Overview of depression: epidemiology and implications for community nursing practice

Chrystalleni Lazarou
Christiana Kouta, Cyprus University of Technology
Margarita Kapsou
Charis P. Kaite, Cyprus University of Technology

Available at: http://works.bepress.com/charis_kaite/12/
Overview of depression: epidemiology and implications for community nursing practice

Chrystalleni Lazarou, Christiana Kouta, Margarita Kapsou, Charis Kaite
Chrystalleni Lazarou, Harokopio University, Department of Nutrition and Dietetics, Athens, Greece, Christiana Kouta, Cyprus University of Technology, School of Health Sciences, Department of Nursing, Cyprus, Margarita Kapsou, University of Cyprus, Department of Psychology, Nicosia, Cyprus, Charis Kaite, Cyprus University of Technology, School of Health Sciences, Department of Nursing, Cyprus

Email: stalolaz@logosnet.cy.net

Depressive disorders are among the most common psychological conditions currently affecting individuals living in the Westernized world (World Health Organization (WHO), 2003a). While philosopher Albert Camus described the 20th century as the century of fear, and Rollo May called it the century of anxiety, the 21st century is often referred to as ‘the century of depression’ (Bloomfield and McWilliams, 2003). Depression is a term used to refer to a spectrum of mood disorders, a group of clinical conditions characterized by a loss of that sense of control and a subjective experience of great distress (Kaplan and Sadock, 2007). The best known and most researched mood disorders is major depressive disorder (MDD) which is basically characterized by the fact that patients are at increased risk of suicide and bipolar depression (BD) described by intermittent periods of manic and depressed disorders (American Psychiatric Association (APA), 2000).

The DSM-IV-TR provides a list of nine symptoms that can be used as a checklist for the diagnosis of depression by trained health professionals. Criteria for major depressive episode are met if the individual meets criteria for at least four of nine listed symptoms, causing significant distress or impairment for the individual (APA, 2000, p. 356). Table 1 presents the list of those criteria. Differential diagnosis should be ensured to rule out the possibility that such symptoms are induced by a substance or medication, and are not attributed to bereavement. Severity is further assessed in terms of impairment caused in functioning, and is usually classified into mild, moderate and severe (APA, 2000, p. 415). A diagnosis of depression is considered chronic if the criteria have been met for at least 2 years continuously (APA, 2000, p. 417). Like other psychological disorders, depending on severity and type, depression can affect and undermine the overall physical, social, family, and occupational functioning and performance of individuals. Thus, timely detection is a crucial step for proper and effective treatment (Christodoulou, 1998; England and Sim, 2009). Yet, according to available data, fewer than one third of adults with depression obtain appropriate professional treatment (Department of Health (DH), 2010; Judd et al, 1996).

This may be owing to the denial of depressed people to seek professional help, because they consider their depression a sign of personal weakness and because of fear of social stigma (Judd et al, 1996; DH, 2010) Moreover, the fact that a low percentage of people with depression obtain appropriate professional help may be owing to the under-recognition of depression by the health professionals with whom the patients have contact (Cronholm et al, 2010).

District or community nurses are among the health professionals who have the most frequent contact with patients (Wood, 2008). It is therefore important that district nurses acknowledge the magnitude of depression and are able to guide and consult people for further treatment. Yet, available evidence documents that district or community nurses often under-recognize instances of depression (Teresi et al, 2001; Saur et al, 2002; Cronholm et al, 2010).

In order to improve recognition rates, it is imperative for district nurses to appreciate the importance of prompt recognition, which presumes both an understanding and

Table 1

<table>
<thead>
<tr>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of deep sadness</td>
</tr>
<tr>
<td>Significant loss of interest in usual activities</td>
</tr>
<tr>
<td>Significant weight loss or gain</td>
</tr>
<tr>
<td>Fatigue and loss of energy</td>
</tr>
<tr>
<td>Feelings of worthlessness</td>
</tr>
<tr>
<td>Feelings of guilt</td>
</tr>
<tr>
<td>Feelings of hopelessness</td>
</tr>
<tr>
<td>Feeling that people are against the individual</td>
</tr>
<tr>
<td>Difficulty in making decisions</td>
</tr>
</tbody>
</table>

**ABSTRACT**

Depressive disorders are among the most common psychological conditions currently affecting individuals living in the Westernized world. Yet, available data indicate that fewer than one third of adults with depression obtain appropriate professional treatment. This is attributed, among other reasons, to the under-recognition of the problem by health professionals, including district nurses. In order to improve recognition of the problem, it is imperative for nurses and especially those working in community settings, to appreciate the importance of prompt diagnosis which presumes both an understanding and knowledge of basic aspects of the problem and, an understanding of their role in dealing with depression.

This overview presents epidemiological data and identifies the potential consequences of depression on daily functioning and other aspects of life among adults in Westernized countries, aiming to raise awareness and sensitize district nurses about the issue The article discusses how the role of district nurses can be enhanced to improve recognition rates.

**KEY WORDS**

Depression • Nursing practice • District nursing • Mental health

British Journal of Community Nursing Vol 16, No 01 41
**The DSM IV TR checklist for depression diagnosis**

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful).

2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

4) Insomnia or hypersomnia nearly every day.

5) Psychomotor agitation or retardation nearly every day (observable by others or account or observation made by others).

6) Fatigue or loss of energy nearly every day.

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely subjective feelings of restlessness or being slowed down).

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Source: American Psychiatric Association, 2000: 356

Knowledge of basic aspects of the problem, and an understanding of their role as nurse practitioners in dealing with depression.

Thus, the scope of this overview is to present basic epidemiological data on unipolar depression and its potential consequences on daily functioning and several aspects of life. This is done in an attempt to raise awareness about depression, its symptoms, and its ramifications among district nurses. The second aim is to suggest ways in which district nurses can contribute in ensuring that appropriate treatment is sought and provided. At this point the authors would like to mention that among European and other countries, professional registered nurses who provide nursing care at home including wound care, advice and support to the patients and their families, in order to limit hospital admissions and readmissions, differ only by term used. For example, they are called district nurses in UK, home care nurses in USA, and community nurses in Cyprus. All of these terms represent district nursing practice and thus will be used interchangeably within the whole document. Since literature referring to district nursing was limited, there would be cases that reference to school nurses and primary care nurses would be used in an effort to support the role of nurses in screening and dealing with depression in order to cover all kind of populations and all spectrums of depression.

**Discussion**

**Epidemiology and trends of depression**

Depression is regarded as the fourth most important cause of disability worldwide (WHO, 2003a). At any given moment, it is estimated that more than 150 million people worldwide experience depression (WHO, 2003a). Worldwide prevalence of clinical depression in the general population is estimated at 3-10%, and is increased among individuals with chronic disorders, ranging from 22-46%. In the United States particularly, it is estimated that 20.3% of the population report major (16.2%) or mild (4.1%) depression (England and Sim, 2009). In Europe, lifetime prevalence of major depression is estimated at 13% overall, 9% of adult men and 17% of adult women (Alonso et al, 2000). One in five women and one in every 10 men in the UK will be affected by depression at some time in their life (Health and Wellbeing UK, 2007; Depression Alliance UK, 2010). The lifetime risk for major depressive disorder in the UK is estimated between 10-25% for women and between 5-12% for men. At any point in time, 5-9% of women and 2-3% of men suffer from depression (PsycNet-UK, 2010). It is thus evident that the prevalence of this disease is high.

Unipolar depression is classified as the third cause of morbidity in the world and is estimated to account for 12-15% of years on disability (WHO, 2003a). It is estimated that by year 2020, the increased burden of depression will render it the first cause of morbidity worldwide (WHO, 2003a). Furthermore, by the year 2020, depression is projected to reach the second place in the ranking of disability-adjusted life years (DALYs) calculated for all ages, male and female, and it is already the second cause of DALYs in ages between 15-44 years for both genders (WHO, n.d.). Depression may affect people of any age or gender, but is considered most common among middle-aged individuals, with a median age of onset in late young adulthood (median age of onset at 32 years) and is most common among women (WHO, 2001a; Kessler et al, 2003), even though this view has not been without challenge (Kleerar, 1998). It has been estimated that 5.8% of men and 9.5% of women will experience a depressive disorder in any given year (WHO, 2001a).

Major depressive disorder (MDD) often has its onset during adolescence (WHO, 2003b). It has been noted that children with MDD with preadolescent onset are more likely to exhibit bipolar disorder, major depressive disorder, and have higher rates of suicide and drug abuse (WHO, 2003b). It is also reported that 20-50% of depressed children and adolescents have a family history of depression. Thus, children of depressed parents are three times more likely to suffer from depression than children without depression history in the family (US Department of Health and Human Services, 1999).

These observations and predictions overall indicate that depression not only appears to be on the rise, but may also increasingly affect individuals at younger ages (Kleerar, 1998; Doris, 1999; England and Sim, 2009). On the other hand, it is important to note that fewer than 25% (in some countries less than 10%) of those suffering from depression have access to effective treatments owing to lack of resources, lack of trained providers, and the social stigma often associated with psychological health conditions including depression (WHO, n.d.).
These data are disconcerting, because clinical depression is associated with long-term negative, and often severe consequences for the lives of the individuals affected.

**Consequences of depression**

**General overview**

Depression results in significant social and economic costs, because of its high prevalence, and the high percentage of individuals who are not treated, or who receive treatment that is inadequate or inappropriate (Hirschfeld et al, 1997; Moussavi et al, 2007). Individuals with depression are three times more likely to fail to adhere to their medical treatment, compared to individuals without depression (WHO, 2003a). Depression affects the life of both individuals and their family environments, and is associated with higher mortality, lower quality of life, and lower productivity (Christodoulou, 1998; England and Sim, 2009).

**Health**

The impact of major depression on an individual's quality of life is estimated to be equivalent to that of a severe physical illness, such as severe stroke (Saarni et al, 2006). Depression affects human endocrinological and immune systems, therefore increasing vulnerability to various physical disorders (WHO, 2001a, Hybels and Blazer, 2003), including cardiovascular diseases, diabetes, and cancer (Colter, 2001; National Institute of Mental Health, 2002). Furthermore, research indicates that 20-60% of breast cancer patients experience symptoms of depression, which may hinder women from adjusting to and participating in treatment activities (APA, 2007).

Depressed individuals are more likely than non-depressed individuals to engage in unsafe sexual behaviours, which place them at higher risks for sexually transmitted diseases, including HIV/AIDS (WHO, 2001a). Major depression is also classified as a mortality risk factor, as it increases risk of premature death by 59% (Ryan and Shea, 1996). It is estimated that 15-20% of individuals with depression commit suicide (WHO, 2001b), and that depression is accountable for about half of suicides and suicide attempts.

In the United States individuals with major depression are 18 times more likely to commit suicide compared to individuals without depression (Society for Neuroscience, 2002; Wald, 2002). In addition to negative consequences on the overall physical health and functions of individuals, depression is also associated with cognitive impairment e.g. excess difficulty in remembering things, finding it hard to concentrate or make decisions etc. (Hybels and Blazer, 2003).

**Economic**

Data regarding the economic costs of depression in the United States referring to the year 2000 and are estimated at $83.1 billion (Greenberg et al, 2003), of which two thirds are accounted for by lost productivity and workplace absence (Hirschfeld et al, 1997; England and Sim, 2009), while 26.1 billion refer to direct treatment (Greenberg et al, 2003). The direct costs per patient are estimated at $3000 annually (WHO, 2003a) and the cost for each working patient is estimated at $6000 (Hirschfeld et al, 1997). It is also estimated that between 1.8-3.6% of a country’s workforce suffers from depression, and that employees with depression are twice as likely to experience disability, compared to individuals without depression (WHO, 2003a). A study conducted in 1994 in a major financial services company in the United States has shown that work absences because of illness included an average of 44 days for depression, compared to 42 days for cardiovascular disorders, 39 days for back pains, and 21 days for asthma (WHO, 2003a). Research conducted in the UK suggested that financial costs for depression equal the costs for chronic cardiovascular diseases. It is estimated that up to 80 million working days per year may be lost due to depression, which corresponds to £3.7 million (WHO, 2001b).

Overall, depression can have serious social, personal, and professional consequences, summed as:

- ‘severe difficulties in the formation and maintenance of close interpersonal relationships... consequences for the entire family, and especially for children, alcoholism, substance abuse, and road traffic accidents... overuse of health services, early retirement, the large number of lost days...’ (Christodoulou, 1998; England and Sim, 2009).

**Implications for district nursing**

District nurses are senior nurses who manage care within the community, leading teams of community nurses and support workers. Their work involves visiting house-bound patients to provide advice and care, follow-up care for recently discharged hospital inpatients and longer-term care for chronically ill patients who may be referred by many other services in order to prevent unnecessary or avoidable hospital admissions (National Health Service Careers, n.d.).

Nurses in community settings are among the first who can recognize signs of depression among patients. They may support patients through telephone support, group meetings, individual counselling and home visits, and with referrals to psychologists and professional therapists. Often they work as a multidisciplinary health-care team (NICE, 2004). Nurses are trained to deliver adult educational programs for anxiety and secondary depression, based on cognitive behaviour therapy (CBT), which has been recommended by the Institute of Health and Clinical Excellence (NICE) (2004). In particular, for mild depression, NICE recommends guided self-help based on CBT and for moderate to severe depression, CBT for patients who do not take or refuse antidepressant treatment (NICE, 2004).
Cognitive therapy seeks to help the patient overcome difficulties by identifying and changing dysfunctional thinking, behaviour and emotional responses. This involves helping patients develop skills for modifying beliefs, identifying distorted thinking, relating to others in different ways and changing behaviours (Beck, n.d.).

The UK’s National Institute of Health and Clinical Excellence (NICE, 2009a) recommends the use of the two following verbal screening questions, especially for people with a past history of depression, or a chronic physical health problem with associated functional impairment:

• During the last month, have you often been bothered by feeling down, depressed or hopeless?
• During the last month, have you often been bothered by having little interest or pleasure in doing things?

Furthermore, NICE guidelines (2009a) suggest that when working with people with depression and their families, health professionals should build a trusting relationship, explaining the different courses of depression and that recovery is possible, as well as being sensitive to diverse cultural, ethnic and religious backgrounds and obtaining informed consent. Families and carers should be provided with all the necessary information about depression and its treatment as well as their confidentiality rights.

Several assessment tools have also been proposed by NICE (2009b), such as the Patient Health Questionnaire (PHQ-9) and the Quality and Outcomes Framework (QOF (NICE, 2009b). The PHQ-9 is a nine-question self-report measure of severity validated for use in primary care setting that takes approximately 3 minutes to complete. The PHQ-9 uses the Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV) criteria for depression and scores are categorized as minimal (1–4), mild (5–9), moderate (10–14), moderately severe (15–19) and severe depression (20–27) (NICE, 2009b).

The British Medical Association GP Contract Quality and Outcomes Framework (QOF) were amended in 2006 to include depression as a clinical indicator for the first time. The QOF is a prospective indicator that applies to adults aged 18 years and over with a new diagnosis of depression, but excludes women with postnatal depression. A measure of severity at the outset of treatment enables a discussion with patients about relevant treatment interventions and options, guided by the NICE guidance stepped model of care. NICE guidance uses the ICD-10 symptoms to define depression as mild, moderate, severe or severe with psychotic symptoms. A higher score indicates greater severity requiring different type of treatment. Clinicians should also consider family and previous history as well as degree of associated disability and patient preference in making an assessment of the need for treatment, rather than relying completely on a single symptom count (Banazak, Wills and Collins, 1998). The QOF is used to target patients with coronary heart disease (CHD) since is more common in people with CHD and the presence of depression is associated with poorer outcomes. QOF is also used to assess patients with diabetes mellitus since is clinically relevant in nearly 1 in 3 patients with diabetes (Banazak, Wills and Collins, 1998).

The American College of Nurses-Midwives (ACNM) supports universal screening, treatment and/or referral for depression in women as part of routine primary health care while recognizing depression as a community problem, requiring the collaboration of the multidisciplinary care team (The American College of Nurse Midwives, ACNM Position Statement, 2003).

Existing empirical evidence overall indicates that understanding of depression and its symptoms among nurses is inadequate (e.g. Haddad et al, 2005), but intervention studies have indicated that awareness raising and training programmes for nurses can be effective in increasing accurate detection and ensuring that proper treatment is obtained. Nurses can assist in differential nursing diagnoses between depression and other mental conditions, using interviews, rating scales and behavioural observations (Lack et al, 2009), as a first step before referring individuals to a mental health clinician for more elaborate assessment and therapy. Illustrative examples of programmes for training nurses in detecting depression are presented in the paragraphs that follow. Haddad et al (2005) conducted a three-area cross sectional study in order to obtain information on the extent of staff contact and input with mental health problems, and to assess their experience, training and attitudes towards mental health. Depression was found to be one of the mental health conditions that district nurses had to manage. District nurses reported lack of training on psychological care activities, but also reported willingness to receive training through educational programmes, and expressed confidence in their role of managing depression.

Brown et al (2010) conducted a study on improving the ability of home care nurses to detect depression in adult home-care patients with medical conditions, since on previous studies (Brown et al, 2004) home care nurses appeared inadequately prepared, and failed to identify cases with depression. Brown et al’s study (2010) was conducted with 36 home care nurses randomly assigned to Training in the Assessment of Depression (TRIAD) intervention (n=17) and control group (n=19) that received no training beyond that which agencies may have provided routinely with the opportunity to observe and practise patient interviewing. Participants randomized to the TRIAD intervention had a statistically significant increase in confidence in assessing for depression mood, whereas the usual care group’s confidence remained unchanged.

Assessment of clinical depression in children by school nurses can be based on a three-point approach, which includes a) assessment of depressive symptoms, b) family relationships, and c) school performance. Assessment of a child’s risk for depression should also include the evaluation of family or community violence, as well as maternal depression (negative impact of postpartum depression) (Nardi, 2007). This means that nursing assessment should include evaluation of community violence, family violence, divorce or stressors or single parenting and any other
recent stressors or changes (Nardi, 2007).

Depression in older adults is often under recognized and untreated owing to the assumption that depression is a normal part of aging. Evidence suggests that older people are often not referred to nurses for depression or refuse to take anti-depressants and this makes treatment ineffective (Saur et al, 2002).

The IMPACT Intervention is a collaborative, stepped care treatment program for late-life depression offered at the study sites 18 participating primary care clinics (Unutzer et al, 2001). Antidepressant medication and problem-solving treatment for primary care is used. IMPACT intervention model integrates mental health services and nurses offer a variety of interventions: antidepressant medication management, behavioural activation, psychotherapy and case management. Registered nurses are trained to identify unresolved health problems, monitor treatment response, address self-care deficits and promote self-management (Saur et al, 2002).

Nurses working with older people in the home should complete a detailed medication history and assess for signs of depression with other side effects and be aware of the risk factors for depression (e.g. family history, co-morbid health conditions, disability/loss of independence, medications, history of substance abuse etc.) (Tanner, 2005). Nurses initiate interventions in order to screen elderly such as the Geriatric Depression Scale (GDS), a 30-item scale comprising statements to which the client responds with a Yes or No answer focusing on psychological rather than somatic symptoms. Therefore, it is essential when screening for depression to assess suicidal thoughts and ideation. Such assessments can be challenging with this population, as individuals may hesitate to share such feelings (Raji, 2004). District nurses should strive to build prolonged relationships, based on trust with their patients, in order to improve the patient’s skills to cope with depression (van Eijk et al, 2004).

Other strategies that can be used by district nurses found to be effective include brief 20-minute sessions to enhance medication adherence, and improve the subset of patients with major depression related to depressive symptoms (Peveler, 1999), as well as 10-minute phone calls which showed improvement in mental functioning and treatment satisfaction (Hunkeler et al, 2000). A study conducted by Tezel and Gozum (2006) comparing the effect of nursing intervention to the effect of problem-solving training, on the level of postpartum depressive symptoms with 62 women (30 in care group and 32 in training group) all of whom were at risk of postpartum depression, but without major depressive symptoms, showed that both nursing care and problem solving training could be used confidently in the primary care setting. Nurses in the community can play an important role it detecting depression as well as reducing depressive symptoms (Tezel and Gozum, 2006).

In Australia, Buist et al (2007) introduced routine screening as a joint research/public health initiative across 43 health services funded by beyondblue, the National Australian Depression Initiative. This programme included assessing risk factors and prevalence of depression in prenatal women. Other objectives included increasing awareness of the condition, training of relevant staff and assessing the feasibility of a screening program. Results showed that all health professionals including nurses showed significant improvement in knowledge following the project, while midwives continued to require training and support (Buist et al, 2007).

In the UK, a postnatal depression intervention was carried out in primary care involving the training of health visitors in clinical assessment for postnatal depression. The intervention included the option for psychological intervention sessions to low-risk women with a previous delivery. Results showed a 32% reduction of new episodes of depression in mothers (Wahlinbeck and Mäkinen, 2008).

In Spain, Aragones et al (2008) introduced a multi-component model, the Interventions of Depression Improvement (INDI) model, for the systematic evaluation and treatment of depression in primary care. The INDI model is mainly carried out by nurses, although it involves the whole primary health-care team. The model includes interventions of a clinical, training-based, organizational, and health educational nature. The programme targets: a) primary care doctors, b) primary care nurses, and c) the interface between primary care and psychiatry. Results suggest that primary care nurses can play a central role in care management, patient education, treatment adherence and clinical monitoring after training (Araxo et al, 2008). Nurses coordinate and integrate the whole health-care management process to ensure continuity throughout the health-care process, between the various personnel and with any clinical physical diseases (Araxo et al, 2008). Nurses usually evaluate the patient using the Henderson model and then establish an intervention plan. Therefore, nurses treat secondary effects, evaluate response to treatment and routine coordination and communication with primary care doctors and psychiatrists. Education and counselling in depression is another responsibility of nurses, they have access to support materials (booklets, DVD etc) and can help patients deal with depression by providing them with information, advice, self-help strategies, etc. (Araxo et al, 2008).

Community nurses need to build trustworthy relationships with their clients in order to improve patients’ skills to cope with their health problems (Jacques et al, 2004). Further, community nurses need to attain educational programmes designed to provide them with the skills and confidence to screen depression (Brown et al, 2010). Nunn et al (2007) suggest that a mental health nursing consultant should be established in order to refer patients and ensure that appropriate follow up is provided to district nursing clients that are positively screened for depression.

In addition, district nurses should encourage patients to seek social interaction, monitor behaviours and engage in activities in order to provoke depressive symptoms. District
KEY POINTS

- The 21st Century is referred to as the century of depression. At least one in 11 people will be diagnosed with depression during their lifetime.
- Less than one third of adults with depression obtain appropriate professional treatment.
- Under-recognition of depression in primary care is a critical public health issue that has high societal costs related to disability, morbidity, mortality, and excessive health care use.
- Community nurses should acknowledge the high prevalence of depression and guide people for further treatment.
- Nurses could be trained to assess and identify depressive symptoms in patients with: a) past history of depression, b) significant physical illnesses causing disability and c) other mental health problems such as dementia.
- Empirically supported training programmes for nurses can contribute to raising awareness and increasing depression detection rates by nurses.

nurses can contribute in ensuring that appropriate treatment is sought and provided by monitoring the prescribed treatments and be in a position to answer patient's questions about the depressive symptomatology. District nurses should be trained on psychological and pharmacological treatments as well as have knowledge on their patients' treatment plans in order to assure that the best care is provided (Wilkinson, 1992; Basco and Rush, 1995; Saur et al, 2002).

Conclusion

Depression is a common mental health problem, but often remains under-recognized by general practice or specialized nurses, either in the community or in the hospital. Understanding the basic aspects and the prevalence of depression can sensitize district nurses and provide insight into the important role that they may have in primary and hospital settings, in recognizing the signs of depression and helping patients seek appropriate treatment. Several studies have already demonstrated empirically the effectiveness of training programmes for nurses for identifying and handling depression among their patients in medical and community settings. Such trainings can contribute to the timely recognition of the symptoms of depression, prompt and effective care, early intervention by a multidisciplinary team, and thus minimize the consequences of depression (life-threatening or not). District nurses need to have an increased awareness of the potential benefits and limitations of the treatments provided and be trained in the use of several interventions of treating depression.
Tanner EK (2005) Recognizing late-life depression: why is this important for nurses in the home setting? Geriatr Nurs 26(3): 145–9
World Health Organization (2003b) Caring for Children and Adolescents with Mental Disorders. WHO, Geneva