

Depression in the Long-Term Care Setting

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Goals

After this presentation, participants will be able to:

- List the signs and symptoms of depression
- Discuss difficulties of diagnosing depression in the long-term care setting
- Briefly describe treatment options for depressed older adults

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Prevalence of depression in the nursing home

- 2nd most common psychiatric diagnosis in LTC
- Wide variance of prevalence data
 - 15 – 50%
- Different
 - rating scales used
 - cutoff scores used
 - duration of symptoms required
 - populations studied
 - definitions of depression used

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**Prevalence of depression
(continued)**

- Risk of depression higher in long term care than in community setting
- 6% to 10% of all nursing home residents meet criteria for major depression
- 20% to 25% of long term care residents without dementia meet criteria for major depression
- “Minor” depression rates even higher

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**Newly-diagnosed depression in the
nursing home**

- 1-year incidence of 7.4%
- Risk higher in those starting with “minor” depression

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“Minor depression”

- Poorly defined
- Apparently common – up to 50% of those in LTC
- 2-4 X more prevalent than major depression
- 40-50% have more than one “kind” of depression

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Depressive symptoms

- Another unique category
- Very common
- May or may not be psychiatric in origin

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Morbidity associated with depression

- Pain complaints
- Suboptimal nutrition
- Cardiovascular disease
- Immune function compromise

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Mortality associated with depression

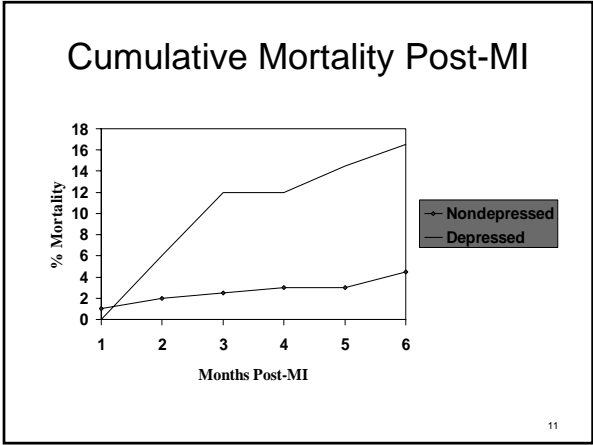
- 1-year mortality rate of newly admitted LTC residents:
 - No depression: 29%
 - Depressive symptoms: 24%
 - Major depression: 47%
- Likely due to
 - poor nutrition
 - decreased activity level
 - immune dysfunction?
 - cardiovascular disease?

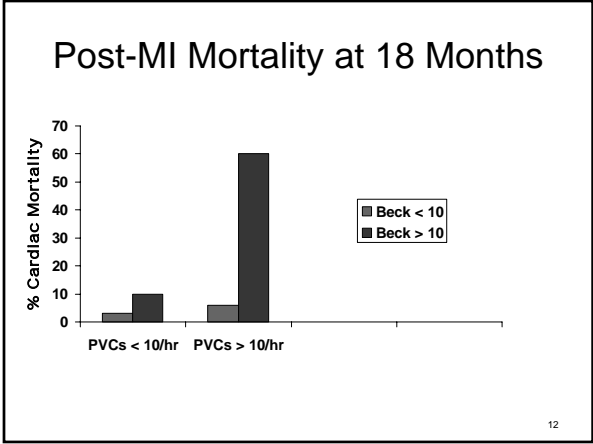
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Post-MI mortality

Risk Factor	Relative Risk
■ Daily smoker	2.2
■ > 3 PVCs /hour	3.5
■ Ejection fraction < 35%	3.5
■ Previous MI	5.2
■ Depression	5.7

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“Excess disability”

- Dementia + depression → more functional loss than expected from dementia alone
- Potentially treatable

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Relationship between depressive symptoms and neurologic disorders

- Alzheimer's disease: 0-86%
 - Apathy from dementia not the same as depression
- Parkinson's disease: 20-40%
 - Psychomotor retardation from PD resembles depression
- Vascular dementia: depression may occur 12-24 months post CVA

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Depression in older adults

- Depressed mood less common
- Anxiety often prominent
- Often present with physical symptoms
 - fatigue
 - sleep or appetite changes
 - hypochondriacal concerns
 - headaches, backaches, abdominal pain

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Depression vs. dementia

- Early dementia → decreased interests, apathy
- Depression → subjective cognitive deficits
 - poor effort on testing: “I don’t know”
- Which came first?
- When in doubt: antidepressant trial

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General medical causes of depressive symptoms

- Anemia
- Thyroid disease
- Metabolic disturbances
- B12 deficiency
- Occult malignancy
- Stroke
- Parkinson’s disease

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Depression rating scales

- GDS: Geriatric Depression Scale
 - 15-item vs. 30-item form
 - Caregiver report vs. patient report
- Beck Depression Inventory: not geared for older adults; 4-point scales
- Cornell Scale for Depression in Dementia
- Hamilton Depression Rating Scale: Used primarily in studies
- DSM-IV criteria

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DSM-IV Criteria for Major Depression (SIG: E CAPS)

- 2-week history of depressed mood OR loss of interest

PLUS at least 4 of the following:

- Sleep disturbance
- Interests low
- Guilt
- Energy low
- Concentration poor
- Appetite changes
- Psychomotor agitation or retardation
- Suicidal thoughts

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Geriatric Depression Scale

- Originally a 30-item form
- Now has 15-item form with good validity
- “Yes/No” questions
- May be filled out by patient or collateral source

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Research on the GDS

- 30-item form in LTC
 - 63% sensitivity, 83% specificity
 - Increases to 84%/91% if MMSE at least 15/30
- 15-item form in outpatient geriatric assessment clinic
 - Little association between patient and collateral source answers
 - Patients under-report
 - Family members over-report

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The Geriatric Depression Scale (GDS) – 15-item form

- Are you basically satisfied with your life?
- Have you dropped many of your activities and interests?
- Do you feel that your life is empty?
- Do you often get bored?
- Are you in good spirits most of the time?

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GDS

- Are you afraid that something bad is going to happen to you?
- Do you feel happy most of the time?
- Do you feel helpless?
- Do you prefer to stay at home rather than going out and doing new things?
- Do you feel you have more problems with memory than most?

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GDS

- Do you think it is wonderful to be alive now?
- Do you feel pretty worthless the way you are now?
- Do you feel full of energy?
- Do you feel that your situation is hopeless?
- Do you think that most people are better off than you are?

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Beck Depression Inventory

- 21 items
- Each item rated from 0 to 3
- Intended for use by cognitively intact persons

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Example of Beck Depression Inventory question

- 0 I do not feel sad
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it
- 3 I am so sad or unhappy that I can't stand it

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Cornell Scale for Depression in Dementia

- 19 items
- Each item rated from 0 to 2
- Intended for a collateral source to do the rating

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Example of Cornell Scale question

- Anxiety: anxious expression, ruminations, worrying

A (unable to evaluate)

0 = absent

1 = mild or intermittent

2 = severe

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What about the Minimum Data Set?

- 400 subject in 20 nursing homes
- Limited validity as a depression screening tool
 - Correlation coefficients of 0.15-0.44
- In another study of 85 NH residents, MDS identified 24% of residents with elevated GDS scores

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Treatment

- Psychotherapy
- Pharmacotherapy
- Electroconvulsive therapy (ECT)

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Nonpharmacologic treatment of depressive symptoms

- Peer volunteers supervised by social worker: 40% drop in GDS scores
- Group cognitive therapy (30% reduction in BDI scores) vs. music therapy (3% reduction)
- "Bicycle therapy": 45% reduction in GDS scores
 - Wheelchair attached to bicycle, pedaled by staff 1 hour/day, M-F
- Bright light: 24% reduction in GDS scores

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Use of antidepressants in the nursing home

- 1991-1997: 13% → 25%
 - Other studies show up to 60% of NH residents on an antidepressant
- 32% on subtherapeutic dosages
- Of those taking an antidepressant, 50% still showed depressive symptoms
 - May be due to lack of adequate follow-up care, inadequate doses used, or that depression in this population is harder to treat

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Antidepressants: research data

- Nortriptyline: best data
 - 58% improved vs. 8% of controls
 - Another study: 9 mg/d better (42% responded) than normal dose (14% responded)
- Serotonin reuptake inhibitors: data less robust
 - Appears to not work as well in demented depressed individuals

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2003 Consensus Statement

- Combined effort of The American Geriatrics Society and The American Association for Geriatric Psychiatry
- Consensus panel recommendations for management of
 - Depression
 - Behavioral problems associated with dementia

in the nursing home.

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Consensus Statement: Screening

- Screen for depression
 - 2-4 weeks after admission
 - And at least every 6 months
- Also assess when new onset of depressive symptoms seen, or worsening of existing symptoms

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Consensus Statement: Use of screening instruments

- Depression screening instruments should be used
- Use self-report scales (e.g. GDS or Beck Depression Inventory) only for those residents with no more than moderate dementia
- Use observer-rated scales (e.g., Cornell) for residents with moderate to severe dementia
- The Minimum Data Set used alone is inadequate for depression screening

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Consensus Statement: When to refer

- Residents with suicidal ideation should be considered for immediate referral to a mental health professional
- Residents who have depression with psychotic features, or who have not responded to 6 or more weeks of treatment should be referred to a mental health professional (or qualified primary healthcare provider)

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Consensus Statement: Treatment

- Non-pharmacologic therapies should be used in conjunction with antidepressants
 - Group/individual psychotherapy (when appropriate)
 - Social activities
 - Volunteering
 - Religious activities

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Consensus Statement: Choice of Antidepressant

- Serotonin reuptake inhibitors are generally the first-line choice
- Other classes of antidepressants may be used
- Avoid amitriptyline, doxepin, monoamine oxidase inhibitors, clomipramine

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Consensus Statement: Treatment of Minor Depression

- Alternatives:
 - Antidepressants
 - Non-pharmacological interventions
 - "Watchful waiting"
- Choice depends upon severity, prior history, and patient/family preferences

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Conclusions

- When in doubt, treat possible depression
 - Consider time-limited trial (e.g. 3-4 months) of an antidepressant
 - Don't forget non-pharmacologic treatment options
- Look for other causes of depressive symptoms
- Give enough medication for enough time
- Watch for potential drug-drug interactions
 - Coumadin

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References

- Peskind ER. Management of depression in long-term care of patients with Alzheimer's disease. *J Am Med Directors Assoc* 2003; Nov/Dec Suppl, S141-145.
- Snowden M, Sato K, Roy-Byrne, P. Assessment and treatment of nursing home residents with depression or behavioral symptoms associated with dementia: a review of the literature. *J Am Geriatrics Soc* 2003; 51:1305-1317.
- American Geriatrics Society and American Association for Geriatric Psychiatry. Consensus statement on improving the quality of mental health care in U.S. nursing homes: management of depression and behavioral symptoms associated with dementia. *J Am Geriatrics Soc* 2003; 51:1287-1298.

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