
DAY CARE	1*	3	49	0	53
SHELTERED HOUSING	3	5	27	3	38
SHELTERED (& V. SHELTERED) HOUSING	0	0	22	1	23
PRIMARY CARE	1**	-	-	-	1
PRIMARY CARE	1***	-	-	-	1
HOME CARE***	1	0	3	0	4
TOTALS	7	8	233	6	255*****

* Client had Alzheimer's disease so referral to MOOD not appropriate
** Referral by district nurse
*** Referral by GP
**** Out of ten potential home care workers agreeing to participate in the study, four went ahead but only one person showed any real commitment.
***** The total number of clients seen is potentially higher than 255, as this does not take into account the numbers using the medical practice during the piloting stage.

Follow-up meetings took place with the managers/supervisors/wardens in all pilot sites

Summary of key findings

233 out of 255 (91%) clients were said not to show any signs of depression and therefore referral was not considered by staff. The total figure is higher than 255 as the number of older people seen in the course of everyday work by staff in primary care was not recorded.

7 clients showed signs and agreed to a MOOD referral.

8 clients showed signs, but declined referral.

6 clients showed signs but staff did not to refer.

Only 4 clients were actually referred to MOOD. One of these was not suitable owing to very poor physical health. Therefore the form elicited three referrals, all of who are now participating in groups offered by MOOD.

5. Discussion and recommendations

The literature identified the main factors and manifestations associated with depression and other mental health problems in older people. These were confirmed by the focus group findings which provided a rich source of data relevant to specific contexts. Using this information, the development of an instrument in a user-friendly and accessible format, based largely on a checklist idea, was relatively straightforward. However, the response rate (based on the number of referrals to MOOD) was lower than expected raising many interesting issues in relation to the process of using such a form, and how best to facilitate this process.

233 out of 255 clients (91%) were identified as not having signs of depression during the pilot stage. Seven potential referrals (under 3%) were agreed by clients but only four people were actually referred. One referral could not be considered as the person had very poor physical health. Therefore, as a result of using the form, three people with depressive symptoms are now participating in groups offered by MOOD. In terms of identifying individuals with depression. these figures are low when compared against the literature findings which indicate a much higher percentage of older people are at risk of depression, especially those in receipt of home care or resident in sheltered housing (27% in one study of people receiving home care had depressive symptoms). This seems to suggest that many people with risk factors or showing early signs of depression are being missed, or that the form was not being used to its best advantage.

Eight clients considered to be showing signs of depression declined a referral to MOOD. Sheltered housing staff reported that some of the clients declining referral did not believe that they were down or depressed as they did not have the 'classic symptoms'. They were being snappy, showing lack of energy, or not eating properly but were not obviously depressed. Others were simply not interested in a referral. This raises two issues. Firstly, how valid or reliable is the form? Some people change their behaviours for a range of reasons; they are not necessarily depressed, there could be an underlying physical problem or it could be early onset of dementia or Alzheimer's disease. Secondly, how did the staff member discuss the issue with the client? Unfortunately there is still much stigma associated with mental health problems, so a degree of sensitivity is required when talking about depression.

"The biggest problem is convincing them"

"Many don't feel they are depressed"

Six clients were considered to be showing signs of depression but staff decided not to refer them. In one day centre, there was the need to discuss the situation with the family before a referral could be made. Another referral was deferred due to physical problems. In sheltered housing the warden was relatively new in this unit (she had worked in sheltered housing for many years previously). She was extremely interested and well-motivated but felt that she had not yet developed a good enough relationship with her clients to discuss

the situation with them. She shared her thoughts regarding the use of such an instrument in sheltered housing e.g. there is not always much contact with people so it can be difficult to detect any changes if the client is quiet.

The form was not seen as potentially useful by staff in primary care. District nurses said they did not see how they could use it as they do not see many of their patients on a regular basis and they do not have the knowledge about some of the areas it covers. Also, most of their regular patients are in younger age groups. Similarly, GPs do not tend to see people on a regular basis and do not develop the kind of relationship to detect such change. GPs said they were already trained in depression, knew what to look for, were aware of the signs, so didn't think the instrument was of any use – but could see its potential uses in other settings. Generally, staff in primary care said that there were already procedures in place for dealing with mental health problems in older people (but did not accept that still many people are left untreated).

Home care was one area where the checklist had greatest potential. Most home care workers see their clients on a regular basis and build a trusting relationship with them. However, of the ten potential home care workers agreeing to participate, only four went ahead with only one producing results. The home care supervisor explained that "it was not something they wanted to do". Although this was unfortunate, it can also be regarded as a very useful part of the research process and be indicative of the way the form is used and regarded. Many home care workers are currently in dispute over conditions of work, such as time allocated to complete duties and restrictions on responsibilities. It is not surprising therefore that the use of the form was seen as an extra burden by some, and also something that was backed up with little support.

Another issue affecting the use of a form was the fear that it might affect or upset the relationship a staff member has developed with a client. This was especially true in the case of sheltered housing (and was also discussed widely in the focus group with home care workers). Completing a form was seen as 'checking up' on someone, making a decision about someone's mental wellbeing, doing something behind their back, and interfering with the 'relationship' developed with the client (usually formed on the basis of trust). Issues around the family were also mentioned; how the family should be involved, or might take offence to such an exercise being undertaken. This perhaps links with the issue around stigma and mental health still prevailing.

In terms of the original objectives, the tool in itself was regarded as useful in relation to its content, familiar jargon and ease of use, and was clearly from this point of view an accessible tool which could be used in a range of non-clinical settings. The purpose of the checklist was to act as an aid or prompt to staff, and to alert them to the potential risk of depression in clients. It was not aimed as a diagnostic tool.

Introducing the checklist and enabling workers to use it proved more difficult than perhaps anticipated for a range of reasons as previously outlined. It is

the process of enabling people to use the form and to have the confidence to make referrals to MOOD which requires further work, for instance to establish:

- Where and how could the form be best utilised?
- What factors are preventing staff from using form?
- How are staff approaching client if client is showing signs of depression?

In order to address these issues, the following recommendations arise form the research project:

- Training and support are required if staff are to use the form. It is also important that staff are getting something out of the form too and are not seeing it as an extra burden. For this reason it is suggested that the form becomes part of an awareness raising initiative. Staff learn and see the benefits of using it, both for themselves and their clients.
- To develop ways of effectively involving staff in the use of the form

The Way Ahead

The research conclusions indicate a need for training in the use and identifications of older people who may be at risk of developing depression. Staff will need to "own", the tool if it is to be used to most effect and they should also be aware of how to proceed with possible referrals to MOOD or any other helping agencies.
The MOOD management committee and staff would welcome further research into the use and development of the tool and would hope that other authorities would be interested in piloting it and providing feedback to improve its format.

Signs associated with depression in older people

Check list for staff working with older people

Please refer to Procedure Guidelines before completing this form.

Before completing the form, it is important to familiarise yourself with some of the factors shown to contribute to depression onset and other mental health problems in older people (see box below).

If your client has experienced any of the factors associated with depression onset, or if you have reason to believe s/he has changed in some way, or seems to be feeling down, low or just not him/herself, then complete the checklist overleaf.

The following factors have been shown to contribute to the onset of depression in older people:

- The **death** of a spouse or partner, family member, friend, neighbour or pet.
- **Loss** of health, fitness, mobility or the ability to do things done previously, such as driving, shopping, gardening, getting out.
- **Changes** to circumstances such as living arrangements, benefits, amount of money coming in, caring for someone.
- Recent **major event** such as illness, family concerns, house break-in, theft.
- **Changes** in relation to availability, frequency and satisfaction with support from **friends, family and neighbours**.
- Stroke, Parkinson's disease, Alzheimer's disease.

Signs of depression

To your knowledge, if over the last few weeks you have noticed any of the following changes, tick the appropriate box.

People who are depressed often change their usual behaviour patterns.

1. Taking less care of self than usual e.g. not washing, changing clothes as often or getting dressed [ ]
2. Taking less care of the home than usual e.g. leaving dishes or not making the bed [ ]
3. Becoming more aggressive or bad tempered than usual [ ]
4. Complaining or moaning about things more than usual [ ]
5. Becoming more withdrawn or quiet than usual [ ]
6. Appearing less confident about doing things [ ]

People who are depressed often experience it through physical changes.

1. Sleeping more or less than usual [ ]
2. Eating more or less than usual, or changing eating patterns [ ]
3. Feeling tired or having less energy than usual [ ]
4. Experiencing, or complaining of more aches and pains than usual [ ]

People who are depressed often express it through their feelings.

1. Becoming more weepy or distressed than usual [ ]
2. Appearing more frustrated or angry than usual [ ]
3. Appearing less content or expressing more sadness than usual [ ]
4. Appearing to feel worthless or hopeless [ ]
5. Experiencing mood swings [ ]

Being depressed often affects how people think.

1. Stating negative thoughts such as “I’m better off dead” [ ]
2. Experiencing strange or unusual ideas which did not previously exist [ ]
3. Becoming more forgetful than usual [ ]
4. Appearing confused [ ]
5. Less able to concentrate [ ]

When people are depressed, this often affects relationships and social activities.

1. Expressing dissatisfaction with the support received from friends/family/neighbours [ ]
2. Having poor relationships with friends/family/neighbours [ ]
3. Lacking interest or not participating in things which were previously enjoyed [ ]
4. Going out less frequently than usual, or becoming isolated [ ]
5. Appearing lonely [ ]

Please note any other factors which you feel are of concern: