

# Depression in Nursing Home Residents

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# Overview

- NH epidemiology
- Depression Differential Dx
  - Depression in Dementia
  - Minor Depression
- PASRR Research
- Evidence Based Treatment Model
  - Depression Care Management
- Case Examples
- PASSR and Evidence Based Practice

# PREVALENCE OF DEPRESSION IN GERIATRIC POPULATIONS

<u>Setting</u>	<u>Maj. Depr.</u>	<u>Depr. Sxs.</u>
Community	1 - 4%	8 - 16%
Med. Clinics	5 - 10%	17 - 35%
Nursing Homes	12 - 20%	30 - 45%

# Nursing Home Depression

## Differential Diagnosis

- **Major Depression**
- **Dysthymia**
- **Depression and Dementia**
- **Subsyndromal**
  - **Minor Depression**
  - **Bereavement**
  - **Failure to Thrive**

# Depression of Alzheimer's Disease (Provisional)

- 1) Clinically significant depressed mood (sad, hopeless, discouraged, tearful)
- 2) Decreased positive affect or pleasure to social contact, usual activities
- 3) *Social isolation or withdrawal*
- 4) Disruption in appetite
- 5) Disruption in sleep
- 6) Psychomotor changes (e.g. agitation, retardation)
- 7) *Irritability*
- 8) Fatigue or loss of energy
- 9) Worthlessness, hopelessness, inappropriate guilt
- 10) Recurrent thoughts of death, suicidal ideation

# Depression of Alzheimer's Disease

- Removal of memory/concentration item
- Adding
  - Social isolation/withdrawal(not due to just cogn)
  - Irritability
- 3 sxS required instead of 5
- Sxs over 2 wks but not necessarily daily

Olin JT et al. Am J Geriatr Psychiatry 2002;10:125-128

# Depression in Alzheimer's Disease

- **12 wk RCT of Sertraline vs placebo**
- **N=22 Outpatients with maj. depression**
  - Avg Age = 77yrs
  - Avg MMSE = 17
- **Sertraline avg dose (81mg)**
  - 8-12 point decrease Cornell Scale for Depression
  - No significant change in Ham-D, Cogn, ADLs

Lyketsos et al. Am J Psychiatry  
2000; 157(10): 1686-1689

# Sertraline in Severely Demented Patients

- RCT, N=31 nursing home patients, 8wks
- All stage 6 or 7 Global Deterioration Scale
- 84% with minor depression
- Sertraline vs. placebo
- Cornell Scale for Depression in Dementia

Sertraline: pre=6, post =3

Placebo: pre=6, post=4

- P=NS

**Magai C et al. Amer  
J Geriatr Psychiatry  
2000;8:66-74.**



# **Minor Depression**

## **Research Criteria for Further Study**

- **2-4 of 9 criteria sxs for Maj. Depression**
- **Depressed Mood or Anhedonia**
- **No hx major depression, Mania**
- **Not Dysthymic**

# **NURSING HOME MINOR DEPRESSION**

- **RCT: Paroxetine vs Placebo**
- **N=24 without criteria Maj. Depression**
- **Mean Age: 88yrs**
- **Results:No differences(CGIC, Ham D, Cornell)**
  - **45% placebo response rate**
- **Paroxetine - Decreased MMSE**

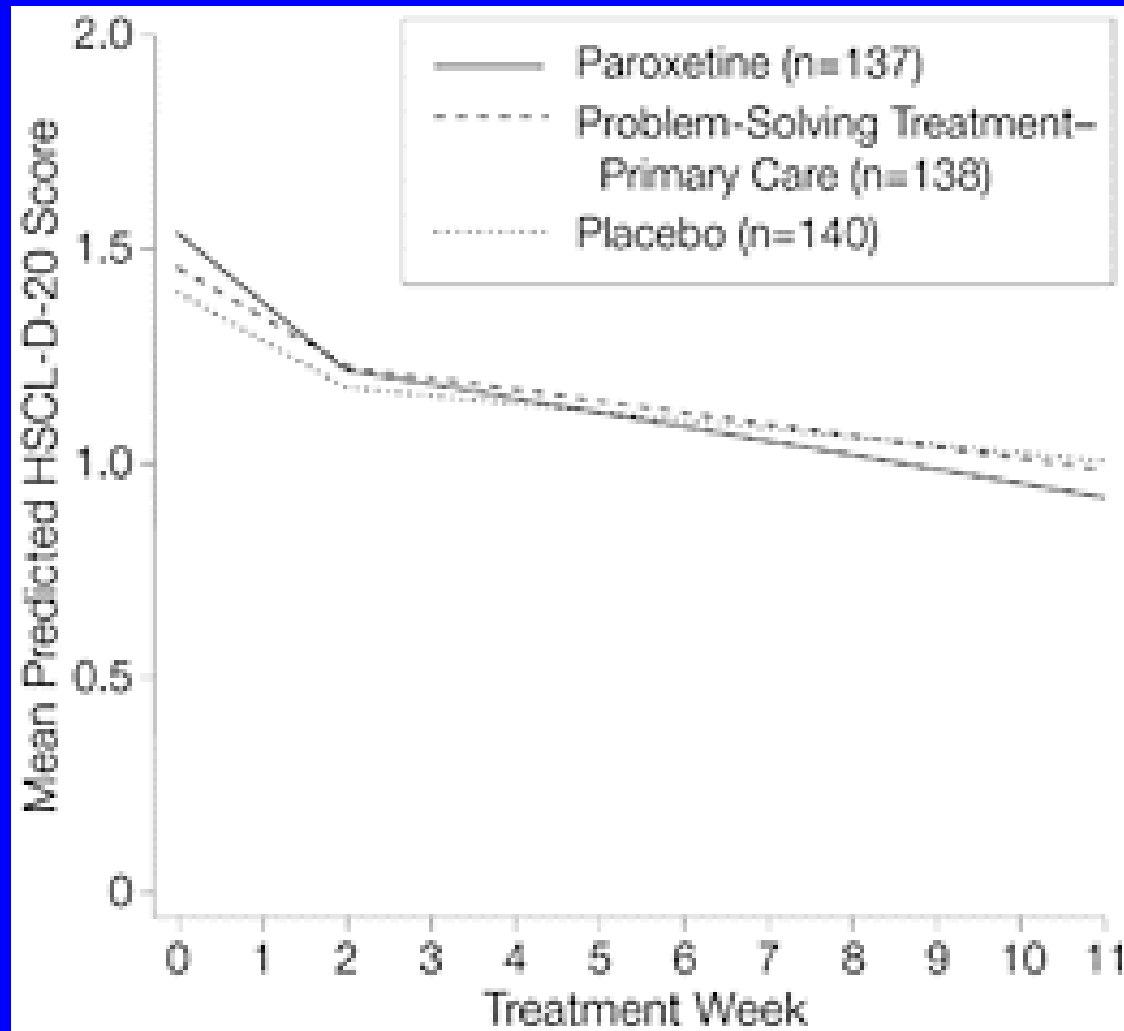
**Burrows A et al. Depress Anx  
2002; 15(3):102-10**

# Minor Depression and Dysthymia in Primary Care Elderly

- **N= 415 pts  $\geq$  60yr**
- **11 wk, multi-center trial**
- **3-4 sxs at least 4wks AND Ham-D  $>9$**
- **RCT paroxetine vs placebo+usual care vs PST**

Williams JW et al. JAMA  
284:1519-1526, 2000

# HSCL-D-20 Scores by Treatment Assignment



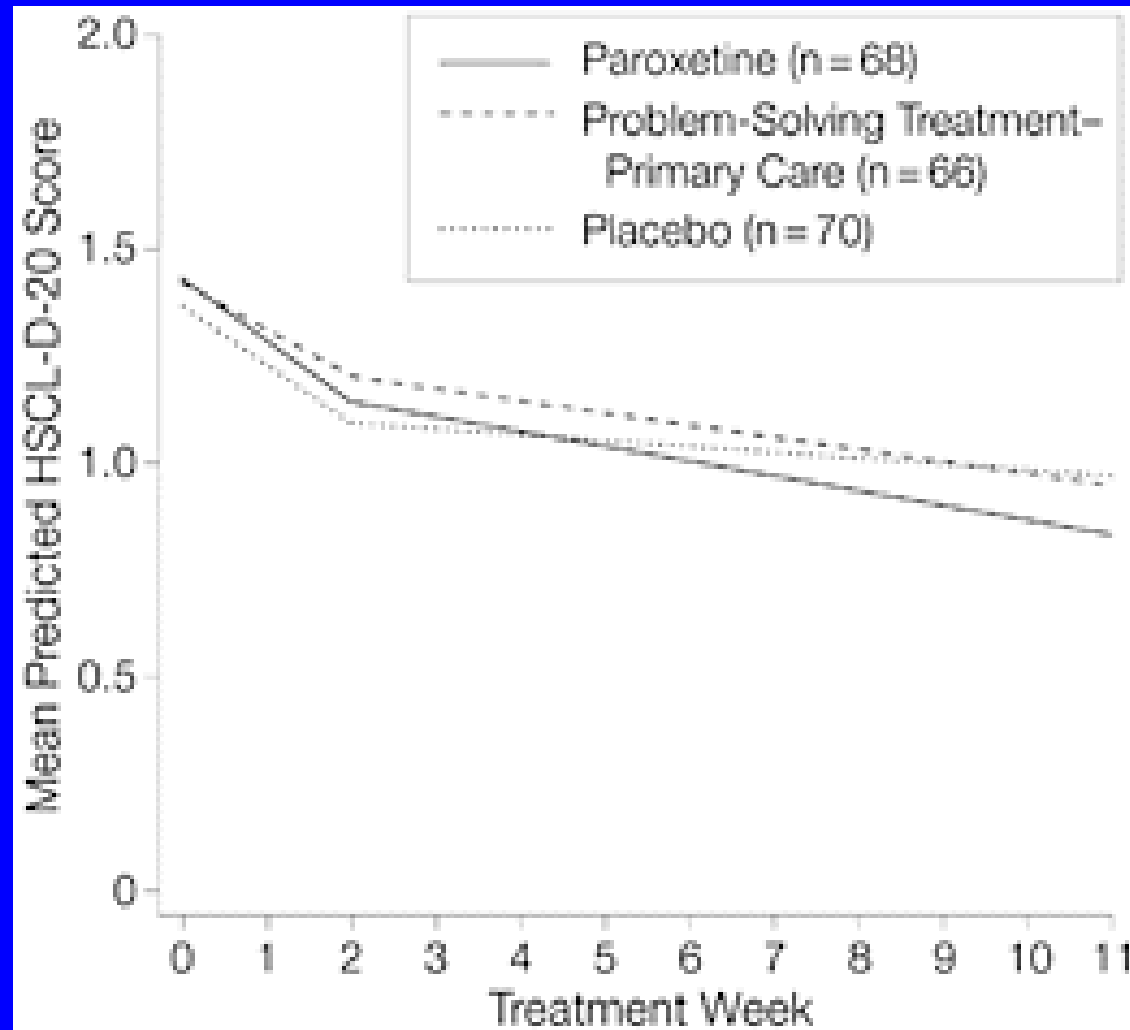
Williams, J. W. et al. *JAMA* 2000;284:1519-1526.

# **Minor Depression and Dysthymia in Primary Care Elderly**

- Statistically significant for paroxetine, not PST

**Williams JW et al. JAMA  
284:1519-1526, 2000**

# HSCL-D-20 Scores of Patients With Minor Depression



Williams, J. W. et al. JAMA 2000;284:1519-1526.

# Remission Rate

- Minor Depression
  - Paroxetine 53%   PST 44%   Placebo 49%
- Dysthymia
  - Paroxetine 46%   PST 51%   Placebo 40%

No treatment statistically significant vs Placebo

**Williams, J. W. et al. JAMA  
2000;284:1519-1526**

# PROSPECT

## Prevention of Suicide in Primary Care Elderly: Collaborative Trial

- N=598 elderly, 20 primary care clinics, 3 cities
- CES-D > 20, depression dx (Major and Minor)
- Minor = 4 symptoms, Ham-D >9, 4 weeks duration
- Intervention: Depression Care Managers
  - Antidepressant algorithm
  - Interpersonal Psychotherapy
- Usual Care

**Bruce ML et al, JAMA  
2004; 291(9): 1081-1091**



# PROSPECT

## Prevention of Suicide in Primary Care Elderly: Collaborative Trial

- Ham-D reduction

- Major Depression

- Statistically significant difference

- 50% vs 43% lower intervention vs usual care

- Minor Depression-

- Not statistically significant

- 38% reduction vs 34%, intervention vs usual care

**Bruce ML et al, JAMA  
2004; 291(9): 1081-1091**

# PEARLS

## Program to Encourage Active and Rewarding Lives for Seniors

- RCT N=138 pts, > 59 yrs old
- Minor Depression (51%), Dysthymia (49%)
- PEARLS
  - Problem Solving Psychotherapy
  - Physical and Social Activation
  - Antidepressant Consultation
- Versus: Usual Care

**Ciechanowski P et al, JAMA  
2004; 291:1569-1577**

# PEARLS RESULTS

- Decrease (50% or more) depression score
  - 43% intervention group vs 15% usual care
- Remission
  - 36% intervention group vs 12% of usual care

**Ciechanowski P et al, JAMA  
2004; 291:1569-1577**

# Psychiatric Treatment

- **Treatment prevalence**
  - **2.3% specialist**
  - **2.2% generalist**

1985 National Nursing  
Home Survey

# Nursing Home Statistics

## 2004 National Survey

- Provision of Mental Health Services

Regular Basis	25.1%
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On-Call Basis	24.2%
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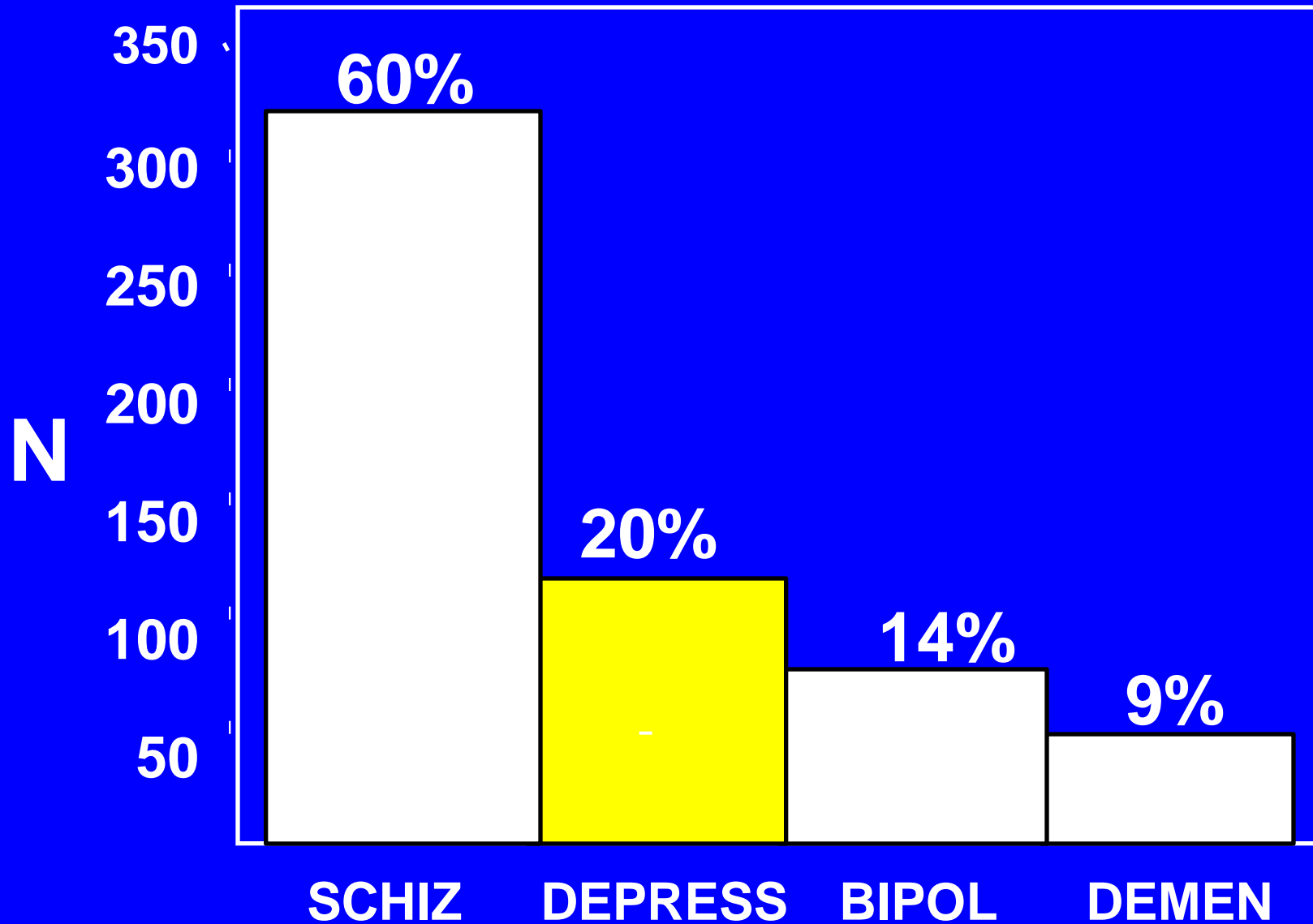
Any	77.7%
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# WA State PASARR Study 1992-1993

- 523 Medicaid recipients with Level 2 eval
  - 33% of all the completed Level 2s
- Age (Mean) - 64.3
- Women – 71%
- Caucasian- 93%
- Urban-84%
- Psychiatric Services in prior year-87%
  - Med mgt 87%
  - Consultation 4%

Snowden M et al  
JAGS 46:1132-36 1998

# DIAGNOSES



# Service Recommendations

- Overall
  - Medication tx-76%
  - Psychotherapy including Behav. Mgt-40%
  - Psychiatric Consultation- 30%
- New Service Recommendations
  - Medication tx- 7.6 %
  - Psychotherapy including Behav. Mgt-40%
  - Psychiatric Consultation- 27%



# Recommendation Compliance

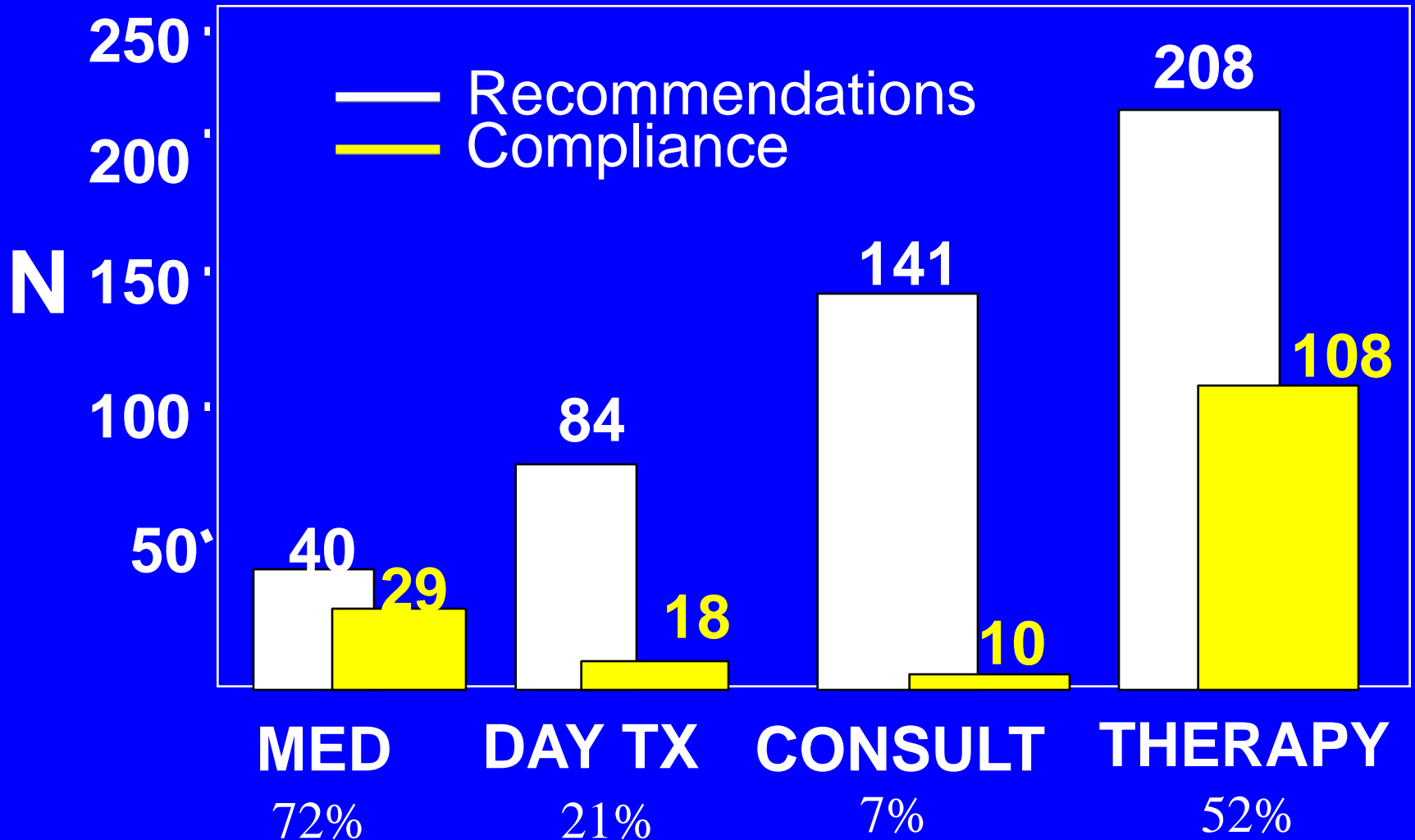
- Overall (Continuation and New Services)

Medication      94%

Therapy          52%

Consultation    7%

# NEW SERVICE RECOMMENDATION COMPLIANCE



# Predictors of Services

- Depression Associated with Decreased Services
  - Odds ratio 0.39 for new service
  - Odds ratio 0.36 for any non-pharmacological service
  - Odds ratio 0.28 for medication mgt

Snowden M et al  
JAGS 46:1132-36 1998

# Depression Care Management for Older Adults

Intervention components:

- Active screening for depression
- Measurement-based outcomes
- Trained depression care manager
- Effective Treatment and Monitoring
- A supervising psychiatrist

# Screening and Measurement Based Outcomes

- Accurate
- Responsive to Change over time

Screening and Identification of depressed individuals are necessary. . .

# Screening and Identification . . .are insufficient to improve treatment or outcomes

*The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow up.*

# Recommended Instruments

- Geriatric Depression Scale (GDS-15)
  - Not as confounded by medical illness sx overlap
- Patient Health Questionnaire (PHQ-9)
  - More aligned with DSM criteria



# Geriatric Depression Scale-15 item

- Cognition: Limited Data
  - Most Studies used cognitively intact (MMSE>24)
  - May be valid down to MMSE 12-18 (NH data)
- Common Problems and Solution Strategies
  - Forced Yes/No format
    - Use “most days”, “some days”

# PHQ-9

- Common Problems and Solution Strategies
  - 4 item response choices
    - Use written response card when performed verbally
    - Dichotomize into “Have you been bothered... Y/N” then present 3 choices for “yes” responses.
    - Request precise number of Days of last 14 days
  - Cognition
    - Less well studied in cognitively impaired
    - Easily valid to MMSE of 21

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- **Trained depression care manager**
- Effective Treatment and Monitoring
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# Care Manager Training

- Focused on Brief Intervention Models
- Often given to those without MH backgrounds
  - Web-based – 2 day in person
  - Some with certification (e.g. PST)
- Team Based
- Provides
  - Pt education
  - Primary care provider education, guidance
  - Therapy and/or monitoring

# Depression Care Management for Older Adults

Intervention components:

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- Trained depression care manager
- **Effective Treatment and Monitoring**
- A supervising psychiatrist

# Psychotherapeutic Approaches

- Cognitive Behavioral Therapy
- Problem Solving Therapy
- Interpersonal Therapy
- Behavioral Activation

# GERIATRIC ANTIDEPRESSANT DOSING

	<u>Initial (mg)</u>	<u>Est. therapeutic Dose</u>
<b>Fluoxetine</b>	<b>10</b>	<b>10-40</b>
<b>Sertraline</b>	<b>25</b>	<b>50-200</b>
<b>Paroxetine</b>	<b>10</b>	<b>20-60</b>
<b>Citalopram</b>	<b>10</b>	<b>20-60</b>
<b>Escitalopram</b>	<b>5</b>	<b>10-30</b>
<b>Duloxetine</b>	<b>30</b>	<b>40-60</b>
<b>Bupropion</b>	<b>75</b>	<b>200-450</b>
<b>Venlafaxine</b>	<b>37.5</b>	<b>150-375</b>
<b>Mirtazapine</b>	<b>15</b>	<b>30-45</b>

# Treatment Monitoring

- Treatments typically over 2-12 sessions
- 2-6 months duration
- Routine outcome measurement
  - E.g. PHQ-9 or GDS-15 each visit



# Depression Care Management for Older Adults

Intervention components:

- Active screening for depression
- Measurement-based outcomes
- Trained depression care manager
- Effective Treatment and Monitoring
- A supervising psychiatrist

# Supervising Psychiatrist

- Antidepressant Recommendations when necessary
- Psychotherapy support and guidance when necessary

# Depression Case #1

**77yo wm in NH for 3y, s/p geropsych hospitalization 1 month ago for depression, Behavioral disturbance (yelling, sobbing). Dxs include vascular dementia (MMSE 19) Narcissistic personality disorder, hx ETOH abuse. Current meds include nortrip 75mg Dextroamphet 10mg bid, olanzapine 7.5mg daily, clonazepam 0.5mg bid, lorazepam 1-2 q 6hrs prn anx/agitation. GDS=12/15, reports sad, anhedonic, poor energy, insomnia, SI w/ request for assisted suicide. Behav mgt plan of meals in dining room to avoid isolation, Move to dining room or chapel at night when yelling/sobbing.**

**Med Problems: CHF, CAD, hx cva, hypothyroidism, arthritis, sleep apnea, obesity, Venous stasis dz w/ leg ulcerations.**

**Soc/Fam hx: retired business professor, divorced, son suicide, another son w/ schiz., Estranged from 2 dtrs and son.**

**Past tx of 4 yrs from MH team to NH w/ dx bipolar depression, vascular dementia, Narcissistic PD, ETOH abuse in remission. Past meds: citalopram, sertraline, bupropion, Venlafaxine, duloxetine, lamotrigine, (hx lithium), lorazepam, trazodone.**

# Depression Case # 2

**70yo WF w/ hx of depression s/p ischemic cva 5y ago, NH placement 1y ago after fall w/ shoulder, hip fx. Reports w/ 3 wks of increased tearfulness, sadness, Tearfulness in excess of sadness but not totally noncongruent, anhedonia, poor concentration, worthlessness though not hopeless, poor energy, insomnia, poor appetite w/o wt loss. She denies SI, has some anxiety re med condition but denies panic attacks. She explains sadness as realization that she will not recover from disability of cva and fall in which she fx'd arm, hip but was felt too frail for surgical repair and thus won't be able to move to assisted living apartment. Now realizes after visit w/ adult kids that none can move her in with them. MMSE=22/30  
GDS= 10/15**

**Meds include citalopram 10mg for 9 mos. Past trial of bupropion dose unknown, intolerable GI sx's on sertraline.**

**Med Probs: Ischemic cva w/ L hemiparesis, frozen L shoulder, chr pain(shoulder, arm), hypothyroidism, s/p SAH, HTN, arthritis.**

**Soc/fam hx: Retired exec assistant, divorced at 42 yo, 3 children involved/supportive, no fam psych hx**

**MH treatment: Supportive therapy after her divorce.**

# Depression Case #3

**75yo WF w/ hx cva and L hemiparesis 6 yrs ago, admitted to NH 3mos ago after sudden death of husband 6mos ago who was her caregiver. Vascular dementia (BIMS=4) 3 Mos of sad, anhedonia, poor appetite w/ 15 # wt loss, passive SI, poor energy, worthlessness, motor retardation (no longer walks). GDS=11/15.**

**Meds include escitalopram 20mg x 6yrs, memantine, donepezil, rozerem, zolpidem  
Past tx w/ fluoxetine caused delirium.**

**Med problems: CHF, UTIs, fall w/ hip fx s/p orif 1 yr ago, hypothyroidism, hx GI Bleed.**

**Sochx: retired teacher, 3 children involved/supportive**

**Past psych: none**

# PASRR as Depression Care Mgt

## Can PASRR be integrated into NH Care?

Intervention components:

- Active screening for depression
- Measurement-based outcomes
- Trained depression care manager
- Effective Treatment and Monitoring
- A supervising psychiatrist