Depression in Older Adults: Assessment, Programming & Resources

Neal C. Buddensiek, MD, CMD, HMDC, WCC

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Relevant Disclosures:

- I have nothing to disclose

Learning Objectives:

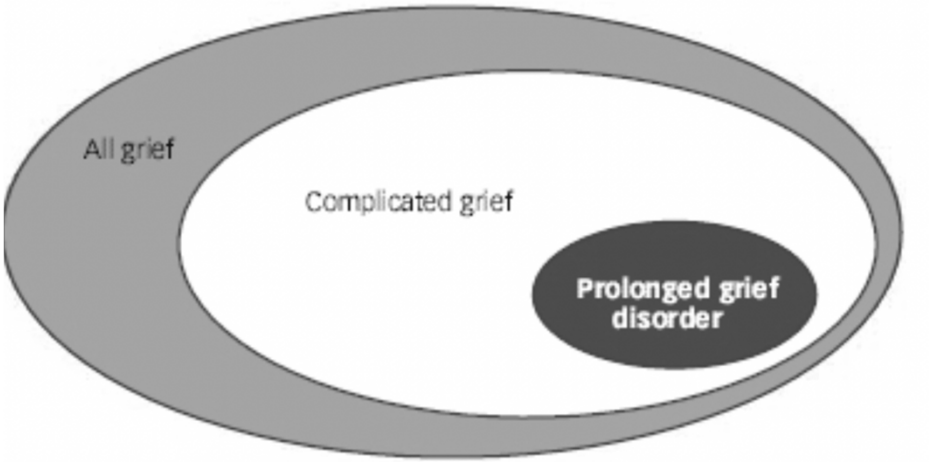
- Explain the importance of early detection for older adults living with depression
- Explain the importance of depression treatment
- Identify the preferred depression screening tool
- Explain the importance of educating older adults on depression
- Understand the critical need for a practical crisis (suicide) protocol

What Depression is (and is not)?

MAJOR DEPRESSIVE DISORDER

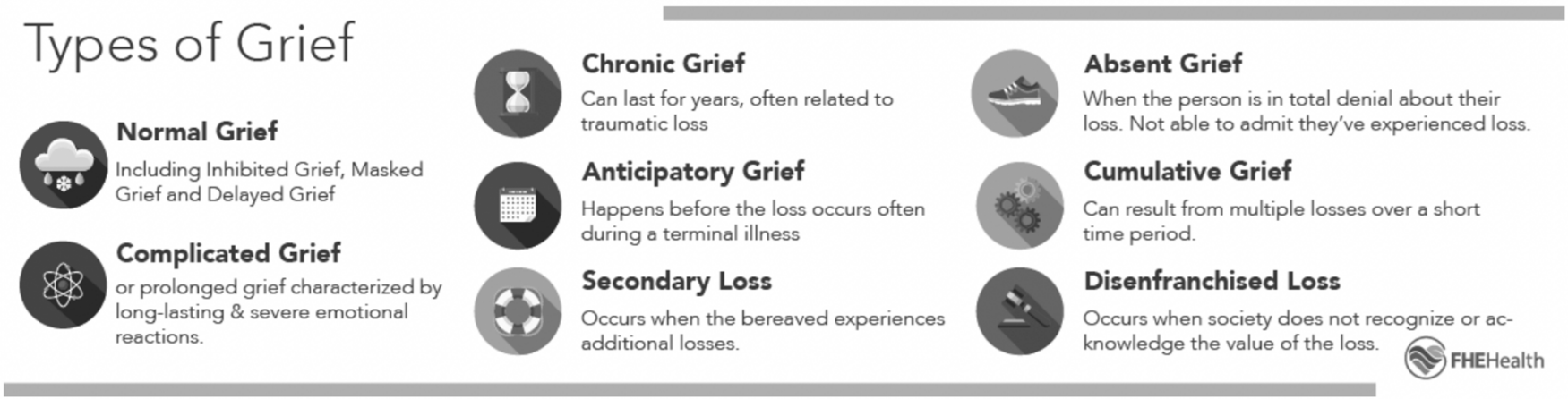
A mental illness that severely impairs a person's ability to function, characterized by the presence of depressed mood, feelings of worthlessness, guilt, or helplessness, reduced concentration, ability to think, sleep problems, loss of interest or pleasure in activities, and/or recurrent thoughts of suicide

Differences Between Sadness, Grief and Depression



- "Sadness" is a natural, healthy human *emotion*
- "Grief" is a normal *reaction* to a tremendous loss

Types of Grief and Grief Reactions



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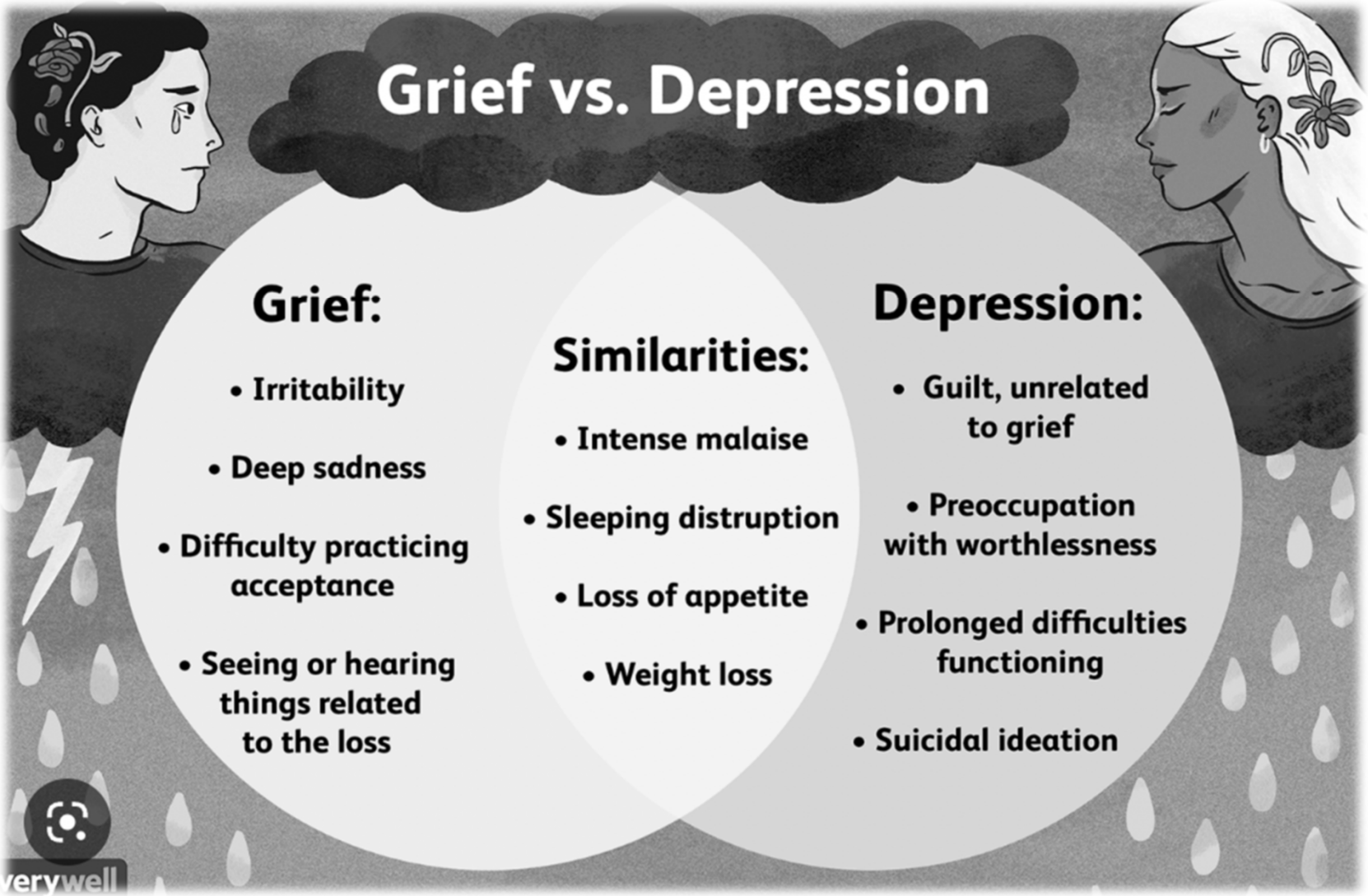
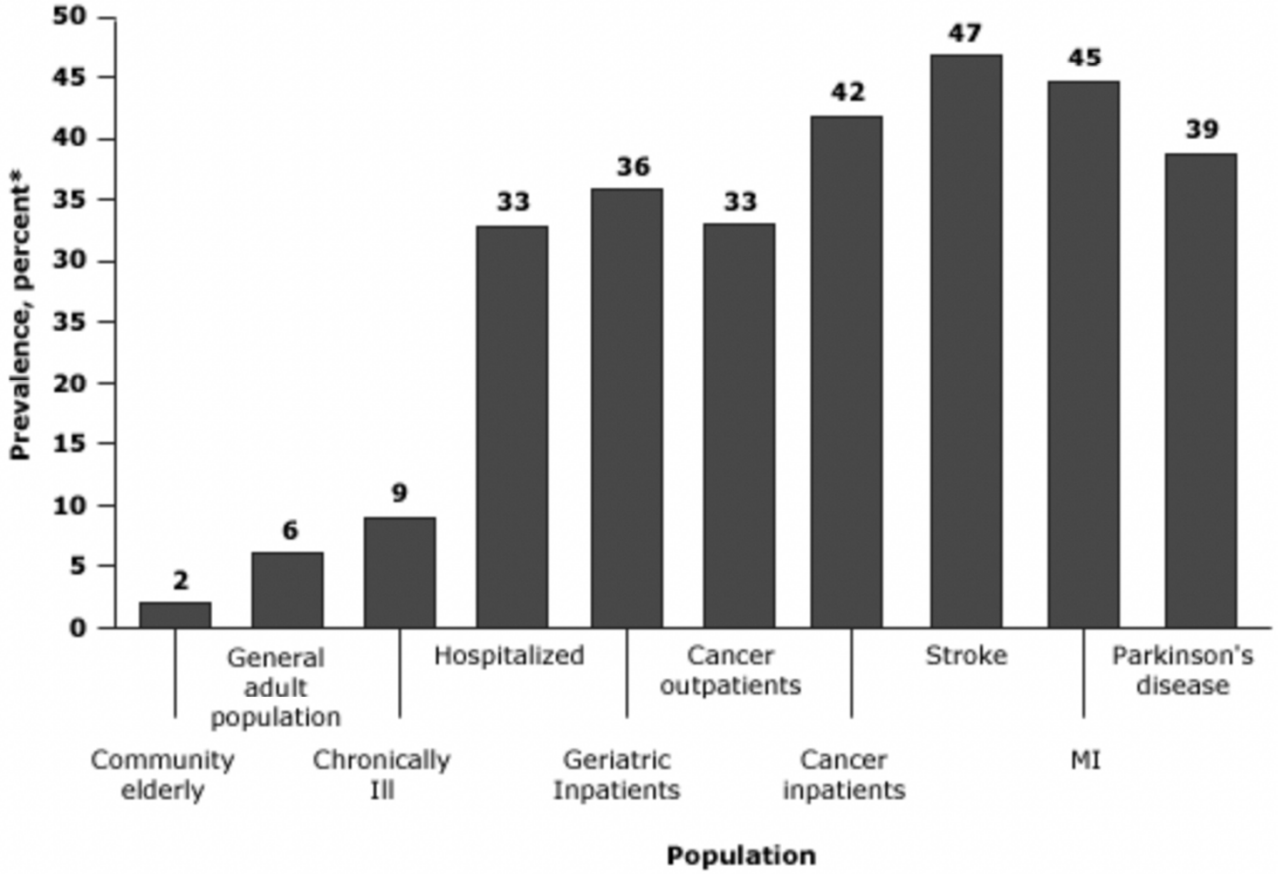


How Common is Depression in Older Adults

- Healthy independent community-dwelling older adults in the US have a lower prevalence rate of depression than the general adult population
- Approximately 2 - 10% *(cultural factors and variations in methods of assessment lead to significant variations in reported prevalence)*
- Higher rates for older adults with comorbid medical illness
- Adults >85 yrs old may be underestimated, yet may have increased prevalence of depressive symptoms (few epidemiologic studies exist)
- As many as 50% or more of nursing home residents are depressed

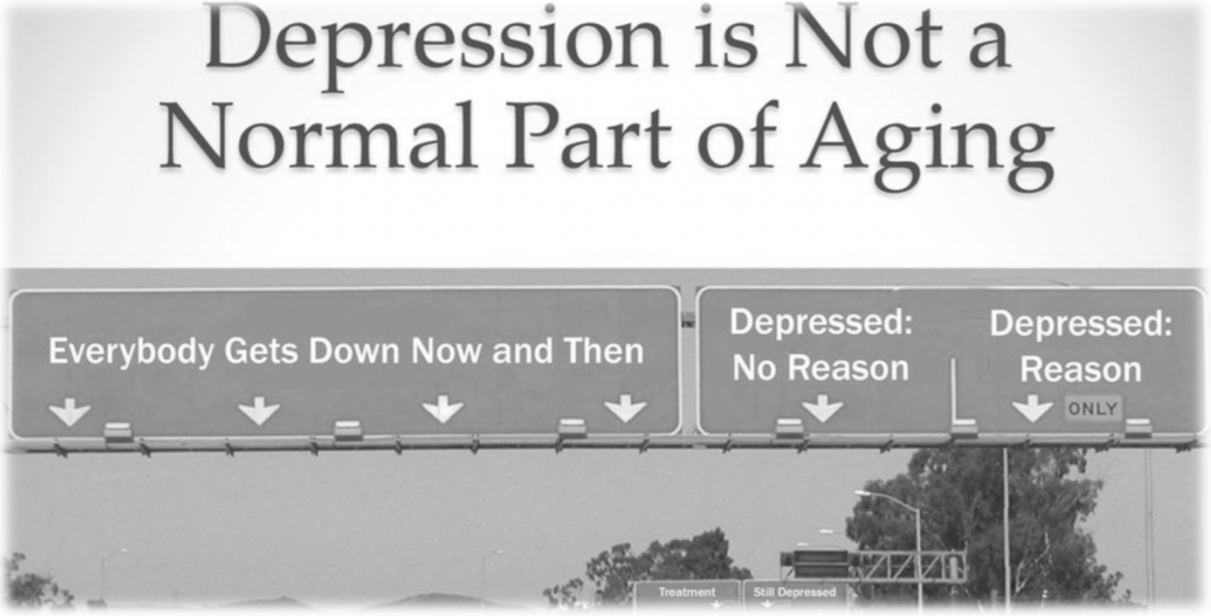
Prevalence of depressive disorders in various patient populations



* Prevalence range varies according to study.

Risk Factors for Depression

- Female
- Social isolation
- Widowed
- Divorced or separate marital status
- Lower socioeconomic status
- Comorbid medical conditions
- Uncontrolled pain
- Insomnia
- Functional impairment
- Cognitive impairment



The Importance of Early Detection of Depression

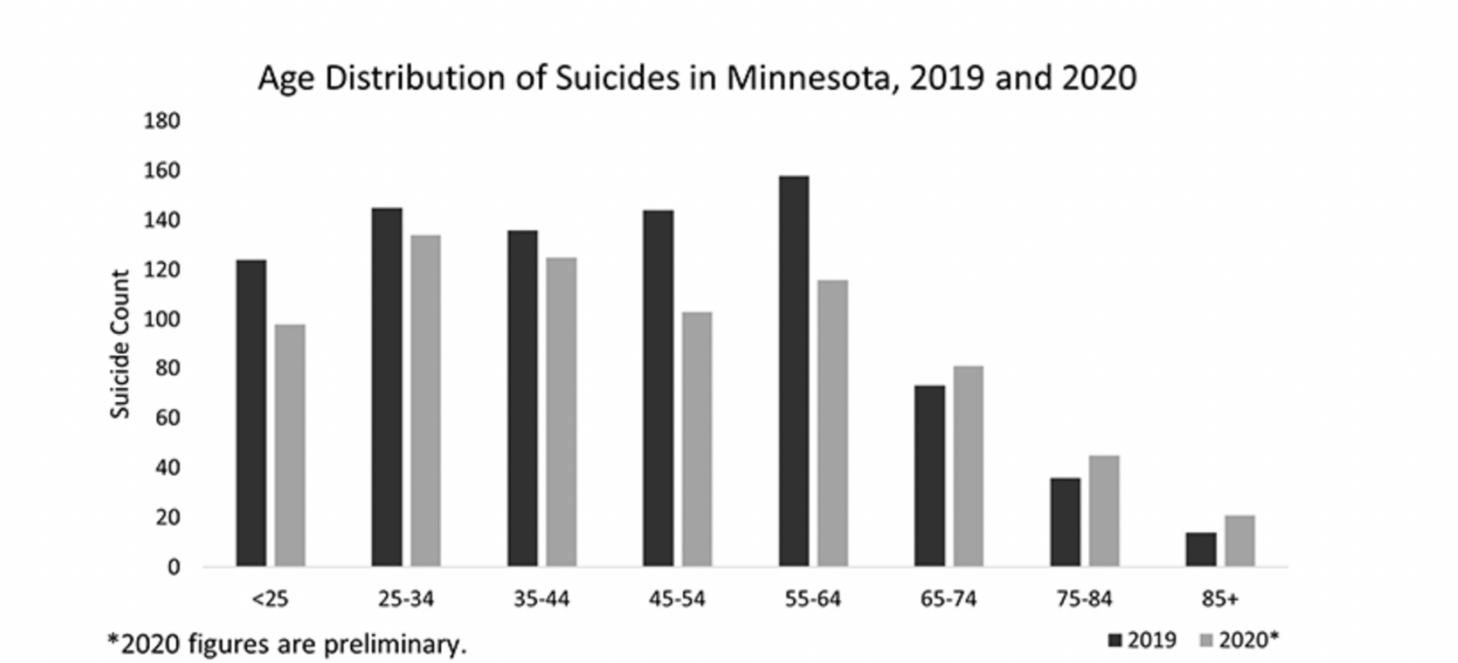
- Treatment CAN be EFFECTIVE!
  - Beneficial effects on health outcomes (such has chronic pain, diabetes, osteoarthritis)

- Left Untreated
  - Outcomes are worse compared to younger adults
  - Higher rates of morbidity (amplifies disability and lessens quality of life)
  - Higher rates of mortality (including suicide)
  - Increased drug use (alcohol and illicit drugs)
  - Increased healthcare utilization (office and ED visits)
  - Increased economic costs

Depression and Risk of Suicide

- Older adults account for approximately 13% of population of US, but nearly 24% of all completed suicides.
- Older adults attempt suicide less often than younger people, but are more successful at completion.
- Older adult men have the highest suicide rate. White men age 85 or older have the highest rate of completed suicide. Most older adults dying by suicide were in their first episode of depression and had seen a physician within the last month of life.
- Acute Risk for Suicide: hopelessness, insomnia, agitation/restlessness, impaired concentration, active psychosis, active alcohol use or intoxication, untreated pain, terminal illness/worsening illness, widowhood/social isolation, personality disorders, prior suicide attempt, family history of suicide

Depression and Risk of Suicide in MN vs Nationally



- Men – tied for 37th in US (22.7%)
- Women – tied for 35th in US (5.6%)
- Overall (65+ years) – tied for 43rd in US (13.5%)

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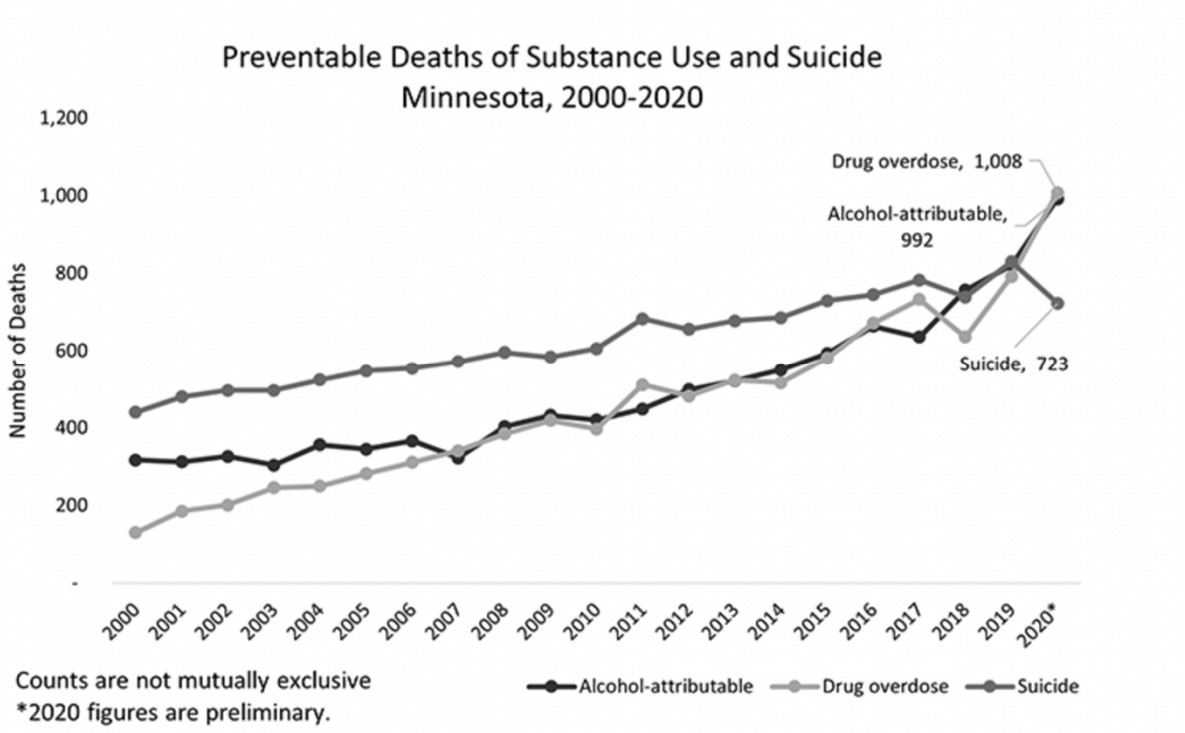

Comparative look (2011 – 2021, US):

- 65+ years: 15.3% → 17.3%
- 85+ years: 16.9% → 22.4%
- 11th leading cause of death

Statistics in Older Adult Depression

- Remains underdiagnosed and inadequately treated or even untreated.
- Older men, especially older AA and Hispanic Americans are at even greater risk of unrecognized depression.
- Over 80% of mental health treatment for depressed older adults is delivered in the primary care setting.
- Depression onset in post-MI patients was associated with fourfold increase in death
- Depression onset after a stroke were 3.4 times more likely to have died over 20-year follow-up period.
- Decrease in overall risk of death at five years, attributed to fewer cancer deaths, was seen in patients age 60 and older with major depression who were randomly assigned to an intervention to improve depression treatment (involving a care manager), compared to patients assigned to a control group (receiving usual care).

Statistics in Older Adult Depression

- The risk of all-cause dementia was greater in subjects with late–life depression than nondepressed controls (risk ratio 1.9). Specifically late life depression was associated with an increased risk of Alzheimers disease and vascular dementia. The elevated risk for all-cause dementia persisted in analyses that included only studies that adjusted for potential confounders (risk ratio 1.6) – 49,000 subjects who did not have dementia at baseline were followed for a median of five years (community-based, observational studies)

- The risk of all-cause dementia was increased 70% in subjects who had late life depressive symptoms. Specifically, depression was associated with an increased risk of Alzheimers disease and vascular dementia - >13,500 individuals who did not have dementia at baseline were followed over a six-year period (retrospective study of medical records)

- What's going on here? Late life depression may reflect a prodromal stage of dementia or may act as an independent risk factor for dementia. Additionally, dementia may give rise to episodes of depression.

- Dementia syndrome of depression (previously termed "pseudodementia"): Antidepressant treatment can resolve the cognitive and mood symptoms in these patients

- Symptoms of Depression
  - Depressed mood most of the time
  - Loss of interest or pleasure in activities
  - Disturbed sleep – too much or too little
  - Change in weight/appetite
  - Fatigue/Lack of energy
  - Feelings of worthlessness or extreme guilt
  - Difficulty concentrating
  - Thoughts of death or suicide
- Minor Depression
  - Two to four symptoms for at least two weeks but not more than two years
- Major Depression
  - Five or more symptoms nearly every day for at least two weeks

DSM-5 diagnostic criteria for a major depressive episode

A. 5 (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least 1 of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
NOTE: Do not include symptoms that are clearly attributable to another medical condition.
1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad, empty, hopeless) or observations made by others (eg, appears tearful). (NOTE: In children and adolescents, can be irritable mood.)
2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3) Significant weight loss when not dieting or weight gain (eg, a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (NOTE: In children, consider failure to make expected weight gain.)
4) Insomnia or hypersomnia nearly every day.
5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6) Fatigue or loss of energy nearly every day.
7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by their subjective account or as observed by others).
9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the direct physiological effects of a substance or to another medical condition.
NOTE: Criteria A through C represent a major depressive episode.
NOTE: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgement based on the individual's history and the cultural norms for the expression of distress in the context of loss.
D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
E. There has never been a manic or hypomanic episode.

Challenges in Diagnosing Depression in Older Adults

- Concurrent medical illness with overlapping symptoms of depression
- Medication side effects overlapping depression symptoms
- Impaired communication skills in older adults
- Presentation with multiple somatic complaints
- Lack of time in the clinical exam to evaluate psychological problems in patients with complex medical issues
- Therapeutic nihilism regarding depression on the part of the patient, family or provider
- Patient reluctance to acknowledge psychological distress due to perceived stigma of mental illness
- A few helpful clues when depression should be considered
    - Mood or somatic symptoms out of proportion to what is expected
    - Poor response to standard medical treatment
    - Poor motivation to participate in treatment
    - Lack of engagement with care providers

Preferred Depression Screening Tool

- Screening tools should not be the sole basis for diagnosing depression
- Sensitivity should be maximized when choosing a screening tool for depression so that cases are not missed
- When screening positive, a clinical diagnostic interview is necessary to determine if criteria for major depression are met

Screening instruments for late-life depression for use in primary care

	Sensitivity percent	Specificity percent	Inpatient	Outpatient	Physically ill	Cognitively impaired
Two-question screen	97	67	Unknown	Yes	Unknown	No
Geriatric Depression Scale (5-item)	94	81	Yes	Yes	Yes	Unknown
Patient Health Questionnaire-9 (9-item)	88	88	Unknown	Yes	Yes	Unknown
Cornell Scale for Depression in Dementia (19-item)	90	75	Yes	Yes	Unknown	Yes
Center for Epidemiologic Studies - Depression Scale (20-item)	93	73	No	Yes	Unknown	No

Patient Health Questionnaire 2 (PHQ-2) evaluated in US sample of over 8000 noninstitutionalized adults (age 65+) and was found to have sensitivity 100% and sensitivity 77%!!

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

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

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

Patient Health Questionnaire - 2 (PHQ-2)

Patient Health Questionnaire - 9 (PHQ-9)

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Depression Treatment

- Physical Movement/Exercise: 30-minutes per day, most days of the week
- Proper nutrition: vary diet with lean meats, fish, fruits, vegetables and whole grains
- Avoid alcohol and illicit drugs
- Minimize (avoidable) stressors
- Family & social support

- Pharmacotherapy (SSRIs are first-line)
- Psychotherapy (Cognitive-behavioral therapy (CBT), interpersonal psychotherapy, and problem-solving therapy (PEARLS approach) – delivered over a period to 2-4 months can be effective for older adults.
- Electroconvulsive therapy (severe and life-threatening, refractory/intolerant to medication(s), does cause transient memory loss)

Problem Solving Therapy

• A 12-week trial compared problem-solving therapy with supportive therapy in 221 nondemented patients with major depression and executive dysfunction (difficulty with goal setting and planning, and with initiating and sequencing behavior). Executive dysfunction is associated with poor response to antidepressants. Remission of depression occurred in more patients who received problem-solving therapy compared with controls (46 versus 28 percent). In addition, improvement of disability (self-care, communicating, and psychosocial functioning) was greater with problem- solving therapy, and the advantage was retained at the 24-week follow-up after the end of treatment.

• Another 12-week trial compared problem-solving therapy with supportive therapy in 74 patients with major depression and cognitive impairment ranging from mild deficits to moderate dementia. Both interventions were administered weekly in the home. Remission of depression was greater with problem-solving therapy than supportive therapy (38 versus 14 percent). In addition, reduction of disability was greater with problem-solving therapy.

Importance of Educating Older Adults on Depression

HEALTH & MEDICAL NEWS, PSYCHOLOGICAL NEWS

Most older adults won't seek help for depression, many think they'll 'snap out of it'

NOVEMBER 16, 2020

by Chris Melore

SALT LAKE CITY, Utah — Depression can be a difficult subject to talk about, even when people aren't isolated by the coronavirus pandemic. For older generations, mental health concerns are often not viewed the same way as other illnesses. A new survey finds more than six in 10 American seniors who are concerned they're suffering from depression won't seek treatment. One third of this group believe they'll "snap out" of their mental health issues on their own.

The nationwide poll, which is part of the GeneSight Mental Health Monitor, reveals 61 percent of Americans who think they have depression won't get help because the "issues aren't that bad." Nearly four in 10 people (39%) think they'll manage without a doctor's care.

Importance of Educating Older Adults on Depression

- Once your depression is properly treated, you can regain your quality of life and even cognitive abilities you might have lost
- Seeking treatment is not a sign of weakness or failure
- Understand that depression is not a choice
- Depression is not something that you can control
- Just like you treat diabetes and hypertension, depression requires intervention

Importance of Educating Older Adults on Depression

- It’s ok to not be ok (normalize this)
- Important to let your family, friends and health-care provider know right away if your experiencing depression symptoms
- If you’re having thoughts about suicide or harming yourself, contact a trusted friend, family member or health-care provider immediately
- You’re not alone; help is available!

Importance of Educating Older Adults on Depression

- Be patient and understanding
  - Just being "present" for someone struggling with depression may provide needed support
- Destigmatize depression
  - Educate to combat the stereotype that depression & seeking help for it is a sign of weakness
- Advocate for treatment
  - Encourage adherence to treatment regimes and offer to help

Importance of Having a Crisis (Suicide) Protocol

- Response in an organized, timely, and compassionate way
- Minimize uncertainty and fear
- Ideally, crisis (suicide) protocol should cover these key components:
  - Responding to the acutely distressed or suicidal older adult
  - Establishing an emergency contact notification procedure (988)
  - Addressing issues around voluntary and involuntary psychiatric hospitalization
  - Documenting encounters with the acutely distressed or suicidal older adult
  - Developing post-crisis follow-up plans

988 SUICIDE & CRISIS LIFELINE

Veterans Crisis Line
1-800-273-8255 PRESS 1

Importance of Having a Crisis (Suicide) Protocol

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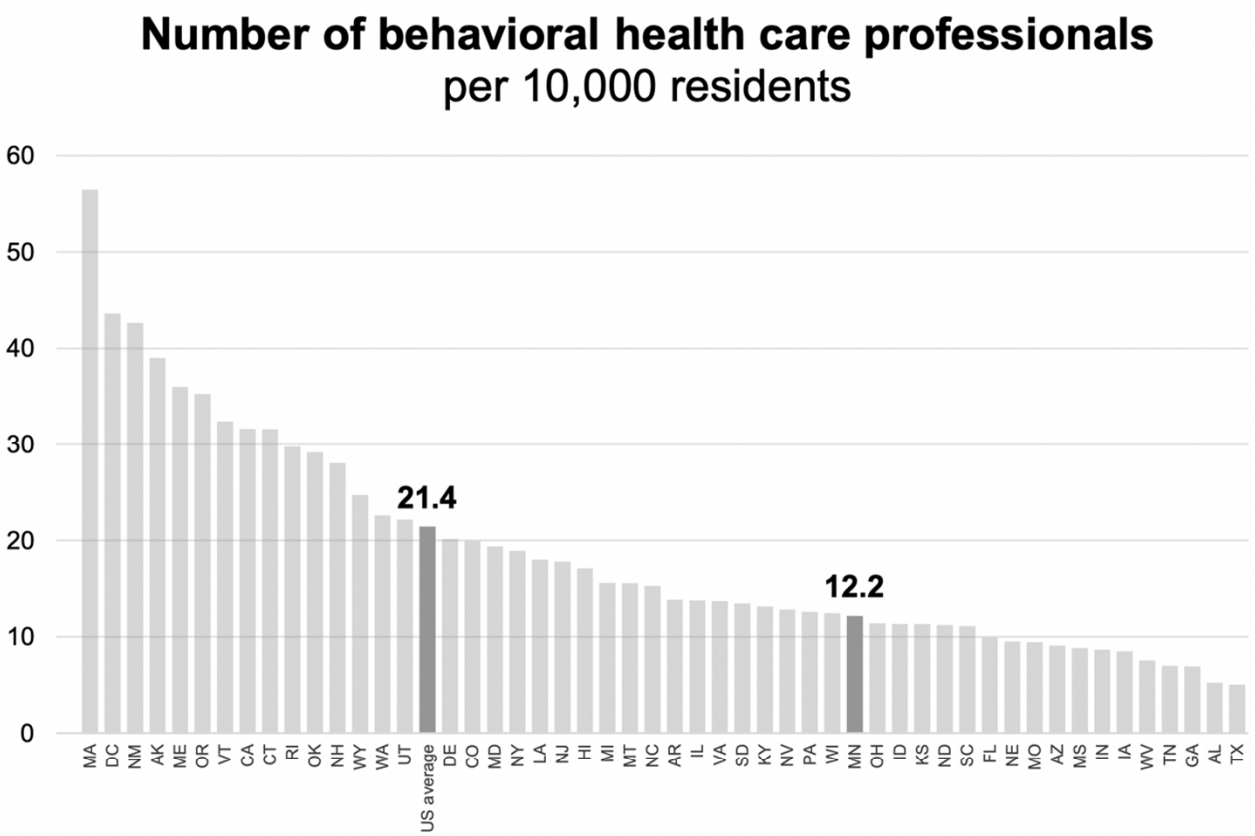
Present Challenges



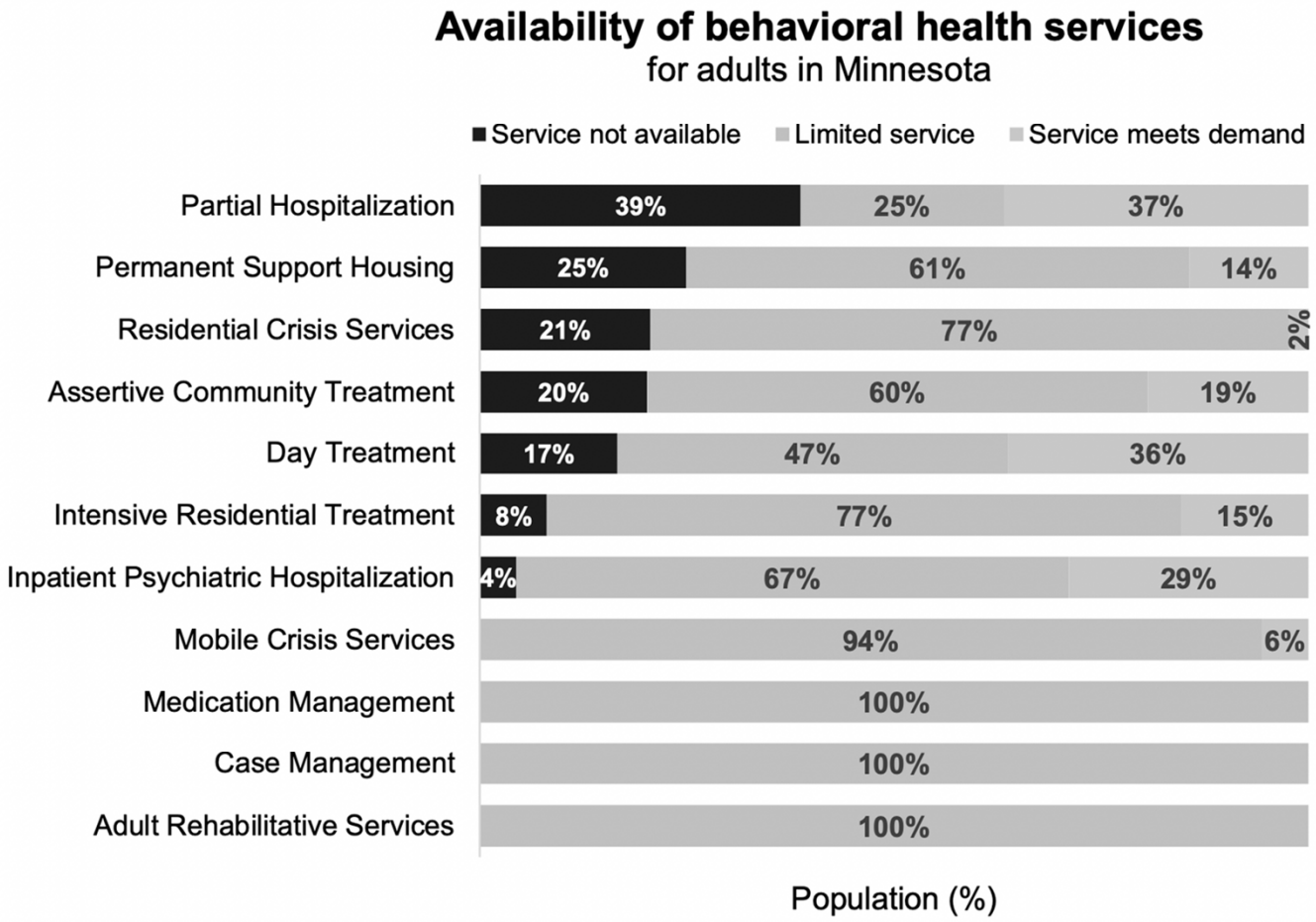
Source: County Health Rankings & Roadmaps, by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

There are approximately 12 behavioral health care professionals for every 10,000 residents in Minnesota, which is much lower than the average in the U.S.

Note that the U.S. average does not represent the optimal number of behavioral health care professionals.

***Behavioral health care professionals include**: psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in behavioral health care*

Present Challenges



A large part of the Minnesota population lives in areas where access to important behavioral health services is limited, and in parts of the state some services are not available at all.

Source: Mental & Behavioral Health Options & Opportunities for Minnesota, MN Hospital Association (2015)

Resources

- National Alliance on Mental Illness MN (NAMI MN) - https://www.namimn.org
- Mental Health MN - https://mentalhealthmn.org
- Suicide Awareness Voices of Education (SAVE) - https://save.org
- MN Department of Health & Human Services - https://mn.gov/dhs/mental-health/
- National Institute on Mental Health - https://www.nimh.nih.gov/health/topics/depression
- UpToDate, *Diagnosis and management of late-life unipolar depression*
- *Prevalence and determinants of depression among old age: A systematic review and meta-analysis. 2021.* *https://annals-general-psychiatry.biomedcentral.com/articles/10.1186/s12991-021-00375-x*
- Long-Term Care Medicine: A Pocket Guide, 2011.
- Essential Practices in Hospice and Palliative Medicine: Psychiatric, Psychological and Spiritual Care, 5th Ed.