Effective Approaches to Depression and Suicide Risk in Older Adults: Integrated Medical and Mental Health Care

Stephen Bartels, MD, MS
Director, Centers for Health and Aging
Dartmouth Medical School

Medical Director
New Hampshire Bureau of Elderly and Adult Services

Overview

– Prevalence and Impact of Depression in Older Adults
– Evidence-based Practices (EBPs) for Older Adults with Depression
– Implementing Evidence-based Depression Care for Older Adults
– Technical Assistance Materials for EBP Implementation
What We all Know Is Coming

• 13 percent of U.S. population age 65+; expected to increase up to 20 percent by 2030

• 83 million ‘Baby Boomers’ (born from 1946-1964) in U.S. Census 2000
  – Second wave ‘Baby Boomers’ (now aged 35-44) contains 45 million

What You May Not Know:
Estimated Projected Prevalence of Major Psychiatric Disorders by Age Group

Jeste, Alexopoulos, Bartels, et al., 1999
## Prevalence of Depression and Other Disorders in Primary Care

<table>
<thead>
<tr>
<th>Study</th>
<th>Major Depression</th>
<th>All Depression</th>
<th>All Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoeper et al.</td>
<td>5.8%</td>
<td>19.9%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Schulberg et al.</td>
<td>----</td>
<td>9.2%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Von Korff et al.</td>
<td>5.0%</td>
<td>8.7%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Barrett et al.</td>
<td>0.4%</td>
<td>10.0%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Coyne et al.</td>
<td>13.5%</td>
<td>22.0%</td>
<td>----</td>
</tr>
<tr>
<td>ECA (highest)</td>
<td>3.5% (6mo)</td>
<td>6.5% (6mo)</td>
<td>8.8% (2wk)</td>
</tr>
</tbody>
</table>

## Prevalence of Late-Life Depression

- Clinically significant depressive symptoms
  - 15% community
  - 25% primary care
  - 25% medical inpatients
  - 40% nursing home

- Major depressive disorder
  - 1-3% community
  - 10% primary care
  - 15% medical inpatients
  - 15% nursing home
Risk Factors for Late Life Depression

- Medical Illness
- Self-report of poor health and disability
- Pain; Use of pain medication
- Cognitive Impairment
- Medications; Substance Abuse
- Prior Depressive Episode
- Financial difficulties
- Bereavement
- Isolation; dissatisfaction with social network
- Physiological changes associated with aging

Depression Associated with Worse Health Outcomes

- Worse outcomes
  - Hip fractures
  - Myocardial infarction
  - Cancer (Mossey 1990; Penninx et al. 2001; Evans 1999)

- Increased mortality rates
  - Myocardial Infarction (Frasure-Smith 1993, 1995)
Impact: Depression and Mortality in Older Women Following Hip Fracture

Osteoporotic Fractures Research Group, 1998

Number of Depressive Symptoms 7-Year Follow Up

N=7518

Impact: Depression Following Heart Attack and Mortality

Frasure-Smith, Lespérance. 1996.
Depression in Cancer

- Increased Hospitalization
- Poorer physical function
- Poorer quality life
- Worse pain control

(Evans 1999)

Depression in Older Adults and Health Care Costs

Unutzer, et al., 1997; JAMA
Suicide in the US

U.S. SUICIDE RATES BY AGE, GENDER, AND RACIAL GROUP

2002

Source: National Institute of Mental Health
Data: Centers for Disease Control and Prevention, National Center for Health Statistics

Suicide risk factors

- Depression, Hopelessness
- Serious medical illness
- Living alone
- Recent bereavement, divorce, or separation,
- Unemployment or retirement
- Substance abuse (alcohol and medication misuse)
Suicide in Older Adults

- 65+: highest suicide rate of any age group
- 85+: 2X the national average (CDC 1999)
- Men>Women; Whites>African Americans
- Peak suicide rates:
  - Suicide rate goes up continuously for men
  - Peaks at midlife for women, then declines
- 20% older men saw PCP on day of suicide
- 40% older men saw PCP on week of suicide
- 70% older men saw PCP on month of suicide

Primary Care Elderly with Depression, Anxiety, or At-risk Alcohol Use

- 27.5% Report Death Ideation
- 10.5% Report Active Suicidal Ideation
- Greatest Suicidal Ideation: Depression with Anxiety (18%), Poor Social Support
- Suicidal Ideation NOT associated with increased visits to the PCP

Bartels et al., Am J. Geriatric Psychiatry 2002, 10:417-427
Poor Quality of Care for Older Persons with Depression

- Increased risk for inappropriate medication treatment
  (Bartels, et al., 1997, 2002)
- 1 in 5 older persons given an inappropriate prescription
  (Zhan, 2001)
- Less likely to be treated with psychotherapy
  (Bartels, et al., 1997)

We Are Failing to Provide Effective Treatments and Services to Those in Need

- **System Barriers:** Fragmentation: A Need for Integrated Mental Health Services in Primary and Long-term Care
- **Training Barriers:** The Limits of Traditional Educational Approaches in Changing Provider Behavior and Ageism
- **Financial Barriers:** Including a Mismatch Between Covered Services and a Changing System of Long-term and Community-based Care
- **Consumer Barriers:** Stigma and education
Setting Priorities for Older Adults

Improving Access:
- Integration of Mental Health and General Health Care
- Home and Community-based Services

Improving Quality:
- Evidence-based Practice Implementation
- Trained Healthcare Workforce with Expertise in Geriatrics

“We Know Treatment Works”
Evidence-based Practices

- Integrated service delivery in primary care
- Mental health outreach services
- Mental health consultation and treatment teams in long-term care
- Family/caregiver support interventions
- Psychological and pharmacological treatments

Bartels et al., 2002, 2003, 2005
Integrated Mental Health Services in Primary Care

The Vast Majority of Mental Health Services Provided to Older Persons are in Primary Care

The Question:

What is the Most Effective Way to Organize and Deliver Mental Health Services to Older Persons in Primary Care Settings?
Three RCT Studies of Integrated mental health in primary care

- PRISMe (SAMHSA-VA)
- PROSPECT (NIMH)
- IMPACT (Hartford Foundation)
**PRISMe Study:**
*Primary Care Research in Substance Abuse and Mental Health for the Elderly*

**RCT Comparing:**
- Integrated/Collaborative Care
  - Co-Located, Concurrent, Collaborative
- Enhanced Referral to Specialty Mental Health and Substance Abuse Clinics
  - Preferred Providers and Facilitated appointments, transportation, payment

**Sample Characteristics (n=2022)**

- Mean Age: 73.5 ± 6.2
- 26% Female

**Diagnoses**
- Depression 70%
- At-Risk Drinking 20%
- Anxiety 3%
- Dual Disorders 7%

**Ethnicity**
- Caucasian 52%
- Black 25%
- Hispanic 6%
- Asian 8%
- Other 9%
Rates of Engagement in MHSA Care: By Diagnosis/Condition

Physical Proximity between Primary Care Clinic and MH/SA Clinic

*Rates of engagement are significantly different across all four practice arrangements for the total sample ($\chi^2(3)=103.15$, $p<.001$) and across the three referral practice arrangements ($\chi^2(2)=7.76$, $p=.02$).

Rates of Engagement in MHSA Care: By Level of Suicidal Ideation

The IMPACT Treatment Model

- Collaborative care model includes:
  - Care manager: Depression Clinical Specialist
    - Patient education
    - Symptom and Side effect tracking
    - Brief, structured psychotherapy: PST-PC
  - Consultation / weekly supervision meetings with
    - Primary care physician
    - Team psychiatrist
  - Stepped protocol in primary care using antidepressant medications and/or 6-8 sessions of psychotherapy (PST-PC)
Substantial Improvement in Depression
(≥50% Drop on SCL-20 Depression Score from Baseline)

Response (≥50% drop on SCL-20 depression score from baseline)


Collaborative Management of Late-Life Depression in Primary Care

Mean SCL-20 Depression Score


IMPACT Study: Unutzer, et al., 2002 - JAMA
Integrated Care is More Cost Effective Than Usual Care

IMPACT participants had lower mean total healthcare costs $29,422 compared to usual care patients $32,785 over 4 years.

Impact Model Implementation Resources

http://impact-uw.org/
PROSPECT Study
Prevention of Suicide in Primary Care Elderly Collaborative Trial

- USUAL CARE vs. INTERVENTION:
- Clinical Algorithm for Geriatric Depression Consisting of Citalopram or IPT (based on patient preference)
- Depression Care Manager: Social Workers, Nurses, Psychologists in Primary Care: Depression recognition, guideline based treatment, monitoring of response to treatment, follow-up

PROSPECT
Improvement in Depression
(≥50% Drop on HDRS Depression Score from Baseline)

Response (≥50% drop on SCL-20 depression score from baseline)

Bruce et al, *JAMA*, 2004;291:1081-1091
The Key to Successful Rx: FOLLOW UP!

A Key Recommendation of the President’s Commission:

Integrated, Collaborative Mental Health Services in Primary Care
Effectiveness of Community-Based Mental Health Outreach Services for Older Adults

Combined Case Identification and Treatment

- Psychogeriatric Assessment and Treatment in City Housing (PATCH) program.
  - Serving Older Persons in Baltimore Public Housing

- 3 elements
  - Train indigenous building workers (i.e., managers, janitors,) to identify those at risk
  - Identification and referral to a psychiatric nurse
  - Psychiatric evaluation/treatment in the residents home

- Effective in reducing psychiatric symptoms
  - Rabins, et al., 2000
Geriatric Mental Health Outreach

% Recovered from Depression*

* Greater than 50% reduction in symptoms or meeting syndromal criteria

Prevention Research Centers

PEARLS Gives Seniors with Minor Depression New Hope

January 2007

Skip to personal stories:
Barbara Myerson: "I would always leave our meetings with a feeling of hope."
Chuck Lazenby: "I never used to laugh like this."

It's easy to open up to Carl Kaiser, with his calm nature and understanding smile, and many people do. As a counselor in Seattle's Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), Kaiser visits the elderly every day, listens to their problems, and helps them figure out solutions. Kaiser estimates he has helped more than 50 seniors overcome minor depression since 2004.
New Hampshire REAP Program

Resident Education & Assistance

- Up to 1.5 Million older adults live in Senior housing (214 settings in NH; 10,000 residents; all low income)
- Residents in these settings can be easily identified & reached
- Brief interventions exist which may help
- Community resources (CMHCs- REAP) can be efficiently focused
- Likely their last stop before institutional care;
- All will need public health and residential assistance

New Hampshire’s REAP Program

- The only preventive program addressing both mental health and substance abuse in older adults
- Blended Funding from NH Housing, NH Bureau of Drug and Alcohol Services, BEAS, BBH, and in-kind CMHC services
- FY 2008: Over 2,100 served including counseling (n=603), educational sessions (n=963), technical assistance to professionals (n=522)
Integrated Depression Treatment in Home Health Care

• Upper Valley VNA one of six sites for a national NIH funded study training home health care agencies to identify and coordinate treatment of depression in older adults

• Screening, case identification, treatment, and referral

Depression in Home Health Care Cornell Study
Recent Federal Technical Assistance Initiatives

• SAMHSA’s Older Americans Substance Abuse and Mental Health Technical Assistance Center

• SAMHSA’s Implementation Resource Kits for Depression in Older Adults

Overview of Substance Abuse & Mental Health Problems in Older Adults

Review of Prevention EBPs for Older Adults

Evidence-Based Practices for Preventing Substance Abuse and Mental Health Problems in Older Adults


Screening and Assessment

- Geriatric Depression Scale: GDS
- Short Zung Scale Interview-Assisted Depression Scale
- Patient Health Questionnaire-9: PHQ-9
  - Practical depression screening instrument in primary care settings
  - Can identify different categories of depressive symptoms, including sub-threshold depression, minor depression, and major depression.
Geriatric Depression Scale

Source: Yesavage, 1983

Score < 4 suggests the patient may not need depression treatment.

Score > 5 - 14 Physician uses clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.

Score > 15 Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.
## Paykel Suicide Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has there been a time in the past month when you felt life was not worth living?</td>
<td></td>
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<tr>
<td>2. Has there been a time in the past month that you wished you were dead, for instance that you would go to sleep and not wake up?</td>
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</tr>
<tr>
<td>3. Has there been a time in the past month that you thought of taking your own life, even if you would not really do it?</td>
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</tr>
<tr>
<td>4. Has there been a time in the past month when you reached the point where you seriously considered taking your own life, or perhaps made plans how you would go about doing it?</td>
<td></td>
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<tr>
<td>5. Have you ever made an attempt on your own life?</td>
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</tr>
</tbody>
</table>

**Total checked:**

Total Score > 2. OR

- Yes to item 5 plus any other item. OR
- Any endorsement of item 4

Moderate to high risk

Source: Paykel et al, 1974

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**Online Resources**

United States Department of Health and Human Services

Substance Abuse & Mental Health Services Administration

*A Life in the Community For Everyone*

SAMHSA

[Home] [About Us] [Grants] [Statistics] [Programs] [Newsroom] [Search] [FAQs] [Contact Us]

**Technical Assistance**

Older Americans Substance Abuse and Mental Health Technical Assistance Center

**Older Americans**

Substance Abuse & Mental Health Technical Assistance Center

**Mission Statement:**

The mission of the Older Americans Substance Abuse and Mental Health Technical Assistance Center is to enhance the quality of life and promote the physical and mental well-being of older Americans through the provision of technical assistance by reducing the risk for and incidence of substance abuse and mental health issues later in life. Through partnerships with state and federal agencies and community health care providers, the Center will serve as a national repository to disseminate information, training, and direct assistance in the prevention and early intervention of substance abuse and mental health problems. Priorities for the Center include prevention and early intervention of:

- Substance abuse
- Medication misuse and abuse
- Mental health disorders, and
- Co-occurring disorders

[Mission Statement [PDF]](https://www.samhsa.gov/OlderAdultsTAC/)

[www.samhsa.gov/OlderAdultsTAC/](https://www.samhsa.gov/OlderAdultsTAC/)
EBP Implementation Guide

A Guide for Implementing Evidence-Based Practices to Prevent Substance Abuse and Mental Health Problems among Older Adults


Available soon at: http://www.samhsa.gov/OlderAdultsTAC/
## Treatment of Depression in Older Adults - KIT at a Glance

**Depression and Older Adults: Key Issues**
- Demographic trends
- Definitions and risk factors for depression
- Prevalence of Depression
- Incidence and cost of depression
- Why implementation of EBPs is important

**Selecting EBPs for Treatment of Depression in Older Adults**
- What are the EBPs?
- Factors to consider in decision-making
- Selecting EBPs for treating depression in older adults
- Information about how to select EBPs: tools and guides

**EBP Implementation Guides**
- Key issues for all stakeholders: depression in older adults
- How to access treatment
- How to make informed choices
- How to work with practitioners
- Resources for older adults and their families

**Practitioner’s Guide for Working with Older Adults with Depression**
- Why you should care about EBPs
- Skills for working with older adults
- Symptoms, assessment, and diagnosing depression
- Selecting treatment
- Delivering evidence-based care
- Evaluating care
- Implementing EBPs

**Evidence-Based Practices (EBPs)**
- Psychotherapy interventions
- Antidepressant Medications
- Multidisciplinary Geriatric Mental Health Outreach Services
- Collaborative and Integrated Mental and Physical Health Care

### Evaluating Your Program
- for practitioners, administrators, and members of the EBP quality assurance team

### Resources and Evidence
- for all stakeholders

## Selecting EBPs for Treatment of Depression in Older Adults

### What’s in Selecting EBPs

- What are Evidence-Based Practices (EBPs) for Depression in Older Adults? 2
- Deciding to move forward with EBP Implementation 5
- Factors to Consider in Selecting an EBP 7
- Specific EBPs for Older Adults with Depression 17
- Psychotherapy Interventions 19
- Antidepressant Medications 43
- Multidisciplinary Geriatric Mental Health Outreach Services 51
- Collaborative and Integrated Mental and Physical Health Care 73
Summary

- Impact of Depression on the Health and Longevity of Older Adults
- Increased Risk of Suicide with Aging
- Primary Care and other Health Care Settings as a Critical Target for Prevention
- Evidenced Based Integrated Models of Medical and Mental Health Care
- Resources and Toolkits for Implementation
Northern New England Geriatric Education Center

www.nnegec.org