Perception, views, and barriers of primary care doctors regarding screening of depression among elderly patients attending public healthcare clinics in Kuching district: a qualitative study

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ABSTRACT

Introduction: Depression in the elderly constitutes 7.3% of the total Malaysian national prevalence of depression. However, depression is commonly underdiagnosed by primary care physicians, which may impact coexisting comorbid conditions and general well-being. As depression in the elderly increases with age, its prevalence is expected to become even more significant due to the increased life expectancy and isolation during the pandemic. This study aims to determine the perceptions, views and barriers encountered among primary care physicians on screening for depression among the elderly.

Materials and Methods: This qualitative study involved five public healthcare clinics in the Kuching district with in-depth interviews (IDI) conducted on 14 primary care doctors (PCDs). Semi-structured interviews and in-depth discussions were conducted via videoconferencing. One representative was selected from each clinic at initiation, followed by snowball method for subsequent subject selection until saturation of themes. Interviews were transcribed verbatim, and analysis based on framework analysis principles via NVivo software. Themes were analysed deductively according to study objectives and evidence from literature.

Results: Three main themes emerged from the IDI: (1) The perception of depression in elderly patients, (2) The perceived barriers to screening, and (3) The screening processes. Majority of the PCDs perceived depression as part of ageing process. Time constraints, lack of privacy in consultation rooms, dominant caregivers and failure to recognise recurrent somatic symptoms as part of depression influenced PCDs decision to screen. Screening was technically challenging for PCDs to use the DASS-21, which was not socio-culturally validated for local native population. Only 21.4% of respondents (3/14) reported screening at least three out 10 elderly patients seen over 1-month period. During the covid pandemic, due to the same human resource support and practices, most participants thought their screening for depression in elderlies had not changed.

Conclusion: Awareness of depression among PCDs needs to be re-enforced via continuous medical education programs to use appropriate screening tools, address infrastructure related barriers to optimise screening practices. The use of appropriate locally validated and socio-culturally adapted tool is vital to correctly interpret the screening test for patients.

KEYWORDS:
Perception, primary care doctors, screening, depression, elderly patients, healthcare

INTRODUCTION

Ageing is an inevitable life process, reflecting the body's physical and psychological changes over time. Depression in the elderly is common and highly prevalent. According to National Health and Morbidity Survey (NHMS) in 2019, the prevalence of depression among Malaysians aged 18 years and above was 2.3%, and among those aged 60 years and above was 7.3%.[1]

Like the other age groups, the elderly population is not exempted from getting depression, and study has shown that the prevalence of depressive illness increases with age and is expected to become an even more significant concern due to the decline in mortality and fertility rates and the improvement in quality of life.[2]

In Malaysia, as in most healthcare systems, primary care doctors (PCD) are the first point of access to healthcare, providing treatment for most non-communicable diseases (NCD) and referral to specialists such as psychiatrists. Although PCDs treat more elderly patients than younger patients, depression is less likely to be detected among the elderly than younger patients in the primary care setting.[3]

Many of the PCDs may lack the necessary skills or confidence in detecting depression in the elderly. A study done in Saudi Arabia showed that 30% of the PCDs had poor knowledge of geriatric depression[4] and similarly, in Japan, Othsuki and colleagues found that doctors seldom diagnosed depression in their patients; in fact, majority of the individuals diagnosed with a mood illness were not given antidepressants.[5]

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In December 2019, the world geared up to fight against the COVID-19 virus health emergency as the pandemic rapidly spread globally, and even the wealthiest countries' health systems were under pressure to respond to the enormous needs of the vulnerable elderly patients. The Malaysian government implemented nationwide Movement Control Order (MCO) on 18 March 2020 to curb the spread of disease. The elderly were constrained from visiting family members, social participation was not allowed, and access to healthcare for non-covid symptoms or NCD monitoring was compromised to a certain extent.

During MCO, not just physical activity was affected, but also mental health. Several earlier studies done during mandatory quarantine and social isolation measures have shown a higher risk of depression, emotional disturbances, stress, low mood, irritability and insomnia.[6,7]

To formulate strategies to improve the recognition of depression among the elderly, we need a better understanding of the PCD's perceptions and views in screening for depression among their elderly patients.

Until now, studies which evaluate the perception and views of PCDs regarding the screening of depression among the elderly in Malaysia are scarce. Thus, this study aimed to explore PCDs' perceptions, screening strategies and barriers in screening for depression among elderlies to enable practical suggestions to improve clinical detection and management of elderly with depression attending primary healthcare clinics.

MATERIALS AND METHODS

Study Design

A qualitative study was conducted, using in-depth interviews (IDI) to obtain the perception and views of PCDs regarding screening of depression among elderly patients attending public healthcare clinics in the Kuching district, Sarawak, Malaysia

Study Setting

This study was conducted at five primary public healthcare clinics located in Kuching district, Sarawak, Malaysia: Klinik Kesihatan Petrajaya, Klinik Kesihatan Batu Kawa, Klinik Kesihatan Jalan Masjid, Klinik Kesihatan Tanah Puteh and Klinik Kesihatan Kota Sentosa.

Participants

Study participants were medical officers' (grade UD44 and above) who have worked at least 6 months in a public healthcare clinic in Kuching District. Family medicine specialists, house officers or allied health personnel (i.e., pharmacist/nurses/medical assistants) were excluded from this study. One representative was selected from each clinic at initiation, followed by snowball method for subsequent subject selection until saturation of themes.

Approvals were obtained from the Universiti Kebangsaan Malaysia Ethics committee (Research ID: JEP-2021-598), the Malaysian Ministry of Health Medical Research, Ethics Committee (MREC) National Medical Research Registry (NMRR ID-21-01945-7WC) . Permission to conduct the study was also obtained from the state health authority, i.e., Jabatan Kesihatan Negeri Sarawak (JKNS) and Pejabat Kesihatan Bahagian (PKB) Kuching, Sarawak.

Data Collection

Data collection took place between July and August 2022. Interviews were conducted using semi structured questions which were vetted by the research team. A pilot test involving two medical officers and two researchers was conducted to ensure that the questions were well understood and allowed participants to further elaborate on the questions asked. Minor adjustments were made to rephrase a few questions before the study commenced. The pilot testing sessions were not included in the final analysis. All videotaped interviews were transcribed verbatim. All interviews lasted between 30 minutes to 60 minutes and were carried out via zoom video calls with two researchers (Researchers involved are listed in Appendix 1). Transcriptions were checked with video recordings for accuracy prior to analysis.

Saturation of themes was decided when no new themes appeared in the interviews, and this was established by the 14th participant.

Two researchers reviewed the transcripts separately and coded the emerging themes using N-VIVO software. Data collection and analysis were conducted simultaneously until data saturation was achieved. All the data that had been coded were grouped based on potential themes, and main themes and subthemes were identified. The analysed codes and themes were then discussed with a third member of the research team to achieve consensus on the interpretation of the data.

All the participants were informed that the interviews would be recorded, and all the participants gave verbal consent as well as signed the informed consent which was sent via email to the researcher.

RESULTS

Demography of Participants

This study presents the results and analysis of interviews conducted with 14 PCDs in Kuching. The mean age of the participants is 35.2 (SD 4.54) years, who have been practicing as primary care providers for mean of 9.86 (SD 5.08) years. The sociodemographic profile and training background details are listed in Table I.

The Perception of Depression in elderly patients

PCD's views on depression among their elderly patients were a crucial factor in determining how they managed patients in this age group. Most of the PCDs regarded depression as part of ageing. The doctors described that as a person ages, the lack of social support, physical limitation, deteriorating vision, hearing difficulties and "empty nest syndrome", where they feel lonely after their children leave home to pursue their careers and livelihood prevail:

> *"The future generation will want to have a development in their career so those who are left behind are the parents, the parents will be ageing and left in the village and somehow get abandoned and of course…(P2)*

Table I: Participants' sociodemographic (N = 14)

Participants	Gender	Age	Duration of practice (years)	Experience in attending geriatric attachment/training/course
P1	Female	34	9	No
P2	Male	42	19	No
P3	Female	38	12	No
P4	Male	32	6	No
P5	Female	35	8	Yes
P6	Female	37	12	Yes
P7	Female	34	7	No
P8	Female	31	6	No
P9	Female	30	3	No
P10	Female	36	11	Yes
P11	Male	36	11	Yes
P12	Male	46	21	No
P13	Female	31	8	No
P14	Female	31	5	No

Table II: Themes

Themes	Transcripts
The perceptions of depression in elderly patients	
Awareness	Nowadays, the MOs are more open on depression, so I guess they do kind have a better idea on depression in elderly, so the screening is better. -P3 I think the awareness regarding mental health has increased after COVID-19. More patients appear with mental issues, after COVID-19. Even in young patients…-P6
Aetiology of depression in elderlies	The future generation will want to have a development in their career so those who are left behind are the parents, the parents will be ageing and left in the village and somehow get abandoned and of course, depression will be there for them. –P2 Most patients will say that it's part of the ageing process, it's just normal for them. -P9 I think there is a strong relationship between ageing and depression… ageing adults that must cope with certain difficulties, so this will play an important role that can trigger the depression in the elderly…We can't deny the relationship between ageing and depression; very strong correlation. -P12
The need to screen the elderlies	For me, yes, it is very important for the healthcare doctors to do the screening in the elderly for depression... -P3 Yes. Ideally, we should be screening everyone. That is the ideal situation where the doctor-to-patient population is good, clinic is not so busy, and you can spend more time with each patient. –P11
The perceived barriers to screening	
Patient-related barriers	"… think is a challenge is family members…some family members don't really agree that their parents are having depression symptoms. They kind of deny it but the parents keep telling us that "I cannot sleep la Dr", the family members keep saying, "dia minum coffee Dr that's why tak boleh tidur"…, it's quite hard when the anak is denying the parents punya complain. So, the parents just tend to shut down and don't tell you anything anymore…" -P3 "… the elderly doesn't understand the DASS-21 score (items), and we must explain one by one with that also, they don't come up with a good answer." -P7 "…patients are accompanied by another relative and not the main caretaker, it is difficult to get history from the patient." -P6 "they just want to vent…For example, they are having trouble sleeping sometimes, it is very similar to symptoms of depression also. So, that can be confusing for me, if it's not clear-cut depression unless it's very severe." -P13
Doctors, infrastructure, and system-related barriers	"…the lack of knowledge. Initially, when I first started, I didn't have much knowledge to screen these elderly patients." -P4 "As you know in Sarawak, there are lots of local people, Bidayuh, Iban, so when you try and use the DASS-21 screening…I would have to translate it to their language because some can't understand English or BM, they only know the Iban, Bidayuh and local language. So, these are the problems that can arise." -P2

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Table II: Themes.

	"It is a challenge for us in a busy clinic, it is very hard to tackle the problem of depression because they come in for their primary problems, NCD follow-ups and other acute problems but the area of depression is something we lack in time to go into." -P10 "Most of the MO s are sharing rooms, at most there are 2 MOs per room, maybe 3 with a houseman, with that current setting there is not much privacy. Very difficult to probe for depression."-P11
The Screening Processes	
Screening tools	"… we have this yearly screening for Saringan Kesihatan Warga Emas and will include DASS-21" -P7 "I try to use the Geriatric Depression Scale (GDS), I find that easier than the DASS-21." -P9 "I will still use either the GDS or the Patient Health Questionnaire. But I prefer to use the Patient Health Questionnaire..." -P4
Strategies for screening and managing depression in elderlies	"If the symptoms are suggestive, then I will arrange another TCA where we have more free time, especially on Fridays… we will have the time to get more history..." -P8 "The more you have a good relationship with the elderly, the better your communication skills are with the elderly." -P3
Impact of COVID-19 pandemic on screening for depression among elderly	"I think almost the same – doesn't really change pre-COVID and the current situation." -P7 "Changed somehow because we have started to do visual consultations so we would have appointments for those stable patients with chronic diseases to follow up through visual consultation… screening for depression in the elderly either through Zoom or through the phone" -P1

Most of the PCDs are aware of the importance of screening for depression among their elderly patients, and mental health awareness has increased among the healthcare providers and the community, especially after the COVID-19 pandemic and lockdown. They felt that the elderly is prone to depression and should be screened opportunistically and regularly, and they are confident in detecting and diagnosing depression. However, not many were able to do screening due to limited time and daily busy clinic services:

> *"It is a challenge for us in a busy clinic… because they come in for their primary problems, … other acute problems but the area of depression is something we lack in time to go into."* (P11)

The Perceived Barriers to Screening

In doctor-related barriers, most of the PCDs perceived that screening for depression in the elderly is very time-consuming where history taking has to be comprehensive, and they do not have the time to perform it during their daily practice:

> *"Routinely no…In one hour, we probably have to see more than 5 patients, no time to really screen for depression…* (P13)

A few of the PCDs questioned the validity of using "self-translated" version of the screening tools such as Depression Anxiety Stress Scale -21 (DASS-21) into the local Sarawak native languages such as Iban and Bidayuh. This raised some concern as some of these groups expressed their emotions and interpreted words and terms differently, in their native language:

> *"As you know in Sarawak, there are lots of local people, Bidayuh, Iban, so when you try and use the DASS-21 screening… is it valid for us to use our own interpretation and translation in using those tools..."* (P2)

One PCD mentioned that he was not confident in performing screening and diagnosing of depression because of a lack of knowledge and training regarding this:

> *"…the lack of knowledge…I didn't have much knowledge to screen these elderly patients..."* (P4)

Many of the PCDs expressed that one of the barriers in screening during their consultation was the lack of privacy in the consultation room as they had to share one room with two to three other PCDs, and that made it very crowded and compromised confidentiality:

> *"…issue with space in my clinic because in my room I have three (3*) MOs*…"* (P9) *(*medical officers)*

Family members' attitudes could be a barrier to elderly patients to express their feelings and symptoms. P10 mentioned that the accompanying relative would dominate the consultation by just telling the history and not allow the elderly patient to participate in the session, leaving the parent/patient to remain silent throughout the consultation.

However, P2 mentioned that at times if the elderly patient comes alone, it is also challenging to attain history due to the language barrier and hence affects the accuracy of making the diagnosis:

> *"If the patients coming alone…there is communication barrier also, it is not that confident to me to further assess whether there is a symptom of depression."* (P2)

P1 reported that patients themselves would be afraid of social stigmatisation if the diagnosis of depression is being made to them, and it poses a significant challenge if the patient is not ready to come forward while in the denial phase:

"…Some may feel that they are being stigmatised or maybe they are not ready to be known that they are depressed." (P1)

Many PCDs described difficulties in screening and diagnosing depression in elderly as the elderly patients tend to present with many vasomotor symptoms for each visit, and hence challenging to differentiate between physical illness and depression as the real diagnosis.

The Screening Processes

Good rapport with the patient is considered crucial in the screening and diagnostic process. Most PCDs reported that they had developed their own routine and questioning approach based on intuition and observation and will re-arrange another appointment to explore further:

"…the one thing I think is the most problematic one is rapport. You don't have a rapport with the elderly, they don't want to tell you anything." (P3)

Depression Anxiety Stress Scale -21 (DASS-21) and Geriatric Depression Scale (GDS) were the most widely used screening tools by most participants in their daily practices. The screening program reported by P2 refers to the use of the DASS-21 questionnaire in the Ministry of Health (MOH) Borang Saringan Status Kesihatan Warga Emas (BSSK) booklet, which is an annual screening requirement for all the elderly patients attending public primary health centres and a measure of the facility's key performance index (KPI)

"… Through this regular yearly Warga emas BSSK routine screening…, so we put the questionnaire, the DASS-21 alongside the BSSK..." (P2)

Patient Health Questionnaire–9 (PHQ-9) was also part of the PEKA B40 (Skim peduli kesihatan untuk kumpulan B40) application form where elderly patent would be opportunistically screened for depressive symptoms upon application:

"… when they come to do the Peka B40, the initial part, the first screening ya they have the PHQ-9 there." (P4)

Only one participant (P5) reported using Beck Depression Inventory (BDI) in screening. If there is any language barrier in translating to another language, they will require assistance from colleagues from the same ethnicity to directly translate the screening questions:

"For Chinese, we ask our colleagues to converse in Chinese. We usually bring them to another room or a corner wherever they can to have time to talk to screen them." (P12)

When prompted for the number of screenings per month out of 10 elderly patients seen, only three participants had screened three patients and more for depression:

"For the last one month, I don't think I screened any depression in patients aged more than 60 but less than that I have." (P8)

"About 3-4 patients. Quite commonly I would ask their mood. 3 out of 10." (P10)

Most of the participants felt that their practice of screening for depression in elderlies had not changed before and during the COVID-19 era, mainly due to the same human resource support and practices:

"I think my practice of screening has not changed because workload is back to usual, the number of patients is a lot compared to the amount of manpower." (P13)

DISCUSSION

This qualitative study presents an in-depth exploration and views of PCDs in screening for depression in elderly patients. The World Health Organisation (WHO) defines NCDs as non-transmissible medical disorders, often also known as chronic diseases, which are long-term illnesses caused by a mix of genetic, physiological, environmental and behavioural factors.[8] While this classification has incorporated a variety of medical diseases, the emphasis of NCD has largely always been four conditions: cardiovascular disease (CVD), type 2 diabetes mellitus (T2DM), cancer and chronic respiratory diseases. In 2018, the United Nations member states expanded the NCD umbrella to include mental health disorders.[9] Meta-analyses have shown associations between diabetes and mental illnesses such as depression and bipolar disorder, as well as between diabetes and cognitive impairment.[10] Improved screening and treatment for depression among our elderly patients will not only help to optimise NCD care such as diabetes and hypertension but will also improve their quality of life.

The strong association between mental health illnesses and other NCDs call for multi-disciplinary care between primary, secondary care and allied health services. Collaborative care models have emerged as an effective evidence-based method for integrating mental health services into primary care settings.[11] In 2019, Klinik Kesihatan Kota Samarahan, Sarawak, launched a geriatric clinic in primary care named "Geriatrik Komuniti – GeKo" to specifically handle geriatric patients 60 years and above with frailty and complex bio-psycho-social issues.[12] Training was provided to PCDs and allied healthcare personnel to detect and manage geriatrics issues. This initiative empowers healthcare providers, elderlies and families to improve the elderly's health. Besides that, Klinik Kesihatan Petrajaya, Kuching, has a collaborative care unit with community psychiatry named MENTARI, where a visiting psychiatrist from the tertiary hospital provides on-site shared care initiative to the primary care team. When mental health treatment and NCD care are integrated and implemented in the primary care setting, it is effective for patients, strengthens healthcare delivery systems, and reduces costs in the long run.[9]

The majority of respondents mainly mentioned two significant factors for doctor-related barriers: time constraints in exploring depressive symptoms and infrastructure barriers such as lack of consultation rooms causing the lack of privacy during consultation as three PCDs have to share one small consultation room together and see patients simultaneously. Lack of time is the most recurring theme of all the respondents, with a total of 41 references made. PCDs perceived screening of depression as time-consuming and required additional time for history taking. Most screening

questionnaires take time to fill up, and in a busy primary healthcare setting where the PCD only has limited time to attend to each patient, this could be a significant obstacle in screening for depression in older people. Since 2023, DASS-21 has been replaced by Whooley, which is shorter, has only two questions, and has been validated for use in primary care as a screening tool. Besides that, Orleans and colleagues concluded that from a study exploring the perception on barriers to treating mental illness, physicians reported patient resistance and time constraints as the most significant hurdles to mental health treatment in primary care.[13]

There are many instruments to screen for depression in the elderly, including the most commonly used: the GDS, which is shown to have a sensitivity of 92% and specificity of 89%.[19] GDS has been validated in many languages and suitable for use in community, acute and also long-term care settings. The tool that is used for screening must consider the logistic challenges apart from its ability to screen, diagnose and aid in monitoring the progress of patients diagnosed with depression. The 14-item Malay version of GDS (M-GDS-14) reported 100% sensitivity and 92% specificity in detecting major depression.[15] However, the participants questioned the validity of the results of the screening program among ethnic groups in East Malaysia, and the accuracy of its results as doubtful.

In the primary care setting, elderly patients usually come with many somatic symptoms and do not directly complain of mood symptoms which may mask the underlying disease.[3] In all studies, depressive symptoms in the elderly were described as unspecified and often concealed by somatic symptoms. Patients seen in primary care often present with ambiguous symptoms, which could potentially be many other diseases, including depression.[16] Diagnosing depression by PCD involves several conversations with patients and families that are often complex and demand high experience-based skills.

To detect a milder form of depression, PCD is likely to rely on clinical judgement compared to formal objective assessment, and they highlighted the importance of establishing a good rapport and knowing the patient holistically. Depression differs from other medical illnesses for which there are objective diagnostic tests and measurable treatment responses.[17]

Professional knowledge and skills were deemed essential for the screening, diagnosis and treatment process. The majority of PCDs in the study felt that there was a lack of training and knowledge on how to screen, diagnose and manage depression in elderly patients. No CME, teaching, or guidance was provided in this matter. To improve the screening and treatment for depression in the elderly, more systematic training and awareness need to be done by primary healthcare providers. If equipped with these competencies, PCD can have a greater awareness, skill, and confidence in detecting and managing elderly with depression.

This study has identified several gaps in knowledge and practice of PCDs on depression screening in older people. Some of the participants interviewed were unsure; generally, the type of tool to screen for depression in the elderly was not Mini-Mental State Examination (MMSE)/Montreal Cognitive Assessment (MOCA). Inappropriate tools were being used for screening depression. CME dedicated to using simplified, locally validated and more reliable tools such as GDS should be organised for PCDs. Self-reported checklists such as BDI and GDS has high specificity and sensitivity.[18,19] yet only one participant used BDI and four used GDS.

The quality of the translation was questioned by most participants, mainly when translating it into the native language of Sarawak, where there are 26 different ethnicities, and 40% of the population are made up of indigenous communities called “Dayak”. Furthermore, some ethnicities have different words to describe their feelings and emotions, which might have led to misinterpretation and the validity of such data collection. This suggests that due diligence is required for the translation process to ensure accurate results obtained from the screening. Bearing in mind that some ethnicities do not have a description for depression or feeling sad. Future research should focus on adapting current screening tools into local native language with accurate representation of local contexts. It could come in handy, especially in primary healthcare clinics in Sarawak's rural areas, by having a tool which is adapted to local socio-cultural norms. Henceforth, KPI for mental health screening targets in Sarawak states should be carefully interpreted based on the issues of the existing tool’s validity and language-related barriers. There is a need to perhaps reconsider the DASS-21 as a screening tool for elderly in the Malaysian community as it might not be suitable across the various multi-ethnic groups which exist in Peninsular and East Malaysia and for the reasons stated earlier. After data collection concluded, in January 2023, the Health Department of Sarawak has implemented Whooley-2-question screening as a standardised screening tool in primary care. The screening of depression using Whooley’s questionnaire in primary care documented a sensitivity of 99% and specificity of 70% and has been validated locally in Malay.[20] However, to date, Whooley’s questionnaire has not been translated into Dayak or any other native Borneo language.

Most respondents felt that there was no change during and after covid pandemic because the main issues were time constraints and lack of supportive resources to actively screen for depression challenged by the heavy work burden and deployment of clinic staff to manage the infection and hence the screening of depression was compromised.

This study, to the best of our knowledge, is the first qualitative study done to explore the perception and views of PCDs in Malaysia regarding screening of depression in elderly patients receiving treatment at public primary healthcare clinics. This study further reinforces the outcome of prior research undertaken in other parts of the world. The research was carried out in Sarawak with a great diversity of ethnicities, demonstrating the need for a screening tool and diagnosis algorithm that factors into local culture and community understanding. The main limitation of this study is that only participants from the capital of Sarawak, Kuching, were enrolled; hence it may not be truly reflective of the general population. Although participants were only

recruited from one district, it provides insight into strategies and policy implementation for future studies.

CONCLUSION

This paper presents the findings of exploring the current views and perceptions of primary care doctors (PCDs) regarding screening of depression in elderly patients. PCDs believe that elderly patients should be screened for depression, however, many reported that time and limited manpower with inconducive consultation room as the main barrier.

Many PCDs doubt the validity of the tool's translation into local dialect in primary care settings with diverse ethnic and cultural characteristics. Recommendation for a shorter screening tool that is socioculturally acceptable, able to correctly screen and detect depression among the elderly local population is vital.

Raising awareness among caregivers of elderly patients in particular regarding depression not being part of normal ageing and somatic symptoms of depression may predominate and warrant further investigation. There is a need for caregivers to realise that these symptoms must be discussed with PCDs to prompt timely intervention in the busy primary care clinic. Likewise, there is also a need for PCDs to be exposed to geriatric depression training programs and continuous medical education sessions to use the appropriate screening tools. The program must prioritise on increasing PCD knowledge and management skills in screening, diagnosing, and managing depression in the elderly.

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