DEPRESSION: PROGRAMMATIC RESPONSES AND TREATMENT: ACUTE CARE TO WELLNESS

ARGEC
Atlanta Regional Geriatric Education Center

Objectives: Depression in Older Adults

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- List and discuss barriers to treatment
- Identify treatment goals
- Understand treatment preferences, provider and patient
- Describe the various treatments modalities

Goals of Treatment

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- Remission/Resolution of depressive symptoms
- Prevent relapse and recurrence
- Improve quality of life and functioning
- Improve medical health and reduce mortality and suicide
- Develop and strengthen coping skills
- Reduce secondary symptoms
- Reduce healthcare cost

Barriers to Depression Care

- Inadequate treatment
- Medication adherence
- Lack of accessible, affordable, and age-appropriate care
- Limited use of specialty mental health care
- Lack of coordination and collaboration between providers

(Ell, 2006)

Considering Treatment Preferences

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Factors for Providers to Consider	Factor Influencing Older Adults
Depression severity & duration	Perceived stigma
Clinical presentation	Experiences of peers
Co-morbidities & medications	Length of treatment needed
Treatment side effects	Program expectations
Prior history of treatment response	Treatment side effects
	Convenience
	Cost (e.g. prescription drug coverage)
	Transportation needs

(SAMHSA, 2011)

Considering Treatment Preferences

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- Older adults may have clear preferences for receiving one type of treatment over another.
  - Examples: doubting that medication is helpful or reluctance to attending group therapy
- African Americans and Latinos are less likely to accept treatment (antidepressants and/or psychotherapy) than are non-Hispanic Whites (Akincigil et al., 2012)
  - Using shared decision-making is key

(SAMHSA, 2011)

Types of Treatment

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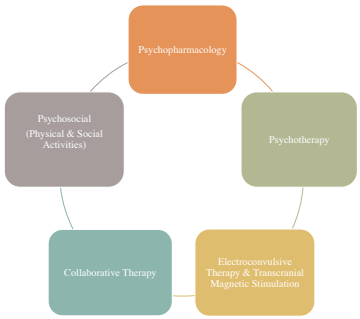

Psychopharmacology for Older Adults

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Commonly Prescribed Medications

Drug class
Selective serotonin reuptake inhibitors Citalopram (Celexa) Escitalopram (Lexapro) Fluoxetine (Prozac) Fluvoxamine (Luvox) Paroxetine (Paxil) Sertraline (Zoloft)
Tricyclic antidepressants Amitriptyline (Elavil) Desipramine (Norpramin) Doxepin (Sinequan) Nortriptyline (Pamelor)
Atypical antidepressants Bupropion (Wellbutrin) Duloxetine (Cymbalta) Mirtazapine (Remeron) Trazodone (Desyrel) Venlafaxine (Effexor)
Monoamine oxidase inhibitors Phenelzine (Nardil) Selegiline (Eldepryl; Emsam) Tranylcypromine (Parnate)

Medication Tips

- Selective serotonin reuptake inhibitors (SSRIs) are first-line treatment because they are better tolerated
- Adverse effects are common, education and monitoring is essential
- Start low and go slow
- Simpler, less frequent dosing regimens are associated with improved adherence (Russell et al., 2006)
- Antidepressant therapy should continue for 6-12 months

Evidence-Based Psychotherapies

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Therapy	Focus of Intervention	Specific Techniques
Cognitive Behavioral Therapy (CBT)	Maladaptive thoughts and behaviors	Self-monitoring, increasing participation in pleasant events, challenging negative thoughts and assumptions
Interpersonal Psychotherapy (IPT)	Unresolved grief, interpersonal disputes, role transitions, skills deficits	Exploration of affect, behavior change techniques, reality testing of perceptions
Problem-Solving Therapy (PST	Problem-solving skills	Identifying specific problems; brainstorming, evaluating, implementing and reviewing solutions

ECT and TMS

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- ECT- *procedure in which electric currents are passed through the brain, to trigger a brief seizure. This seizure releases many chemicals in the brain which make the brain cells work better.* Click on or copy and paste the weblink below to access more information on ECT:
  - http://www.fuquacenter.org/TreatmentOptions#ect

- TMS-*procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression*. Click on or copy and paste the weblink below to access a video that demonstrates TMS:
  - http://www.youtube.com/watch?v=sC_vGdAHMpE

Case Study

- Ms. G is a 75-year old female living alone in her apartment in New York City. Her husband died suddenly two years ago of a heart attack. Their two children are alive and living out-of-state. Both of her sons maintain weekly phone contact with Ms. G and visit usually once a year. Ms. G has been doing well until about 6 weeks ago when she fell in her apartment and sustained bruises but, did not require a hospital visit. Since then, she has been preoccupied with her failing eyesight and decreased ambulation. She does not go shopping as often, stating she doesn't enjoy going out anymore and feels "very sad and teary." Ms. G states that her shopping needs are less, since she is not as hungry as she used to be and she states, "I'm getting too old to cook for one person only".

Case Study Discussion Questions

- What type(s) of treatment/interventions would be beneficial for the depression Ms. G may be experiencing? Describe why you think this type of treatment/intervention may be an appropriate choice.
- What would be the goals of the intervention that you selected?
- What are some of the barriers to treatment you should consider for Ms. G?

Evidence Based Programs

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- IMPACT
  - *(Improving Mood--Promoting Access to Collaborative Treatment) intervention for patients >60 who have major depression /dysthymic disorder. The intervention is a 1-year, stepped collaborative care approach in which a nurse, social worker, or psychologist works with the patient's regular primary care provider to develop a course of treatment*. Click on or copy and paste the weblink below to access more information of IMPACT:
    - http://impact-uw.org/
- PEARLES
  - *(Program to Encourage Active, Rewarding Lives for Seniors) is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies*. Click on or copy and paste the weblink below to learn more about PEARLES:
    - http://www.pearlsprogram.org/OurProgram/PEARLS-for-Older-Adults.aspx

Evidence Based Programs

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- Healthy IDEAS
  - *(Identifying Depression, Empowering Activities for Seniors) is a program to detect and address depressive symptoms in older adults with chronic health conditions and functional limitations*. Click on or copy and paste the weblink below to learn more about IDEAS:
    - http://careforelders.org/default.aspx?menugroup=healthyideas
- PROSPECT
  - *(Prevention of Suicide in Primary Care Elderly: Collaborative Trial) aims to prevent suicide among older primary care patients by reducing suicidal ideation and depression. It also aims to reduce their risk of death*. Click on or copy and paste the weblink below to learn more about PROSPECT:
    - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181574/

Table 1: Factors to Consider in Selecting an EBP. Does the intervention fit with the needs and capacities of your organization?

	Type of Depression Included in Studies	Outcomes Affected[a]	Service Delivery Settings	Timeframe	Practitioner Qualifications and Requirements
Psychotherapy					
Cognitive Behavioral Therapy	Major depression Minor depression Dysthymia Depression symptoms Sub-clinical depression	Depression symptoms, Coping strategies, Quality of life	Home, Outpatient mental health, Primary care	Up to 20 sessions	Mental health practitioners with an advanced degree
Behavioral Therapy	Major depression Minor depression Depression symptoms	Depression symptoms, Coping strategies, Quality of life	Inpatient physical health, Outpatient mental health	Up to 18 sessions	Mental health practitioners with an advanced degree
Problem Solving Treatment	Major depression Minor depression Dysthymia Depression symptoms	Depression symptoms, Functional impairment, Quality of life, Problem-solving skills	Home, Nursing home, Outpatient mental health, Primary care	Up to 12 sessions	Mental health practitioners with a Bachelors degree or higher
Interpersonal Psychotherapy	Major depression Minor depression Sub-clinical depression	Depression symptoms	Outpatient mental health, Primary care	Up to 16 sessions	Mental health practitioners with an advanced degree
Reminiscence Therapy	Major depression Depression symptoms	Depression symptoms, Hopelessness, Functional impairment, Life satisfaction	Long-term care, Retirement apartments, Senior community center	Usually 3 to16 sessions	Physical or mental health practitioner with an advanced degree
Cognitive Bibliotherapy	Major depression Minor depression Dysthymia Depression symptoms	Depression symptoms	Home	Discretion of older adults	Self-administered, with at least minimal contact from a mental health practitioner with experience providing cognitive therapy
Antidepressant Medications	Major depression Minor depression Dysthymia	Depression symptoms, Prevention of relapse and recurrence of depression	Home, Inpatient mental or physical health, Outpatient mental or physical health	Acute treatment typically lasts 12-16 weeks	Physical or mental health practitioner with prescribing authority

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(SAMHSA, 2011)

Table 1: Factors to Consider in Selecting an EBP. Does the intervention fit with the needs and capacities of your organization?

	Type of Depression Included in Studies	Outcomes Affected[1]	Service Delivery Settings	Timeframe	Practitioner Qualifications and Requirements
Multidisciplinary Geriatric Mental Health Outreach Programs[2]	PATCH: All types of depression	Depression symptoms, Psychiatric symptoms, Length of time living independently	Home / Senior public housing	Determined by treatment needs	Multiple practitioners involved, including: psychiatrist; nurse; case manager
	PEARLS: Minor depression Dysthymia	Depression symptoms, Functional and emotional well-being, Access to care	Home	Determined by treatment needs	Multiple practitioners involved, including: psychiatrist; primary care practitioner; social worker
Collaborative and Integrated Mental and Physical Health Care[3]	IMPACT: Major depression Dysthymia	Depression symptoms, Functional impairment, Quality of life, Access to care	Primary Care	Determined by treatment needs	Multiple practitioners involved, including: primary care practitioner, psychiatrist, depression care manager (e.g., nurse, social worker, psychologist)
	PROSPECT: Major depression Minor depression	Depression symptoms, Thoughts of suicide	Primary Care	Determined by treatment needs	Multiple practitioners involved, including: primary care practitioner, psychiatrist, depression care manager (e.g., nurse, social worker, psychologist)

1 The outcomes listed here have been identified in at least one randomized controlled trial. All studies show that these EBPs reduce the symptoms of depression in older adults.

2 This KIT describes two models of Multidisciplinary Geriatric Mental Health Outreach. These include: PATCH (Psychogeriatric Assessment and Treatment in City Housing) and PEARLS (Program to Encourage Active, Rewarding Lives for Seniors).

3 This KIT describes two models of collaborative and integrated mental and physical health care. These include: IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) and PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial).

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(SAMHSA, 2011)

- Click on or copy and paste the weblink below for more information
  - http://store.samhsa.gov/shin/content//SMA11-4631CD-DVD/SMA11-4631CD-DVD-Selecting.pdf

Additional Treatment Considerations

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- Technology-Based Applications (e.g. Telemedicine, Videoconferencing and Computer Assisted Therapy)
- Use of religion or spirituality in therapy (Stanley et al., 2007)
- Bright light therapy (Seasonal Affective Disorders)
- Sensory Stimulation Therapies (e.g. pet therapy, massage therapy) (Gellis et al., 2009)
- Hypericum or St. John's Wort and S-adenyl-L-methionine or SAM-e

(http://fuquacenter.org/TreatmentOptions)

Treatment Phases

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Acute Phase (resolve current episode)

- Duration: about 3 months
- Goal is complete recovery from signs and symptoms of acute episode

Continuation Phase (prevent a relapse)

- Duration: 4-6 months
- Goal is to prevent relapse as symptoms continue to decline and functionality improves

Maintenance Phase (prevent future recurrence)

- Duration: 3 months or longer
- Goal is to prevent recurrence of a new depressive episode

Podcast

Eve H. Byrd, MSN, MPH, APRN-BC

- Eve Byrd is a certified Family Nurse Practitioner and licensed Psychiatric Clinical Nurse Specialist. She is the Executive Director of the Fuqua Center for Late Life Depression in Atlanta, GA.
- Eve will talk about her experience
- Click on or copy and paste the weblink below to access the podcast:
  - https://gsu.sharestream.net/ssdcms/i.do?u=4fb8fd52d79545b

Final Thoughts

- Depression in older adults is treatable in up to 80% of cases.
- Combination treatment, medication and psychotherapy, is the most effective for treating depression and preventing relapse.

References

- Ell, K. (2006). Depression care for the elderly: Reducing barriers to evidence-based practice. *Home Health Care Services Quarterly*, *25*(1/2), 115-148.
- Substance Abuse and Mental Health Services Administration. (2011). *The treatment of depression in older adults: Selecting evidence-based practices for treatment of depression in older adults*. HHS Pub. No. SMA-11-4631. Retrieved from http://store.samhsa.gov/shin/content/SMA11-4631CD-DVD/SMA11-4631CD-DVD-Selecting.pdf
- Akincigil, A., Olfson, M., Siegel, M., Zurlo, K. A., Walkup, J. T., & Crystal, S. (2012). Racial and ethnic disparities in depression care in community-dwelling elderly in the United States. *American Journal of Public Health*, *102*(2), 319-328. doi: 10.2105/AJPH.2011.300349
- Russell, C.L., Conn, V. S., Jantarakupt, P. (2006). Older adult medication compliance: Integrated review of randomized controlled trials. *American Journal of Health Behaviors*. *30*(6), 636-650.
- Stanley, M. A., Bush, A. L., Camp, M. E., Jameson, J. P., Phillips, L. L., Barber, C. R.,... Cully, J. A. (2011). Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging & Mental Health*, *15*(3), 334-343. doi: 10.1080/13607863.2010.519326
- Gellis, Z. D., McClive-Reed, K. P., & Brown, E. L. (2009). Treatments for depression in older persons with dementia. *Annals of Long-Term Care*, *17*(2), 29-36.
- Katon, W., Lin, E., Russo, J., & Unutzer, J. (2003). Increased medical costs of a population-based sample of depressed elderly patients. *Archives of General Psychiatry*, *60*(9), 897-903.