et al, 2006). However, there is evidence that GPs continue to refer younger rather than older people for talking treatments (Kendrick et al, 2009).

District/community nurses are in an ideal position to address these health inequalities. They have the most direct healthcare contact with elderly housebound patients and are highly respected by them. Furthermore, they can enable access to psychological therapies at an early stage in a client's onset of symptoms. The diagnostic criteria for major depression is taken from the Diagnostic and Statistical Manual, fifth edition (DSM-5) (American Psychiatric Association, 2016), and sadness or anhedonia (the inability to feel pleasure in normally pleasurable activities) must be present with five or more symptoms over two weeks (DSM-5; Table 1).

However, NICE (2009b) recommends looking beyond a symptom count when assessing clients with long-term conditions for depression, and that the effect of mood on function must be a primary consideration.

The Whoolley questions provide an early identification tool for depression (NICE, 2009b). They are:

- 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?

If a patient with a chronic physical health problem answers ‘yes’ to either of the depression identification questions, a healthcare professional who is competent to perform a mental health assessment should ask three further questions to improve the accuracy of the assessment of depression:

- During the last month, have you often been bothered by feelings of worthlessness?
- During the last month, have you often been bothered by poor concentration?
- During the last month, have you often been bothered by thoughts of death?

There is no reliable data on how many of the patients on a district/community nurse’s caseload would fall within the diagnostic criteria for depression, as the questions are not routinely asked. However, given the compounding factors for these clients, it is likely to be a high proportion.

Current district/community nurse interventions for depression do not include the use of CBT principles. While the delivery of pure CBT may be impractical for them, it could be that imparting CBT strategies may be enough for some clients, or provide a useful stop-gap to specialist mental health services.

CBT involves psycho-education, which relies on the ability of the practitioner to explain how it works to patients. This would involve training district/community nurses in the core principles of CBT. Positive therapeutic outcomes are shown to be heavily dependent on the relationship between client and practitioner (Bachlor and Horvath, 2000; Duncan, 2002). An empathetic and collaborative alliance is proven to be essential to therapeutic effectiveness (Beck et al, 1979). In the author’s clinical opinion, district/community nurses are highly skilled at communicating with elderly clients and are seen as trusted sources of support. CBT could enhance their skill set and be another tool which improves quality of life for older people.

A primary focus of CBT is identifying and challenging thinking patterns and ways of behaving that perpetuate psychological difficulties (Hayton et al, 2006). A central premise is that ‘how you think affects how you feel affects how you behave’ (Kennerley, 1997; Veale and Willson, 2005). Negative automatic thoughts are seen as having a negative effect on mood (Greenberger and Padesky, 1995). In the CBT model (Figure 1), thoughts are the most important aspect of depression. It is less the event but how you interpret that event that affects your mood and subsequent behaviour.

Figure 1. Negative cognitive triad, which characterises depression (as developed by Beck, 1967, 1983).

Table 1: DSM-5 Diagnostic Criteria for Major Depressive Disorder*

| Five or more of the following symptoms must be present nearly every day during a two-week period: |
| Core symptoms (≥ one required for diagnosis) |
| • Depressed mood most of the day |
| • Anhedonia or markedly decreased interest or pleasure in almost all activities |
| Additional symptoms: |
| • Clinically significant weight loss or increase or decrease in appetite |
| • Insomnia or hypersomnia |
| • Psychomotor agitation or retardation |
| • Fatigue or loss of energy |
| • Feelings of worthlessness or excessive or inappropriate guilt |
| • Diminished ability to think or concentrate, or indecisiveness |
| • Recurrent thoughts of death or suicidal ideation |

* DSM-5 denotes Diagnostic and Statistical Manual of Mental Disorders, fifth edition.
patient’s thoughts, feelings and behaviour to the stresses in their life. Often thoughts get mixed up with feelings, e.g. ‘I think I’m a failure’. It is important to track back to the thought and connect the thought with feelings and behaviour.

This cognitive model of depression involves characteristic thinking patterns. Negative automatic thoughts (NATs) reflect the negative cognitive triad, e.g. ‘I’m useless’, ‘nothing will ever go right for me’, and ‘the world is full of selfish people’. Cognitive restructuring with older people may take more time. Entrenched ways of thinking are difficult to change. However, district/community nurses are in a position to look out for NATs and teach clients strategies for managing unhelpful thoughts (Hyer et al., 2004; Figure 2). Strategies include examining the evidence for the negative thought and learning how to internally challenge this thinking with balanced, rational thoughts (Laidlaw et al., 2009). Understanding the effect of negative thinking on mood is part of self therapy in CBT.

Assessment should consider current difficulties with a focus on identifying situations-thoughts-feelings-behaviours. Tracking a particular incident in detail will gain this information. With symptoms in mind it is useful to agree a problem list with the client, and ask what specifically would be important to change. Agreeing goals is helpful. Presenting the treatment rationale and evidence base may enable older clients to become psychologically minded. Hope and recovery are linked with the beliefs of the practitioner, and district/community nurses can enable elderly patients to work towards a life without depression. If the practitioner holds a negative perspective on ageing, it can be harmful and unhelpful and limits the possibility of change.

Typical thinking styles that are challenged in CBT are:

- Jumping to conclusions
- Seeing situations in ‘black or white terms’
- All or nothing thinking.

Adopting a more balanced approach is regarded by psychologists as helpful and protective (Gilbert, 2006). Modern approaches to the treatment of mental health problems include an emphasis on self-help (Kennerley, 1997; Veale and Willson, 2005). The NICE guidelines on depression recommend self-help strategies for mild disorders. Popular books, such as Mind over Mood, are based on CBT principles and offer a variety of self-help materials (Greenberger and Padesky, 1995). The ‘Overcoming’ books are easy to read and are written by experts in CBT (Gilbert, 2000). Computer programmes, such as MoodGYM (2008), have also contributed to self-help treatments.

CBT also has a strong behavioural aspect (Gilbert, 2000). For example, in the case of depression, clients are helped to perceive the link between behaviours such as staying in bed or avoiding seeing friends and low mood. Therapists might help clients to develop ways of increasing their activity levels and finding social support, and monitoring the impact of any such lifestyle changes on the way they feel. This has been reinforced by the NICE guidelines which recommend exercise as an effective treatment for depression (NICE, 2009a). However, this poses challenges for elderly housebound patients, as mobility is limited and access to resources scarce. As exercise is a known mood enhancer, this inequality requires urgent attention and creative solutions to enable better quality of life for.

![Figure 2. The cognitive triad related to core beliefs.](image-url)
elderly clients. District/community nurses have access to local knowledge of community resources, which may mean that clients can be involved in recreational activities to enhance well being.

The evidence base for CBT is strong (Hofman et al, 2012). It does involve active client participation in collaborative efforts to alter patterns of thinking and this could be challenging for older patients, but change has been proven to be possible with this client group (Laidlaw et al, 2009).

CONCLUSION

With an ageing population and the increase in people living with a long-term condition, it is vital that education of district/community nurses reflects the psychological as well as clinical needs of clients to give elderly housebound patients hope for recovery from depression. JCN

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TOP TEN TIPS FOR MENTAL HEALTH

➤ Things are rarely black or white. They are often grey, try and look at things through tinted spectacles
➤ One mistake does not mean you will keep making the same mistake
➤ Do not just focus on the negatives in a situation. Remember the positives
➤ Do not jump to conclusions
➤ Do not try and be a mind reader. Do not be a fortune teller. No one can predict what the future will bring
➤ Do not magnify things and make them seem bigger than they are
➤ Do not assume that your emotions reflect what is actually happening
➤ Use words like ‘should, must or ought’ sparingly. They can make you feel unhappy
➤ Do not use over-the-top words, they can colour your thinking
➤ Do not blame yourself for things which are not fully your responsibility.

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‘No health without mental health, parity of esteem between mental and physical health, Prince Harry’, everyone is at last talking about mental health. In the recent election, mental health was mentioned 75 times in the major party manifestos. Extra monies have been promised by Theresa May to support mental health services in the present election term.

The reality, as throughout the NHS, is stretched resources, long waits to access talking therapies, queues for hospital beds, and erosion of local services. The elderly can easily be overlooked, as much of their suffering is invisible, quiet, and deemed low risk.

The stigma around mental health is slowly breaking down, but many people still have shame and poor emotional language to recognise or discuss mental health difficulties. It therefore falls on staff who are working with this client group to be vigilant for mental health problems. District/community nurses, as the article describes, are often frontline professionals with the housebound elderly and have longstanding, trusted relationships. However, there are also multiple other staff; carers, social workers, physiotherapists, occupational therapists (OTs), podiatrists, hospital nurses, GPs, clergy, who have regular contact with the elderly and all of whom are in an excellent position to recognise distress and mental illness.

The expanding elderly population is indeed a group with high risk factors for mental illness. Chronic illness, chronic pain, unwanted medication side-effects, immobility, loneliness, bereavements, lack of social structure, dispersed families, poverty, stretched social care, fear of mortality, can all contribute to mental ill health.

As the article describes, it is easy to overlook mental health issues in the time-pressured treatment of multiple comorbidities and social needs by the staff who visit elderly patients. Even after recognising mental health issues, organising treatment for this population group poses problems of its own, e.g. mobility, waiting lists, stigma, and accessing appropriate care.

The suggestion for training district/community nurses (and I would argue other associated professionals) to use simple screening tools to recognise mental health problems and then to be able to implement CBT strategies or other interventions when required in line with National Institute for Health and Care Excellence (NICE) guidance is timely, and perfectly manageable. Introduction to CBT is a short training, available within all trusts, and can be accessed easily by all healthcare professionals if endorsed by line managers. It is possible to use aspects of CBT to help people without a full course of treatment. The screening tools described in the article are similarly simple to use by any healthcare professional who has a trusted relationship with the client.

Dr Vikram Patel, cofounder for global centre for health, gave a presentation at an international conference last year. He talked about mental health care in India and the extremely scarce resources available. He described how simple mental health training screening tools and interventions are cascaded down via the few healthcare professionals to train lay workers, so that there were opportunities to screen for and offer treatment for mental health issues in many social settings, not just health settings. His message was, ‘Stop focussing on lack of resources, look at the resources you have and work imaginatively and collaboratively within your means’.

This has to be the message for the future. The squeeze on the NHS will continue and the elderly population will increase and remain vulnerable. Let’s train district nurses and other associated healthcare professionals to offer simple and efficacious interventions, such as CBT, mindfulness, distress tolerance, bereavement counselling, anxiety management, and sleep hygiene. And yes, of course, there is an ongoing need to champion improved services for the elderly with appropriate social care, day facilities, transport links, supported housing, welfare benefits, befriending schemes and easy access to named GPs — all of which would support mental health by improving life quality.

This article brings into clear focus the neglected mental health needs of a vulnerable patient group and a perfectly possible way of providing care. Physical and mental health are flip sides of the same coin, and treatment of any ill health by involved healthcare professionals has to become increasingly holistic.

Let’s make every contact with a professional an opportunity to provide that holistic care by imaginative working and appropriate training.