Depression and Older Adults: Key Issues is an overview of important information that you should know about depression in older adults. Depression is one of the most common mental health problems in older adults. It negatively affects functioning, health outcomes, quality of life, and health care costs.

This booklet provides you with important information about depression in older adults, including demographic trends, definitions and risk factors for depression, prevalence of depression, and the impact and cost of depression. It also provides you with a brief summary stating why implementation of evidence-based practices (EBPs) is important. This booklet is relevant to the following:

- Older adults and their families or caregivers;
- Practitioners who care for older adults with depression;
- Agency administrators and program leaders; and
- Mental health, aging, and general medical health authorities.
The Older Adult Population is Growing

Adults aged 65 and older currently make up more than 12 percent of the American population, but will grow to one-fifth of the American population by 2030 (U.S. Census Bureau, 2000).

The rapid growth in the older adult population requires attention. The demand for mental health services is likely to increase. Baby boomers tend to use mental health services more frequently than previous groups of older adults. They also tend to be less stigmatized by seeking mental health care.

The older adult population also is expected to become increasingly diverse. Currently, less than one-fifth (19 percent) of older adults are members of racial or ethnic minority groups (Administration on Aging, 2007):

- Eight percent are African American;
- Six percent are Latino;
- Three percent are Asian or Pacific Islander; and
- Less than one percent are American Indian or Native Alaskan.

More than one-fourth (26 percent) of older Americans will be members of racial or ethnic minority groups in the year 2030. Notably, the percentage of older adults who are Latino is expected to nearly double to 10.5 percent by the year 2030. The increasing racial and ethnic diversity will affect the following:

- Access and barriers to depression treatment;
- Language barrier;
- Stigma;
- Older adults and care provider dynamics; and
- The need to understand cultural differences in the perception of depression, treatment preferences, and the response to treatment.

Successful aging is possible

Successful aging is possible and common. Older adults emphasize the importance of several factors for achieving successful aging (Reichstadt and colleagues, 2007; Rowe and Kahn, 1998; Vaillant, 2001).

Factors for achieving successful aging

- A positive attitude, realistic perspective, and the ability to adapt to change (for example, humor, altruism, and anticipation).
- Security and stability in living environment, financial resources, and social support (for example, spouse, family, and friends).
- Health and wellness, including prevention of disease and disease-related disability, maintenance of high cognitive and physical function, healthy exercise and nutrition, the absence of smoking, high-quality health care, the ability to manage stress, and minimal pain.
- Active engagement with life, including being socially involved, participating in stimulating activities, learning, feeling a sense of purpose in life, and being useful to others and to society.

Other factors that research has shown predict good outcomes in old age include more years of education, healthy weight, good physical health at age 50, and the absence of alcohol abuse or a depressive disorder.

It is important to encourage activities that lead to successful aging. Many of the behaviors associated with aging well can be achieved by following a healthy and active lifestyle (for example, absence of smoking or substance abuse, healthy diet and exercise, and engagement in activities and social relationships).
What Is Depression in Older Adults?

Depression is not a normal part of aging.
Depression is a medical problem that affects many older adults and usually can be successfully treated. However, it is widely under-recognized and under-treated in older adults.

Depression can impair an older adult’s ability to function independently and contribute to poor health outcomes. It can cause suffering and family disruption. Without treatment, the symptoms of depression can last for years and inhibit an older adult’s ability to achieve successful aging.

Several treatments can reduce the symptoms of depression for most older people. These treatments can be delivered by practitioners from different disciplines and in multiple locations where older adults receive services.

Types of depression

Different types of depressive disorders can vary in severity from mild to very severe, based on the number and duration of symptoms. This KIT describes some of the common types of depression in older adults, including the following:

- Major depression;
- Minor depression; and
- Dysthymia.

Major depression

Major depression includes a combination of symptoms that affect an older adult’s ability to sleep, eat, and enjoy activities that were once pleasurable. Older adults with major depression have five or more of the following symptoms that are present nearly every day for at least a 2-week period. At least one complaint must be either depressed mood or loss of interest in activities.

Symptoms of depression

- Depressed mood most of the time
- Loss of interest or pleasure in activities
- Disturbed sleep (sleeping too much or too little)
- Weight loss or gain (changes in appetite)
- Fatigue or a lack of energy
- Feelings of worthlessness or extreme guilt
- Difficulties with concentration or decisionmaking
- Noticeable restlessness (agitation) or slow movement
- Frequent thoughts of death or suicide, or an attempt of suicide

The diagnostic criteria for major depression apply to all ages, including older adults. Older adults may display fewer symptoms than younger adults, but must still meet the criteria of five or more symptoms for a diagnosis of major depression.

Unexplained physical complaints are often a sign of depression in this age group. Older adults with depression may complain of physical problems, such as fatigue and headaches, or sleep disturbances, rather than feeling sad or depressed.

Common symptoms in older adults also may include expressions of hopelessness, anxiety, worry, and loss of pleasure. Older people with depression also may appear confused, have memory loss, or be agitated.

Because many of these symptoms can be signs of physical health disorders, misdiagnosis is common and major depression is often not detected in older adults. For this reason, older adults with symptoms of depression should receive a physical health assessment to rule out other medical causes for these symptoms.

Minor depression

Despite its name, there is nothing minor about the impact of minor depression on the quality of life and functioning of older adults.

Older adults with minor depression have two to four depressive symptoms, which must include either depressed mood or loss of interest or pleasure, that occur over at least 2 weeks, but not more than 2 years. Impairment in functioning is less severe than in major depression, although it can still affect physical and mental functioning and complicate recovery from illness.

Minor depression often is not detected in older adults, and one in four older people with minor depression will develop major depression within 2 years (Alexopoulos, 2005).

Dysthymia

Dysthymia is less severe than major depression, but also is characterized by long-term, chronic symptoms that may keep an older adult from functioning well or feeling good. Older adults with dysthymia are often described as having a depressive personality or a chronic depression that is marked by a persistent negative perspective and low mood.

Older adults with dysthymia have two to four of the symptoms of depression that occur most of the time almost every day for at least 2 years.

Risk factors for depression

Aging people often experience changes in their health and their lifestyles that can affect their ability to function. These changes can be risk factors that make an older adult more vulnerable to becoming depressed. Risk factors for depression can include changes in the following:

- Physical health or functioning;
- Mental health; or
- Circumstances or social support.
Physical health or functioning

Physical health problems, functional disability, and chronic pain can make an older adult more susceptible to developing depression.

A variety of physical disorders place older adults at risk for developing depression. These include common medical conditions that affect older adults, such as hip fracture, heart attack, stroke, congestive heart failure, chronic obstructive pulmonary disease, cancer, arthritis, diabetes, and macular degeneration.

Untreated depression can also increase the risk of developing various physical disorders, including heart attacks, and can complicate recovery from physical disorders, when left untreated. Physical disorders also are associated with problems in mobility and functioning that can increase an older adult’s risk for depression. For example, one-fifth of older adults have impairments that limit their ability to perform daily activities and one-third have mobility limitations.

Several sensory and functional impairments affect older adults. All five senses (taste, smell, touch, hearing, and vision) tend to decline in old age. One-third of adults aged 70 and older have hearing problems; one-fifth have vision problems that cannot be corrected through glasses or contact lenses alone. Sensory impairments can be associated with increased social isolation and decreased ability to engage in valued activities, including work, hobbies, social functions, reading, listening to music, and other pleasurable activities. The loss of these opportunities can be a risk factor for the development of depression.

Older adults with sensory and other physical health problems should be encouraged to seek appropriate care. Practitioners should be aware that physical disorders may make an older adult more likely to develop mental health problems.

Common risk factors for depression in older adults

Changes in physical health or functioning

- Presence of a new or chronic physical disorder, such as diabetes, or development of multiple chronic physical disorders
- Stroke, bypass operation, or hip fracture
- Poor health, physical or functional disability, and sensory impairment
- Severe and chronic pain

Changes in mental health

- Prior episode of depression
- Family history of major depression
- Cognitive impairment
- At-risk drinking, alcohol abuse, or illicit substance abuse
- Medication misuse or abuse
- Side effects of some medications
- Changes in medications or newly prescribed medications for other disorders

Changes in circumstances or social support

- Income changes, such as retirement or financial difficulties
- Social changes
- Recent loss of a loved one
- Living alone or social isolation
- Diminished social network
Some interventions, such as problem-solving treatment, can teach older adults skills for managing and living with chronic physical or sensory impairment. (This and other EBPs are described in *Selecting Evidence-Based Practices for The Treatment of Depression in Older Adults* in this KIT.) Preventive programs can be used by practitioners to reduce the risk for developing depression in older adults.

### Mental Health

A family history of depression can place an older adult at risk for developing depression. Older adults with an immediate relative with major depression or those who have had previous episodes of major depression have a greater risk of developing depression in older age.

Minor depression and significant depressive symptoms also put older adults at risk for developing major depression and other physical health problems (for example, diabetes).

Cognitive impairment also can be a risk factor for developing depression. Depression frequently co-occurs with Alzheimer’s disease and other types of dementia. It also is common for depression to co-occur in older adults with other mental disorders, such as anxiety disorders or schizophrenia.

Older adults with alcohol abuse, medication misuse or abuse, and illicit substance abuse are at risk for developing depression. Even small amounts of alcohol use, such as drinking more than one drink a day, can place older adults at risk for depression and other poor health outcomes. Alcohol also can interact with many prescribed medications, especially pain, anxiety, and sleep medications, and can result in greater risk for depression and other complications. The side effects of some medications also can cause or worsen symptoms of depression.

Older adults, their families and caregivers, and their practitioners should be aware that these risk factors exist. Assessment of depression in older adults should include an evaluation of family history of depression, cognitive functioning, other mental health disorders, and substance abuse and medication misuse.

### Circumstances or Social Support

Changes in personal circumstances or responsibilities can be risk factors for depression in older adults. Depression can be preceded by changes in the following:

- Income or financial resources (for example, changes in employment status or financial difficulties); and
- Social support (for example, recent loss of a loved one, living alone, or diminished social network).

### Income or Financial Resources

Poverty is a risk factor for a variety of health conditions in older adults, including depression. About one in 10 older adults lives in poverty. Certain groups of older adults experience higher rates of poverty. These include older Latinos (19 percent) and African Americans (23 percent), and older adults who live alone (17 percent). Overall, the poverty rate for older women is almost twice that of older men (12 percent versus 7 percent). For older women who are unmarried, the rate is much higher, with more than one in four living below the poverty line. The highest poverty rates are experienced by older Latino and African American women who live alone (41 percent and 38 percent, respectively) (Administration on Aging, 2007).

Inadequate income or poverty may be lifelong, or alternatively, may follow the death of a spouse or dwindling income after the loss of a job or retirement. Although retirement is often a time to celebrate accomplishments and enjoy successes, some adults may struggle to redefine their lives and may not feel financially secure. Some older adults choose to work in order to remain engaged and connected with their peers and colleagues and to provide more financial security.
One in seven older Americans (aged 65+) is working or actively seeking work, including about 20 percent of older men and 12 percent of older women. Up to one-quarter of older adults are active in volunteer activities. Remaining active in meaningful activities, participating in organized group or educational activities, and volunteering or engaging in paid part-time work are commonly cited by older adults as contributing to successful aging (Reichstadt, 2007).

**Social support**

Older adults can experience grief and bereavement due to the loss of family members and friends. These losses may have significant and long-lasting effects on emotional well-being. The support of caregivers, friends, and family is helpful during these difficult times.

Strong social support networks and social contact are related to good physical and mental health and can decrease the risk for developing depression (Oxman and Hull, 2001). Older adults with depression and strong social support networks also have a lower risk for suicide (Alexopoulos, 1999).

Although social activities may become less frequent in older age, the total number of people in the social network typically remains steady. As people age, their social network tends to include more younger people, children, and relatives, and fewer older friends and neighbors.

Older adults with low levels of social support and a history of serious suicide attempts should be carefully evaluated for thoughts of suicide. Precautions should be taken even when the older adult’s depression is mild. The Practitioners’ Guide for Working with Older Adults with Depression in this KIT provides more information on assessing depression, risk for suicide, and other areas.

### Prevalence of depression

Depressive disorders and symptoms affect many older adults. A review of literature conducted by Hybels and Blazer (2003) identified the prevalence of depression in older adults of all ethnicities.

<table>
<thead>
<tr>
<th></th>
<th>Minor depression, dysthymia, or depressive symptoms</th>
<th>Major depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Up to 26%</td>
<td>Up to 5%</td>
</tr>
<tr>
<td>Primary care</td>
<td>10%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Hospital inpatient care</td>
<td>23%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Home health care</td>
<td>8%</td>
<td>Up to 16%</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>Up to 35%</td>
<td>Up to 15%</td>
</tr>
</tbody>
</table>

Depression, especially minor depression and dysthymia, is under-recognized and under-treated. As such, the prevalence of depression may actually be higher than these estimates. In addition, the prevalence of major depression doubles after age 80 years (Alexopoulos, 2005).

Of note, depressive disorders tend to be more common in older women, compared to older men. Gender stereotyping may contribute to the more frequent under-diagnosis of depression in older men.

Few racial or ethnic differences are in the prevalence or diagnosis of depression. However, African American and Latino older adults have lower rates of treatment than Caucasian older adults.

Depressive symptoms can be persistent. More than half of patients with less severe types of depression remain depressed 1 year later (Alexopoulos, 2005).
Impact of depression

According to the World Health Organization (2001), depression is among the top causes of worldwide disability. Depression in older adults is associated with decreased levels of functioning, worse health status, and reduced quality of life.

Depression in older adults can lead to disability in functioning and physical health. Older adults with depression are more disabled with respect to self care and daily community living skills, compared to older adults without depression. They also tend to recover more slowly from physical disorders, such as stroke or hip fractures. Older adults with depression are more likely to die, either because of worsening of physical disorders or by suicide (Reynolds and Kupfer, 1999).

Depression is a leading risk factor for suicide in older adults. Older Caucasian males complete suicide more often than any other group of people (Hoyert, 1999; NCIPC, 2008). Treatment of depression may help prevent suicide in older adults.

Cost of depression

Depression is an expensive health problem. Health care costs for older adults with depression are approximately 50 percent higher than for those without depression (Unützer and colleagues, 1997). Older adults with depression are more likely to be admitted to a hospital or a nursing home, visit their physician, visit an emergency room, and more often prescribed multiple medications.

Effective depression treatment can be provided to older adults at a modest cost. For example, Katon and colleagues (2005) found that integrated and collaborative treatment of depression in the primary care setting produces positive clinical outcomes and increases health care costs by less than $150 per older adult per year.

In some instances, treatment of depression in older adults can reduce the overall cost of health care. For example, one study found that providing psychiatric consultation services to older adults who were hospitalized with a hip fracture resulted in fewer days of hospitalization and a significant reduction in overall yearly health care costs. Cost savings were greater than the costs of providing psychiatric treatment (Mossey and colleagues, 1990).

The potential cost savings for treatment of depression in older adults may be best appreciated by taking a long-term perspective. For example, Unützer and colleagues (2008) found that older adults who received one year of integrated and collaborative treatment of depression in the primary care setting had lower average costs for all of their health care over a four-year period. Even when the cost of team care treatment was included, total health care costs were approximately $3,360 less than costs for older adults who received traditional care.
Why EBPs for Older Adults with Depression Are Important

The primary reason that you should focus on EBPs is that these interventions have been scientifically proven to improve the health and functioning of older adults with depression.

Providing EBPs for depression is an effective way to address these problems and to do the following:

- Reduce the symptoms of depression;
- Improve functioning;
- Improve overall health outcomes; and
- Ensure that older adults receive effective types of care.

Reduce depressive symptoms

One important way to improve the quality of care that older adults receive is to implement EBPs for depression.

Depression treatments are designed to do the following:

- Reduce the symptoms of depression;
- Prevent relapse, recurrence of symptoms, and suicidal thinking;
- Improve cognitive and functional status; and
- Help patients develop skills to cope with disability or other problems.

Strong scientific proof shows that EBPs for treating depression in older adults can reduce the symptoms of depression. Sixty to 80 percent of older adults who receive appropriate treatment will have lower severity of depressive symptoms.

Recovery from depression also is possible and should be pursued. EBPs vary with respect to their ability to help older adults achieve full remission of depression.

Improve functioning

Depression affects older adults’ ability to perform their usual daily activities. Older adults with depression can have low energy, poor concentration, low motivation, apathy, lack of attention to appearance and hygiene, lack of interest in personal surroundings and usual activities, and withdrawal from personal relationships and social activities.

Treatment of depression can improve an older adult’s ability to do the following:

- Engage in self-care;
- Participate in meaningful activities related to work or relationships;
- Engage in social or community activities; and
- Engage with their peers and other members of their social network.
**Improve health outcomes**

Untreated depression in older adults is likely to lead to high levels of physical disability and functional impairment. It may contribute to longer recovery periods for illness or surgery, as well as premature death. It may also contribute to poor cognitive functioning in older adults.

When older adults receive appropriate treatment for depression, many of these health issues can be improved or prevented.

**Ensure that older adults receive effective types of care**

Despite the importance of providing effective care, many EBPs for treating depression are not available to older people. This problem has been highlighted in several reports, including those by the United States Surgeon General (1999, 2001), the President’s New Freedom Commission on Mental Health (2003), and the Institute of Medicine (2001, 2006).

Top recommendations from the White House Conference on Aging (2005) note that practitioners who care for older adults need training to do the following:

- Address issues that are common or unique to older adults; and
- Improve their ability to recognize, assess, and treat depression in older adults.

These reports highlight both the need to understand issues that are important in caring for older adults with depression and to improve the quality of services for older adults.

EBPs must be available in the settings where older adults receive their health care. Delivering EBPs can help ensure that older adults receive effective depression care.

There are several effective treatments for older adults with depression. For a description of these EBPs, see Selecting Evidence-Based Practices for The Treatment of Depression in Older Adults in this KIT.

**EBPs for depression in older adults**

- Psychotherapy interventions
  - Cognitive behavioral therapy
  - Behavioral therapy
  - Problem-solving treatment
  - Interpersonal psychotherapy
  - Reminiscence therapy
  - Cognitive bibliotherapy
- Antidepressant medications
- Multidisciplinary geriatric mental health outreach services
- Collaborative and integrated mental and physical health care
Psychotherapy interventions and antidepressant medications are both effective treatments for depression. In some cases, these EBPs are more effective when they are provided together.

Psychotherapy interventions and antidepressant medications can be provided within specific models of outreach services and collaborative and integrated mental and physical health care.

The choice of treatment depends on many issues. These issues can include the following:

- The severity and duration of depression;
- The older adult’s clinical presentation;
- The older adult’s prior history of response to treatments;
- The presence of other health conditions or medications;
- The tolerability of the treatments with respect to side effects or required effort; and
- The older adult’s treatment preferences.

Selection of the most appropriate and effective treatment should be made in consultation with experienced practitioners. Despite state of the art treatment, including EBPs, some proportion of older adults with depression may not respond favorably. Older adults with a lifetime history of recurrent depression or with a particularly complex case of depression require attention by a specialist in geriatric mental health treatment. In addition, referral to specialists outside the mental health care system may be warranted to improve recovery.

Although effective treatments exist, older adults are less likely than younger people to receive appropriate medications or psychotherapy. Factors that may contribute to this include the following:

- Stigma;
- Poor recognition of depression in older people;
- Lack of practitioners who are trained to assess and treat depression;
- Provider bias, or ageism, in providing appropriate and effective services; and
- Lack of accessible, affordable, and age-appropriate care.

Several of these factors can be overcome by doing the following:

- Educating practitioners, older adults and their families or caregivers, and the general population; and
- Implementing EBPs.
Summary of Key Facts About Depression in Older Adults

- Depression is one of the most common mental health disorders in older adults. One in ten older adults in primary care has symptoms of depression, and higher rates are found among older adults who are hospitalized or residing in a nursing home.

- Different types of depressive disorders can vary in severity from mild to very severe.

- Depression is among the top cause of worldwide disability. Depression in older adults is associated with decreased levels of functioning, worse health status, reduced quality of life, and increased disability and mortality. Depression is a leading risk factor for suicide in older adults.

- Health care costs for older adults with depression are approximately 50 percent higher than for older adults without depression.

- Providing EBPs for depression in older adults can reduce depressive symptoms, improve health and functioning, and ensure that effective types of treatment are available and used.

- Sixty to 80 percent of older adults who receive appropriate treatment achieve a reduction in their symptoms of depression.

- The incidence of major depression and suicide can be decreased by identifying older adults who are at risk for depression and providing them with effective prevention and intervention programs.
Available Fact Sheets that Describe Depression in Older Adults

- Older Adults: Depression and Suicide Facts (revised April 2007).
  http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm

- Facts About Depression in Older Adults (September 2003).

- Late-Life Depression: A Fact Sheet.
  http://www.gmhfonline.org/gmhf/consumer/factsheets/depression_factsheet.html

- Depression in Older Adults (updated November 2006).
  http://www.mentalhealthamerica.net/go/information/get-info/depression/depression-in-older-adults

- Depression in Late Life: Not a Natural Part of Aging.
  http://www.gmhfonline.org/gmhf/consumer/factsheets/depression_latelife.html

Available in Spanish: Depresión Tardía: No Es Una Parte Natural Del Envejecimiento.

http://www.gmhfonline.org/gmhf/consumer/factsheets/depression_tardia.html
Part 2

Practitioners’ Guide for Working with Older Adults with Depression

The Practitioners’ Guide for Working with Older Adults with Depression gives practitioners strategies for providing effective and appropriate care to older adults with depression. Practitioners include people who provide care to older adults with depression. The training and activities of practitioners may differ among the mental health, aging, and general medical health settings. Practitioners may include psychiatrists, psychologists, physicians, nurses, social workers, aging service providers, and other providers of care.

This booklet describes how practitioners can screen for depression, assess and diagnose depression, select an appropriate treatment, deliver care, and evaluate outcomes. It also describes how practitioners can participate in implementing evidence-based practices (EBPs).

Why You Should Care About EBPs for Older Adults with Depression

Demand is growing for mental health services for older adults. Older adults make up 12 percent of the American population, but will grow to 20 percent of the population by 2030.

Although depression is not a normal response to changes that occur in older adulthood, this medical problem affects many older adults. It is widely underrecognized and undertreated.
Depression can impair an older adult’s ability to function independently and can contribute to poor health outcomes. It can cause suffering and family disruption. Without treatment, the symptoms of depression can last for years.

Several effective treatments can reduce the symptoms of depression for most older adults. Increasing the availability of these treatments is an important way of improving the quality of care for older adults. Providing EBPs for the treatment of depression can help in these ways:

- Reduce or eliminate the symptoms of depression;
- Lower the risk for suicide;
- Improve physical health; and
- Reduce functional disability.

A variety of skills can help you provide effective depression care to older adults. You can improve delivery of care by strengthening your ability in these areas:

- Working with older adults;
- Screening for depression;
- Assessing and diagnosing depression;
- Selecting a treatment;
- Delivering evidence-based care; and
- Evaluating care.

Working with Older Adults

The relationship that you form with an older adult is one of the most important parts of delivering effective care. Building a therapeutic relationship includes showing respect for the older adult, demonstrating your competence in issues of aging and depression, and communicating empathetically with the older adult.

Understanding older adults in terms of their cohort, or age group, is an essential part of developing a therapeutic relationship, especially if you are considerably younger. Each generation can identify cultural norms or historic events that influence their style of coping with problems, family relationships, and outlook on life. Today’s older adults grew up during times of racial segregation. Some remember the Great Depression and many served during World War II.

Cultural and generational issues, as well as physical changes associated with aging, may affect the way you interact with older adults. Showing an interest in how older adults view the nature of their problems, and the coping style they are familiar with, can enhance your relationship with them. For important tips for working with older adults, see the next page.
Tips for Working with Older Adults

Communication

- Speak slowly so your words don’t run together. Speak in a clear, normal tone. Some pitches are difficult for some older adults to hear.
- Sit directly in front of an older adult so he or she can see your face and lips as you speak. You may also ask if he or she can hear you better out of one ear or the other so you can speak in that direction.
- Provide printed information to older adults. Use large print materials with at least 14-point font size, black print on white, nonglare paper.
- Avoid using slang terms or medical jargon.
- Word choice is crucial. Try to be careful when choosing your words to minimize the effect of mental health stigma, which may prevent an older adult from accepting services.
- Refer to older adults with titles of respect, that is, Mr., Mrs., Miss, Ms, Dr., or other title until given permission to use the first name.
- Depending on the older adult’s culture, it may be necessary to communicate directly with family members as well as incorporating family members and caregivers into the treatment plan.
- Encourage the older adult to ask questions.

Privacy

- During in-home visits, be aware that privacy may be an issue. It is often helpful to have family present to help obtain historical information. It also is important to meet with the older adult individually so sensitive information can be shared more comfortably (for example, elder abuse).
- Obtain consent to talk with the older adult’s physical health doctor as soon as possible.
- At each contact assure the privacy of the information given.

Assessment

- Take into account literacy and fluency in speaking and understanding English when working with minority older adults.
- Use words that are acceptable and familiar when assessing an older adult’s feelings, such as stress, nerves, fatigue, or feeling low or sad.
- Plan more time for assessments than with younger adults. Plan more time for each contact.
- Try not to cut off sentences or fill in words while an older adult is pausing. Some older adults may give useful information in a story format.
- Find out the older adult’s beliefs and knowledge concerning depression.
- At times it may be necessary to help older adults refocus. A gentle but decisive approach is needed.
- Never underestimate any inference of feeling worthless or wanting to die. Always indicate your concern and attempt to get more detailed information. Plan to act on that information as indicated.
- While assessing, look at the whole person. Consider whether assistive devices might help older adults stay in their homes longer.
- Ask for a current list of prescription and over-the-counter medications. If an older adult does not have a current list, ask him or her to bring in all medications so a list can be made.

Adapted from Tips from the Southern Illinois Gero-Psychiatric Specialists.
Screening for Depression

Screening for depression improves your ability to recognize and diagnose depression, and thereby provide appropriate treatment and improve outcomes of depression. Screening for depression is recommended by the U.S. Preventive Services Task Force (2002) in health care settings where practitioners are prepared to confirm an accurate diagnosis and provide effective treatment and followup.

Several instruments can help you screen for depression in older adults. Two common measures are the Patient Health Questionnaire and the Geriatric Depression Scale. For older adults with a positive screen on either of these measures, you should conduct a full diagnostic evaluation for depression or refer the older adult to a practitioner who can do so. See Evaluating Your Program in this KIT for more information about these and other measures for evaluating older adults.

Patient Health Questionnaire (PHQ-2)

The PHQ-2 includes the following two questions. If the answer to either is “Yes,” the older adult should receive further evaluation for depression.

- Over the past 2 weeks, have you felt little interest or pleasure in doing things?
- Over the past 2 weeks, have you felt down, depressed, or hopeless?

Geriatric Depression Scale

The short form of the Geriatric Depression Scale is a 15-item screening tool designed specifically for older adults who may need further evaluation for depression. You can use this scale to screen for depression and to monitor outcomes of depression treatment.

The Geriatric Depression Scale has been translated into multiple languages (for example, Spanish, French, Korean, Chinese, and many others) and is available at http://www.stanford.edu/~yesavage/GDS.html.
Geriatric Depression Scale (Short Form)

Choose the best answer for how you have felt over the past week.

1. Are you basically satisfied with your life?
   - Yes
   - No

2. Have you dropped many of your activities and interests?
   - Yes
   - No

3. Do you feel that your life is empty?
   - Yes
   - No

4. Do you often get bored?
   - Yes
   - No

5. Are you in good spirits most of the time?
   - Yes
   - No

6. Are you afraid that something bad is going to happen to you?
   - Yes
   - No

7. Do you feel happy most of the time?
   - Yes
   - No

8. Do you often feel helpless?
   - Yes
   - No

9. Do you prefer to stay at home, rather than going out and doing things?
   - Yes
   - No

10. Do you feel that you have more problems with memory than most?
    - Yes
    - No

11. Do you think it is wonderful to be alive now?
    - Yes
    - No

12. Do you feel worthless the way you are now?
    - Yes
    - No

13. Do you feel full of energy?
    - Yes
    - No

14. Do you feel that your situation is hopeless?
    - Yes
    - No

15. Do you think that most people are better off than you are?
    - Yes
    - No

Scoring: Score 1 point if you answered NO to Questions 1, 5, 7, 11, 13.
Score 1 point if you answered YES to Questions 2, 3, 4, 6, 8, 9, 10, 12, 14, 15.

Total your points. Total point score: ______________

A score > 5 is suggestive of depression and a score > 10 is almost always indicative of depression.

Assessing and Diagnosing Depression

Depression is often underrecognized and undertreated in older adults. Some reasons include the following:

- Older adults often emphasize physical rather than cognitive and mood complaints, or they may report mild or nonspecific symptoms of depression.
- Symptoms of depression often overlap with symptoms of physical disorders.
- Depression may be a side effect of a medication or result from adverse drug interactions.
- Depression can be mistaken for anxiety, as mixed depression and anxiety is common.
- A misconception is that depression is a normal or understandable component of aging.
- Older adults may deny symptoms of depression and refuse to accept the diagnosis because of stigma.
- Inadequate mental health training exists among practitioners working with older adults.
- Practitioners may be uncertain of the diagnosis, available treatment, or expected outcomes of treatment.
- Time limitations in primary care interfere with the practitioner’s ability to address both physical health and mental health problems.

You can improve recognition of depression by conducting a careful evaluation of older adults who screen positive or have risk factors for depression. The goal of an evaluation is to determine the causes of depression and the best course of treatment.

To evaluate depression in older adults, you can perform the following assessments:

- Conduct an individualized depression assessment and interview.
- Ensure that the older adult has a recent physical evaluation. Symptoms of depression can be caused by serious (and even life-threatening) undiagnosed medical disorders.
- Review physical health history. Obtain the older adult’s permission to review relevant medical records and communicate directly with the primary care practitioner.
- Review social history, including personal supports.
- Assess for the presence of risk factors, including history of depression in the older adult and his or her family members.
- Ask direct questions about symptoms of depression, thoughts of suicide, psychosis, and recent losses or crises.
- Review medications.
- Assess cognitive dysfunction and functional disability.
- Obtain the older adult’s permission to consult family members, if available, to verify information and to provide a different perspective on the older adult’s problems.
- Use a standardized assessment tool to rate the severity of symptoms (for example, Patient Health Questionnaire [PHQ-9], Geriatric Depression Scale-Short Form).

Patient Health Questionnaire (PHQ-9)

The nine-item PHQ-9 can help you rate the severity of depressive symptoms and help make a diagnosis of depression. The questions of the PHQ-9 align with the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) diagnostic criteria for depression.

The PHQ-9 has been translated into multiple languages (for example, Spanish, Chinese, and many others). To learn more about the PHQ-9, visit [http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/](http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/)
Patient Health Questionnaire (PHQ-9)

Rate question 1 with the following categories:

Not at all (score 0),
Several days (score 1),
More than half the days (score 2), or
Nearly every day (score 3).

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
   a. Little interest or pleasure in doing things
   b. Feeling down, depressed, or hopeless
   c. Trouble falling asleep, staying asleep, or sleeping too much
   d. Feeling tired or having little energy
   e. Poor appetite or overeating
   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   g. Trouble concentrating on things such as reading the newspaper or watching television
   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   i. Thinking that you would be better off dead or that you want to hurt yourself in some way

Rate question 2 with the following categories:

Not difficult at all,
Somewhat difficult,
Very difficult,
Extremely difficult

2. If you checked off any of these problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Total point score (Questions 1a-1i): ______________
A score > 10 is indicative of depression when problems are at least somewhat difficult.

Selecting a Treatment

The Institute of Medicine (2001) defines evidence-based practice (EBP) as the integration of the best research evidence with clinical expertise and patient values.

When you select an EBP for a particular older adult, you should consider these factors:

- The older adult’s presenting problems and diagnosis, including the severity and duration of depression;
- The older adult’s prior history of response to treatments;
- The presence of other health conditions or medications;
- The tolerability of the treatments with respect to side effects or required effort;
- The older adult’s access to care;
- The availability of treatment for the older adult, including the preferred setting for the delivery of the service;
- The older adult’s personal preferences and choice in treatment interventions; and
- The ability to finance the treatment.

It is important to select the treatment that best fits the needs of the older adults you serve. When selecting an appropriate intervention, you should work with older adults to identify the best available evidence and the expected outcomes of the treatment, and understand their treatment preferences.

Best available evidence

Treatments that have been labeled as EBPs are different from other treatments. EBPs have been rigorously evaluated by scientists (in at least two studies) to determine that they reduce the symptoms of depression in older adults. These evaluations have compared the EBP to a comparison group.

Several effective treatments are available to treat depression in older adults. It is important to implement these EBPs because they are proven to be more effective than usual care, and they are not being implemented broadly in practice. For a description of these EBPs, see Selecting Evidence-Based Practices for Treatment of Depression in Older Adults in this KIT.

EBPs for Depression in Older Adults

- Psychotherapy interventions
  - Cognitive behavioral therapy
  - Behavioral therapy
  - Problem-solving treatment
  - Interpersonal psychotherapy
  - Reminiscence therapy
  - Cognitive bibliotherapy
- Antidepressant medications
- Multidisciplinary geriatric mental health outreach services
- Collaborative and integrated mental and physical health care

Several other interventions have been developed to treat depression but lack rigorous testing among older adults. In the future, these promising practices may meet the criteria for an EBP for treating depression in older adults.
Older adult preferences

It is important for you to understand the treatment preferences of older adults. Older adults may have clear preferences for receiving one type of treatment over another.

Preferences may be based on the following factors:
- Side effects of treatment;
- Program expectations;
- Length of treatment;
- Experiences of peers; or
- Perceived stigma.

For example, some older adults who are on a large number of medications prefer psychotherapy interventions. Others prefer the convenience of medication over the multiple visits and homework that are part of psychotherapy.

Conversations with older adults can help you identify their preferences and values. You can engage older adults in ongoing discussions that allow them to actively participate in treatment decisions. These discussions can empower the older adult to help decide what type of depression care he or she wishes to receive. This model of care is sometimes called shared decisionmaking and is an important principle identified by the Institute of Medicine (2001).

Shared decisionmaking often represents a different way of thinking for older adults. While some older adults may be hesitant to participate in treatment decisions, you can encourage their participation and use their feedback to guide the selection of the best treatment. For information for older adults on becoming more involved in making treatment decisions, see Older Adult, Family, and Caregiver Guide on Depression in this KIT.

Steps You Can Take

- Know how demographic characteristics and cultural beliefs influence perceptions of depression, treatment access, treatment preferences, and desired outcomes.
- Use screening tests and a standard depression evaluation to improve your recognition of depression.
- Understand the treatment preferences and values of older adults and involve them in making treatment decisions.
- Work with practitioners from different disciplines to address the multiple physical health, mental health, and social needs of the older adult.
- Learn specialized skills for communicating and working with older adults with depression.
- Use standardized depression scales (for example, Geriatric Depression Scale, PHQ-9) as outcome measures to evaluate the effectiveness of implementation and treatment.
- Monitor treatment participation and response. Reevaluate older adults (in person or by phone) within the first 2 weeks after beginning treatment and at least every 3 weeks during the first 3 months of treatment.
Delivering Evidence-Based Care

A person-centered approach to delivering care should focus on the goals that are set by the older adult. You are more likely to meet his or her goals with an understanding of the following:

- An array of services is available to older adults;
- Collaboration among practitioners from different disciplines is desirable; and
- Your treatment approach will be guided by understanding key principles of aging.

An array of services is available

Treatment for depression in older adults is not limited to EBPs. EBPs should be one component of a larger continuum of services. Other services may lack the scientific rigor of an EBP but may still be important for older adults.

The effectiveness of EBPs may be improved if you can provide them along with other supportive services. Supportive services can include the following:

- Education about depression;
- Support for family members and caregivers;
- Assistance with other health and social concerns;
- Treatment of co-occurring physical or mental disorders; and
- Treatment of co-occurring substance use problems (including problems with alcohol and illicit drug abuse, and medication misuse).

Collaborating with other practitioners

Older adults with depression typically need multiple medical and social services. You are more likely to provide comprehensive and effective care by working together with mental health, aging, and general medical health practitioners.

You can achieve effective collaboration in these ways:

- Obtaining the older adult’s permission to contact his or her other practitioners;
- Identifying health and social issues that can be addressed together; and
- Establishing a mechanism for clear and frequent communication.

As an example, practitioners who deliver the PATCH (Psychogeriatric Assessment and Treatment in City Housing) model of multidisciplinary community-based outreach comment that their ability to help an older adult is often improved because they can address physical health problems, transportation, housing stability, and assistance with access to medical visits and medications. (For a description of the PATCH model, see Selecting Evidence-Based Practices for Treatment of Depression in Older Adults in this KIT.)
Principles for delivering care to older adults

For those adults who suffer from symptoms of depression, recovery is possible. Effective treatments can help up to 80 percent of older adults feel better.

Remembering several important principles can help you provide more effective care to older adults.

Issue 1: Co-occurring physical illness is the rule, not the exception

A distinguishing feature of old age is the common presence of chronic physical illness. About 80 percent of older adults (over age 65) have at least one chronic physical disorder, and 50 percent have at least two. Some of the most common physical disorders include arthritis and musculoskeletal conditions, and heart disease and other circulatory problems. Despite the high rate of chronic physical disorders, two-fifths of older adults consider their health to be excellent or very good.

Among older adults with depression, approximately one-fifth suffer from heart disease, one-fifth have diabetes, two-fifths have arthritis, and nearly half have hypertension.
Co-occurring physical illness is the rule, not the exception. Obtain a recent physical evaluation to rule out potential physical causes or contributors to symptoms of depression.

Co-occurring anxiety can complicate the course and treatment of depression.

Cognitive impairment can be both a risk factor and a symptom of depression.

Older adults take multiple medications and their bodies handle the medications differently than younger bodies. Drug interactions can cause serious medical problems.

Small amounts of substance use can cause serious problems for older adults.

Mental and physical functioning varies widely among older adults of the same age.

Coordination and collaboration among mental health, aging, and general medical practitioners is essential.

Family members and other social supports are critical to successful treatment.

Maintaining independence and aging in place are common values of older people.

Ageism and stigma affect treatment access, expectations, and outcomes.

Cultural differences can affect perceptions of depression, treatment preferences, and desired treatment outcomes.

Depression can be prevented.

Older adult depression is associated with the highest rate of suicide.

Psychotherapy can be as effective as medications.

Physical disorders complicate the identification, course, and treatment of depression. Therefore, you should simultaneously evaluate physical and mental causes of symptoms. Depression shares symptoms with physical disorders such as congestive heart failure and cancer. These can include low energy, poor appetite, impaired functioning, fatigue, irritability, and feelings of hopelessness. A recent physical evaluation can help you exclude potential physical causes or contributors to symptoms of depression.

When chronic physical illness occurs with depression, physical illness can worsen the course of depression and, conversely, depression can worsen the course of physical illness. In either case, you should provide coordinated and integrated care for both depression and the physical disorder. Approaches that neglect one area at the expense of the other are unlikely to be successful.
Assess and treat co-occurring depression and physical disorders in a coordinated manner. Evidence-based models of collaborative and integrated care are an effective treatment approach for such coordination.

**Issue 2: Co-occurring anxiety can complicate the course and treatment of depression**

Depression and anxiety commonly occur together in older adults. About one-quarter to one-half of older adults with major depression also have an anxiety disorder. Older adults with mixed anxiety and depression often have more severe symptoms of depression, poorer social functioning, greater use of health care services, more physical health symptoms (for example, chest pain, headaches, sweating, gastrointestinal problems), and more thoughts of suicide. The presence of anxiety with depression makes treatment more difficult because there is an increased risk of missing the diagnosis of depression, a more chronic course of illness, and a greater likelihood that older adults will not respond to treatment or withdraw early from treatment.

In addition, the prescription of anti-anxiety medications known as benzodiazepines can worsen symptoms of depression and increase the risk for confusion and falls. You should periodically assess older adults for possible reduction and discontinuation of benzodiazepine medications to minimize the risk for adverse effects (for example, falls, hip fractures, impaired cognition, and depressive symptoms).

You can help reduce an older adult’s anxiety and improve the likelihood of treatment success through these steps:

- Explaining adverse effects of medications and reassuring the older adult that you will be available by phone if problems occur; and
- Providing intensive followup, particularly in the early part of treatment when older adults are most likely to drop out because of anxiety-related medication intolerance.

**Older adults with depression and anxiety are more likely to stay in treatment if they are seen frequently and are told that they should call with any concerns related to treatment.**

**Issue 3: Cognitive impairment can be a risk factor and a symptom of depression**

Cognitive impairment (for example, memory loss, disorientation, or confusion) is not an inevitable part of aging. Instead, these problems may be symptoms of a possible dementia, such as Alzheimer’s disease. One in 10 adults aged 65 and older and nearly half (47 percent) of adults aged 85 and older have Alzheimer’s disease. The second most common cause of dementia is stroke or small blood vessel disease in the brain (also known as vascular dementia).

These cognitive impairment disorders are associated with increased rates of depression. For this reason, your assessment and treatment of depression in older people should include a formal evaluation of cognitive functioning. Common measures for evaluating cognitive functioning include the Mini-Mental State Examination and the Mini-Cog. See *Evaluating Your Program* in this KIT for more information about these measures.
Cognitive problems also can be a symptom of depression. Depression can cause impairment in memory, concentration, and executive functioning (for example, planning, organizing, and initiating purposeful behaviors). Successful treatment of depression can often reverse the cognitive problems associated with depression.

Severe cognitive impairment in an older adult can affect treatment decisions. Older adults with severe cognitive impairment may have a limited ability to benefit from some psychotherapy interventions.

Include a formal evaluation of cognitive functioning when you assess and treat depression in older adults.

**Issue 4: Older adults take multiple medications. Their bodies handle the medications differently than younger bodies because of normal metabolic changes of aging**

On average, older adults regularly consume two to six prescription medications and one to three over-the-counter medications. Notably, nearly two-thirds of older adults with depression receive five or more prescriptions, compared to only one-third of older adults without depression. Physical and cognitive changes associated with aging can make older adults particularly vulnerable to medication interactions and medication misuse.

Changes in body fat distribution and other physical characteristics change the way that older adults metabolize or break down medications and psychoactive substances. An important principle of treatment is to begin with low medication dosages and increase dosages slowly, as necessary. Once medications are started, it may take much longer for the medication to be eliminated from an older adult’s body compared to a younger adult’s body.

Several medications for physical disorders can cause, worsen, or mimic symptoms of depression. For example, some medications used to treat high blood pressure or endocrine disorders can cause depression. Side effects of some medications also can include low mood, decreased energy, poor appetite, impaired concentration, lack of interest, fatigue, agitation, and poor sleep.

Some prescribed and over-the-counter medications for common physical disorders can interact with antidepressant medications, causing serious side effects or toxicity. Side effects can include confusion, increased chance of falls, and lower functioning and can result in hospitalizations and even death. For older adults taking multiple medications, you should ask a pharmacist or prescribing practitioner to review the person’s prescribed and over-the-counter medications for potential adverse drug interactions or impact on dosage levels.

The high number of medications taken by older adults also can lead to poor medication adherence and medication self-administration errors.

You can increase the safety of older adults who take multiple medications in these ways:

- Reducing the complexity of scheduling times to take medications;
- Recommending the use of medication organizers; and
- Providing educational supports.

For more information about selecting and prescribing antidepressant medications to older adults, see *Selecting Evidence-Based Practices for Depression in Older Adults* in this KIT.

Ask a pharmacist or other prescribing practitioner to review the older adult’s prescribed and over-the-counter medications for potential adverse drug interactions or impact on dosage levels.

Ce4Less.com
**Issue 5: Small amounts of substance use can cause serious problems for older adults**

Problems with either alcohol or medication misuse (overuse, underuse, and irregular use of medications) affect up to one-fifth of older adults.

Compared with younger people, older adults have an increased sensitivity to alcohol, as well as to over-the-counter and prescription medications. Metabolic and physical changes in older adults have implications for alcohol and medication use. These age-related changes can increase the circulating amount of alcohol in the body. Liver enzymes that metabolize alcohol also become less efficient with age. For some older adults, ANY alcohol use with specific over-the-counter or prescription medications can be problematic.

Because of the age-related changes in how alcohol is metabolized, and the potential interactions between medications and alcohol, alcohol use recommendations for older adults are generally lower than those for adults under age 65. The National Institute on Alcohol Abuse and Alcoholism (1995) and the Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol on older adults recommend that adults over age 65 drink no more than one standard drink per day or seven drinks per week. In addition, older adults should not consume more than two drinks on any drinking day. A standard drink is the equivalent of 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of brandy (Center for Substance Abuse Treatment, 1998).

Alcohol and medication misuse and abuse can make treatment of depression more difficult. Compared to older adults with either depression or a substance use disorder alone, those with both disorders have more serious health and social problems:

- More symptoms of anxiety and more frequent sleep disturbances;
- Worse physical health;
- Lower quality of life;
- Lower perceived social support;
- Greater use of inpatient and outpatient services; and
- Greater likelihood of thinking about or attempting suicide.

Regular use of even small amounts of alcohol, pain medications, or other psychoactive substances can cause serious problems for older adults. See **Evaluating Your Program** in this KIT for information on instruments to assess substance use in older adults.

Evaluate the older adult’s use of alcohol and psychoactive substances. Treatment should address both depression and substance use problems.
Issue 6: Mental and physical functioning varies widely among older adults of the same age

Chronological age is not a good indicator of a person’s physical and mental capacities. A wide range of normal functioning exists in the 35-year span between ages 65 and 100.

As people age, variation among age groups increases. For example, a 65-year-old person can have the mental and physical functioning of an 85-year-old and vice versa.

Treating an older adult with depression requires thinking beyond the person’s chronological age and assessing his or her actual functional capacities. This includes evaluating daily abilities to care for oneself as well as social, physical, and mental functioning that can change with age.

Evaluating and addressing functioning is the key in developing treatment plans.

Evaluating and addressing functioning is the key in developing treatment plans.

Issue 7: Coordination and collaboration between mental health, aging, and general medical health practitioners is essential

Older adults often benefit from services that are provided by an array of health and social service practitioners. For instance, an older adult may receive diabetes management from a primary care practitioner, bi-weekly medical checks from a home health nurse, weekly home health aid assistance with activities of daily living, daily delivery of meals-on-wheels from an aging services practitioner, and a medication visit every 3 months for a memory-enhancing agent from a psychiatrist. For older adults with depression, another layer of complexity is added by the need to coordinate antidepressant medications or psychotherapy with the above-mentioned services.

Older adults with depression often fail to receive appropriate and effective treatment due to fragmented service delivery systems. Treatment typically occurs across discrete settings that provide either mental health, aging, or general medical health services. These settings can include primary health care clinics, long-term care facilities, and home and community-based care.

These different service systems often have different financing, organization, and delivery models with little or no collaboration among the practitioners. The complexity of receiving care from many practitioners in many settings often leads to a lack of coordinated services.
Integrated services can improve access, coordination, efficiency, and effectiveness of care for older adults with depression. This must occur across mental health, aging, or general medical health service settings and practitioners. Evidence-based models for integrating mental and physical health treatment should be used to provide effective depression treatment to older adults.

**Issue 8: Engagement of family members and other social support is critical to successful treatment**

Many older adults receive support and informal services from spouses, children, friends, neighbors and other people. Family involvement may be particularly important for support issues such as providing transportation, helping with activities of daily living, supporting adherence to prescribed medications, and helping to negotiate the complex system of health care and social services. Social support can help offset the risk of developing depression in older age.

Family members and other social supports are critical to successful treatment. Involve family members in assessment and treatment planning to improve the effectiveness of depression treatment, so long as it is desired by the care recipient.

**Issue 9: Maintaining independence and aging in place are common values of older adults**

A common goal for many older adults is to remain in their own homes or in supported community settings as long as possible. Maintaining independence contributes to healthy aging and acts as a deterrent for depression. For many older adults, the loss of independence associated with living in a nursing home is a major fear and concern.

Treatment of depression should support the independent community functioning goals of the older adult. In some instances, this may require a discussion with the older adult and family members about the potential risks of continuing to live alone or to live in the home when a supervised setting may be safer.

You can support the older adult in his or her desired living setting and lifestyle in these ways:

- Arranging for in-home health care, homemaker services, home-delivered meals, and access to transportation; and
- Installing medication distribution devices, electronic help alert buttons, automated phone check-ins, telemedicine monitoring devices, and mechanical assistive devices for walking and climbing stairs.

**Take a preventive approach in supporting the older adult in his or her desired living setting and lifestyle.**

When desired by the older adult, involve family members and caregivers in assessment and treatment planning.
**Issue 10: Ageism and stigma affect treatment access, expectations, and outcomes**

It is common to hear the statement that “depression is normal in older age.” Alternatively, one hears “if I had all those losses and physical health problems I’d be depressed, too.” These views perpetuate the lack of recognition, diagnosis, and treatment of depression in older adults.

The societal stigma placed on depression can discourage older adults from seeking treatment because they may feel ashamed, that it is their fault, or that they should be able to help themselves feel better.

Only about half of older adults with any mental health disorder receive treatment (Klap, Unroe, & Unützer, 2003). Recognizing ageism and stigma is a critical component of effective depression treatment. Important strategies for reducing ageism and stigma include the following:

- Educating the public about mental health and aging issues; and
- Educating and empowering older adults about treating their depression.

Recognizing and addressing ageism and stigma is a critical component of effective depression treatment.

**Issue 11: Cultural differences can affect perceptions of depression, access to treatment, treatment preferences, and treatment outcomes**

Cultural and ethnic differences affect older adults’ understanding of depression, feelings of stigma, and incentives to seek and engage in treatment.

Different racial and ethnic minority groups approach and understand treatment for depression in different ways. For example, older African-Americans often seek a remedy for depression through their spiritual communities. Older Asian Americans tend to perceive more stigma from needing or using mental health services than older Caucasian or African American adults. Asian Americans also tend to focus on physical problems, rather than emotional problems, and their use of formal mental health services is relatively low. Latino older adults may report problems with their nerves, which is an indicator of anxiety or depression in their culture, yet it is not a diagnostic symptom of depression.

Cultural expressions and understanding of depression in older adults can serve as barriers to developing and delivering effective treatment if they are not addressed by practitioners. Some ethnic groups may not readily disclose information related to depression and you may need a different approach to interact with them and encourage them to speak up. Training in cultural competency will help you deliver effective depression treatment.

Finally, EBPs for depression in older adults have typically been studied in populations that lack diversity. Very little research has included enough representation of racial and ethnic minority groups. Older adults from racial and ethnic minority groups have more health and social disparities than Caucasian older adults.
These issues, along with different perceptions of depression and treatment seeking behavior, may change the effectiveness of an EBP for older adults from racial and ethnic minority groups. However, the prevailing approach is to assume that if the EBP works for one group of older adults, it should work for another group.

### Issue 12: Depression can be prevented

Prevention is not limited to the young. You should identify older adults who are at risk for developing depression and encourage them to participate in effective preventive interventions. Older adults who are at risk for depression include those who have been recently bereaved or who have had recent disabling physical health problems. Loss of vision, a recent stroke, or loss of the ability to walk can be associated with an increased risk for depression.

Existing programs, such as problem-solving treatment and regular exercise, can help prevent the onset of a depressive disorder in some older adults.

When appropriate, encourage older adults who are at risk for depression to participate in a program of problem-solving treatment or regular exercise.

### Issue 13: Older adult depression is associated with the highest rate of suicide

Older adults with untreated depression, particularly those who are isolated and have had recent losses, are at high risk for suicide. The rate of suicide among older adults is higher than that for any other age group. The vast majority of older adults who complete suicide are males, especially white males (Miniño, Arias, Kochanek, Murphy, & Smith, 2002; National Center for Injury Prevention and Control, 2008).

Prevention of suicide in older adults is of special importance for several reasons. Older adults are less likely to report suicidal ideation compared to younger adults, and suicide attempts are more likely to be deliberate and lethal. Compared to younger adults, older adults make fewer attempts per suicide (Heisel and Duberstein, 1995).

It is common for older adults who complete suicide to visit a primary care practitioner very close to the time of suicide, yet not disclose their suicide intentions. More than half (58 percent) of older adults (over age 55) contact their primary care practitioner within 1 month of completing suicide. In contrast, only 11 percent of older adults contact a mental health practitioner within one month of completing suicide (Luoma, Martin, & Pearson, 2002). Primary care practitioners should be particularly aware of the need to identify and provide treatment to older adults with thoughts of suicide.
You should carefully assess suicide risk in older adults with depression and implement appropriate precautions and interventions. Screening for depression, psychoeducation, telephone-based support, and group-based activities can reduce the rate of suicide among older adults. Providing EBPs for treating depression can reduce thoughts of death and suicide.

You can access more information on suicide prevention strategies through the Suicide Prevention Resource Center: [http://www.sprc.org/](http://www.sprc.org/)

**Issue 14: Psychotherapy can be as effective as medications**

Psychotherapy for older adult depression is effective. However, adaptations and modifications may be necessary, particularly in older adults with cognitive impairment. Important modifications include repetition, breaking down tasks into smaller components, and other individually tailored changes.

Short treatment with therapies such as cognitive behavioral therapy or problem-solving treatment can be very effective for older adults with depression. For some older adults with major depression, the combination of antidepressant medication and psychotherapy is more effective than either approach alone. For older adults with minor depression, psychotherapy may be more effective than medications and is the treatment of choice.

Tailor psychotherapy interventions to address the cognitive, physical, and sensory needs of older adults (for example, repetition and breaking tasks into smaller components). Consider whether the combination of psychotherapy and antidepressant medications will be effective for the older adult.
<table>
<thead>
<tr>
<th>Steps You Can Take</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess and treat co-occurring depression and physical disorders in a coordinated and integrated manner.</td>
</tr>
<tr>
<td>2. Offer more frequent practitioner appointments and contact to older adults with co-occurring depression and anxiety.</td>
</tr>
<tr>
<td>3. Include a formal evaluation of cognitive functioning when you assess and treat depression in older adults.</td>
</tr>
<tr>
<td>4. Ask a pharmacist or other prescribing practitioner to review the older adult’s prescribed and over-the-counter medications for potential adverse drug interactions or impact on dosage levels.</td>
</tr>
<tr>
<td>5. Evaluate the older adult’s use of alcohol and psychoactive substances. Treatment should address both depression and substance use problems.</td>
</tr>
<tr>
<td>6. Evaluate and address functioning, which is key in developing treatment plans.</td>
</tr>
<tr>
<td>7. Ensure that collaboration and integration of services occur across mental health, aging, or general medical health services to provide the most effective care for older adults with depression.</td>
</tr>
<tr>
<td>8. When desired by the older adult, involve family members and caregivers in assessment and treatment planning.</td>
</tr>
<tr>
<td>9. Take a preventive approach in supporting the older adult in his or her desired living setting and lifestyle.</td>
</tr>
<tr>
<td>10. Recognize and address issues of ageism and stigma.</td>
</tr>
<tr>
<td>11. Receive training in cultural competence and provide culturally appropriate care for older adults with depression.</td>
</tr>
<tr>
<td>12. When appropriate, encourage older adults who are at risk for depression to participate in a program of problem-solving treatment or regular exercise.</td>
</tr>
<tr>
<td>13. Assess suicide risk in older adults with depression and implement appropriate interventions.</td>
</tr>
<tr>
<td>14. Tailor psychotherapy interventions to address the cognitive, physical, and sensory needs of older adults. Consider whether the combination of psychotherapy and antidepressant medications will be effective for the older adult.</td>
</tr>
</tbody>
</table>
Evaluating Care

You can use outcome data to provide feedback to older adults. This information can be useful in discussions about the effectiveness of treatment and whether treatment goals are being met.

Monitoring the symptoms of depression in your older adults will help you determine the effectiveness of treatment. If the symptoms of depression do not improve after an appropriate course of treatment, it may be time to change your approach and reconsider other treatment options.

For helpful ideas for collecting and evaluating data, see Evaluating Your Program in this KIT.

Implementing EBPs

Implementing an EBP can help improve the care that your organization provides to older adults. You have an important role in creating these system changes and helping to develop plans for providing a new EBP. You can support the implementation of a new program in these ways:

- Identifying the characteristics of the older adults you serve and what services are needed;
- Providing recommendations to supervisors or program administrators;
- Participating in an implementation task force or advisory board;
- Receiving training, supervision, and ongoing coaching in the new practice; and
- Using data to monitor and provide feedback on the effectiveness of the program.

Identify characteristics of your older adults and what services are needed

Several characteristics of older adults affect the delivery and effectiveness of programs to treat depression. Gender, age, ethnicity, and health status can influence health beliefs and behaviors and affect how older adults access and respond to depression care.

You can be particularly helpful in identifying the gaps in agency services for older adults with depression by taking these steps:

- Identifying priority problem areas for your older adult population;
- Identifying what existing services can address these identified areas; and
- Identifying new programs that may fill remaining gaps in the services that your agency provides.

For suggestions on how to match EBPs with the characteristics of your older adult population and your organization, see Selecting Evidence-Based Practices for Treatment of Depression in Older Adults in this KIT.
## Provide recommendations to supervisors or program administrators

After you have identified a program that may be beneficial to your organization and the older adults you care for, you may wish to begin discussions with your supervisor or program administrator.

Be prepared to describe the following:
- The characteristics of the program;
- The areas that the program could improve;
- The fit between the program and the mission of your organization;
- The resources necessary to implement the program; and
- The evidence supporting the new program.

This KIT provides some of this information in the booklet on *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults*.

## Participate in an advisory board

Most organizations that choose to implement a new practice will develop an advisory board or an implementation task force. An advisory board may include practitioners, agency and program administrators, older adults and their family members or caregivers, community members, and other important stakeholders.

If your agency develops an advisory board, you can offer to participate. The advisory board can help guide how the EBP fits with the culture of the organization and can identify what changes the organization can make to adopt the new practice.

## Receive training, supervision, and ongoing coaching in the new practice

You should expect to receive training, supervision, and ongoing coaching to ensure that you provide the EBP in the correct manner. You also should receive support for training in aging and geriatrics.

Training is essential to successfully implement any EBP. Most practitioners are introduced to the knowledge and skills needed to incorporate EBPs into their own work with older adults through preservice training, inservice training, and other continuing education.

Helpful learning methods include the following:
- Participating in case conferences;
- Modeling of interventions by a trainer or consultant; and
- Job shadowing at model sites.

The most valuable trainings include a demonstration of skills necessary for carrying out an intervention, immediately followed by an opportunity to practice skills and receive feedback.

Skill-based training may be of particular importance if you are new to working with older adults. A lack of training or experience working with older adults can interfere with your ability to communicate or work effectively with this population.
The importance of training practitioners to care for older adults, especially those with depression, was listed as a priority by the White House Conference on Aging (2005). In addition to specific skills needed to implement EBPs, practitioners who care for older adults need training in these key areas:

- Addressing issues that are common or unique to older adults and
- Recognizing, assessing, and treating depression in older adults.

**Agency training**

At least some portion of your training in the new EBP will be provided by the agency for which you work. Agency training often includes instructions for incorporating the new practice into existing work activities and organizational practices.

Sometimes agencies will send one of their practitioners to receive training in the new EBP. However, simply attending a single workshop is not adequate for mastering an EBP. Practicing the EBP through roleplaying, experience-based learning, and ongoing supervision is critical. Once the EBP is mastered, trained practitioners can then train their colleagues.

**Supervisor or coach support**

Ideally, training will be accompanied by set-aside time for ongoing supervision from trained practitioners within the agency.

Ongoing supervision and coaching will help you develop and maintain newly learned skills. Once the initial training is completed, you should have routine and ongoing feedback to ensure that the specific EBP is delivered with fidelity. Retraining exercises can reinforce your behaviors and correct problems that result from misinterpretation or poor application of programs. Coaching helps incorporate formal learning with clinical expertise in ways that will help you see how new skills apply to your individual practice.

**Accessing training manuals and technical assistance**

The availability of training resources varies for the different EBPs for depression in older adults. Some programs offer comprehensive training resources. Some provide manuals for how to deliver the intervention. Other programs may offer no support for training practitioners.

For a description of available training resources and program manuals, see *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults* in this KIT.
Use data to monitor and provide feedback on the effectiveness of the program

You have an important role in assessing both the effectiveness of the implementation process and the effectiveness of the EBP for the older adult.

Data collected over several time points will help you provide feedback and identify the strengths and weaknesses of a program. Evaluations of process and outcome measures can help you monitor the effectiveness of program implementation.

One of the most important reasons that health care organizations support using EBPs for older adults with depression is that these treatments reduce symptoms of depression. This means that, if the EBP is implemented correctly, it should result in fewer symptoms of depression among older adults who receive the treatment.

Sometimes you can use specific process measures called fidelity instruments to evaluate whether you are providing the program in a way that is consistent with the core features of the EBP. When fidelity instruments are not available, you can answer other questions to assess the quality of implementation.

By monitoring standardized outcome measures, you can determine an older adult’s progress toward desired treatment outcomes. You may already be using standardized outcome measures. If not, you may need support from your supervisor or agency administrators and assistance from your quality assurance or information technology teams to institute these measures.

By continuously monitoring the effectiveness of an EBP for older adults, you can assess how well the EBP has been implemented. If outcome monitoring does not show improvements among older adults who receive the treatment, this may be a sign that the EBP is not fully or appropriately implemented, or that the selected intervention was inappropriate for the older adult. When aggregated, these data can indicate whether there are issues at the program level related to EBP implementation.

If you recognize problems with implementation, you should work with your colleagues, supervisor, coach, and administrators to evaluate the components of the program and determine where improvements are needed.

For helpful ideas for collecting and evaluating data, see Evaluating Your Program in this KIT.
**Steps You Can Take**

- Know the characteristics of older adults who receive treatment at your health care setting or organization and identify common problem areas that they wish to address.
- Identify existing resources that address problem areas.
- Identify additional programs or resources that are needed to address these areas.
- Recommend adopting a specific EBP to your supervisor or program administrator.
- Help guide the process of implementing an EBP by participating on an advisory board.
- Work with agency administrators and program leaders to develop the needed supports for EBP implementation.
- Learn new skills to provide effective depression treatment to older adults.
- Monitor process and outcome measures to evaluate the effectiveness of implementation and treatment.