Late Life Depression

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New Approaches for Late Life Depression in Residential Care

A Silent Epidemic

- Late life depression in residential care is a major public health problem in many parts of the world
- Depressive disorders (defined by psychiatric diagnostic criteria) affect up to 1 in 5 residents (Ames, 1993)
- Reported rates vary depending on the type of facility, the assessment instrument used, and the diagnostic criteria applied
- Most depressed older adults in residential care do not receive help

Late Life Depression

- Is under-recognised by health professionals and other carers (Lavizzo-Mourey et al., 1991)
- Is poorly managed in some residential care settings (Gillis et al., 1982; Ames et al., 1988; Brown et al., 2002)
- Accounts for considerable morbidity in the elderly when untreated (Bruce et al., 1994; Ariyo et al., 2000)
- Results in high health service utilisation (Waxman et al., 1983; Koenig & Kuchibhatla 1999)
- Is associated with premature mortality (Chiu et al., 1999)

Multifaceted Intervention Programs for Late Life Depression in Residential Care

Rationale

- Recently multifaceted interventions have been recommended:
  - Due to the complexity of depression in residential care
  - Given the potential for synergy between different elements of the intervention
    ie "the whole is greater than the sum of its parts"
- They can be targeted both at individual residents as well as entire facility populations
- "Whole of population" interventions are recommended since the health of individuals is profoundly effected by culture of the community in which they live (Rose, 1992)
Effective Interventions for Late Life Depression

- These include:
  - Pharmacotherapy (Katz, 1990; Salzman et al., 2002)
  - Psychological Treatments, especially CBT (Cuijpers, 1998)
  - Exercise (McMurdo & Rennie, 1993; Brosse et al., 2002)
  - Group discussion (Rattenbury & Stones, 1989)
  - Social skills program to improve conversational skills (Fernandez-Ballesteros et al., 1988)
- Inclusion of such interventions in multifaceted intervention programs has been recommended

Trials of Multifaceted Interventions for Depression in Residential Care

- Two large trials have been conducted:
  - Multifaceted Shared Care Intervention
    - Initially evaluated in Sydney among a non-nursing home (hostels or independent living units) population of 1466 residents (Llewellyn-Jones et al., 1999)
    - Recently implemented in three other aged care hostels in Northern Sydney (Healthy Ageing Research Unit, 2001)
  - Secondary Prevention of Depressive Symptoms Intervention (Cuijpers and Lammeren, 2001)

Multifaceted Shared Care Intervention: Key Elements

- Removing Barriers to Care
- Carer Education
- Health Promotion and Education


Shared Care

- This model promotes collaboration between:
  - General practitioners
  - Psychiatrists
  - Other mental health professionals
  - Aged Care Professionals (hospital & community based)
  - Residential Care Staff
  - Patients, and their friends and relatives
- In this sense care is shared.
Removing Barriers to Care

- The Intervention provides holistic, co-ordinated health care
- It addresses not only depression, but also depression-related co-morbidity, such as:
  - Physical illness, chronic pain; mobility problems; visual and hearing impairment; and social isolation
- It encourages residential care organisations to take ownership of the problem of late life depression and make changes to facilitate more effective clinical care
- "Late Life Depression Working Groups" involving key stakeholders caring for depressed residents, including residential care staff, which facilitates the implementation of programs for depressed elders
- Increased GP / Residential Care Staff Liaison to improve GP/staff communication, particularly as it relates to the care of depressed residents

Carer Education: GPs

- GP Interactive Workshops on:
  - Assessment and management of late life depression
  - Dementia and depression
  - Using cognitive enhancers in dementia
  - Chronic pain: pharmacological/psychosocial approaches
  - Managing challenging behaviours in dementia
  - Managing personality disorders in late life

Carer Education: Staff

- This has included the following topics:
  - Caring for the carers: how to take care of ourselves
  - Depression recognition and management
  - Communicating with and motivating the depressed elderly
  - Understanding grief and loss
  - Assisting lonely and isolated residents
  - Depression and dementia
  - Acute confusion in the elderly
  - Challenging behaviours in dementia
  - Pain management in the older person

Health Promotion and Education

- The goals of the Health Promotion and Education Programs are:
  - To reach frail, isolated, depressed residents
  - To combat misconceptions about late life depression and its management
- "Bright Horizons" newsletter for residents, GPs and staff, providing information about late life depression and its management
- Positive activities for depressed elders, including exercise programs designed for the frail elderly
- Talks for residents about:
  - Depression and its management
  - Grief and loss
  - Managing chronic pain
  - Managing chronic conditions
Marketing the Message: Healthy Ageing Programs

Health Education Interventions

- The rationale for the Health Education Interventions is to provide accurate information about late life depression, its treatment and on depression-related topics
- The message of the Health Education is that:
  - Depression is not an inevitable part of ageing
  - Depression is not a spiritual or personal weakness
  - Non-pharmacological treatments can be effective alone
  - Pharmacological treatments should always be complemented by some form of "talking" therapy and/or involvement in positive activities

Health Promotion Interventions

- A crucial issue has been to increase participation in activity programs
- The intervention addresses several factors that prevent frail, isolated depressed residents from participating in activities, including their need for:
  - Physical assistance when walking outdoors
  - Safe outdoor walking areas and exercise programs specially designed for their use
  - Staff/volunteers to encourage and assist with their attendance

Evaluation

- We compared the outcome, as measured by the Geriatric Depression Scale (GDS), of two randomly selected cohorts of depressed residents
- One cohort received routine care and the other received the Intervention
- The cohorts were studied serially, each over 9.5 months
- A significant intervention effect was found after controlling for possible confounders (Llewellyn-Jones et al 1999)

Secondary Prevention of Depressive Symptoms Intervention

- Study conducted by Cuijpers and Lammeren (2001)
- Intervention consisted of:
  - Carer education
  - Depression related health education for all residents
  - Group interventions for depression for residents.
- The intervention was delivered by staff of the local community mental health centres
- Intervention is now widely implemented in Holland

Secondary Prevention of Depressive Symptoms Intervention: Results

- The intervention had a positive impact:
  - Among residents who were initially classified as depressed (30 item GDS ≥ 11)
  - Among residents who were initially classified as non depressed (30 item GDS < 11)
  - On the overall mood of all residents
- The intervention had a positive impact on residents who were initially more severe "cases" of depression
Other Multifaceted Interventions for Depression in Residential Care

- Positive results have also been reported for the following interventions:
  - An intensive multifaceted intervention aimed at enhancing care staff skills in detecting and managing depression (Moxon et al., 2001)
  - Specialist nurses collaboratively assessing and managing depression with nursing home staff (Bell & Goss, 2001)
  - A depression screening and primary care physician notification protocol for patients in long term care (Soon & Levine, 2002)

Implications for the Provision of Residential Care

Challenges

- Depression in residential care has been a known public health problem for nearly 40 years
- Effective interventions exist
- Will depression remain the scourge of residential aged care for another 40 years?
- What will it take to widely implement interventions that we know are effective?

Being Realistic

- A "bleeding hearts" approach will not change care practices
- Most people agree that reducing depression rates in residential aged care is a good idea
- But many think that we don't have funds to address this issue
- But does meeting an unmet need always increase the costs of care?
- And if it does, how can we pay for such initiatives??

What are the Opportunities?

- Implementing effective depression interventions holds the promise of:
  - Reducing transfers to higher levels of supportive care
  - Reducing physical and psychological morbidity
  - Reducing mortality
  - Reducing staff stress and "burn out"
  - Reducing staff turnover and absenteeism
- These factors may offset the costs of program implementation
Key Points

- Multifaceted interventions for depression in residential aged care have been shown to be effective
- Future research needs to determine:
  - How to enhance their reach and penetration
  - What their impact is on industry indices such as:
    - Staff stress/burn-out/absenteeism
    - Care costs
- As well as determining if they can be made even more clinically effective
- Late life depression remains common despite ongoing advances in clinical practice and research
- We need to raise awareness so that the wider community takes on a stronger advocacy role in meeting the needs of depressed older people
- This conference can be a powerful catalyst in changing clinical practice and attitudes to depression
- One in three of us is likely to spend time in residential care: complacency isn't an option!!