Models of Care for Late-Life Depression of the Medically Ill: Examples from Chronic Obstructive Pulmonary Disease and Stroke

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Depression worsens most treatment outcomes in medically ill older adults. Chronic medical illnesses weaken and demoralize patients and compromise their ability to adhere to treatments requiring consistency and effort. Acute medical illnesses create a psychosocial storm that finds patients and their ecosystem unprepared. We describe two intervention models that can be used to target and personalize treatment in depressed, chronically, or acutely medically ill older adults. The Personalized Adherence Intervention for Depression and COPD (PID-C) is a model intervention for depressed patients with chronic medical illnesses. It targets patient-specific barriers to treatment engagement and aims to shift the balance in favor of treatment participation. PID-C led to higher remission rates of depression, reduction in depressive symptoms, and reduction in dyspnea-related disability. The addition of problem-solving training enables patients to use resources available to them and hopefully improve their outcomes. Ecosystem-focused therapy (EFT) is a model intervention for depression developing in the context of an acute medical event. It was developed for patients with poststroke depression (PSD) and targets five areas, part of the "psychosocial storm" originating from the patient's sudden disability and the resulting change in the patient's needs and family's life. A preliminary study suggests that EFT is feasible and efficacious in reducing depressive symptoms and signs and disability in PSD. (Am J Geriatr Psychiatry 2015; 23:477–487)

Key Words: Poststroke depression, psychotherapy, chronic obstructive pulmonary disease, late-life depression

INTRODUCTION

Late-life depression preferentially affects older adults with comorbid medical illnesses. In community settings, 2% of older adults suffer from depression.[1] Prevalence is 6%–8% in primary care settings and 12%–22.4% among long-term care residents. Late-life depression has a modest response to pharmacotherapy, promotes disability, worsens medical outcomes, undermines adherence, and increases expense.[2] Behavioral interventions for depressed medically ill patients, although needed, have been both underdeveloped and underused.

Depression afflicts patients with both chronically deteriorating medical illnesses and acute debilitating medical events.[3] In each scenario, patients and

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http://dx.doi.org/10.1016/j.jagp.2014.06.004

families are presented with distinct sets of clinical and psychosocial problems that can serve as treatment targets. We discuss intervention models for depressed patients with chronic obstructive pulmonary disease (COPD), a chronic disease, and patients with post-stroke depression (PSD), an acute medical event. These models could be modified to treat depression within the context of other chronic and acute medical illnesses that share similar characteristics.

COPD is a chronic illness that typifies the challenges faced by depressed, chronically ill patients. More than 20% of COPD patients suffer from at least one episode of major depression, often of longer duration.[3] In addition to high comorbidity, COPD leads to chronic disability, and its rehabilitation and treatment requires active and consistent patient participation. Depressed patients are typically demoralized from the hopelessness and fatigue of depression and the increasing disability of COPD. This impairs their ability to carry out everyday activities and interferes with adherence to efficacious treatments. Antidepressant, although available, safe, and often effective, are undermined by slow onset of their effects and often incomplete remission. This necessitates development of a long-term approach to these patients.[3]

Unlike COPD, stroke occurs abruptly and exemplifies the problems of aging adults facing sudden disability after an acute medical event. Stroke afflicts 700,000 Americans each year, and more than 20% of them subsequently develop depressive syndromes.[4] PSD develops during the psychosocial and biologic storm ensuing after stroke. The "storm" affects the patient and challenges the patient's ecosystem.[4] The intervention model we describe below is based on a dissection of contributors to the "storm" and interventions targeting each if its components.

Evidence-Based Psychotherapies

Therapy models for the treatment of late-life depression exist, although they have been inadequately studied. A recent article reviewed psychosocial intervention studies using explicit selection criteria: a treatment manual, supervision by experts, raters blind to treatment assignment administering reliable and valid instruments, at least 30 participants per condition, intent to treat analysis, and reliance on both statistical and clinical significance.[5] One study of problem-solving therapy (PST)[6,7] and one study of cognitive-behavioral therapy (CBT)[8] found these treatments more efficacious in reducing depression than an active comparison condition. Interpersonal therapy (IPT) also reduced depressive symptoms more than usual care[9,10] but had no advantage over usual care in increasing response or remission rates. The only study of supportive therapy that met the above criteria found it less efficacious than PST in reducing depressive symptoms and disability.[6,7]

Most participants in the studies reviewed were in stable medical health and few, if any, had chronic, deteriorating medical illnesses or a dramatic acute medical event.[5] Accordingly, the interventions targeted the behavioral pathology of depression rather than the distinct behavioral problems and needs arising from the clinical context of severe medical conditions.

Collaborative Care Models

The Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) trial and the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) studied the effectiveness of care management models in depressed, older primary care patients. The IMPACT trial compared usual care to a disease management program that used depression clinical specialists following a stepped-care algorithm including medication or PST modified for the primary care setting. At the 1-year follow-up, the intervention group had lower depression severity, higher rates of response, and higher rates of complete remission of depressive symptoms.[11] The PROSPECT intervention used depression care managers and a treatment algorithm with antidepressants as the first line of treatment and if medications were refused, interpersonal therapy. This intervention was effective in reducing suicidal ideation and depressive symptoms and increasing remission rates 1 and 2 years later.[12] The Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) study compared integrated behavioral healthcare and enhanced referral care. Results showed that less severe depression responded well to an integrated setting, whereas severe depression responded better to enhanced specialty clinic care.[13]

The above studies demonstrated the value of several care management models in primary care patients. These models are flexible and can be