Mood & Risk Screening After Stroke: Developing a Shared Strategy
Timing

**Venue: Liberty Stadium Swansea**

14:05 to 15:05  Presentations

15:05 to 15:35  Exercises
AIMS

Delegates will:
• appreciate the frequency and impact of mood disorders after stroke;
• know the National guidance for screening and the treatment of mood disorders;
• appreciate what screening can offer to patients and carers;
• understand some of the barriers to implementation of screening;
• know what needs to happen to implement 100% screening;
• be introduced (briefly!) to a scheme for screening for mood and risk;
• be introduced to a plan for treatments based on screening outcomes;
• have the opportunity to consider how to implement screening in their own service setting.

NOTE: This session is NOT designed to improve screening in specific settings. That requires a hands-on workshop with the materials.
Anxiety & Depression

- 50% of stroke survivors suffer *clinical depression* at some time.
- Many recover but have further episodes (Ayerbe et al, 2011).
- 30% are *clinically* depressed at any one time.
  
  - Probably 40% are *clinically anxious* at some time after stroke.
  - 20% to 25% of survivors suffer from *clinical anxiety* at any one time.

About 66% of carers and survivors Feel anxious or depressed!!
(Stroke Association, 2013)

**Depression is associated with:**
- Increased mortality
- Poorer recovery of function
- Lower quality of life
- Social isolation
- Low activity level

**Anxiety is associated with:**
- Poorer recovery of function
- Increased dependency
- Poorer social functioning
- Speed of recovery
Screening Permits Effective Treatment

**Anti-depressant Treatment**
- Improvement in depression scores
- ADL’s improve
- Cognitive impairment decreases
- Better survival

(Hackett et al. 2008)

Some depressed survivors benefit from psychological treatment—motivational interviewing (Watkins et al., 2007).

**Williams et al. (2007)**
Anti-depressant with psychological support is better than anti-depressant alone.

**Anxiety** can be treated with medications.
There are also cognitive-behavioural treatments.
Rehabilitation can be adapted for anxiety; a gradual approach with reassurance and correction of anxious thoughts.
Screening: Guiding Principles

• A screening system must:
  – be practical and feasible;
  – acceptable to survivors, carers and staff;
  – meet NHS Wales Commissioning governance requirements;
  – fit within the care model.

• It will not look like
Greater Manchester Stroke Mood Pathway

Is the person confused? (i.e. reduced alertness/awareness, delirium/delirious)

Yes

Does the person have a language problem?

Yes

SLT input required – ensure referral has been made

No

Does the person have a visual impairment?

Yes

Complete SADQ-H-10

No

Complete DISCs

Complete PHQ-9 and GAD-7 (if visual impairment present, read aloud questions)

Record scores in patient notes. Discuss scores and interpretation within multidisciplinary team

No or mild symptoms

No intervention

Moderate symptoms

Discuss referral to non-statutory agencies (peer support / befriending / expert patient scheme / IAPT) with patient and carer and refer as required

Severe symptoms

Refer to psychology

Brief solution focused therapy, motivational interviewing, CBT given by designated member of stroke team

Intervention delivered psychology health services

Monitor and re-assess as required whilst under specialist stroke services

Reassess after intervention

Start antidepressant medication

Review and reassess according to protocol
Comprehensive approach to psychological care throughout the pathway, including the voluntary sector (National Stroke Strategy, 2007), using a three tiered ‘stepped care’ model (NCGS, 2012; Gillam & Clarke, 2012).

The whole MDT should be provided with relevant training to identify and manage psychological issues (Gillam & Clarke, 2012).

Stroke service staff should provide screening and support sessions for those with sub-clinical psychological problems (National Stroke Strategy, 2007; Gillam & Clarke, 2012; Gillam, Carpenter, & Leathley, 2012).
The Big Picture

The Stepped Care Model (Gillam & Clarke, 2011)

**Step 1:** All stroke survivors screened for mood *(and cognitive impairment)* within 6 weeks of diagnosis. ‘Sub-clinical problems’ are common after stroke; support provided by peers, and general stroke staff.

**Step 2:** Survivors with Mild/Moderate mood *(or cognition)* problems offered further assessment (past history, potential causes, impact, and treatment preferences). These problems addressed by trained non-psychology stroke staff, supervised by a stroke psychologist.

**Step 3:** Survivors with severe or persistent disorders of mood *(or cognition)* that don’t respond to step 1 and 2 treatment may require a psychology/psychiatry sessions and medication.
Mood Disorder Screening: Guidance

All survivors after stroke:

- screened within six weeks of diagnosis using a validated tool (NICE, 2011; NCGS, 2012).

- assessed one month after stroke (or discharge, or six weeks after discharge), and at 3 and 6 months after stroke (Gillam & Clarke, 2012).
Survivors with mild or moderate symptoms and their carers should be given information, support and advice about mood disorder and considered for:

- increased social interaction;
- increased exercise;
- goal setting;
- other psychosocial interventions. (NCGS, 2012).

Brief, structured psychological therapy (with or without medication) should be considered for survivors with persistent depression (NICE, 2011), adapted as necessary for neurological impairments (NCGS, 2012).
Stroke survivors should be assessed for safety risks from persisting cognitive impairments (NCGS, 2012).

There should be risk assessment for those with moderate to severe depression (Gillam & Clarke, 2012).
What We Aren’t Doing!

National Sentinel Stroke Care Audit (2010).

- Mood screening is **not** given to 20% of survivors in the UK.

Bowen et al. (2002)

- Of 145 UK stroke services, 88% had a local protocol for psychological assessment.
  - Despite this only 50% of survivors were screened.


Post –Stroke depression is frequently unrecognised and untreated.
**Why no screening?**

**Hart & Morris (2007)**

*Staff in stroke do not screen because;*

- They lack knowledge about depression and screening.
- They are unsure of the effectiveness of screening.
- Senior colleagues don’t seem to expect screening.
- Screening for depression isn’t part of routine assessment.

- They aren’t given time to screen.
- They are unaware of guidelines about screening all stroke survivors.
- They don’t feel ‘in control’ when it comes to screening.
Screening is Brief, Simple and Effective

**DEPRESSION**

Verbal people can be assessed with the PHQ-9.
(10 minutes).

The Stroke Aphasic Depression Questionnaire (SADQ-10) can be used with people with communication difficulty.
(10 minutes).

**Anxiety**

Verbal people can be assessed with the GAD-7. (5 minutes).

The BOA can be used with people with communication difficulty. (7 minutes).
How can we increase screening?

- Educate staff about depression; nature, signs, consequences and treatments.
- Demonstrate the clinical value of screening.
- Inform more staff about guidelines.
- Train and empower more staff to screen.
- Develop screening resources (tests).
- Allow more staff time to screen.
- Support screening from the top.
- Make screening for depression a routine assessment.
- Monitor outcome and support staff to improve outcome further.

(Hart & Morris, 2007)
Recording screening scores, decisions and outcomes

• It is vital that the results of screens are **properly recorded** AND available to all staff.

• Each service should have a recording system integrated with patients’ notes.

• GP’s and community services have requested that psychological screening results are **recorded in discharge summaries**.
Depression Screening: The PHQ-9

• The Patient Health Questionnaire (PHQ-9) was designed to detect depression in primary care patients. It can be used to monitor change in symptoms over time and provides a depression severity index:

  - 0 – 4  None
  - 5 – 10  Mild
  - 11 – 14  Moderate
  - 15 – 19  Moderately Severe
  - 20 – 27  Severe

• Anyone who scores 11 or above can be considered to be suffering from clinically significant depression.
## Patient Health Questionnaire—PHQ-9

Fill in the boxes with pen or pencil to mark your answers.

**A. Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all (0)</th>
<th>Several days (1)</th>
<th>More than half the days (2)</th>
<th>Nearly every day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td></td>
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<tr>
<td>2. Feeling down, depressed, or hopeless</td>
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<tr>
<td>3. Trouble falling/staying asleep, sleeping too much</td>
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<td>4. Feeling tired or having little energy</td>
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<tr>
<td>5. Poor appetite or overeating</td>
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<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have</td>
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<tr>
<td>let yourself or your family down.</td>
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<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper</td>
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<tr>
<td>or watching television.</td>
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<tr>
<td>8. Moving or speaking so slowly that other people could have noticed.</td>
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<tr>
<td>Or the opposite — being so fidgety or restless that you have been</td>
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<tr>
<td>moving around a lot more than usual.</td>
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<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in</td>
<td></td>
<td></td>
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<tr>
<td>some way.</td>
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</tr>
</tbody>
</table>

**Total Score _____ = _____+ _____+ _____+ _____**

**cut-off:** A score of 11 or more.
# The Generalized Anxiety Disorder Scale (GAD-7)

The **GAD-7** (Spitzer et al., 1999) is marked on the same scale as the PHQ-9 and contains 7 items.

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4</td>
<td>Minimal Anxiety</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild anxiety</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate anxiety</td>
</tr>
<tr>
<td>15 – 18</td>
<td>Moderately severe anxiety</td>
</tr>
<tr>
<td>19 – 21</td>
<td>Severe anxiety</td>
</tr>
</tbody>
</table>

Points are added to give a score out of 21, with a score of **10 or more** indicating possible anxiety.
**Generalized Anxiety Disorder 7-item (GAD-7) scale**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Add the score for each column**

| + | + | + | + |

**Total Score (add your column scores) =**

**Cut-off:** A score of 10 or more.
The BOA (Kneebone et al, 2011) was developed to screen for anxiety in community-living stroke survivors who have severe communication difficulties.

It is completed with someone who knows the stroke survivor.

It has not yet been validated, but a validation study is in preparation.

There is no accepted cut-off score at present. But it is proposed that we use a score of 14 or more.

Suggested scale:

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Anxiety Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 6</td>
<td>Minimal anxiety</td>
</tr>
<tr>
<td>7 – 13</td>
<td>Mild anxiety</td>
</tr>
<tr>
<td>14 – 17</td>
<td>Moderate anxiety</td>
</tr>
<tr>
<td>18 – 21</td>
<td>Moderately severe or severe anxiety</td>
</tr>
</tbody>
</table>
Behavioural Outcomes of Anxiety (BOA) Questionnaire - Carer

Please read each item and place a tick in the box which comes closest to how he/she has been feeling in the PAST WEEK. Try not to take too much time over it, as your immediate reaction should be accurate.

Today’s Date: ______________________

<table>
<thead>
<tr>
<th></th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Score (points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has he/she appeared particularly tense or on edge?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has he/she had a strained face?</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Has he/she had trouble falling asleep?</td>
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<td></td>
<td></td>
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<tr>
<td>Has he/she been getting tired easily?</td>
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<tr>
<td>Has he/she been restless or constantly on the move? (e.g. do they pace)</td>
<td></td>
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</tr>
<tr>
<td>Has he/she appeared anxious?</td>
<td></td>
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<td></td>
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<tr>
<td>Has he/she appeared to suddenly panic?</td>
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<tr>
<td>Has he/she appeared fearful of falling?</td>
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<td></td>
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</tr>
<tr>
<td>Has he/she avoided activities or social engagements?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has he/she been jumpy or easily startled?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score : ______________________

Provisional Cut-off: A score of 14 or more, or 4 questions at 2 or more.
The Stroke Aphasic Depression Questionnaire (SADQ-10)

- The SADQ-10 (Sutcliffe et al, 1998) is designed to detect depression in stroke survivors with severe communication difficulties.
- It is completed with someone who knows the stroke survivor.
- It is available in a validated community version, with ratings of ‘often’ to ‘never’.
- The cut-off is a score of 6 or more (for two consecutive weeks).

Suggested scale

1 – 5  Minimal or mild depression
6 – 13  Moderate depression
14 – 21  Moderately severe depression
21 – 30  Severe depression
# Stroke Aphasic Depression Questionnaire 10

Please indicate how often in the last week ________________has shown the following behaviours:

1. Does he/she have weeping spells?
   - Often
   - Sometimes
   - Rarely
   - Never

2. Does he/she have restless disturbed nights?
   - Often
   - Sometimes
   - Rarely
   - Never

3. Does he/she avoid eye contact when you talk to him/her?
   - Often
   - Sometimes
   - Rarely
   - Never

4. Does he/she burst into tears?
   - Often
   - Sometimes
   - Rarely
   - Never

5. Does he/she complain of aches and pains?
   - Often
   - Sometimes
   - Rarely
   - Never

6. Does he/she get angry?
   - Often
   - Sometimes
   - Rarely
   - Never

7. Does he/she refuse to participate in social activities?
   - Often
   - Sometimes
   - Rarely
   - Never

8. Is he/she restless and fidgety?
   - Often
   - Sometimes
   - Rarely
   - Never

9. Does he/she sit without doing anything?
   - Often
   - Sometimes
   - Rarely
   - Never

10. Does he/she keep him/herself occupied during the day?
    - Often
    - Sometimes
    - Rarely
    - Never

   *Often
   *Sometimes
   *Rarely
   *Never

---

**Scoring Items 1-9:**
- Often= 3
- Sometimes= 2
- Rarely= 1
- Never= 0

**Scoring Items 10:**
- Often= 0
- Sometimes= 1
- Rarely= 2
- Never= 3

**Cut-off:** A score of 6 or more (for two consecutive weeks.)
The TAG (Slade et al, 2002;2003) assess the level of risk posed to or by people with possible mental health problems.

- It can be completed after the session
- Scores indicate if a person is suitable for referral to mental health services.
- Cut-off: Score of 5 or more, or at least two ‘moderate’ domains.
<table>
<thead>
<tr>
<th>SAFETY</th>
<th>NONE</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
<th>VERY SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Intentional self harm</td>
<td>No concerns about risk of deliberate self-harm or suicide attempt</td>
<td>Minor concerns about risk of deliberate self-harm or suicide attempt</td>
<td>Definite indicators of risk of deliberate self-harm or suicide attempt</td>
<td>High risk to physical safety as a result of deliberate self-harm or suicide attempt</td>
</tr>
<tr>
<td>Domain 2</td>
<td>Unintentional self harm</td>
<td>No concerns about unintentional risk to physical safety</td>
<td>Minor concerns about unintentional risk to physical safety</td>
<td>Definite indicators of unintentional risk to physical safety</td>
<td>High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Risk from others</td>
<td>No concerns about risk of abuse or exploitation from other individuals or society</td>
<td>Minor concerns about risk of abuse or exploitation from other individuals or society</td>
<td>Definite risk of abuse or exploitation from other individuals or society</td>
<td>Positive evidence of abuse or exploitation from other individuals or society</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Risk to others</td>
<td>No concerns about risk to physical safety or property of others</td>
<td>Minor concerns about risk to physical safety or property of others</td>
<td>Risk to property and/or minor risk to physical safety of others</td>
<td>High risk to physical safety of others as a result of dangerous behaviour</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Survival</td>
<td>No concerns about basic amenities, resources or living skills</td>
<td>Minor concerns about basic amenities, resources or living skills</td>
<td>Marked lack of basic amenities, resources or living skills</td>
<td>Serious lack of basic amenities, resources or living skills</td>
</tr>
<tr>
<td>Domain 6</td>
<td>Psychological</td>
<td>No disabling or distressing problems with thinking, feeling or behaviour</td>
<td>Minor disabling or distressing problems with thinking, feeling or behaviour</td>
<td>Disabling or distressing problems with thinking, feeling or behaviour</td>
<td>Very disabling or distressing problems with thinking, feeling or behaviour</td>
</tr>
<tr>
<td>Domain 7</td>
<td>Social</td>
<td>No disabling problems with activities or in relationships with other people</td>
<td>Minor disabling problems with activities or in relationships with other people</td>
<td>Disabling problems with activities or in relationships with other people</td>
<td>Very disabling problems with activities or in relationships with other people</td>
</tr>
</tbody>
</table>

**No. of ticks**

| TAG score | 0 points for each None rating: | 1 point for each Mild rating: | 2 points for each Moderate: | 3 points for each Severe: | 4 points for each V. Severe: |

**Cut-off:** Score of 5 or more, or at least two ‘moderate’ domains.
What do we do if a screen suggests someone is depressed, anxious or at risk?

**Mild to moderate mood symptoms**: initially give information, support and advice about mood disorder and considered for: increased social interaction; increased exercise; goal setting; other psychosocial interventions. (NCGS, 2012)

*Local Procedure: [Develop for your service context]*

**Persistent mood symptoms**: refer to GP and provide access to brief, structured psychological therapy (with or without pharmacological treatment) (NICE, 2011), adapted as necessary for neurological impairments (NCGS, 2012).

*Local Procedure: [Develop for your service context]*

**Concerns about risk**: If severe and immediate contact the designated care professional if any (CPN, social worker), or emergency services and inform GP (if health-related). Otherwise discuss with supervisor or manager.

*Local Procedure: [Develop for your service context]*
OK. So we screen. So what?

• Survivors and carers can access specialist treatments and support for anxiety and depression.

• Potential risks to survivors and carers can be identified and steps can be taken to manage them.

• Survivors and carers can be informed and educated about anxiety, depression and risks

Survivor and carer outcomes improve!
Devising and Implementing Screening in a community Service.

Jan Tyrrell
The BASF screening programme.
Introducing BASF

• Small to medium sized charity
• Mission: Supporting people to adjust to life after stroke
• Referrals mostly from NHS, self-referral or family members
• Work with individuals to identify main issues of concern and offer advice, signposting, counselling and group work
• Strong focus on emotional/psychosocial effects of stroke because of the impact of low mood and social isolation on all aspects of recovery
Why introduce screening?

- Research shows the need for more accurate identification of mood and psychological problems in stroke care
- See a pressing need to improve stroke services locally and to work more closely with statutory services – part of the jigsaw
- Want to improve our own service by ensuring that as much as possible our work is in line with best practice, is evidence based and that we document our work in a way that can be understood and recognised by external agencies
- Day-to-day pressure of field-workers wanting more clarity about how they can help clients.
Possible obstacles

• Organisation practice and culture – informal, emphasis on relationships, having a contrast with statutory services perceived as a strength

• Workload, staff time, possible increase in costs

• Guest in home environment - formal assessments more difficult to introduce

• Wide range of clients and severity of stroke – does one-size fit all?

• Health and stamina of client on visit. Might feel uncomfortable introducing formal assessment. Might take more than one visit.

• Fear that will identify a higher level of need with onus on staff to meet the need
How to introduce screening?

• Worked with staff and service users to look for a good fit with current practice
• Took advice on best stroke-validated assessments to use
• Worked with expert advice from Reg Morris and BASF staff to agree process and results chart
• Working with our database designer to incorporate screening assessments in our client records
• Training from Reg plus internal training and practice with staff
• Pilot to tease out any difficulties.
The BASF scheme

Gad-7 & PHQ-9
or
SADQ-10 & BOA

Mild to moderate

Co-ordinator Support

ACT for Stroke

Moderately Severe

Counsellor

Severe

Samaritan and Mindline contact details

GP
How can we increase screening?

Now you have some idea of what is involved, work in pairs or threes (survivor or carer and staff in each group if possible) and make a list of things to answer these three questions:

(1) What would help me to screen all survivors and carers effectively?
(2) What might prevent me from screening and using the results of screening?
(3) What might help to overcome any barriers identified in 2 above?

[15 minutes]

In groups or pairs with a survivor, carer and staff in each one, make a plan to:
1) increase screening, (e.g. training, materials, staffing) and
2) improve the action response to the outcome of screening.

[15 minutes]
THANK YOU
NEXT STEPS