Issue Brief #2:
Addressing Depression in Older Adults: Selected Evidence-Based Programs

In recognition of the essential role mental health plays in overall health, the Healthy Aging Program at the Centers for Disease Control and Prevention (CDC) and the National Association of Chronic Disease Directors (NACDD) are releasing two issue briefs focused on the mental health of older adults in the United States.

The first issue brief presented CDC data and set the foundation for understanding key issues related to mental health in adults over age 50. This second brief focuses on the topic of depression, an important and emerging public health issue with several evidence-based programs that communities can use to improve the mental health and quality of life of older Americans.

CDC

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

The State of Mental Health and Aging in America

Depression as a Public Health Issue

Depression is the most prevalent mental health problem among older adults (1). Recent CDC Behavioral Risk Factor Surveillance data indicated that among adults age 50 or older, 7.7% reported current depression and 15.7% reported a lifetime diagnosis of depression (2).

Depression is associated with distress and suffering and can lead to impairments in physical, mental, and social functioning (1). The presence of depressive disorders often adversely affects the course and complicates the treatment of other chronic diseases (3)—a particular concern among older adults given the high prevalence of multiple chronic conditions in this age group. Older adults with depression also visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer in the hospital (1). Although the rate of older adults with depressive symptoms tends to increase with age (1), depression should not be considered a normal part of growing older. Rather, in 80% of cases it is a treatable condition (3). Because depression is a highly treatable but currently undertreated condition among community-based older adults, all disease prevention programs for older adults should include a depression treatment component (4).

Over the last decade, depression and other mental health problems have gained increased attention from the public health community. Mental health, including treatment of depression, is one of the Healthy People 2010 Leading Health Indicators requiring priority action (5). The World Health Organization has launched a new initiative focused on depression in public health (6). The Guide to Community Preventive Services (Community Guide), developed by the non-federal Task Force on Community Preventive Services, has given the rating of "Recommended" to interventions involving collaborative care for treatment of adults 18 years of age or older who have major depression, as well as to home- and clinic-based depression care management interventions for older adults (7). Additionally, states are becoming increasingly aware of the burden of depression on their residents. For example, in 2005, Michigan (through its Michigan Public Health Institute) engaged in strategic statewide planning efforts to bring diverse partners together around the area of depression (8).

The Selected Programs

IMPACT (Improving Mood-Promoting Access to Collaborative Treatment)
PEARLS (Program to Encourage Active Rewarding Lives for Seniors)
Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)

Why these three programs?

With this issue brief, CDC and NACDD are seeking to increase awareness that depression is a public health issue and can be effectively addressed through community-based programs. The three programs presented here (described in detail below) are all evidence-based and have been successfully replicated in other communities. They were also featured as part of the *Effective Programs to Treat Depression in Older Adults* conference held in May 2008, sponsored by the CDC Prevention Research Centers Healthy Aging Research Network and the Rosalynn Carter Georgia Mental Health Forum. They do not represent all available evidence-based programs, but rather a sample of what can be done.

What do they have in common?

These three programs follow the depression care management model (9), a systematic, team-based approach to treating depression in older adults. This approach was designed to improve low rates of treatment engagement among older adults and to identify and treat people who are not responsive to initial treatments. Elements of this approach include identification of depression with a validated screening instrument, ongoing assessment with a validated depression severity instrument to assess effectiveness of treatment and to adjust treatment accordingly, and treatment using proven psychotherapies and/or antidepressants, according to evidence-based guidelines. These programs add two new members to the existing care team, which is made up of the patient and the primary care provider. A depression care manager, typically a trained social worker, nurse, or other practitioner, facilitates patient education, tracks outcomes, and delivers or facilitates evidence-based treatments. A psychiatric consultant supervises the care manager and makes antidepressant recommendations to the primary care provider. The intervention can be clinic- or home-based. In clinics, the depression care manager works with the patient's primary care provider, a consulting psychiatrist, and other health care personnel to deliver the intervention. In the home-based intervention, the depression care manager makes home visits and coordinates with other members of the collaborative care team outside of the participant's home.

Web Resources on Depression in Older Adults

American Psychological Association's Depression and Suicide in Older Adults Resource Guide
http://www.apa.org/pi/aging/depression.html

CDC's Prevention Research Centers Healthy Aging Research Network Conference: Effective Programs to Treat Depression in Older Adults
http://www.prc-hanconferences.com/2008-conference

CDC Prevention Research Centers Healthy Aging Research Network Depression Webinars – hosted by the National Council on Aging
http://www.ncoa.org/content.cfm?sectionid=379

Geriatric Mental Health Foundation
http://www.gmhfonline.org/gmhf/consumer/depression.html

National Council on Aging Center for Healthy Aging Mental Health Resources
http://www.healthyagingprograms.org/content.asp?sectionid=71

National Institute of Mental Health Depression site
http://www.nimh.nih.gov/healthtopics/depression/index.shtml

SAMHSA Older Adults and Mental Health site
http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/olderadults/default.asp

SAMHSA National Registry of Evidence-Based Programs and Practices
http://www.nrepp.samhsa.gov/

The Community Guide Mental Health Recommendations
http://www.thecommunityguide.org/mentalhealth/index.html

Program 1: IMPACT (Improving Mood-Promoting Access to Collaborative Treatment)

"IMPACT focuses on improving the quality of depression care so that a significantly larger proportion of patients benefit from treatment. Patients are followed in a proactive manner that measures the effectiveness of treatment on a regular basis and prompts a change in the treatment plan if the patient is not adequately improved." —Diane Powers, manager of IMPACT Implementation Center

IMPACT is a program for older adults who have major depression or dysthymic disorder. The intervention is a stepped, collaborative care approach in which a nurse, social worker, or psychologist works with the participants' regular primary care provider to develop a course of treatment.

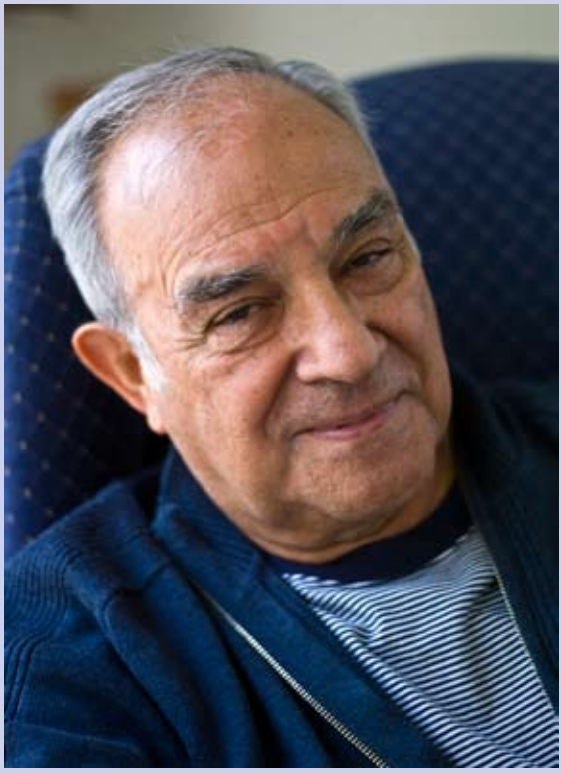
Target population: Older adults.

Setting: Primary care settings. (The program has also been implemented in other settings, including home health care and chronic disease management.)

Description of activity: Potential participants are either referred by the primary care provider or identified via routine screening of all clients. During the initial visit, the depression care manager (DCM) completes an assessment, provides education about depression and available treatments, and asks the participant about his or her depression treatment preferences. All participants are encouraged to engage in some form of behavioral activation, such as engaging in physical activity or scheduling pleasant events. For participants already taking antidepressant medications who are still depressed, the recommendation typically is to increase the dose, augment the antidepressant with a trial of problem-solving treatment (PST) or switch to a different medication or PST.

Intensity and duration: Once participants have started treatment, the DCM follows up in person or by telephone approximately every two weeks during the intensive phase and approximately monthly thereafter until the participant's symptoms are stable enough to move to the maintenance phase. Participants stay in the maintenance phase for several months to insure that symptoms are stable before completing the relapse prevention plan and ending treatment. Participants electing to take the PST course receive six to eight sessions of brief structured psychotherapy delivered by a DCM in the primary care setting.

"I didn't know anything about depression so I didn't know I was depressed. I didn't realize there was a connection between my diabetes and depression. The questionnaire was essential to getting me in for treatment. It was sent to me three times before I sent it back. I took medication and went to a class that helped me learn skills to work on the depression. I reduced the amount of diabetic medication I was taking including getting off insulin, which I had recently started. I now have two friends getting treatment for depression since I told them about my situation."
—IMPACT participant



Partners: A partnership is needed with a psychiatrist who can provide regular caseload-based consultation and supervision. If the DCM is not able to offer evidence-based counseling/psychotherapy as a treatment option, the program should partner with a mental health professional within the organization or an external organization. If the program is being initiated in a mental health setting, a partnership is needed with the participant's primary care provider.

Staff requirements, training, and supervisory issues: The DCM role can be filled by a variety of professionals, including nurses, social workers, and psychologists. Two training options are available: a 2-3 day in-person course or free on-line training. Training is also available in the brief, evidence-based psychotherapy. There is no official certification in IMPACT care, but trainees can receive certification in PST after completing training. The DCM works with the primary care physician and receives additional support from a consulting psychiatrist, who focuses on difficult cases and individuals not responding as expected.

Evidence base: Patients receiving IMPACT care were twice as likely as usual care patients to experience a 50% or greater reduction in depression symptoms. IMPACT patients also experienced greater rates of depression treatment, greater satisfaction with their depression care, less functional impairment, and better quality of life (9). These benefits were sustained 12 months after IMPACT care ended (10). To date, over 50 peer-reviewed articles documenting the extensive evidence base for IMPACT, including evaluations of adaptations and implementations that took place after the conclusion of the original randomized controlled trial, have been published.

Costs: The estimated cost per participant is $750 per year in 2008 dollars. Start-up costs vary significantly depending on how the organization chooses to implement the program. All the program materials are available free of charge via the IMPACT Implementation Center website. In-person training comprises the primary start-up cost; however, free online training is available. If an organization chooses in-person training for DCMs, the average cost is $250 per trainee. Case-based training in the PST technique costs approximately $1,000-$1,500 per trainee.

IMPACT has been found to reduce total health care costs by about $3,300 per person over a four-year period compared to persons receiving usual care (11).

Resources: Program materials address clinical, administrative, financial, and participant issues related to the delivery of this intervention and are all available at no cost on an easy-to-use website. In-person, webcast, and free interactive web-based trainings are available to implementers. The program developer is available for telephone consultation and support throughout implementation.

Contact information: For more information and to obtain resources, visit www.impact-uw.org. For technical support, contact Diane Powers, manager of the IMPACT Implementation Center at powersd@u.washington.edu; (206) 685-7095.

Program 2: PEARLS (Program to Encourage Active Rewarding Lives for Seniors)

PEARLS is a brief, time-limited, and participant-driven program that teaches depression management techniques to older adults with depression. It is offered to people who are receiving home-based services from community services agencies. The program consists of in-home counseling sessions followed by a series of maintenance session contacts conducted over the telephone.

Target population: Community-dwelling older adults (60+ years).

Setting: Participant's place of residence in the community.

Description of activity: PEARLS is an intervention for older adults who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS requires its depression care managers (DCM) to use three depression management techniques: (1) problem-solving treatment, in which participants are taught to recognize depressive symptoms, define problems that may contribute to depression, and devise steps to solve these problems; (2) social and physical activity planning; and (3) pleasant event planning and scheduling.

Intensity and duration: The intervention comprises eight 50-minute sessions with a trained social service worker over a 19-week period with 3-6 subsequent telephone contacts.

Partners: Mental health specialty care providers, including a professional (typically a psychiatrist) to serve as a PEARLS supervisor, are essential partners.

"At the conclusion, I wasn't even recognizable as the same person. With my counselor's encouragement and understanding, I not only was able to make the health improvements necessary to avoid going to a nursing home, but I overcame my depression and anxiety so that I can now lead a more active and rewarding life." —PEARLS participant

"PEARLS is particularly useful because it is multi-faceted. This program addresses physical and social activation, and helps individuals learn effective methods to solve problems." —Dr. Mark Snowden, geriatric psychiatrist

Staff requirements, training, and supervisory issues: The DCM is typically a trained social worker or mental health counselor who has also undergone training in delivering problem-solving treatment, as well as techniques that encourage physical and social activation. The DCM works closely with a supervising psychiatrist, who helps with eligibility questions, supervision of the problem-solving treatment process, medication management, and more. A PEARLS team member should be familiar with psychiatric resources so that participants who are not progressing as expected can be referred for alternative or more intensive services. A manual is used to support the DCM in delivering the program.

Evidence base: Participants who received the PEARLS intervention were three times more likely than those receiving usual care to significantly reduce their depressive symptoms (43% vs. 15%) or completely eliminate their depression (36% vs. 12%). Participants were more likely to report greater health-related quality of life improvements in functional and emotional well being, as well as reduced use of health care services, including hospitalizations, compared to those receiving usual care (12).

Costs: The cost to implement PEARLS is about $630 per patient. This estimate is based on mean costs for the services provided to PEARLS participants in the 2002-2003 study, which included problem-solving treatment sessions ($422), follow-up and psychiatric telephone calls ($40), psychotherapy quality assurance ($87), and depression management team sessions ($81) (12).

Resources: Resources include a free user-friendly implementation toolkit and a training program (with a $500 registration fee), held in Seattle on a twice-yearly basis. Technical assistance by phone or email is available on an ongoing basis; a charge may be incurred for intensive technical assistance. Guidance and suggestions for program adaptation are available for certain populations and settings.
Quality assurance forms are provided to assist supervisors in monitoring implementation fidelity.

Contact information: The PEARLS Implementation Toolkit and other resources and information are available at http://depts.washington.edu/pearlspr. For general PEARLS questions, please contact Sheryl Schwartz at sheryls@u.washington.edu or (206) 685-7258.

Program 3: Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)

Healthy IDEAS is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations through existing community-based case management services. Healthy IDEAS integrates depression awareness and management into existing case management services provided to older adults (such as those that offer assistance with home-based care). The program also seeks to improve the linkage between community aging service providers (for example, area agencies on aging) and health care professionals through appropriate referrals, better communication, and effective partnerships.

Target population: Community-dwelling, underserved, frail, high-risk, older adults (60+ years) receiving case management services.

Setting: Participant's place of residence in the community.

Description of activity: Potential participants are identified via routine screening of case management clients for symptoms of depression using a standardized depression scale. Participants and their caregivers, if appropriate, receive education about depression treatment and self-care, and participants receive active assistance in obtaining further treatment from primary care and mental health providers. They receive coaching and support as they engage in behavioral activation to manage their depression and pursue personal, meaningful activities.

Intensity and duration: Typically, the program involves at least three face-to-face visits and three to six telephone contacts over a three-to- six-month period. Participants with more severe symptoms of depression may require more contacts over a longer time period.

"I feel better, and I am thankful I am not depressed anymore... I take a walk almost every day now."
—Healthy IDEAS participant

"I truly believe education on depression in all age groups is a responsibility of our public health departments." —Healthy IDEAS coordinator and trainer

Partners: Behavioral health experts are essential to help with training and ongoing consultation around services and outcome assessment activities. It is also important to have mental health professionals who can act as consultants to staff and who are available for outside referral when needed.

Staff requirements, training, and supervisory issues: On-site training is available. A manual outlines the steps of the intervention and includes written worksheets, client handouts, and forms to support and document the process and client outcomes. Program implementers are not required to have professional licensure in any particular field.

Evidence base: Participants showed reductions in depression severity and self-reported pain, increased knowledge of how to get help for depression, increased activity levels, and knowledge of how to manage depressive symptoms (13).

Costs: A free consultation is available to assess the organization's readiness to implement Healthy IDEAS. For agencies that decide to pursue the program, an implementation package, including consultation with the local leadership team, ongoing technical assistance, and all the Healthy IDEAS materials, including a program manual, a staff manual, and a training DVD and facilitator's training guide, are available for a one time fee of $3,000 plus travel expenses from Houston, TX. Per patient costs have not yet been determined.

Resources: The basic replication toolkit includes a program manual with sections for agency leaders and direct providers, client handouts, sample assessment and reporting forms, a training DVD, and a training curriculum. Self-Assessing Readiness for Implementing Healthy IDEAS is a tool to assist a community aging service provider and other partnering organizations in determining their capacity to implement Healthy IDEAS. It is designed to help organizations identify what additional commitments, capabilities, resources and partners might be needed to progress with plans to implement this program.

Contact information: For more information on the basic replication toolkit, contact Healthy IDEAS Program Developer Nancy Wilson at nwilson@bcm.edu; (713) 798-3850.The organizational readiness self-assessment tool, as well as replication guidance, case studies, and technical assistance, is available at the Care for Elders website www.careforelders.org/healthyideas.

Next Steps

While living with depression can be difficult for older adults, the good news is that there are effective, community-based treatment programs. Although public health professionals may not necessarily be the leaders in implementing these programs, they are clearly important partners in raising awareness and assuring that depression is integrated with other chronic disease program efforts. Future work will focus on continued education about the importance of depression as a public health issue, encouraging the implementation of evidence-based community programs to address depression, and continued collection and reporting of mental health data for older adult in the United States.

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