DEPRESSION MANAGEMENT OUTLINE
MANAGEMENT OF DEPRESSION
IN OLDER ADULTS*

OBJECTIVES

• Identify depressive signs and symptoms in defined Medicare Advantage members
• Provide appropriate treatment of depression in defined Medicare Advantage members
• Improve the quality of life for defined Medicare Advantage members who have been diagnosed with depression
• Decrease morbidity and mortality in defined Medicare Advantage members

BACKGROUND

Depression is usually a treatable, recurrent disease which is often underdiagnosed and undertreated in the older adult. Depression can occur alone or in combination with other psychiatric and medical conditions. More positive patient outcomes are associated with early diagnosis. Treatment generally involves psychotherapy, medication or a combination of both.

DEFINITIONS

• Major Mood Disorder — depressed mood or loss of interest or pleasure not due to a physical illness for at least two weeks and representing a change from previous functioning with at least five of the following:
  • Depressed mood most of the day and most days
  • Markedly diminished interest or pleasure
  • Significant change in weight or appetite
  • Insomnia or hypersomnia
  • Psychomotor agitation or retardation
  • Fatigue or loss of energy
  • Feelings of worthlessness or excessive/inappropriate guilt
  • Diminished ability to think or concentrate or indecisiveness
  • Recurrent thoughts of death or suicidal ideation
• Dysthymia—a milder, more long-lasting, disabling form of depression in which persons are depressed for a majority of time during a period of at least 2 years

A. STATISTICS

• Rates of major depression in the older adult population may range from 5 percent in the primary care setting and 15 percent to 25 percent in the nursing home setting
• Suicide rate for the older adult population is approximately twice that for all other age groups, and the rate of successful suicide is very high especially for older adult, white males
• Approximately 70 percent of the older adult population who commit suicide have visited their primary care physician within one month of their death but generally their depressive mood remains undiagnosed and untreated
• Lifetime prevalence of dysthymia is approximately 2 percent
B. RISK FACTORS

Depression Risk Factors
- Prior episodes of depression
- Family history of depressive disorder
- Prior suicide attempts
- Female gender
- Age of onset of depression over 40
- Medical co-morbidity
- Lack of social support
- Stressful life events particularly loss of a spouse
- Current substance abuse

RISK FACTORS FOR DYSTHYMIA-mixed case
- Chronic illness
- Psychosocial stressors
- Alcoholism
- Borderline personality

C. CLINICAL ASSESSMENT-HISTORY AND PHYSICAL:

History-interview patient and family/significant other about:
- Symptoms experienced (SIGECAPS)
  - S-sleep disturbances
  - I-interest
  - G-guilt
  - E-energy
  - C-concentration
  - A-appetite
  - P-psychomotor retardation
  - S-suicide
- Substance abuse/dependency, anxiety, somatization or personality disorders
- Feelings of hopelessness and/or helplessness in the medically ill older adult
- Recent losses such as bereavement, loss of health or societal role as with retirement or changes in social/family support
- Medications which may contribute to development of depressive symptoms such as methyldopa, propranolol, cimetidine, neuroleptics, NSAIDs, reserpine, benzodiazapines among others

Physical Examination
- Complete a thorough physical examination – pay particular attention to relevant comorbid conditions which may contribute to depressive symptoms, such as cancer, diabetes mellitus, cardiovascular disease, CHF, COPD, arthritis, Parkinson’s disease, central nervous system disease or dementia

Functional Assessment – consider the use of screening tools to use as a guideline in the assessment of the patient; however, clinical judgment must be used in the interpretation of these tools.
- Geriatric Depression Scale for suspected affective disorder (Refer to Geriatric Depression Scale and Geriatric Depression Scoring Key at the end of this section or in the Tools section of the binder.)
- Mental State Examination for suspected cognitive deterioration (Refer to the Annotated MiniMental State Examination and the Annotated MiniMental State Examination Scoring Key at the end of this section or in the Tools section of the binder.)
D. MANAGEMENT AND TREATMENT

- Treat underlying medical condition(s)
- Non-drug therapies
  - Listening to patient
  - Encouraging patient to engage in positive discussion
  - Exploring habits and life patterns

- Acute Phase (6-12 weeks)
  - Select most appropriate treatment according to intensity of symptoms
  - Severe intensity – antidepressant with weekly monitoring
  - Moderate to mild intensity – antidepressant with biweekly monitoring and/or weekly psychotherapy

- Continuation Phase (4-9 months)
  - Maintain therapeutic dosage for full 6-9 months
  - Reduce medication monitoring to bimonthly
  - Reduce psychotherapy as appropriate
  - If history of chronic/complicated symptoms, place in Maintenance Phase

- Maintenance Phase (12 months)
  - Maintain therapeutic dose
  - Reduce medication monitoring to tri-monthly
  - Reduce psychotherapy as appropriate

- Administration of antidepressant medications such as Selective Serotonin Reuptake Inhibitors, tricyclics, and heterocyclics with monitoring (Refer to Drug Utilization Outline for effects of medication on the older adult)

- Psychiatrist/psychologist consult
- Inpatient hospitalization
- Electroconvulsive Therapy (ECT)
- Day treatment programs such as Partial Hospitalization Program/Intensive Outpatient Program
- Community outreach/supportive programs
E. SUMMARY

- Maintain a high index of suspicion and evaluation of risk factors relevant to the patient
- Develop plans/intervention strategies which include the patient and family/significant other
- Make referrals to behavioral health specialists and community resources as indicated
- Arrange timely follow-up visits

References

1. American Medical Directors Association, 1996 Clinical Practice Guideline on Depression
2. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Depression in Primary Care: Detection, Diagnosis and Treatment. Quick Reference Guide for Clinicians, No. 5; Publication No. 93-0552, April 1993

Web Sites:

www.ahrq.gov.com
www.ama-assn.org/insight/spec-con/depressn/depress.htm

Special thanks to Vincent Balestrino, MD, and Highmark’s Geriatric Committee on the development of these guidelines.
Geriatric Depression Scale

Geriatric Depression Scale (short form)

Choose the best answer for how you felt over the past week.

1. Are you basically satisfied with your life?  yes/no
2. Have you dropped many of your activities and interests?  yes/no
3. Do you feel that your life is empty?  yes/no
4. Do you often get bored?  yes/no
5. Are you in good spirits most of the time?  yes/no
6. Are you afraid that something bad is going to happen to you?  yes/no
7. Do you feel happy most of the time?  yes/no
8. Do you often feel helpless?  yes/no
9. Do you prefer to stay at home, rather than going out and doing new things?  yes/no
10. Do you feel you have more problems with memory than most?  yes/no
11. Do you think it is wonderful to be alive now?  yes/no
12. Do you feel pretty worthless the way you are now?  yes/no
13. Do you feel full of energy?  yes/no
14. Do you feel that your situation is hopeless?  yes/no
15. Do you think that most people are better off than you are?  yes/no

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For additional information on administration and scoring refer to the following references:
Geriatric Depression Scale

Geriatric Depression Scale Scoring Key (short form)
(This screening tool should be used as a guideline in the assessment of the patient. Clinical judgment must be used in the interpretation of this tool. The same caregiver should administer this tool each time. A quiet place and preferably the same location should be used each time the test is administered. Administration of this tool should not occur immediately following some mental trauma or unsteady period.)

1. Are you basically satisfied with your life? YES/NO
2. Have you dropped many of your activities and interests? YES/NO
3. Do you feel that your life is empty? YES/NO
4. Do you often get bored? YES/NO
5. Are you in good spirits most of the time? YES/NO
6. Are you afraid that something bad is going to happen to you? YES/NO
7. Do you feel happy most of the time? YES/NO
8. Do you often feel helpless? YES/NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES/NO
10. Do you feel you have more problems with memory than most? YES/NO
11. Do you think it is wonderful to be alive now? YES/NO
12. Do you feel pretty worthless the way you are now? YES/NO
13. Do you feel full of energy? YES/NO
14. Do you ever feel your situation is hopeless? YES/NO
15. Do you think most people are better off than you? YES/NO

Scoring is as follows:
Answers indicating depression are highlighted. Each answer counts one point.
If a patient circles four to nine of the responses, the probability of depression exists.
If a patient circles ten or more responses, this is almost always indicative of depression.

Source: Courtesy of Jerome A. Yesavage, MD. Reprinted with permission.
For additional information on administration and scoring refer to the following references:
The Highmark Geriatric Specialty Advisory Board recommends the use of the Folstein Annotated MiniMental State Exam (AMMSE) as a guide for assessment of dementia in the older adult patient. An example of this guide is included in the Geriatric Resource Binder for reference purposes only. This guide is protected under copyright laws. The copyright is wholly owned by the MiniMental LLC, a Massachusetts limited liability company. For information about how to obtain permission to use or reproduce the MiniMental State Examination, please contact in writing:

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or by telephone at 617-587-4215

All fees related to obtaining the AMMSE are the responsibility of the Provider. Further description of the original Folstein MMSE may be read in the following journal article: “MINI-MENTAL STATE.” A PRACTICAL METHOD FOR GRADING THE COGNITIVE STATE OF PATIENTS FOR THE CLINICIAN. *Journal of Psychiatric Research, 1975* 12(3): 189-198.
**MiniMental LLC**

**NAME OF THE SUBJECT** ____________________________ **AGE** ____________________________

**NAME OF EXAMINER** ____________________________ **Years of School completed** ______

Approach the patient with respect and encouragement  
Date of Examination ____________

**Ask:** “Do you have any trouble with your memory?  □ Yes □ No
“May I ask you some questions about your memory  □ Yes □ No

<table>
<thead>
<tr>
<th>SCORE</th>
<th>ITEM</th>
<th>CONTENT</th>
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| 5 ( ) | **TIME ORIENTATION** | “What is the year _________ (1), season _________ (1),
month of the year _________ (1), date _________ (1),
day of the week _________ (1)?” |
| 5 ( ) | **PLACE ORIENTATION** | “Where are we now? What is the state _________ (1), city _________ (1),
part of city _________ (1), building _________ (1),
floor of the building _________ (1)?” |
| 3 ( ) | **REGISTRATION OF THREE WORDS** | “Say: “Listen carefully. I am going to say three words. You say them back after I stop, Ready? Here they are.. PONY (wait 1 second), QUARTER (wait 1 second), ORANGE (wait 1 second). What were those words?”
______________________ (1)
______________________ (1)
______________________ (1) |

Give 1 point for each correct answer, then repeat them until the patient learns all three.

| 5 ( ) | **SERIAL 7’s AS A TEST OF ATTENTION AND CALCULATION** | “Subtract 7 from 100 and continue to subtract 7 from each subsequent remainder until I tell you to stop. What is 100 take away 7?”__________ (1)
“Keep Going” ____________ (1) ____________ (1) ____________ (1) |

| 3 ( ) | **RECALL OF THREE WORDS** | “What were those three words I asked you to remember?”
Give 1 point for each correct answer ____________ (1) ____________ (1) |

| 2 ( ) | **NAMING** | “What is this?” (Show pencil) ____________ (1)  “What is this?” (Show watch) ____________ (1) |

**OVER**
REPETITION
Say:
“Now I am going to ask you to repeat what I say. Ready? ‘No ifs, ands, or buts.’ Now you say that.” (1)

COMPREHENSION
Say:
“Listen carefully because I am going to ask you to do something:
Take this paper in your left hand (1), fold it in half (1), and put it on the floor.” (1)

READING
Say:
“Please read the following and do what it says, but do not say it aloud.” (1)

WRITING
Say:
“Please write a sentence.” If the patient does not respond, say: “Write about the weather.” (1)

DRAWING
Say:
“Please copy this design.”

TOTAL SCORE
Assess level of consciousness along a continuum

Alert
Drowsy
Stupor
Coma

FUNCTION BY PROXY
Please record date when patient was last able to perform the following tasks.

Ask caregiver if patient independently handles

Family History of Dementia:
Head Trauma:
Alcohol Abuse:
Thyroid Disease:

Money/Bills:
Medications:
Transportation:
Telephone:

YES
NO
DATE


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Annotated MiniMental State Examination Scoring Key

The Annotated MiniMental State Examination (AMMSE) is one of the standard tools to screen for memory loss and cognitive impairment. Clinicians should consider screening older adults if the patients themselves, or family members or other caregivers, express concerns about a decline in memory function. This screening tool is not sufficient in and of itself to make the diagnosis of dementia. Most well older adults will score in the 28-30 range. Scores in the 20-27 range could represent evidence of early dementia, delirium, depression, or adverse effects of medication(s). Generally, scores below 20 in alert patients reflect organic pathology. Sensory impairments and educational level can influence patient performance of the AMMSE.