Community Treatment of Older Adults

Principles and Evidence Supporting Mental Health Service Interventions

Whitney L. Carlson, MD*, Mark Snowden, MD, MPH

KEYWORDS

• Depression • Older adult • Mental health services • Nursing home

KEY POINTS

- Effective models of evidence-based treatment for depression and severe and persistent mental illness exist, but access has been limited by slow implementation and application in real-world settings.
- Despite evidence-based treatment for these conditions, many individuals do not respond to such treatment or have been excluded from research studies.
- A recent focus of qualitative research has been to investigate the barriers to engaging difficult-to-reach populations.
- Training and supervising those who work with the geriatric population to use and develop interventions in nontraditional research settings could help leverage the expertise of limited geriatric psychiatry specialists.

INTRODUCTION

The Institute of Medicine Committee on the Mental Health Workforce for Geriatric Populations noted that while precise prevalence rates are not known, reasonable estimates based on available data suggest that 14% to 20% of the overall elderly population of the United States has one of the 27 Diagnostic and Statistical Manual (DSM) and other conditions it identified as significant mental health- or substance use-related disorders.[1] Depressive disorders are the most common, followed by dementia-related psychiatric and behavioral symptoms. Depression broadly impacts quality of life, medical costs, mortality, and functional independence of older adults. Prevalence estimates for major depression in older adults range from 1% to 4%.[2] Rates of minor depression range from 8% to 16% of older age population-based samples and occur

Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, 325 Ninth Avenue, Seattle, WA 98104-2499, USA
* Corresponding author.
E-mail address: cwhitney@u.washington.edu

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in twice as many home-bound elders.[2–6] Those with minor depression are 5 times more likely than nondepressed individuals to develop major depression and develop similar rates of hopelessness and death or suicidal ideation even though they have fewer depressive symptoms.[7–9]

Antidepressants and several forms of psychotherapy have been shown to effectively treat depression in older adults; yet system gaps result in inadequate treatment for many patients. The high prevalence of depression in older people, good evidence for treatment efficacy, widely recognized problems of underdiagnosis and undertreatment, and the limited supply of psychiatrists have spurred development and testing of new models of depression care that extend access to individuals who would not otherwise be treated. Health services research has focused on ways to structure and implement existing depression treatments into system-based interventions that improve outcomes compared with usual care approaches. These models increasingly rely on interventionists employed by community agencies, and redefine the role of psychiatrists as expert caseload supervisors rather than providers of direct care. Depression care management interventions in clinic and community settings are discussed here in terms of quantitative outcomes and qualitative studies of ongoing implementation challenges.

Community-based organizations serve large numbers of depressed older adults. For example, in an analysis of 2005 Washington statewide data for clients 60 years and older (N = 16,032) being evaluated for receipt of home- and community-based services by Aging and Disability Services Administration case workers using the Centers for Epidemiological Studies Depression Scale 10-item version, 27% had scores of 10 or greater, suggesting major depression, and 35% had scores between 6 to 10 felt to be consistent with minor or subsyndromal depression. In nursing homes, rates of clinically significant depression are estimated to be between 27% and 34%.[10,11] Like major depression, minor depression is linked to impaired functional status, increased service use, and poorer physical, social, and mental health[12] and impacts performance of activities of daily living needed for maintaining independence.[13] Depression can increase mortality unrelated to suicide.[14] Ambulatory medical costs in depressed older adults have been shown to be 43% to 51% higher and inpatient ambulatory total costs 47% to 51% higher in older adults with depression.[15] Reducing the number of adults with major depressive disorder is a major objective of Healthy People 2020.[16]

More severe and persistent mental illnesses such as schizophrenia, although much more rare than depression, with estimates of 0.2%–0.8% of all elderly, have significantly greater negative impact on function.[1] Because of their greater care needs, individuals with these illnesses continue to experience higher rates of institutional care, with nursing home prevalence rates exceeding 10%.[10]

HEALTH SERVICE INTERVENTIONS

Home-Based Care for Depression

Effective treatment for depression in older adults through collaborative care depression care management models in primary care has been demonstrated in several randomized controlled trials such as Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)[17] and Prevention of Suicide in Primary Care: Collaborative Treatment (PROSPECT).[18] However, many depressed older adults are socially isolated, have significant medical comorbidity and impaired physical functioning, and may be homebound. These groups are less able to seek appropriate care for depression via clinic-based models even where collaborative care has been implemented. The