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Abstract

Aims and objectives. To explore how nurses' recognise depression in older patients with multiple long term conditions and the strategies they use to support the patient.

Background. Depression decreases an older person's quality of life and sense of wellness, and increases functional impairment. The positive role of nurses working with patients with long term conditions is now being recognised internationally, however there is a gap in the research about how nurses' recognise depression in older patients and how this impacts on their practice.

Design. This is a qualitative study informed by a constructivist grounded theory approach.

Methods. In-depth telephone interviews were conducted with 40 nurses working in geographically diverse areas in New Zealand.

Results. Having the conversation with older patients about their low moods, or specifically about depression was not something that all the nurses had, or felt they could have. Whilst some nurses knew they could provide specific advice to patients, other believed this was not their responsibility, or within the scope of their role.

Conclusion.

Faced with an increasing number of older people with long term conditions, one of which maybe depression itself or as a result of living with other long term conditions, on-going monitoring and support pathways are necessary in order to prevent further decline in the older person's quality of life and well-being.

Relevance to clinical practice. Nurses in Primary Health Care can build on current knowledge and skills to increase their capability to promote 'ageing well' with older people who have long term conditions and depression

This study supports the adoption of a 'health promotion' approach to enhancing primary care services for older people with multiple long term conditions, incorporating early recognition and integrated pathways for support and management of depression.

Keywords: depression, long term conditions, older people, primary health care, primary health care nursing

Introduction

Depression has a major impact on the quality of life of an older person and on their ability to live their lives with the complexity of multimorbidity (WHO 2010). Integrating care that supports mental health and mental health promotion is now recognised as a priority (Grundberg *et al.* 2014). Long term conditions (LTCs) are the most significant health problem for older people in developed and non-developed countries (Kinesella & Wan 2008) and are associated with an increased risk of depression (Worrall-Carter *et al.* 2012). Certain medications used in the management of LTCs can also increase the risk of depression, e.g. anti-parkinsonian drugs, beta-blockers and non-steroidal anti-inflammatory medication (Wattis & Curran 2013). The New Zealand Mental Health Survey (Oakely Browne *et al.* 2006) found that whilst mental health conditions were lower in the older population (65 and over), people with LTCs experienced a higher prevalence of such conditions. The additional cost to the health system of having a LTC and a co-morbid mental health problem has been estimated at 45% (Naylor *et al.* 2012). Significantly, older people may deny or minimise concerns they may have about their mental health (Forlani *et al.* 2014), or even accept a lower mood as a normal part of the ageing process (Coventry *et al.* 2011).

Background

Depression decreases an older person's quality of life and sense of wellness, increases functional impairment, and decreases recovery from illness (Unsar & Sut 2010, Stojanovic-Spehar *et al.* 2011). Identifying older people with LTC's who may be at risk of developing or already have depression is critical, as depression can impact on the way the person attempts to manage their other LTC's (NICE, 2009). Guidelines that specify the need for assessment of risk and a 'stepped care' approach to management have been developed to

manage depression in people with LTCs, including older people (New Zealand Guidelines Group (NZGG) 2008, NICE 2009). However, screening and assessment does not occur on a routine basis (Worrall-Carter *et al.* 2012, Maxwell *et al.* 2013). Routine care of older people with LTC's and depression is often reported as being of low quality (McEvoy & Barnes 2007).

Whilst Primary care has been identified as the most appropriate and effective setting for assessment and ongoing management of depression among patients with LTC's (NZGG 2008, NICE 2009), there is a lack of consistency in recognition and management of depression by GPs (National Health Committee 2007, Maxwell *et al.* 2013). Significantly, older patients in Primary care have been found to have lower rates of receiving interventions for depression (Kendrick *et al.* 2009). The positive role of the nurse in working with patients with specific long term conditions has been acknowledged and it is recognised that nurses are in a unique position to assess patients for depression (Worrall-Carter 2012, Winkley 2013). However, there is a lack of published studies exploring key features of primary care nurse interactions with older patients who have multiple LTCs and depression. Specifically there is a need to explore how nurses recognise depression in older patients with multiple LTCs and how they view their effectiveness in managing these patients. In this paper we report on how nurses working with older people with multiple LTCs recognise and assess older patients for depression and the strategies they use to support the patient. We address the gaps in knowledge and understanding in order to inform future development of primary care and community services for older people.

Method

As part of a qualitative study exploring the role of the primary nurse in supporting older patients navigating the health system (insert reference), we also wanted to determine the nurses' experiences of working with older patients with multiple LTCs who have, or may have, depression. A qualitative approach offered advantages in being to explore in depth sensitive questions about the nurses' practice (Charmaz 2014). Telephone interviews which were digitally recorded enabled us to conduct interviews from different locations across New Zealand. Potential participants were identified from three major areas of nursing practice; primary health care nurses working in General Practice; heart failure nurse specialists; and district nurses. These three groups had been identified by the research advisory group as 'key informants' (Patton, 1990), as each group is involved in the care of older people with multiple long term conditions and provided a diverse range of experience across the health system. Heart failure is one of the commonest conditions affecting older people and also one that is associated with depression (Worrall-Carter *et al.* 2012). Including heart failure nurses in our sample provided a specialist nursing perspective. A decision was made to involve District nurses (registered nurses who provide a range of services to people at home), as there is little research on their role supporting older people with multiple LTCs and depression. Primary health care nurses, usually referred to as Practice Nurses are largely based in General or Family Practices, providing preventative health care and some have specific roles in supporting patients with long term conditions. The three groups of nurses provided a means of comparing cases (Charmaz 2014).

Key individuals in national networks were contacted to provide information about the study, and nurses who had completed postgraduate study in long term condition management at universities across New Zealand were identified. The latter group were identified as key informants having completed study to enhance their practice in working

with people living with long term conditions. Email contact was then used to provide specific information to nurses. Information on non-responders is not available. Interviews were conducted during 2012 by SW and DR. On average interviews took between 40 to 60 minutes. Participants were asked specific questions regarding their experiences of providing care to older patients with multiple LTCs and depression, including: Tell me about your experiences of working with older people with multiple LTCs that may have depression? How do you go about screening patients for depression? Do you have systems in place for managing older patients with depression, is it referable? How do you work with patients when they are depressed?

Ethical approval was obtained from the Northern X Regional Ethics Committee (NTX/11/EXP/301).

Data Analysis

To ensure rigour transcripts were read by SW and DR and entered into Nvivo 9 for coding purposes. Initial coding of transcripts was carried out by SW and DR and preliminary categories identified. Further analysis was conducted by SW and informed by Charmaz's (2014) constructivist grounded theory approach. Analysis focused on processes, reviewing preliminary categories and creating a table based on Charmaz's key questions:

- name the process, define it, how does this develop?
- how does the research participant act while involved in the process?
- what do they profess to think and feel while involved in this process?
- what might her/his observed behaviour indicate?
- when, why and how does the process change?
- what are the consequences?

Comparative analysis progressed as each preliminary category was compared and links made to identify similarities and differences. Minor categories were subsumed into higher level categories paying particular attention to context and the language the nurses used to describe their experiences. This approach to analysis makes 'crucial processes more evident' (Charmaz 2014 pp 248). Writing memos aided this process, for example, a number of nurses identified they had GPs who were interested in depression. This was noted in a memo and the question posed, 'so does this change the nurses' own practice'?

Results

A total of forty nurses participated in the study, age range; 28-40 years (n=9), 41-55 years, (n=23), 56-70 years, (n=8). All nurses had over five years' experience, and thirty nurses had been qualified for over 21 years. This sample of nurses represented an experienced group of nurses and working with older patients was part of their everyday practice. The analysis revealed how they viewed depression as a problem for older patients and associated this with the challenges of living with not only more than one long term condition, but also challenges associated with ageing, and risk of further deterioration and frailty. Having the conversation with older patients about their low moods, or specifically about depression was not something that all the nurses had, or felt they could have. Whilst some nurses knew they could provide specific advice to patients, other believed this was not their responsibility, or within the scope of their role.

Being alert

Being alert to the fact that older patients were at risk of developing depression associated with their long term conditions was at the forefront of their practice for some of the nurses. They stressed the importance of broaching the topic early on in the consultation, and viewing this as a priority. This was reflected in their experiences and practical knowledge of working with older patients who had multiple long term conditions, and also awareness from further postgraduate study of the associations between long term conditions and depression.

You might say well how is your mood, and so sometimes they're relieved that you mentioned that and they might even put that top. I often mention that quite early on because we do have quite a good system here for brief intervention counselling and there is quite a lot of support and help. (P1)

Generally it's the older ones and their conditions are progressing. That can be very depressing and along with the loss of their friends and things as they get older; the loss of identity, the loss of independence. (P15)

Knowing the patient over a period of time

Importantly, knowing the patient over a period of time was identified as crucial for determining any changes in behaviour that would act as 'red flags' with the need to follow up with a more detailed assessment of the patient.

I think for me a lot of people I have contact with because, I've known them over seventeen years that I've been in the practice. Sometimes you can pick what is normal behaviour and what is not.(P20)

The nurse talked about how she could also note any change in behaviour during telephone consultations with patients that she had known for a while.

When you're talking to them on the phone and they let loose, act out of character and often you find there's something going on with them, that they're not themselves and that's not regular behaviour. (P20)

Asking questions

Various tools are available for asking questions about depression and a number of these were referred to by the nurses, although not used routinely. Specific tools had been part of a routine formal assessment process for diabetes but were no longer being used.

Most of the nurses did not use a formal assessment tool, but their practice was based on informal ways of assessing the patient, and asking the patient what might appear as general questions. They were clearly observing for patterns of behaviour that could be indications of changes in mood and the risk of depression.

I don't formally assess them with a schedule, but when you can see there are elements of depression coming through; you know I would ask them about their sleep patterns and their motivation to do things, like getting up and doing the tasks of the day. Whether they are still enjoying life, how happy they feel generally and people almost will you to ask the questions so they can talk about it. (P19)

Asking specific questions about the patient's mood revealed differences in the way in which nurses went about this, and how comfortable they felt in doing this. It was evident that gaining experience and developing confidence to ask, what for some nurses were difficult or sensitive questions, had taken time to develop. Asking the difficult questions appeared to constitute 'emotion work', as nurses were dealing with managing their own emotions as well as the patients.

One is that someone bothers to ask me, and that is how are you feeling, do you think you might be a little bit depressed or have you thought of killing yourself. If you've got

the courage to say that to someone, if they are feeling depressed or suicidal there's a massive relief that happens because someone's asked them. (P3)

Sometimes, when I ask about how they're feeling within themselves, some people can just cry. That can be really scary for me because I'm thinking oh crumbs, you know, but it's just that someone is caring, someone is asking how they're going.(P5)

'Asking the questions' was influenced by a number of factors, e.g. time, being able to refer onto others, having support from colleagues or other professionals and having a culture within their practice in which certain team members considered depression important and something that they should endeavour to identify and support the older person in managing.

Like it took me quite a long time to pluck up the courage to ask somebody if they were suicidal. Because what are you going to do with the information. If you ask the question you've got to be able to do something with information. (P5)

The opportunity for some nurses to explore the patient's mood and assess for depression was possible when working in specialist roles or roles in which they had a specific focus on long term condition management. However, not all nurses who were working in these roles were able to focus on assessing the patient's mood, putting this down to work pressures and the number of patients and time they had available in their clinics.

Offering options

Having a particular interest in and being knowledgeable about depression made a difference to how the nurses engaged with the patient. They believed they could have conversations about how patients' were feeling and any changes in their mood.

Consulting with other nurses or specialists e.g. psychologists was made possible by the structures and ways in which their service was organised. For the practice nurses, having a GP with an interest in depression was highly valued by the nurses, as they felt supported and had someone they could easily discuss the patient with and gain additional expertise in managing the patient. Other nurses made use of colleagues who had mental health expertise.

So the ones that I've had real issues with, we're really spoilt here inHospital we've got a clinical nurse specialist for mental health who has, I sort of bypass the GPs if I don't get any response and go straight to her. But that's not her scope either. But you sort of do anything to get a better outcome for your patients. (HF7)

Being able to offer patients approaches to managing their mood illustrated the nurses' knowledge about services that were available. However, whether an older person would consider certain approaches as workable for them highlighted different perspectives.

Focusing on an individual approach was seen as paramount.

You've got to talk about what sorts of options there are and what things will help or you know, what's right for them. I mean we have psychology which are, you know, there's some really brilliant counsellors out there. They do a good job, but if that's not right for them, you have to talk about what other sorts of things that there are. You know, lifestyle changes or medication or whatever. (P11)

Specific strategies that the nurses spoke about incorporating into their practice included providing information about medication, motivational interviewing, goal setting, and suggesting relaxation therapy:

It's about small goals, small steps. So one of the behavioural techniques that is really effective for people with depression is to write a little list of things they want to do the following day, and write that list before you go to bed. Often you'll ruminate at night, so before you go to bed write out a list of who you want to call, what you want to do, things you want to do at home or do you want to go for a little walk, or you want to do a little bit of reading or you want to watch this on TV, or bigger things. So they've got

that to look forward to, they've already put that plan in place, they've written it down, they know that and it's right there when they wake up.(P9)

It depends on where they are because there is a computer based programme which looks at cognitive behavioural therapy. It's basically it's a new computer based system and I've put a few people on that. But admittedly not many old people because sometimes they're just not, it's not how they operate. They don't want to go on a computer. (P17)

In contrast, concern that resources were not available in order to provide effective care for patients was identified and revealed not only the gaps in services, but the attitudes of other health professionals. When barriers were identified, knowing the system and being able to work around the system to achieve improved care for patients was reliant on relationships with, and access to, other people the nurse could refer onto.

Providing time to listen

Nurses considered that patients required time to talk about how they were feeling and identified that patients' experienced relief when they were able to do this. However, participants reported that a patient may not talk to their GP about certain concerns, e.g. low mood and that the consultation with the GP was limited by the time available and by the patient not wanting to appear 'bothersome'.

That's another plus for the autonomy of our job, like my clinic visits are an hour, you know, that gives people the opportunity to talk. It's amazing how many people won't talk to their GP about relationship issues and sexual performance issues and all sorts come up in our clinics, which is a great safe forum for them. (HF2)

Nurses themselves expressed some difficulty in making the decision that the patient was depressed. Importantly, they understood it could be difficult for the patient to talk about their feelings and moods, or whether they were actually feeling depressed. Indeed, the idea

that there might be a stigma associated with depression influenced how one of the nurses spoke about 'treading lightly'. That a patient may not want to be referred for their low mood was also spoken about, in particular by the District Nurses who were involved in negotiating and gaining permission from the patient to speak to their GP.

If we have concerns then we would talk to them and say do you mind if I speak to your GP because I'm just a little bit concerned that you seem to be heading in this downward spiral and we would really like to make sure you don't get there. (DN2)

Maintaining frequent contact, either by telephone or arranging visits to the practice, was considered important for those patients whom they considered to be at risk of depression or had a definite diagnosis of depression.

People with depression I'm more likely to ring them more frequently, check on them, see them coping, as more appointments, more contacts with those patients. (P2)

Providing a holistic perspective was demonstrated by the participants as they revealed the ways in which they considered the 'bigger picture' for the patient. In doing so the nurses were able to offer strategies that focused on some basic self-care practices that in their experience would be helpful to the patient, aside from specific treatment for depression:

You have to talk about what's going on, if there's any other things that you can help with, like sleep or diet and exercise and, their whole lifestyle. It's more than just saying 'oh we'll send you to a counsellor'. Depression's tied up with how you sleep and how you, it's everything to do with your lifestyle as well as what's happening with you. So I mean, you know, you treat those things as well as the other, it's the whole thing, it's not just part of it. (P21)

In considering the bigger picture and exploring options with patients, the complexity and challenges of working with older patients became evident. Emotional issues, such as low mood, sadness, a sense of hopelessness, loneliness and whether or not this meant that patients were actually depressed were spoken about by the participants. Nurses highlighted the significance of timing and also recognising how the patient could be different from one consultation to the next. Participants were mindful that depression was highly complex and being responsive to the individual patient and respecting their wishes was seen as essential.

Sometimes it's difficult to say that they are depressed when they might not be and not in a depressed state. You've got to treat them with respect and allow them to make the decisions no matter what. I think, yeah, you wouldn't go bustling in, you would tread lightly as to however they were feeling that day. You might want to write things down, or they might want to, I don't know, work things out differently. Home might not be the right place, they might be better in another environment, they might feel better. (P11)

I mean you know if they're depressed and they're tired and they're flat but they can also be very sad. And sometimes I wonder if the depression is a reactive depression because nobody's actually listened to them enough. (HF5)

Discussion

This study presents the complexities of working with older patients who have multiple LTCs and are at risk of depression. Findings highlight that nurses are in a unique position to assess older patients for depression. This is important as the older populations with LTCs and a comorbidity of depression is projected to increase (WHO 2010).

For some nurses in this study, the recognition and on-going assessment of the older person for depression was an integral part of their nursing practice and as such, they viewed this as a priority and 'legitimate work' (Maxwell *et al.* 2013). Providing a holistic assessment of the patient by asking questions related to self-care behaviours was helpful in identifying issues and symptoms that may suggest the older person was at risk of depression. For example, questions about the person's sleep, pain, reduced mobility and diet. It is acknowledged that

all of these can precipitate depression in older people and also add further complications, such as increasing the risk of falls (Bird & Parslow 2002). Symptoms associated with certain long term conditions e.g. in heart failure the decrease in energy and fatigue, that these may in fact be indicative of depression rather than symptoms of heart failure.

Whilst the evidence based practice guidelines (NZGG 2008 pp 5) identify that “every interaction in primary care should be an opportunity to assess the person’s psychosocial wellbeing”, this was happening in some situations, but not all. Formal assessment tools were available and used in some practice and services, but weren’t consistently used as a standard form of assessment. Our findings are similar to Dowrick *et al.* (2009) who found GPs regarded their clinical judgement to be of more value than using depression questionnaires. However it is suggested that the use of tools that could aid the nurses’ practice and enable those older patients who were experiencing depression to be identified would be helpful as a part of the assessment process. This is significant as Pollock (2007) found that attempts to ‘preserve face’ in the consultation with GPs involved not disclosing psychological distress. Our findings would also support this, indicating that from the nurses’ experience some patients may not want to, or feel they can discuss their low mood with health professionals. Within the NZ mental health survey (Oakley Brown *et al.* 2006) suicidal ideation, planning and attempts were evident in the older age group that is by the age of 75. Whilst some nurses in this study felt confident to ask questions about suicide, other nurses did not see this as either within their remit or felt confident to do this. Asking what could be viewed as sensitive or difficult questions may lead to avoidance behaviour by nurses, limiting disclosure by the patient if the nurse appears to be busy or task focused. Feeling that a consultation was rushed was also perceived as a barrier to family practitioners

'conversations with patients', leading to frustration, and in some cases the process of diagnosing depression was found to be draining (Schumann *et al.* 2012).

Some nurses practised in a way that demonstrated an understanding not only the demands on the person of living with multiple long term conditions, but also recognising that for an older person additional challenges and transitions may arise (Waterworth *et al.* 2010). The need to understand the 'big picture' and have the 'whole story' enabled those nurses to explore beyond a checklist, task or tasks in order to offer further support and management. In a sense they were working with the patient in a way that recognised the adaptive work that patients do in order to live with complexity (Thygeson 2010). Supporting this adaptive work may lessen the burden of depression, because even with stable LTCs negative cognitive processes arise (Dickens *et al.* 2011).

Providing consistency of relationship between them and the patient was highly valued by the nurses and the benefits that could be gained in building a therapeutic relationship which enabled small changes in a patient's self-care, and self-management to be achieved. Being able to develop therapeutic relationships with patients is integral to best practice and increases the chance of depression being recognised (NZGG,2008, Schumann *et al.* 2012). Hunkeler *et al.* (2000) found that building on the nurse-patient relationships that were already present in primary care, and introducing a nurse telehealth support system, was more effective than antidepressants in patients without severe depression. The researchers also found that within what is often referred to as a 'time constrained environment' (Waterworth *et al.*2011), only minor changes in the nurses practice was required to implement the model. Certainly within our research, practice nurses viewed telephone

contact with patients as part of their routine practice, so ways of optimising this would be worthy of further development and research.

The 'stepped care' approach to depression (NZGG, 2008; NICE, 2009) is reliant on health professionals being aware of, and having the resources, to support this process. There was not a general awareness by all the nurses in this study that a 'stepped care' approach was standard best practice for recognising and managing depression, neither was there evidence that support structures were in place in all areas that patients could be referred to. As such there was variation in practice and resources available to support the older person with LTCs, low mood and depression. Maxwell *et al.* (2013) note the importance of ensuring that primary health care professionals not only feel confident, but have a supportive environment and appropriate structures in place. Our findings also indicate that the emotional work of supporting older patients with complex needs warrants further research. In particular, identifying ways in which nurses can develop their own resilience in order to provide ongoing support to older patients over significant periods of time, especially as the older person with multiple LTCs faces further deterioration in their condition. Further education in mental health at undergraduate and postgraduate level to ensure nurses have the capabilities to translate this into actual practice is required. Indeed, enabling nurses to have 'critical conversations' with older patients about their mental well-being will be a critical success factor for supporting older people with multiple long term conditions.

It seems timely with the predicted increase in the older population with multiple LTCs who will be at risk of depression that particularly within primary and community care, a preventative approach is adopted (Bird & Parslow, 2002). This would mean another step is required before the 'stepped care' approach, and that is a 'preventative step'. That older

patients may accept depression as being part of the ageing process, with subsequent negative feelings or sense of hopelessness is of concern and the nurses spoke about the reluctance of some older people to follow up on referrals to other services and support. The stigma that can be associated with depression and understanding of possible treatments, particularly if this involves additional medication, can affect the help seeking behaviour of patients (Elwy *et al.* 2011, Schumann *et al.* 2012). The insidious onset of depression for some patients may make recognising symptoms particularly problematic, not only for the patient but also for the health professional (Coventry *et al.* 2011).

Significantly, the older person may not be clinically depressed, but experiencing low mood and a medical diagnosis of depression would not be helpful (Middleton & Shaw 2000). Other long term conditions, e.g. heart failure, can also present symptoms that may be associated with depression, but are part of the other long term conditions, creating further uncertainty for the patient in approaching health professionals for help. Ways of engaging older people in the community to develop their programs about healthy aging incorporating mental wellbeing, and approaches to preventing depression e.g. by strengthening resilience can be a future direction for research using a co-design approach. Exploring how older people respond to what has been referred to as 'digital engagement' (van der Wardt *et al.* 2010) as a way of managing depressive symptoms would be important.

Limitations of the study

This paper offers an important contribution to the literature regarding nurses' practice and experiences of working with older people with multiple LTC's Maxwell *et al.* (2013) and Winkley (2013) to assess and coordinate the patient's management. There are limitations to this study; we acknowledge that participants were self-selecting and as such, we can

assume that they had an interest in sharing their experiences and had views on the topic. Both the District Nurse and Heart Failure samples are small. The views expressed by the nurses are self-reports and may not represent actual practice, or how older people would view that practice. However, overall the views provided by the nurses give us insight into their experiences and importantly how nursing practice could be optimised further to support older people who are at risk of depression.

Conclusion

Nurses who can create the opportunities for on-going monitoring and support pathways to prevent further decline in an older person's quality of life and well-being and are confident in their skills are ideally placed to improve the quality of care and well-being of older people with LTC's and depression. Indeed if nurses are viewed as being in the ideal position to demonstrate leadership to support older people, then nurses themselves can collaborate to create a culture of practice within their local communities; recognising depression as a priority and ensuring nurses working with older people have the support they need to achieve this can only benefit the well-being of older people.

Relevance to clinical practice

Nurses in Primary Health Care can build on current knowledge and skills to increase their capability to promote 'ageing well' with older people who have long term conditions and depression.

This paper supports the adoption of a 'health promotion' approach to enhancing primary care services for older people with multiple long term conditions, incorporating early recognition and integrated pathways for support and management of depression.

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