

MENTAL HEALTH AND OLDER ADULTS

CHAPTER 3: DEPRESSIVE DISORDERS IN OLDER ADULTS

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Significance of Depression among Older Adults

- ◆ Depression is a frequent cause of distress in older adults; leads to physical, mental, and social dysfunction; and significantly decreases quality of life.
- ◆ Increasing percentage of U.S. population will be 65+ over next decade with an increasing prevalence of African American, Latino, and Asian Americans who have more difficulty accessing healthcare services.
- ◆ Older adults may be reluctant to seek services for depression because of mental illness stigma, fear of jeopardizing health care, and insurance. They may also fear loss of financial security and independence, embarrassment, isolation, or being declared incompetent. Service access barriers including limited financial resources, language barriers, and a lack of culturally-sensitive programs are other reasons for not seeking treatment.
- ◆ Sometimes, due to fragmented mental health services or gaps in services, older adults do not receive appropriate care when they do seek help. Financial constraints of managed care are increasingly restricting the time spent with clients, forcing mental health concerns to compete with comorbid medical conditions.

Between the years 2015 and 2030 older adults (65 years+) will account for 20% of the total population, up from 13% in 2000 (U.S. Bureau of the Census, 2000). Added to this trend is the increasing proportion of minority older adults including African-American, Latino, and Asian-Americans (Areán et al., 2005; Gellis & Taguchi, 2003; Harada & Kim, 1995), who tend to have more obstacles than Caucasians do in accessing mental health services. According to the Surgeon General's Mental Health Report, depression in older adults leads to physical, mental, and social dysfunction (U.S. Department of Health and Human Services [DHHS], 1999). Primary care physicians

often report feeling too pressured for time to investigate mental health problems in older people (Glasser & Gravdal, 1997).

Epidemiology of Depression in Older Adults

- ◆ Rates of depression vary widely in older adults in different settings, and the rate of clinically significant depressive symptoms is even higher than the rate of diagnosable depressive disorders.
- ◆ Community dwelling older adults. Major depression: 1-4% overall (higher among women); dysthymia: ~2%; minor depression: 4-13% (similar distribution across gender, race, and ethnicity).

The prevalence estimates of major depression in community elderly samples are low, ranging from 1 to 4% overall, with a higher prevalence among women. The prevalence rate for dysthymia is about 2% although for minor depression estimates are higher, ranging from 4 to 13% with the same pattern of distribution across gender, race, and ethnicity (Blazer, 2002; Beekman et al., 1995). There are no significant racial or ethnic differences in prevalence rates for depression (Beekman, Copeland, & Prince, 1999; Steffens et al., 2000; Zalaquett & Stens, 2006).

- ◆ Medically ill older adults. Major depression: 10-12%; significant depressive symptoms: 23%. Rates of clinically significant depressive symptoms among medically ill elderly: 10-43%.
- ◆ Home health care. Major depression: 13.5%; significant depressive symptoms: 27.5%. Depression twice as prevalent in home health care as in primary care; it is persistent, intermittent, and associated with medical illness, pain, and disability.
- ◆ Depression is one of the most common mental disorders in primary care and home health care settings.

Estimates for rates of major depression in medically ill elderly range from 10-12% with an additional 23% experiencing significant depressive symptoms (Koenig, Meador, Cohen, & Blazer, 1988). In home health care, estimates of 13.5% for major depression and 27.5% for significant depressive symptoms were found (Bruce et al., 2002; Gellis, 2006). Rates of clinically significant depressive symptoms among medically ill elderly range from 10 to 43% (Williams-Russo, Sharrock, Mattis, Szatrowski, & Charlson, 1995; Peterson, Williams-Russo, Charlson, & Myers, 1996; Steffens et al., 2000). In fact, depression is twice as prevalent in home health care as in primary care; it is persistent, intermittent, and is associated with medical illness, pain, and disability (Lyness, King, Cox, Yoediono, & Caine, 1999). Late life depression is one of the most common mental disorders to present in primary care and home health care settings (Bruce et al., 2002;

Gellis & Kenaley, 2008; Gellis, McGinty, Horowitz, et al., 2007; Lyness et al., 1999; Reynolds & Kupfer, 1999). Nearly 5 million of the 31 million Americans over 65 suffer from clinically significant depressive syndromes.

- ◆ Long-term care. Major depression: 6-24%; minor depression and dysthymia: 30-50%; subthreshold clinically significant depressive symptoms: 35-45%. Depression often is undetected in long-term care and when detected is inadequately treated.

Prevalence rates of depression in long-term care vary depending on study definitions and measures used. For elderly patients with major depression, rates range from 6 to 24% in nursing homes (Blazer, 2002). Prevalence estimates for minor depression and dysthymia are even higher and range from 30 to 50% in the majority of studies; and for subthreshold clinically significant depressive symptoms, the range is 35 to 45% (Hyer, Carpenter, Bishmann, & Wu, 2005). Depression is underdetected in long-term care facilities and if detected, is inadequately treated (Teresi, Abrams, Holmes, Ramirez, & Eimicke, 2001; Brown, Lapane, & Luisi, 2002).

- ◆ Prognosis of depression among older adults can often be poor. Depression predicts poor treatment adherence, may exacerbate other common chronic medical conditions, slows recovery from other illnesses and surgery, and is associated with increased mortality.

A meta-analysis of depression outcomes at 24 months estimated that only 33% of older patients were well, 33% were depressed, 13% were hospitalized, and 21% had died (Cole, Bellavance, & Mansour, 1999). Depression is also an independent predictor of overall poor treatment compliance and may exacerbate other common chronic medical conditions in older adults (DiMatteo, Lepper, & Croghan, 2000). Moreover, late life depression slows recovery rates from illnesses and surgeries and is associated with increased mortality (Beekman et al., 1999; Unützer et al., 2003).

- ◆ Risk factors for depression among community-dwelling older adults includes female gender, sleep disturbance, disability level, prior history of depression, and bereavement.

Cole and Dendukuri (2003) completed a systematic review of risk factors for depression in community-dwelling elderly that involved a qualitative and quantitative synthesis of the data. They examined 20 studies and identified key risk factors that included female gender, sleep disturbance, disability level, prior history of depression, and bereavement.

Comorbidity of Depression in Older Adults

- ◆ Comorbidity of depression with physical disorders is common and negatively influences the course of the depression, increases functional impairment, health costs, and use of health services.
- ◆ Common medical illnesses known to be associated with depression include heart disease, stroke, hypertension, diabetes, cancer, and osteoarthritis.

Depression with physical illness increases levels of functional disability (Alexopoulos et al., 1996; Proctor et al., 2003), use of health services (Beekman, Deeg, Braam, Smit, & van Tilburg, 1997; Saravay, Pollack, Steinberg, Weinsched, & Habert, 1996), and health care costs (Callahan, Kesterson, & Tierney, 1997; Manning & Wells, 1992; Simon, VonKorff, & Barlow, 1995), particularly among older adults (Unützer et al., 1997). It also delays or inhibits physical recovery (Covinsky, Fortinsky, Palmer, Kresvic, & Landefeld, 1997; Katz, 1996).

Depression and Suicide in Older Adults

- ◆ The suicide rate among older adults is twice that of the general population accounting for about 20% of all suicides, though they are only 13% of the population. Males 85 and over have the highest suicide rate of any age group, and males over 80 take their lives at twice the rate of women.
- ◆ Risk factors for suicide among older adults.
 - Medications: Tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) are effective in treating anxiety disorders. They are used less frequently since the development of newer antidepressants, such as serotonin selective reuptake inhibitors (SSRIs).
 - Demographic: Older age, male gender, white race, and unmarried status.
 - Clinical: Depression (especially late-onset unipolar depression), comorbid anxiety, substance abuse, isolation, loneliness, lack of social supports, and declining physical health.
- ◆ Over 70% of older suicide victims had had contact with their primary care physician in the 3 months prior to the suicide. The majority of older patients had late onset undetected or untreated depressive symptoms, likely reflecting high rates of comorbid illness and/or fears of pain or dependency on others.

In the elderly, suicide is almost twice as frequent as in the general population (Conwell, Duberstein, & Caine, 2002). The elderly account for 20% of all suicides, yet they make up only 13% of the population (Hoyert, Kung, & Smith, 2005; Pearson & Brown, 2000). Some of the most common demographic correlates of suicide are older age, male gender, white race, and unmarried status (Peters, Kochanek, & Murphy, 1998). In the U.S., older white males age (85+) have the highest suicide completion rates (65 per 100,000) (U.S. Dept. of Health and Human Services, 2003), over six times the rate of all age-adjusted suicides (Peters et al., 1998). Men 80+ take their own lives at four to six times the rate of older women (Scocco & DeLeo, 2002). Depression, comorbid anxiety, substance abuse, isolation, loneliness, lack of social supports, and declining physical health are some of the risk factors for suicide among older adults (Conwell et al., 2002). Retrospective studies identified that greater than 70% of older suicide victims have had contact with their primary care provider within 3 months prior to their death (Conwell, Olsen, Caine, & Flannery, 1991; Conwell, 1994; Diekstra & van Egmond, 1989; Frierson, 1991; Uncapher, 2000). In these studies, the majority of older patients had late onset undetected or untreated depressive symptoms, likely reflecting high rates of comorbid illness and/or fears of pain or dependency on others (Duberstein, 1995).

- ◆ During the past decade, attention to detecting and treating depression in healthcare settings have led to reduced rates of depression.
- ◆ A large multisite randomized trial known as PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) enrolled patients with different types of depression and conducted follow-up studies with followed them for 2 years. Patients were offered medication or interpersonal therapy (IPT) and were seen regularly by care managers who monitored symptoms, adherence, treatment response, and side effects. Patients who received this intervention had less severe depression symptoms and higher remission rates than those who did not.

A large multisite randomized trial known as PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) enrolled patients who met criteria for major depression, dysthymic disorder, or minor depression and tracked their status for a period of 2 years through acute, continuation, and maintenance phases of treatment (Bruce & Pearson, 1999; Alexopoulos et al., 2005). The experimental intervention was implemented by depression care managers who monitored psychopathology, treatment adherence, response, and side effects at predetermined times. Patients were offered antidepressant medications and/or interpersonal psychotherapy, an evidence-based intervention. The PROSPECT trial demonstrated that elderly patients receiving a depression care management intervention had less severe depressive symptoms and

greater remission rates at 4, 8, and 12 months than patients receiving usual primary care (Bruce et al., 2004).

- ◆ Suicide management.
 - LISTEN: Take note of clues in what your clients say.
Most people who are thinking about suicide will communicate their intent through clues. “I can’t go on”, “What’s the use?” “I gave some things away.”
 - INQUIRE: Ask the client if (or how often) he/she is thinking about suicide.
 - INFORM: Tell clients that you are concerned for their wellbeing.
 - MYTH: “Asking someone about suicide will encourage it.” Not true.
 - PLAN: Develop a safety plan with clients.
 - REFER: Give clients referrals to mental health/psychiatric professionals.

Evidence-based Treatment of Depression in Older Adults

Psychosocial Interventions

- ◆ Psychosocial interventions have been demonstrated to be effective among older adults, particularly those who reject medication because of unpleasant side effects or who are coping with low social support or stressful situations.
- ◆ Evidence-based approaches such as structured problem-solving (PST) cognitive-behavioral (CBT), and interpersonal (IPT) therapies are effective intervention alternatives or adjuncts to medication treatment.
- ◆ Psychosocial interventions alone are effective with older populations including minorities. Cognitive therapies, including PST, are particularly promising among older men and women of diverse ethnic backgrounds.
- ◆ The majority of primary care patients prefer counseling over medication, which should be kept in mind since patient attitudes and preference affects acceptance of and adherence to the prescribed treatment for depression.

Psychosocial interventions have been demonstrated to be effective among older adults, particularly those who reject medication because of unpleasant side effects or who are coping with low social support or stressful situations (Choi & Morrow-Howell,

2007; Gellis, 2006). Evidence-based approaches such as structured problem-solving (PST) cognitive-behavioral (CBT), and interpersonal (IPT) therapies are effective intervention alternatives or adjuncts to medication treatment (Gath & Mynors-Wallis, 1997; Gellis, McGinty, Horowitz, et al., 2007; Hegel, Barrett, Cornell, & Oxman, 2002; Jacobson & Hollon, 1996; De Rubeis, Gelfand, Tang, & Simons, 1999; Schulberg, Pilkonis, & Houck, 1998).

There is evidence that psychosocial interventions alone are effective with older populations including minorities (Coulehan, Schulberg, Block, Madonia, & Rodriguez, 1997; Mossey, Knott, Higgins, & Talerico, 1996; Munoz, et. al., 1995). Cognitive therapies, including PST, are particularly promising (McCusker, Cole, Keller, Bellavance, & Berard, 1998; Nezu, 2004; Robinson et al., 1995) among older men and women of diverse ethnic backgrounds (Gil et al., 1996). Patient attitudes and preference for type of treatment has been shown to affect acceptance of and adherence to the prescribed treatment for depression (Schulberg, Magruder, & deGruy, 1996), and the majority of primary care patients prefer counseling over medication (Brody, Khaliq, & Thompson, 1997; Landreville, Landry, Baillargeon, Guerette, & Matteau, 2001).

- ◆ PST has been found to be effective in frail, homebound, medically ill individuals, and a short (6-week) course of treatment is as effective as medication in individuals with major and minor depression.
- ◆ Written educational materials for patients and family members improve medication adherence and clinical outcomes.

PST interventions for depression by non-medical mental health practitioners have also demonstrated effectiveness for homebound, frail, medically ill populations (Gellis, McGinty, Horowitz, et al., 2007; Mynors-Wallis, Gath, Davies, Gray, & Barbour, 1997). Adjunct written educational materials for patients and family members have been shown to improve medication adherence and clinical outcomes (Robinson et al., 1997). Some studies have found that 6 sessions of PST are as effective as pharmacotherapy among ambulatory primary care patients with minor and major depression (Hegel et al., 2002; Mynors-Wallis, Gath, Lloyd-Thomas, & Tomlinson, 1995).

- ◆ CBT (either individual or group) is at least as or more efficacious than pharmacotherapy and other forms of psychotherapy such as IPT, brief insight-oriented therapy, PST, and reminiscence therapy.
- ◆ Combined case management and CBT may have more efficacy than CBT alone for low-income and/or certain minority group members.

Literature reviews on the effect of CBT on late-life depression noted that CBT was at least as or more efficacious than pharmacotherapy and other forms of psychotherapy such as IPT, brief insight-oriented therapy, PST, and reminiscence therapy (Areán &

Cook, 2002; Cuijpers, van Straten, & Smit, 2006; Laidlaw, 2001; Pinguart & Soerensen, 2001; Zalaquett & Stens, 2006).

Among low-income older adults with Major Depressive Disorder (MDD) or dysthymia, cognitive behavioral group therapy (CBGT) augmented with clinical case management and clinical case management alone led to greater improvements in depressive symptoms at the 12-month follow-up than did CBGT alone (Areán, Gum, & McCulloch, 2003). In a study of low-income older primary care patients with MDD, Spanish-speaking and English-speaking patients responded equally well to CBT alone versus case management (Miranda, Azocar, & Organista, 2003). Moreover, CBT and supplemental case management was associated with greater improvement in symptoms and functioning than CBT alone for Spanish speakers, but it was less effective for those whose first-language was English.

- ◆ IPT, another evidence-based intervention for late life depression, focuses on relationships and conflicts with family and friends. Its purpose is to improve communication in those relationships, and develop or enhance the social support network.

IPT is another evidence-based intervention for late life depression that focuses on the depressed person's relationships and conflicts with family and friends (Hinrichsen, 1999). The overall purpose is to improve communication in those relationships and to develop or enhance the social support network of the identified depressed patient (Weissman & Markowitz, 1994). Several meta-analytic reviews noted findings of the efficacy of IPT for depression (de Melo, de Jesus, Bacaltchuk, Verdelli, & Neugebauer, 2005; Parker, Parker, Brotchie, & Stuart, 2006; Thase et al., 1997; Weston & Morrison, 2001).

- ◆ Adjunct written education materials for clients and family members improve medication adherence and clinical outcomes.

Educational materials written for patients and family members have been shown to improve medication adherence and clinical outcomes (Robinson et al., 1997).

- ◆ Treatment protocols for late life depression are typically time-limited (6-20 sessions) psychotherapeutic interventions.
- ◆ The goal of brief interventions is to treat the problem, specifically, changing the behavior of individuals who are experiencing mental health problems in later life. These psychosocial interventions include assessment and direct feedback, contracting and goal setting, cognitive and behavioral techniques, and the use of educational and other written materials.

- ◆ There is unfortunately less available evidence on culturally appropriate mental health treatments for older adults.

Interventions for depression generally range from 6 to 20 sessions, each lasting about an hour (Gellis, McGinty, Horowitz, et al., 2007; Hegel et al., 2002; Nezu, 2004; Nezu & Nezu, 2001).

- ◆ Interventions for approaching late-life depression.
 - Questions to ask.
 - How are things at home?
 - How have you been coping?
 - Have you had any stress lately?
 - How are you handling it?
 - Discuss your concerns with client.
You can say:
 - It is a very common
 - It is a medical condition
 - It is very treatable
- ◆ Prior to referral for mental health services:
 - Be supportive. Be patient.
 - Allow the individual to express his/her concerns/fears.
 - Listen without being judgmental.
 - Don't take things personally if the client is irritated or angry.
 - Provide choices and be complimentary.
 - Attempt to provide daily activities.
- ◆ Guidelines for making a referral to a mental health program (from a non-mental health setting such as primary care, social service agency).
 - If the older client has a psychiatric history.
 - If there is suicidal ideation.
 - If there is risk of suicide or you are concerned about client safety.
 - If there is need for hospitalization.
 - If client needs medication evaluation.
 - If client needs ongoing therapy that can't be provided in your setting.

Pharmacological Interventions

- ◆ Antidepressants are widely used and are safe and effective for the treatment of moderate to severe depression in older adults. All antidepressants are equally effective, though the most widely studied are tricyclic antidepressants and SSRIs. Medically ill older adults have fewer adverse effects with SSRIs, which has led them to be more widely prescribed in primary care settings.
- ◆ As older adults are prescribed more medications for other medical diseases, the likelihood of self-medication, multiple drug use, drug-drug interactions, and unpleasant side effects increases.

Based on several literature reviews of pharmacologic treatment for geriatric depression, antidepressants are safe treatments for depressed older adults (Barkin, Schwer, & Barkin, 2000; Mamdani, Parikh, Austin, & Upshur, 2000; Salzman, Wong, & Wright, 2002; Solai, Mulsant, & Pollock, 2001). Almost all antidepressant medications are equally effective for treating major depression (Blazer, Hybel, Simensick, & Harbin, 2000; Salzman et al., 2002). During the past two decades, over 30 randomized placebo controlled clinical trials as well as many comparative trials (Das Gupta, 1998; Salzman et al., 2002) have been conducted that have documented the efficacy and safety of antidepressant medications (Tricyclics and SSRIs) for older adults with depression. Naturalistic studies have shown that medically ill older adults have more adverse effects to tricyclics than to SSRIs (Cole, Elie, McCusker, Bellavance, & Mansour, 2001; Landreville, Landry, Baillargeon, Guerette, & Matteau, 2001), and the use of SSRIs in primary care has become more common (Crystal, Sambamoorthi, Walkup, & Akincigil, 2003).

Minor Depression

- ◆ Minor (or subsyndromal) depression is more common among older adults than major depressive disorder.
- ◆ Prevalence of minor depression in older adults: community-dwelling: 10-30%; primary care: 5-9%; Latinos: 15%; Asian-Americans: 12%; African Americans: 10%.
- ◆ Minor depression is associated with increased risk of mortality in older men.

Minor depression, more often than major depression, is observed in numerous settings (Charney et al., 2003; Lavretsky & Kumar, 2002; Judd, Schettler, & Akiskal, 2002). Minor depression ranges from 10 to 30% in older community-dwelling adults (Hybels & Blazer, 2003) and approximately 5 to 9% in primary care settings (Lyness et

al., 1999). Minor depression has been found to be associated with an increased risk for mortality in older men and to have a relatively high prevalence in some ethnic groups (Penninx et al., 1999). This subthreshold disorder is common in older minorities in primary care settings. As many as 15% of older Latinos, 12% of older Asian-Americans, and 10% of older African Americans meet the criteria for minor depression (Areán & Alvidrez, 2001).

- ◆ While the symptoms of minor depression remit over time, a substantial percentage of older adults continue to experience them many months later. For many, minor depression is a precursor to major depression.
- ◆ CBT, IPT, and PST approaches appear promising; however, further studies are needed to confirm their effectiveness.

A recent systematic review of adults and older adults diagnosed with minor depression found remission rates in the range of 46 to 71% after 3 to 6 years (Hermens et al., 2004). Two studies reported that 62% of adults and older adults still had minor depression at the 5-month follow-up evaluation, whereas 16% had persistent or recurrent minor depression at the 1-year follow-up (Broadhead, Blazer, George, & Tse, 1990; Penninx et al., 1999). At the 1-year follow-up, 12.7% of the adults originally with a diagnosis of minor depression had developed major depression (Broadhead et al., 1990). CBT, IPT, and PST models appear to be promising treatments for older adults with minor depression (Rowe & Rapaport, 2006). However, the research literature is less clear about these therapies effectiveness in minor depression compared to major depression because of the dearth of treatment studies, particularly among older adults.

Depression Screening

- ◆ The goal of screening is early identification and thus prevention through early intervention.
- ◆ Key criteria to be used by agency personnel to justify mental health screening for late life depression include the following:
 - Is the national incidence of depressive disorders in the elderly population high enough to justify the cost of screening in an agency?
 - Does the problem have a significant effect on the quality of life of the older adult?
 - Is effective treatment available?
 - Are valid and cost-effective screening instruments available?
 - Are the adverse effects (if any) of the screening tests acceptable to social workers and older adult clients?

- ◆ The literature demonstrates the following (in relation to the above questions):
 - Depression is prevalent among older adults in a wide variety of settings, and social workers encounter older adults in many areas of clinical practice.
 - Depression among older adults causes serious health and social consequences.
 - Effective psychosocial and pharmacological treatments are available for depression.
 - Valid cost-effective depression screening procedures exist.
 - Older adults do not find screening for depression aversive, outside the time and effort required to complete a short interview or form, if the need for the screening is explained clearly and the screening is conducted in an empathetic manner (Gellis & Kenaley, 2008; Gellis & Taguchi, 2003).
- ◆ A number of standardized rating scales for assessing the presence and severity of depressive symptoms in long-term care include self-reports such as the Center for Epidemiological Studies-Depression Scale (CES-D), Geriatric Depression Scale (GDS), Zung Self-Rating Depression Scale, Beck Depression Inventory (BDI), the Patient Health Questionnaire-9 (PHQ-9), and clinician-interview instruments including the Hamilton Rating Scale for Depression (HAM-D), and the Cornell Scale for Depression in Dementia (CSDD). All the measures are frequently used in long-term care settings (see Table 1 for citation and download information).

Table 1. Screening Tools for Identifying Depression Disorders in Older Adults

Administration	Screening Tool	Source
Self-report	Geriatric Depression Scale http://www.neurotransmitter.net/depressionscales.html	Brink et al., 1982
Clinician	Hamilton Rating Scale for Depression http://www.neurotransmitter.net/depressionscales.html	Hamilton, 1960
Self-report	Center for Epidemiologic Scale for Depression http://www.neurotransmitter.net/depressionscales.html	Radloff, 1977
Self-report or clinician	Patient Health Questionnaire (PHQ-9) http://www.americangeriatrics.org/education/dep_tool_05.pdf	Kroenke & Spitzer, 2002
Self-report	Beck Depression Inventory	Beck & Beck,

		1972
Clinician	Cornell Scale for Depression in Dementia http://www.health.gov.au/internet/wcms/publishing.nsf/Content/2EED125A69192179CA2571AB0012C7D2/\$File/08dementia.pdf	Alexopoulos et al., 1988

- ◆ For DSM diagnosis.
 - Structured Clinical Interview for DSM-IV (SCID).
 - Mini-International Neuropsychiatric Interview (MINI) is available in several languages. Register and download the instrument free at: <https://www.medical-outcomes.com/indexSSL.htm>.
- ◆ Steps in screening:
 - Obtain the person's agreement to be screened.
 - Explain the purpose for the screening.
 - Administer and score the screening tool as instructions direct.
 - If the screen is positive, make initial treatment referrals for further diagnostic assessment to the older person's primary care physician for possible psychotherapy and antidepressant medication.
- ◆ The social worker is in a unique position to:
 - Identify resources if financial barriers exist.
 - Address stigma through psychoeducation.
 - Encourage client follow through with the referral.

Special Settings

Late Life Depression in Primary Care

- ◆ Integrating specialty mental health care within primary care has been found to be more effective than efforts to improve the psychiatric skills of primary care physicians. Multifaceted collaborative care approaches packages involve nurses, social workers, or other depression care managers, and vary in content and intensity.
- ◆ These interventions often aim to increase knowledge about depression (psychoeducation), improve adherence to antidepressant medication, improve physician-patient communication, and decrease depressive symptoms.

Much effort has been expended trying to improve the psychiatric skills of primary care physicians, but with only modest effects (Lin et al., 1997; Rihmer, Rutz, & Pihlgren,

1995). Integration of specialty mental health care within primary care and system of care enhancements, such as “collaborative or integrative care” are found to be more effective (Meyers, 1996; Schulberg et al., 1998; Gilbody, Whitty, Grimshaw, & Thomas, 2003). Collaborative care approaches are multifaceted intervention packages that involve nurses, social workers, or other depression care managers, and vary in content and intensity (Katon et al., 1999; Swindle et al., 2003). These interventions often aim to increase knowledge about depression (psychoeducation), improve adherence to antidepressant medication, improve physician-patient communication, and decrease depressive symptoms (Unützer et al., 2001; Von Korff & Goldberg, 2001).

- ◆ Effective components of educational and organizational interventions to improve depression management in primary care settings include: enhanced depression care manager role, clinician education, and improvement in communication between primary care provider and psychiatry liaison. Documentation alone of simple practice guidelines and educational strategies were generally ineffective.

A systematic review of 21 studies on educational and organizational interventions to improve depression management in primary care settings found positive results (Gilbody et al., 2003). Intervention components that were found effective included enhanced depression care manager role, clinician education, and improvement in communication between primary care provider and psychiatry liaison. Documentation alone of simple practice guidelines and educational strategies were generally ineffective.

- ◆ PST alone and in combination with medication and other components such as enhanced education and support, social and physical activation, self-care management, information and decision-making, counseling and support, and communication with primary care providers have been found to be effective.

A recent systematic review of 22 studies on PST was undertaken to determine the effectiveness of PST on reducing depressive symptoms in noninstitutionalized adults 18 years and older (Gellis & Kenaley, 2008). Four studies employed a multi-faceted intervention (Ciechanowski et al., 2004 [Program to Encourage Active, Rewarding Lives for Seniors or PEARLS]; Doorenbos et al., 2005; Katon et al., 2004; Unützer et al., 2002 [IMPACT]). The studies found that combined use of PST and antidepressant treatment had more favorable depression outcomes compared with PST alone. (To view a description and synopsis of the research on IMPACT and PEARLS go to:

<http://www.nrepp.samhsa.gov/listofprograms.asp?textsearch=Optional+Search+Terms&ShowHid=1&Sort=A1&T2=2&T3=3&A6=6>)

- ◆ Studies of multifaceted collaborative care of depression have found that mental health training background of staff, systematic identification of patients, and continuous depression specialist supervision predict good depressive symptom outcomes.

In a systematic review of 34 studies of multifaceted collaborative care interventions with outcome data on depressive symptoms and 28 studies on antidepressant medication use, positive effects were found for both antidepressant use and depressive symptom reduction (Bower, Gilbody, Richards, Fletcher, & Sutton, 2006). The studies reviewed found no variables that predicted variation of effectiveness by antidepressant medication use. Nonetheless, several key predictors of good depressive symptom outcomes were found, including mental health training background of staff, systematic identification of patients, and continuous depression specialist supervision.

- ◆ Collaborative management home care is another promising approach to the management of depression in older adults.

Flaherty and colleagues (1998) found that a collaborative management home care intervention for depression resulted in lower hospitalization rates (23.5%) compared to that of an historical control group (40.6%). A randomized controlled trial with blind follow-up evaluation 6 months after recruitment found that psychogeriatric team home care versus usual primary care improved depressive outcomes for 58% versus 25% of people 65 and over (Banerjee, Shamash, Macdonald, & Mann, 1996).

Late Life Depression in Home Health Care

- ◆ Home care services are essential to maintaining elders with disability in the community and reducing their hospitalization and nursing home use. Compared with the general elderly population, home care recipients are older, more socially isolated, more likely to be women, and more likely to have high rates of physical illness, disability, and depression. Unfortunately, many individuals with depression do not receive treatment.
- ◆ A variety of factors interact to interfere with the detection and treatment of depression in older adults.
 - The heterogeneity of depression coupled with physical and cognitive impairment, social vulnerabilities, and various medical conditions prevalent in health care make it more difficult for accurate assessment, diagnosis, and treatment in the elderly population.

- Older adults are less likely to voluntarily report affective symptoms of depression, more likely to ascribe symptoms to a physical illness, and less likely to use specialty care.

Compared with the general elderly population, home care recipients are older, more socially isolated, more likely to be women, and more likely to have high rates of physical illness, disability, and depression (Banerjee, 1993). However, few elderly persons receive appropriate treatment of depression. For instance, in two studies only 21% (Brown, McAvay, Raue, Moses, & Bruce, 2003) and 16% (Banerjee et al., 1996) received treatment.

The client, treating physician, and health care organizational factors interact to impede the detection and treatment of depression, particularly among older clients (Klinkman, 1997; Meyers, 1996; Schulberg et al., 1996). Older clients are less likely than younger ones to voluntarily report affective symptoms of depression (Lyness et al., 1995). They are more likely to ascribe symptoms of depression to a physical illness (Knauper & Wittchen, 1994). Depressed older adults of various ethnic backgrounds are less likely to use specialty care and more likely to use the general health care system (Brown et al., 1995; Unützer et al., 1997).

- ◆ PST is a promising approach to treating depression in the context of home health care.

A recent randomized controlled trial in home care tested the effectiveness of home-delivered problem solving therapy (PST-HC) for depression in medically ill elderly over a 6-month period (Gellis, McGinty, Horowitz, Bruce, & Misener, 2007). Data suggested significant reductions in depression scores at post-baseline, and at 3 and 6 months, relative to the usual primary care condition. They also reported higher quality of life and improved problem solving ability. In a randomized trial of brief PST, the therapy was found to result in decreased symptoms of minor depression in older home care patients post-treatment, and the decrease was maintained over a 6-month period (Gellis, McGinty, Tierney, et al., 2007). Participants in the PST group were also more satisfied with treatment compared to the those in the control group..

Depression in Assisted Living

- ◆ Assisted-living residents appear to have significant rates of depression and depressive symptoms, yet their conditions are underdetected and undertreated.
- ◆ Depression may be associated with cognitive impairment, agitation, recent hospitalization, dependence on others for activities of daily living, psychosis, and social withdrawal.

A recent study attempted to obtain estimates of depression and related factors, and treatment rates of 196 ALF residents recruited from 22 facilities in Maryland (Watson et al., 2006). Most residents were female and widowed; a majority met criteria for dementia (68%), and 24% of the participants met the cutoff score for depression on the Cornell Scale for Depression in Dementia. Almost half (43%) of those depressed were receiving some type of antidepressant medication, while 57% of those depressed had not been referred to nor were receiving any psychiatric services.

Researchers examined a large data set of assisted living residents (N=2,078 residents aged 65 and older) in 193 assisted living facilities (Watson, Garrett, Sloane, Gruber-Baldini, & Zimmerman, 2003). They found relationships between depression and cognitive impairment, agitation, recent hospitalization, dependence on others for more than three activities of daily living, psychosis, and social withdrawal. At the 1-year follow-up study, 370 depressed residents had been transferred to a nursing home, and 250 residents with severe depressive symptoms had died.

- ◆ Multifaceted shared care appears to be a promising approach to treatment.

A randomized trial in Australia examined the effectiveness of a population based, multifaceted shared care intervention for late life depression in 220 depressed residential care residents in one large residential facility (Llwellyn-Jones et al., 2001). The intervention sought to provide depression related health education and activity programs for residents, increase the detection rate of depression by care staff, get elderly people to accept that depression is treatable, and provide accessible treatment programs in residential care. Follow-up results at the 9.5 month point showed that the experimental condition had resulted in reduced depressive scores compared to scores associated with the usual primary care control condition.

Depression in Long-term Care/Nursing Homes

- ◆ About 5% of older adults live in a long-term care facility. (Other prevalence data reported above.)
- ◆ A significant proportion of long-term care elderly with cognitive impairment and dementia have depression. Conversely, depression is a risk factor for dementia.
- ◆ Rapid screening, accurate diagnosis, and early treatment are likely to reduce symptoms of depression.

McCabe and colleagues (2006) studied the prevalence of depression among older people with cognitive impairment and found that 17.7% met criteria for a diagnosis of MDD, while 38.9% had clinically significant depressive symptoms. Individuals with moderate to severe cognitive impairment were more likely to present with MDD than

were those with mild cognitive impairment or normal cognitive function. Depression is frequently a comorbid condition with dementia with estimates at 30% (Evers et al., 2002; Terri & Wagner, 1992), and studies indicate that depression is a risk factor for dementia (Alexopoulos, Meyers, Young, Mattis, & Kakuma, 1993; Lichtenberg & Mast, 2003).

In a study of outcomes of depression in 201 long-term care residents with dementia and depression, it was found that at 6 months post-admission, 15% of the original sample was still depressed, and at 12 months only 7.5% were depressed (Payne et al., 2002).

- ◆ Undetected, untreated, or inadequately treated depression may result in high rates of nursing home placement in patients with dementia, due to an increase in their functional disability.

A recent study focused on specific factors that might contribute to nursing home placement by examining the detection and course of coexisting dementia and depression (CDD) in elderly patients compared with patients with either disorder alone (Kales, Chen, Blow, Welsh, & Mellow, 2005). This study found lower rates of depression detection by treating (i.e., non-study) physicians in CDD patients. Only 35% of the CDD group were correctly diagnosed and received adequate treatment. The CDD group had significantly higher levels of functional impairment when compared to the dementia-only group. The CDD subjects used nursing home care at significantly higher rates.

- ◆ Many long-term care residents present with signs and symptoms that overlap with depression (for example, anhedonia, irritability, flat affect).
- ◆ Comorbidity of anxiety and depression is most prevalent in more severely depressed and anxious nursing home patients.

Many long-term care residents present with signs and symptoms that overlap with depression (for example, anhedonia, irritability, flat affect) (Gauthier, 2003). Smalbrugge and colleagues (2005) examined the occurrence and risk indicators of depression, anxiety, and comorbid anxiety and depression among 333 nursing home patients in the Netherlands. Using a diagnostic research interview, they estimated the prevalence of major depression at 17.1%, anxiety at 4.8%, and comorbid anxiety and depression at 5.1%. The prevalence of depressive disorders (both major and minor) was 22.2%, and that of anxiety was 9.9%. The researchers concluded that the comorbidity of anxiety and depression is most prevalent in more severely depressed and anxious nursing home patients.

- ◆ Research literature on interventions for depression in older adults residing in long-term care is sparse and deficient.

- ◆ Researchers recommend a combined approach to depression treatment including behavioral interventions and antidepressants. They suggest psychosocial intervention as an initial treatment step and the introduction of medication in more severe forms of depression. A few psychosocial interventions such as group and individual behavioral therapies show some potential but require further investigation.

A randomized trial compared an individual 8-week life review treatment with friendly visiting as the control on depressive symptoms in 201 nursing home residents (Haight, Michel, & Hendrix, 1998). Results demonstrated that the treatment group had reduced BDI scores compared to control participants at 1-year follow-up evaluations.

In a small pilot study, Hyer and colleagues (1990) compared the effectiveness of a 12-week group psychotherapy, in a cognitive behavioral format, to usual primary care in a sample of 22 residents. At post-treatment, depression scores decreased in the treatment group but not in the control group.

Teri and colleagues (1997) conducted a randomized controlled trial of two psychosocial interventions for depression in Alzheimer's patients living with their caregivers in the community. Participants met diagnostic criteria for major or minor depression. Patient-caregiver dyads were randomly assigned to 1 of 4 conditions and assessed at pre-, post-, and 6-months follow-up intervals. Conditions included (1) behavior therapy-pleasant events (BT-PE), (2) behavior therapy-problem solving (BT-PS), (3) typical care control (TCC), and (4) wait-list control (WLC). They found that patients in both behavioral treatments showed significant improvement but not in the other two conditions. Caregivers in each behavioral condition also showed significant improvement in depressive symptomatology. In contrast, caregivers for patients in the other two conditions did not.

Researchers have recommended a combined approach to depression treatment including behavioral interventions and antidepressants (Lyketsos & Olin, 2002).

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Curriculum Resources



Suggested Readings:

- Cuijpers P., van Straten A., & Smit F. (2006). Psychological treatment of late-life depression: A meta-analysis of randomized controlled trials. *International Journal of Geriatric Psychiatry, 21*, 1139-1149.
- Gellis, Z. D. (2006). Mental health and emotional disorders among older adults. In B. Berkman (Ed.), *Oxford Handbook of Social Work in Health and Aging* (pp. 129-139). New York: Oxford University Press.
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Case Study: Mrs. D.

Mrs. D. is a 77-year-old woman living alone in own apartment who lost her husband 2 years ago.

About 3 years ago, she was diagnosed with cardiac disease. Her daughter/son (Pat) decided to contact the primary physician's office for the following reasons.

During the past 2 months:

- 1) Mrs. D. has complained of not sleeping well, loss of appetite, and back pain.
- 2) She is not remembering things as well as she used to.
- 3) She has difficulty concentrating and making decisions.
- 4) She worries about paying bills.
- 5) She has stopped playing cards.
- 6) She is no longer interested in seeing friends or going out.
- 7) She has related thinking that things would be better if she were not around, "not a burden to my daughter," but is not suicidal.

Activity #1. Class Discussion

- ◆ What information do you collect?
- ◆ What are the risk factors?
- ◆ What are the symptoms?
- ◆ What do you say to Mrs. D. and her daughter?
- ◆ What is your assessment and treatment plan?

Activity #2. Role Plays

- ◆ Divide students into groups of three.
- ◆ Ask students to go on-line and download the PHQ-9.

- ◆ Ask the students to take the following roles:
 - Ms. D.
 - Pat (daughter)
 - Social worker
- ◆ If a particular task only requires two people, the third person becomes an observer and after the task provides the following discussion and question feedback to the other participants:
 - What did you do that you liked?
 - What would you do differently next time?
 - This is what you did that I liked...”
 - This is what you might consider doing differently next time...”

(If time allows—and if appropriate for the particular students, you may ask the client in the role play to provide feedback to the social worker. *This is what you did that I liked... This is how I felt when you... This is what you might try next time...*)
- ◆ Remind students that the case example only provides an outline, they are to improvise additional details as needed. (Be kind to one another. The goal is not to “stump the chump” but to have an opportunity to practice using skills with an older adult and family member.)
- ◆ Depending on the level and experience of the students, it may be necessary to model the tasks before doing the role plays.
- ◆ Task #1: Social worker role plays an initial review of depression with Mrs. D. (Third student observes.) Use intervention questions for approaching late-life depression, for example:
 - How are things at home?
 - How have you been coping?
 - Have you had any stress lately?
 - Have you experienced any losses?
 - How are you handling it?

End role play; observer provides feedback.
- ◆ Task #2: Rotate roles. Social worker introduces the screening and conducts a PHQ-9 interview with Mrs. D. [Download from http://www.americangeriatrics.org/education/dep_tool_05.pdf]
 - Obtain the person’s agreement to be screened.
 - Explain the purpose for the screening.
 - Administer and score the PHQ-9 as instructions direct.
- ◆ Task #3: Rotate roles. Social worker discusses his/her concerns and makes initial treatment referrals for further diagnostic assessment to Mrs. D’s primary care physician for possible psychotherapy and antidepressant medication.
 - Discuss your concerns with Mrs. D and Pat.
 - You can say:
 - Depression is very common.
 - Depression is a medical condition.
 - Depression is very treatable.
- ◆ Task #4 (optional): Ask one student to take the role of the social worker and the other to take the role of the primary care physician (PCP). Social worker presents

his/her concerns and the results of the PHQ-9 to the PCP. (Remind students that the PCPs time is quite limited and that they will need to be concise and focused in their presentation of Mrs. D and her situation.)

- For example: I am concerned that Mrs. D may be depressed, and I think that she would benefit from further diagnostic assessment and treatment. Here is what I have seen that leads to my concern... [present a brief overview of her situation and the results of the PHQ-9].