

Depression in Long-Term Care

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OBJECTIVES

- Know and understand:
- Incidence and morbidity of depressive disorders among older adults
- Signs and symptoms of depression
- Standard of care for management for older adults with depression in long-term care – understand the American Medical Directors Association Clinical Practice Guideline (AMDA CPG) for treating depression in long-term care

Definition Depression

- A spectrum of mood disorders characterized by a sustained disturbance in emotional, cognitive, behavioral, or somatic regulation and associated with significant functional impairment and a reduction in the capacity for pleasure and enjoyment

-AMDA CPG



EPIDEMIOLOGY AMONG OLDER ADULTS

- Minor depression is common
 - 15% of older persons overall
 - 50% long-term care
 - Causes ↑ use of health services, excess disability, poor health outcomes, including ↑ mortality

EPIDEMIOLOGY AMONG OLDER ADULTS

- Major depression is not common
 - 1%–2% of physically healthy community dwellers
 - 12-16% in long-term care
 - Elders less likely to recognize or endorse depressed mood

EPIDEMIOLOGY AMONG OLDER ADULTS

- Up to 70% of residents in long-term care may feel sad, depressed or “blue” mood



EPIDEMIOLOGY AMONG OLDER ADULTS

- Bipolar disorder: incidence declines with age
 - However, bipolar disorder remains a common diagnosis among aged psychiatric patients



AMDA Clinical Practice Guideline for Depression in Long-Term Care

- Standard of Care
- Stepwise Approach
- Panel of Experts reviewing medical literature



DSM-IV DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION

- Gateway symptoms (must have 1)
 - Depressed mood
 - Loss of interest or pleasure (anhedonia)
- Other symptoms
 - Appetite change or weight loss
 - Insomnia or hypersomnia
 - Psychomotor agitation or retardation
 - Loss of energy
 - Feelings of worthlessness or guilt
 - Difficulty concentrating, making decisions
 - Recurrent thoughts of suicide or death

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- **Step I – Recognition**
 - History of Depression
 - Positive depression screening test
 - Appropriate for facilities to formally screen all residents
 - Some options for tools:
 - Geriatric Depression Scale (GDS)
 - Cornell Scale for Depression in Dementia (CSDD)

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▶ Step 2 – Signs/Symptoms of Depression

- DSM IV Criteria
- Mood and behavior patterns
- Nutritional problems
- Weight changes
- Depressed mood most of day
- Diminished interest/pleasure most activities –social withdrawal
- Thoughts of death or suicide
- Helpless/Hopeless – psychomotor agitation
- Increased somatic symptoms – fatigue, pain, insomnia
- **USE YOUR MDS**

Diagnostic Approach to Clinical Depression

- | | |
|----------|-----------------------------------|
| S | Sleep disturbance |
| I | Interest diminished |
| G | Guilt excessive and inappropriate |
| E | Energy diminished |
| C | Concentration impaired |
| A | Appetite disturbance |
| P | Psychomotor disturbance |
| S | Suicidal ideation |

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- **Step 3 – Risk factors for Depression**
 - Alcohol or substance abuse
 - Medication contributing to depression (see slide)
 - Hearing or Vision impairment
 - History attempted suicide
 - Psychiatric hospitalization
 - Medical diagnosis with high risk depression (see slide)
 - Change in environment
 - Personal or family history depression
 - New stress, loss

Medications causing symptoms of depression

- Anabolic steroids
- Digitalis
- Glucocorticoids
- H2 Blockers
- Metoclopramide
- Opioids
- Some Beta-blockers
- Anti-arrhythmics
- Anti-convulsants
- Barbituates
- Benzodiazepenes
- Carbidopa/Levodopa
- Clonidine

Comorbid Conditions with High Risk Depression

- Alcohol dependency/Substance abuse
- Cerebrovascular/neurodegenerative disease
- Cancer
- COPD
- Chronic pain
- CHF/CAD/MI
- DM/electrolyte imbalance
- Head trauma/ Orthostatic hypotension
- Abuse
- Schizophrenia

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- **Step 4** – Has the patient had a persistently depressed mood or loss of interest or pleasure for at least 2 weeks?



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- **Step 5** – Consider medical work-up
 - H&P
 - Basic labs, serum drug levels, thyroid
 - Consider other testing based on patient condition
 - Medical work-up may not be indication in some patients (i.e. terminal patients) **MAKE NOTE IF WORK-UP NOT DONE**



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- **Step 6** – Review Medications
- **Step 7** – Review medical conditions and optimize treatment
- **Step 8** – Do depressive symptoms improve with treatment medical conditions?
 - May still need to treat both conditions

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- **Step 9 – Clarify the diagnosis**
 - Mild episode of major depression
 - Moderate episode of major depression
 - Severe episode of major depression
 - Severe episode of major depression with psychotic features
 - Minor depression disorder
 - Bipolar Type II
 - Dysthymic disorder
 - Adjustment disorder with depressed mood or with mixed anxiety and depressed mood

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- **Step 10** – Is additional psychiatric support needed?
 - Low threshold in LTC to consult psychiatry, especially with significant behavior issues, suicidal ideation, psychosis



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- **Step 11** – Does depression exhibit complications that may pose a risk to the patient or to others?



DIAGNOSTIC CHALLENGES IN MEDICAL SETTINGS

- Symptoms of depressive and physical disorders often overlap, e.g.,
 - Fatigue
 - Disturbed sleep
 - Diminished appetite
- Depression can present atypically in the elderly
- Seriously ill or disabled persons may focus on thoughts of death or worthlessness, but not suicide
- Side effects of drugs for other illnesses may be confused with depressive symptoms

DIAGNOSIS IN OLDER PATIENTS IS DIFFICULT BECAUSE THEY . . .

- More often report somatic symptoms
- May be considered part of normal aging
- Cognitive impairment may interfere with diagnosis
- Practitioners may focus more on physical symptoms
- Less often report depressed mood, guilt
- May present with “masked” depression cloaked in preoccupation with physical concerns and complicated by overlap of physical and emotional symptoms

HALLMARKS OF PSYCHOTIC DEPRESSION

- Patients have sustained paranoid, guilty, or somatic delusions (plausible but inexplicably irrational beliefs)
- Among older patients, most commonly seen in those needing inpatient psychiatric care
- In primary care, may be seen when patients exhibit unwarranted suspicions, somatic symptoms, or physical preoccupations

DIFFERENTIAL DIAGNOSIS

▶ Medical illness can mimic depression

- Thyroid disease
- Conditions that promote apathy



▶ Dementia has overlapping symptoms

- Impaired concentration
- Lack of motivation, loss of interest, apathy
- Psychomotor retardation
- Sleep disturbance

DIFFERENTIAL DIAGNOSIS

- Pseudo - Dementia
- Bereavement is different because:
 - Most disturbing symptoms resolve in 2 months
 - Not associated with marked functional impairment



CLINICAL COURSE IN MAJOR DEPRESSION

- Often slow onset, recurrence, partial recovery, and chronicity . . .

↑ disability

↑ use of health care resources

↑ morbidity and mortality

suicide

OLDER ADULTS AND SUICIDE

- Older age associated with increasing risk of suicide
- One fourth of all suicides occur in persons ≥ 65
- Risk factors: depression, physical illness, living alone, male gender, alcoholism
- Violent suicides (e.g. firearms, hanging) are more common than non-violent methods among older adults, despite the potential for drug overdosing

STEPS IN TREATING DEPRESSION

- Acute—reverse current episode
- Continuation—prevent a relapse
 - Continue for 6 months
- Prophylaxis or maintenance—prevent future recurrence
 - Continue for 3 years or longer

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◎ **Step 12** – Implement appropriate treatment for the patient's depression

– Common threads of treatment in LTC

- Minimize institutional feel of environment
- Facilitate interaction with family members and friends
- Provide opportunities for patients to engage in spiritual or religious activities if they so desire



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- Common threads of treatment in LTC, continued:
- Provide socialization interventions and structured, meaningful physical and intellectual activities, (age and gender appropriate)



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Common threads of treatment in LTC, continued:

- INTERDISCIPLINARY



- INCLUDE FAMILY/DECISION MAKER

- Complete Psychotropic paperwork



TYPES OF THERAPY FOR DEPRESSION

- Psychotherapy
- Pharmacotherapy
- Electroconvulsive therapy (ECT)

PSYCHOTHERAPY

- Individualize standard approaches
 - Cognitive-behavioral therapy
 - Interpersonal psychotherapy
 - Problem-solving therapy



PSYCHOTHERAPY, Continued

- Combine with an antidepressant (has been shown to extend remission after recovery)
- Watch for depressive syndromes in caregivers, who might benefit from therapy
- Psychosocial interventions – bereavement groups, family counseling

PHARMACOTHERAPY

- Individualize choice of drug on basis of:
 - Patient's comorbidities, age
 - Drug's side-effect profile
 - Patient's sensitivity to these effects
 - Drug's potential for interacting with other medications
 - Drug cost
 - Prior med use and response



ANTIDEPRESSANTS

- Tricyclic antidepressants (TCAs)
- Selective serotonin-reuptake inhibitors (SSRIs)
- Others: bupropion, venlafaxine, duloxetine, nefazodone, mirtazapine, MAOIs, methylphenidate

TRICYCLIC ANTIDEPRESSANTS (TCAs)

- Secondary amine TCAs most appropriate for older patients are nortriptyline and desipramine (caution now with Beers List)
- For severe depression with melancholic features
- Avoid in the presence of conduction disturbance, heart disease, intolerance to anticholinergic side effects
- Most patients achieve target concentrations at:
 - Nortriptyline: 50–75 mg per day
 - Desipramine: 100–150 mg per day

SELECTIVE SEROTONIN-REUPTAKE INHIBITORS (SSRIs)

- Citalopram, escitalopram, fluoxetine, paroxetine, sertraline
- For mild to moderately severe depression
- Use if TCA is contraindicated or not tolerated
- Side effects:
 - Anxiety, agitation, nausea & diarrhea, sexual effects, pseudoparkinsonism, ↑ warfarin effect, other drug interactions, hyponatremia/SIADH, anorexia
 - Falls and fractures in nursing-home patients

SSRI DOSING

Drug	Recommended Dose
Citalopram	10–40 mg/day
Escitalopram	10–40 mg/day
Fluoxetine	10–40 mg/day
Paroxetine	10–40 mg/day
Sertraline	50–200 mg/day

BUPROPION

- Generally safe & well tolerated
- ↑ activity of dopamine & norepinephrine
- Side effects:
 - Insomnia, anxiety, tremor, myoclonus
 - Associated with 0.4% risk of seizures
- Dose range: 200–300 mg/day

VENLAFAXINE

- Acts as SSRI at low doses; at higher doses SNRI (selective norepinephrine reuptake inhibitor)
- Effective for major depression & generalized anxiety
- Side effects:
 - Nausea
 - Hypertension
 - Sexual dysfunction
- Dose range: 75–225 mg per day

DULOXETINE

- Equally SSRI and SNRI
- Effective for major depression and FDA-approved for neuropathic pain
- Precautions: drug interactions (CYP450 1A2, 2D6 substrate), chronic liver disease, alcoholism, serum transaminase elevation
- Dose range: 15–60 mg per day

NEFAZODONE

- Has SSRI and 5-HT₂ antagonist properties
- Approved for depression & anxiety
- Not associated with insomnia, sexual dysfunction
- Potent inhibitor of CYP-450 3A4 system—use with caution with other medications
- Dose range for young adults: 300–500 mg per day; older adults may not tolerate same doses due to sedating side effects

MIRTAZAPINE

- Norepinephrine, 5-HT₂, and 5-HT₃ antagonist
- **Associated with weight gain, increased appetite**
- May be used for nursing-home residents with depression & dementia, nighttime agitation, weight loss
- Dose range: 15-45 mg per day
- May be given as single bedtime dose (sedative side effects); available in sublingual form

METHYLPHENIDATE

- No controlled data demonstrating efficacy for depression
- Has been used for decades to treat major depression
- May have role in reversing apathy, lack of energy in patients with dementia or disabling medical conditions
- Short term use, often as a bridge to other treatment
- Can use with appropriate documentation

PHARMACOLOGIC ALGORITHM

Initiate citalopram, escitalopram, or sertraline

If response is inadequate, switch to paroxetine or fluoxetine,
OR switch class based on symptom profile



PHARMACOTHERAPY

- ▶ Individual response to treatment
- ▶ May take weeks to see response so high risk premature discontinuation
- ▶ Risk for poorer outcome – multiple stressors, older age, difficulty with ADLs, prior depression at younger age, poor sleep, higher anxiety, poor social support
- ▶ Can sometimes use one medication to treat more than one need/behavior

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©Step 13 – Monitor patient response to treatment

– Possible goals of treatment

- Resolution of signs and symptoms
- Improvement in score on screening tool
- Improvement in attendance at and participation in usual activities
- Improvement in sleep pattern

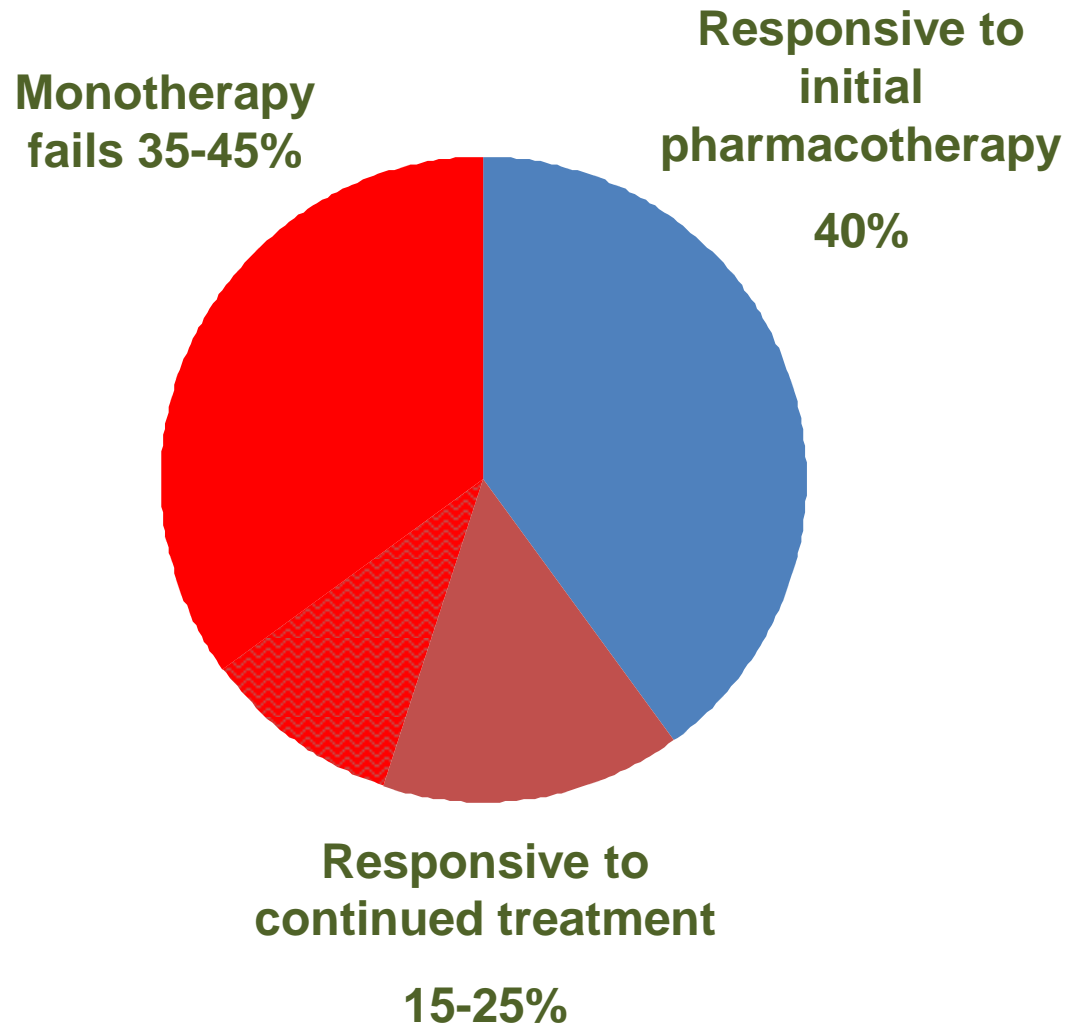
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- **Step 13, Continued:**
- Monitor for side effects of treatment
- Duration of treatment
 - First episode 6 months to a year, longer if complicated
 - 2-3 years if recurrent



INCIDENCE OF RESPONSE

- 40% of cases of major depression respond to initial pharmacotherapy within 6 weeks
- Additional 15% to 25% achieve remission with continued treatment for 6 weeks



Adjuvant Medical Treatment

- Anxiety
- Insomnia
- Constipation
- Shortness of Breath
- **FAMILY!!**



Nonpharmacologic Treatment



- Physical/Occupational therapy
- Touch – massage
- Increased social interaction
- Support groups if patient is able

MANAGING NONRESPONSE

- *The most common prescribing error is failure to increase the dose to the recommended level within the first 2 weeks of treatment*
- When monotherapy fails:
 - Consider switch to another drug class
 - Combine lithium carbonate, methylphenidate, or triiodothyronine with secondary amine TCA
 - Add psychotherapy
 - Consult a geriatric psychiatrist

REASONS TO USE ECT (Electroconvulsive Therapy)

- Effective for treatment of major depression & mania; response rates exceed 70% in older adults
- First-line treatment for patients at serious risk for suicide, life-threatening poor intake
- Standard for psychotic depression in older adults; response rates 80%

SUMMARY

- In older adults, depression is
 - Common (especially “minor” depression)
 - Associated with morbidity
 - Difficult to diagnose because of atypical presentation, more somatic concerns, overlap with symptoms of other illnesses
- Differential diagnosis: medical illnesses, dementia, bereavement

SUMMARY

- ***Suicide*** is a serious concern in depressed older patients, particularly older white males



SUMMARY

- Treatment (acute & preventive) should be individualized and may include:
 - Psychotherapy
 - Pharmacotherapy
 - ECT
- Choice of antidepressant should be based on comorbidities, side-effect profiles, patient sensitivity, potential drug interactions

SUMMARY – LONG-TERM CARE

- Make Diagnosis – use all your staff/MDS
 - Treat and monitor response to treatment
 - Document why not treating if choose not to treat
 - Try to get double benefit with one drug
- Low threshold to use psychiatry
- Watch for side effects and document if do not feel medication cause effect (i.e. fall, anorexia, confusion, etc.)
- Involve family

CASE 2 (1 of 3)

- A 72-year-old woman with a longstanding history of smoking and hypercholesterolemia had an inferior MI 3 weeks ago. Her ejection fraction was well preserved, and she was discharged from the hospital to subacute rehab on a regimen of metoprolol, enteric-coated aspirin, and a statin.
- She reports low energy, poor sleep, poor appetite, low mood with crying spells, and hopeless thoughts about her future. She believes she would be better off if she had died from the heart attack, but she denies any suicidal thought, plan, or intent.
- Laboratory tests, including thyroid-stimulating hormone, are unremarkable.

CASE 2 (2 of 3)

•Which of the following is most appropriate in the management of this patient?

- (A) Discontinue metoprolol
- (B) Discontinue the statin
- (C) Start nortriptyline
- (D) Start sertraline
- (E) Start venlafaxine

CASE 2 (3 of 3)

•Which of the following is most appropriate in the management of this patient?

- (A) Discontinue metoprolol
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- (D) Start sertraline**
- (E) Start venlafaxine

