Lown Right Care

Reducing Overuse and Underuse

Collaborative Care for Depression in Older Adults

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Case Scenario

A 93-year-old woman has mild cognitive impairment and lives in an assisted-living facility. Before the COVID-19 pandemic, her daughter, a medical social worker, and son-in-law visited her weekly. The patient has severe sensorineural hearing loss but chooses to not wear hearing aids. Her facility prohibited visitors during the pandemic, allowing her daughter to communicate by phone, FaceTime, or standing outside her mother's window. The patient was often unable to hear what her daughter was saying. She rarely left her room because of COVID-19 protocols, lost weight, and slept poorly despite taking mirtazapine (Remeron) and sertraline (Zoloft) for chronic depression. She continued to recognize her daughter and son-in-law throughout the pandemic; however, she was often unsure why they had not visited her in person. Because of her insomnia, the patient wandered around her apartment at night, occasionally falling. She also refused to wear an alert device designed to call for help.

A related *FPM* article is available with the online version of this department.

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This clinical content conforms to AAFP criteria for CME. See CME Quiz on page 241.

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Clinical Commentary

Up to 88% of people 65 years and older have at least one chronic medical condition, and 25% have more than four chronic diseases.[1] Major depression occurs in 1% to 3% of older adults in the general population (8% to 16% in those with dysthymia).[2] However, fewer than 20% of cases are diagnosed or adequately treated because the symptoms of depression are likely to be attributed to comorbid conditions instead of sadness.[2] In a 2020 national survey, participants 65 years and older reported significantly lower percentages of an anxiety disorder (6.2%), depressive disorder (5.8%), or trauma- or stress-related disorder (9.2%) compared with younger participants.[1] However, family physicians need to consider or screen for depression in older adults and treat it when present.

IDENTIFICATION AND SCREENING

The U.S. Preventive Services Task Force recommends screening all adults for depression.[3] Screening is important in older adults because of the likelihood of contributing risk factors, the masking of symptoms by comorbid conditions, and the tendency for depressive symptoms to compromise function and increase general health care utilization and cost. The Patient Health Questionnaire (PHQ)-2 and PHQ-9 are practical depression screening tools for adults. On a scale of 0 to 27 (nine questions representing the nine symptoms listed in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. [DSM-5], each worth 0 to 3 points, with 0 representing "not at all" and 3 representing "nearly every day"), a PHQ-9 score of 5 to 9 is consistent with mild depression, 10 to 14 moderate, 15 to 19 moderate/severe, and 20 or greater severe. An online calculator is available at https://www.mdcalc.com/calc/1725/phq-9-patient-health-questionnaire-9. Persistent depressive disorder

TAKE-HOME MESSAGES FOR RIGHT CARE

- Consider a collaborative care approach to depression management in older adults.
- Screen all adults for major depressive disorder using a validated tool such as the Patient Health Questionnaire-2 or Patient Health Questionnaire-9.
- Use selective serotonin reuptake inhibitors with a lower risk of drug interactions such as citalopram (Celexa), escitalopram (Lexapro), and sertraline (Zoloft) at low doses when initiating therapy for depression.

is diagnosed only if symptoms continue longer than two years. The prognosis for patients older than 60 years with untreated depressive symptoms is poor. In a meta-analysis, 33% of patients were well, 33% were depressed, and 21% had died at 24 months.[4]

Risk factors for depression in older adults include previous depression, loneliness, loss of function, new medical diagnosis, poor health status, bereavement, poor self-perceived health, low self-esteem, helplessness because of racism or ageism, ST-segment elevation myocardial infarction, multiple chronic conditions, certain medications, insomnia, and pain.[5-7]

TREATMENT

Older patients generally respond to the same treatments as other adults. A PHQ-9 score greater than 15, accompanied by the DSM-5 additional criteria, is suggestive of major depression and generally warrants treatment with medication. Close follow-up is indicated because older adults are at higher risk of adverse effects. Older adults tend to metabolize drugs more slowly (increasing the risk of serotonin syndrome) and are more sensitive to anticholinergic effects (i.e., confusion, dry mouth, blurry vision, constipation, urinary retention, decreased perspiration, and excess sedation) from tricyclics and paroxetine (Paxil).[8] Anticholinergic medications have also been associated with an increased risk of dementia.

Selective serotonin reuptake inhibitors with a lower risk of drug interactions, such as citalopram (Celexa), escitalopram (Lexapro), and sertraline, should initially be administered at low doses because of the increased risk of drug-drug interactions due to polypharmacy (more than five daily medications).[9,10] Tricyclic antidepressants should be avoided because of the potential for overdose or medication confusion.[11]

Cognitive behavior therapy and problem-solving therapy are supported by evidence and can be combined with medication.[12] Behavior activation, an approach based on motivational interviewing, was noninferior to cognitive behavior therapy in a randomized controlled trial in the United Kingdom and could be delivered by nonlicensed personnel, decreasing costs.[13] Cognitive behavior therapy and selective serotonin reuptake inhibitors are effective in older adults, and treating pain and other comorbid conditions may be more effective than focusing only on depression.

Collaborative care may be the ideal primary care model for older adults with depression because of comorbid conditions, risk factors, and loneliness. Collaborative care involves a team of health care professionals working with the patient within a primary care setting.[14] This includes a depression registry to track patients to ensure follow-up and measure outcomes; frequent contact with a licensed care manager who serves as a patient support and care coordinator, including management of chronic conditions; talk therapy delivered by registered nurses and licensed clinical social workers; or medication management with psychiatric consultation. Cognitive behavior therapy led by registered nurse care managers with additional training or behavioral specialists is also recommended.[15] Having a case manager from a similar racial and ethnic background as the patient improves communication and helps to avoid misdiagnosis or ineffective care.[16]

Collaborative care doubles the effectiveness of depression treatment for older adults in primary care settings. In a randomized controlled trial of 1,801 patients older than 60 years with depression, 45% of the patients receiving collaborative care in 18 clinics reported at least a 50% reduction in depressive symptoms at 12 months, compared with only 19% of those receiving usual care. Usual care included primary care and referrals to psychiatry and other behavioral health specialists. Collaborative care also resulted in lower mean total health care costs than usual care over four years.[17]

When older patients do not respond to initial treatment (medication titration, medication changes, or behavior interventions alone), clinicians should have a shared decision-making discussion with the patient about adding a complementary approach (e.g., if treated with medications, therapy should be considered, or vice versa). If PHQ-9 scores are greater than 15 for three months or the patient does not respond to treatment despite multimodality therapy and medication titration, referral to a psychiatrist should be considered.

Patient Perspective

Depression in older adults can have many causes, including loneliness, debilitation, and a loss of purpose in life. Such causes are often outside the realm of medical treatment. In many cases, antidepressants are among the first treatments for depression in older adults. Studies indicate that approximately one-half of nursing home residents

take antidepressants, although benefits beyond placebo are unclear.[18,19] *Antidepressant adverse effects, including falls and sleep disturbances, can be particularly worrisome for this population.*[20]

From a concerned family member's point of view, the goal should be to reduce as many nonmedical contributors to depression as possible while minimizing the burden of medication use. It seems intuitively obvious that engagement in meaningful social activities helps lift one's spirits. This is supported by studies showing that even ordinary social outlets, such as biweekly card nights, can reduce depression in older adults who are isolated.[21] *We must find a balance between limiting the spread of diseases such as COVID-19 and exacerbating the loneliness and confusion of vulnerable people.*

With this patient's age, mild dementia, serious hearing loss, and history of falls, there are clear opportunities for collaborative care to create a safer and happier lifestyle. Collaborative care team members can provide regular check-ins, a social activity in itself. They can arrange an appointment with an audiologist to determine the reason for the patient's discomfort with hearing aids. They can assess her medications, inspect her apartment for fall hazards, and help plan activities that might bring meaning to her daily life.

One of us was part of a team that cared for 90-year-old parents a few years ago. One parent had short-term memory loss, and the other had serious, progressive dissociation from reality. The loss of purpose in life contributed to chronic depression. The death of friends led to times of acute depression. One parent asked, "If all my friends die before me, who will come to my funeral?" Managing medications was challenging in the parent with gout, heart failure, and end-stage renal disease. On the positive side, their great-grandchildren created moments of exceptional joy. Primary care physicians were valued sources of medical advice on the journey through the years of progressive dementia, mounting comorbidities, and bouts of depression.

Resolution of Case

After COVID-19 vaccines became available and the patient, her daughter, and her son-in-law were immunized, they were able to visit in person again. This allowed the patient's daughter to better evaluate her mother's mood and overall status. The patient's sense of humor soon returned, she gained weight, and her sleep quality improved.

This patient would have been better served by a collaborative care approach delivered through her primary care physician during the pandemic. Although she could not receive family visitors, a home visit by a registered nurse working with her primary care physician might have lessened the loneliness she experienced. Telemedicine was not an option because of her hearing deficits.

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