Instructions on Completing the Module

Screening for Depression in Older Adults

*The results of the assessments and evaluations are confidential, and the data is used to meet requirements of our federally funded grant.

Please make sure to turn in Pre-Test, Post-Test, and Module Evaluation.

1. **Before** reading the module, and without looking at it, complete the Pre-Test. Record your answers on the examination form marked Pre-Test. *(Found at the start of the module.)* Keep the completed answer form to turn in at the completion of the module.

2. Complete the module as outlined in the syllabus.

3. **After** reading the module, please complete the Post-Test. Use the questions in Appendix E and record your answers on the examination form marked Post-Test. *(Found at the end of Appendix E.)* Keep the completed answer form to turn in with the pre-test at the completion of the module.

   Complete the Module Evaluation. *(Found after the post-test.)* Keep the completed module evaluation form to turn in with the pre-test and post-test at the completion of the module.

4. **To obtain credit for the module you must:**
   - Complete and turn in MTGEC Participant Profile
   - Turn in the Pre-Test, Post-Test, and Module Evaluation
   - Obtain a score of 70% or better on the Post-Test

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Pre-test:  Screening for Depression in Older Adults

Record responses on examination form.

1) Depression is under-diagnosed and under-treated in older adults for all of the following reasons EXCEPT:
   a) Aging stereotypes: “Older people’s lives are just hard, and sadness is just a normal part of aging.”
   b) Older people believe “Other people (especially doctors) don’t need to hear about my problems.”
   c) It’s difficult to clearly separate medical symptoms, medication problems, and depression symptoms.
   d) Depression screenings are expensive and most people can’t afford them.
   e) Health care professionals don’t have the time to ask about depression.

2) The percentage of men and women over age 65 who are clinically diagnosable as depressed:
   a) Increases with disability.
   b) Is higher than for younger cohorts.
   c) Is higher for men than women.
   d) Is approximately 22-27%.
   e) All of the above.

3) Which of the following is NOT true? The symptoms of diagnosable depression include:
   a) Changes in sleep and appetite.
   b) Slow or agitated movements, speech or thinking.
   c) Suicidal thoughts.
   d) Feelings of guilt.
   e) Lack of pleasure in previously favorite activities.
   f) Intense grief following the death of a loved one.
4) Which of the following is NOT one of the top five most significant risk factors for depression in seniors?
   a) Bereavement
   b) Sleep disturbance
   c) Being unmarried
   d) Disability
   e) Prior depression
   f) Female gender

5) Depression in older people, unlike younger people, often includes:
   a) Less irritability but more memory problems.
   b) More physical complaints and less sadness.
   c) Less anxiety and better self care.
   d) More guilt, but fewer sleep problems.

6) How often should a depression assessment such as the Geriatric Depression Scale be given to someone over 65?
   a) At each visit with a health care provider.
   b) Every five years, or whenever a major medical event occurs.
   c) At the initial visit with a health care provider, and then annually and/or after any major change occurs in his/her mood.
   d) As often as is financially possible.

7) All of the following are well established depression screening tools with researched reliability and validity for the diagnosis of depression EXCEPT:
   a) Geriatric Depression Scale (GDS)
   b) Patient Health Questionnaire (PHQ-9)
   c) Hamilton Rating Scale for Depression (HAM-D)
   d) Mini-Mental Status Exam (MMSE)
   e) Beck Depression Inventory (BDI)

8) Medications to treat depression in older adults
   a) Should be started at higher dosages than with younger people because drugs are metabolized more slowly in older adults.
   b) Are not addictive, but may have side effects.
   c) Are chosen after analyzing blood samples to match the right medication to the most effective antidepressant for that person.
   d) Should be stopped immediately after the depressive symptoms ease.
   e) Should not be prescribed until all other medical conditions have stabilized.
9) Which of the following statements is/are true about suicide?
   a) Most older adults who commit suicide visited their doctor during the month before their suicide.
   b) More women attempt suicide, but men are more likely to succeed.
   c) Older Caucasian men have the highest suicide rate of any group.
   d) Asking about suicidal thoughts will not increase the risk of suicide.
   e) c and d.
   f) All of the above.

10) Effective treatments for late life depression include all of the following EXCEPT:
   a) Hormone replacement therapy (HRT).
   b) A combination of antidepressants and psychotherapy.
   c) Cognitive Behavioral Therapy.
   d) Increased physical activity.
   e) Medications that increase the availability of serotonin in the brain.
### Participant Information

1. **Name:** ________________________________

2. **Mailing address:** ________________________________
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3. **Date exam completed** ________________

### Questions: (Please circle one response per question)

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Screening for Depression in Older Adults

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In consultation with Jane C. Wells, MD, MHS

A 2-hour Geriatric Health Screening Module from the
Montana Geriatric Education Center

A Consortium of
The University of Montana, Missoula
St. Vincent Healthcare
Montana Tech

http://mtgec.montana.edu

April 2012

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Required Disclosures to Participants

**Goal/Purpose**
Improve health outcomes for older adults in rural Montana via increased knowledge of geriatric care and treatment of health problems by health professionals.

**Successful Completion of this Continuing Education Activity:**

- Completion of Participant Profile
- Completion of Pre-Test
- Reading of Text
- Completion of Post-Test with at least 70% accuracy
- Completion of module evaluation

**Contact Hours: 2**

**MT Nurses Association Continuing Education Expiration Date: 4/9/2014**

**Conflicts of Interest**
A conflict of interest occurs when an individual has an opportunity to affect educational content about health-care products or services of a commercial company with which she/he has a financial relationship.

The planners and presenters of this CE activity have disclosed no relevant financial relationships with any commercial companies pertaining to this activity.

**Commercial Company Support**
There is no Commercial Company Support for this CE activity

**Noncommercial Sponsor Support**
This CE activity is supported 100% by a federally funded grant from the Health Resources and Services Administration (HRSA) Grant Number UB4HP19056 for $2,136,009 (07/01/2010 – 06/30/2015).

**Non-Endorsement of Products**
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**Off-label Product Use**
This CE activity does not include any unannounced information about off-label use of a product for a purpose other than that for which it was approved by the Food and Drug Administration (FDA).
Description of Module

Content: This module will present

1. An overview of the incidence and prevalence of depression in the older adult population;
2. Review of signs and symptoms of depression in older persons;
3. Discussion of screening tests used to identify depression; and
4. A summary of treatment and follow-up, including appropriate referral sources for older adults with depression.

Objectives
At the completion of this module the learner will:

1. Review the impact of depression in the older persons.
2. Describe the procedures for conducting basic depression assessments, including the Geriatric Depression Scale.
3. Summarize the need for referral and the treatments for depression.
# Table of Contents

I. Incidence and Prevalence of Depression in Older Adults ............................................. 10

II. Symptoms of and Risk Factors for Depression in Older Adults .................................. 11
   A. What is Depression? ........................................................................................................ 11
   B. Causes and Risks of Depression .................................................................................... 15

III. Screening Tests Commonly Used to Identify Depression in Older Adults .................. 17
   A. Informal Interview Assessment ..................................................................................... 17
   B. The Most Common Depression Screening Tests for Older Adults .............................. 18
   C. Physical Exams .............................................................................................................. 20

IV. How to Conduct and Score the Geriatric Depression Scale (GDS) .............................. 20

V. Types of Referrals and Referral Sources for Depressed Patients ................................. 24

VI. Overview of Treatment for Depression ...................................................................... 26
   A. Pharmacologic Treatments ......................................................................................... 27
   B. Psychotherapy Treatment ............................................................................................ 29
   C. Hospitalization and Residential Treatment Programs ............................................... 30
   D. Self Care to Assist with Depression ........................................................................... 30

VII. Depression Screening – Video Review ...................................................................... 31

VIII. Depression Web Resources .......................................................................................... 31

IX. Depression Glossary ....................................................................................................... 33

X. References .................................................................................................................... 35

XI. Appendix A- Geriatric Depression Scale – alternate formats ........................................ 38

XII. Appendix B: Geriatric Depression Scale (Long Form) .................................................. 39

XIII. Appendix C: Depression Brochure for Participants IPHARM/MTGEC Screening Program 41

XIV. Appendix D: Depression Screening Tool used in IPHARM/MTGEC Screening Program ... 42

XV. Appendix E: Post-test: Screening for Depression in Older Adults ............................ 43

XVI. Appendix F: Evaluation for MTGEC Module: ............................................................... 47
Screening for Depression in Older Adults

I. Incidence and Prevalence of Depression in Older Adults

An annual survey shows that there has been a gradual upward trend of American adults of all ages who self-report 14 or more mentally unhealthy days in the last month, defined as “frequent mental distress”. The largest increases are seen in the ages 45-54 and 55-64. The lowest increases in this upward trend and the lowest percentages are consistently shown in people ages 75+ and ages 65-74 (National Center for Chronic Disease Prevention and Health Promotion, 2011).

Different age groups and cohorts seem to have varied vulnerability to depression for a variety of reasons. Some speculate that the current cohort of older adults has lower expectations from living through the Great Depression and WWII, but higher life satisfaction having seen unprecedented lifetime societal improvements in the American financial and medical systems and supports (with historically unique pensions, Social Security, and Medicare). Others would say that there is a correlation between depression and conditions which lead to earlier deaths, so that those who survive to age 65 tend to be those who are less depressed. Another view is that a lifetime of experience teaches seniors coping skills and resiliency that younger people lack. Others believe that “The Greatest Generation” simply under-report their depression, having been raised with a “stiff upper lip” philosophy and unwillingness to share their problems.

For whatever reason, Baby Boomers seem to have higher rates and earlier incidence of depression. As a result, health care professionals should be prepared to see the rates of depressed seniors rise as this large new cohort reaches 65. Currently, both older and younger adults are less likely to seek mental health services than the middle-aged cohort. (Hinrichsen & Clougherty, 2006).

Nonetheless, depression is THE most prevalent mental health problem found among older adults. Other common mental health conditions are anxiety and severe cognitive impairment (Centers for Disease Control and Prevention (CDC), 2009). Depression often goes undiagnosed and untreated because seniors may not seek help, because families may not recognize signs of depression, and because health professionals may not inquire. Even when seniors request help, they tend to receive less care. Health professionals may mistakenly think that depressive symptoms are a reasonable and acceptable response to the physical, social and financial challenges of aging. Major depression, more than any other medical condition, is the leading cause of disability in the United States, and depression costs Americans billions of dollars each year and results in a significant reduction in quality of life. Without treatment, the frequency and severity of depressive episodes tend to increase over time. Left untreated, depression can lead to increased morbidity in other illnesses and suicide (National Alliance on Mental Illness (NAMI), 2011; CDC, 2009).

Depression affects women roughly two to three times more than men. Rates are also higher in the ‘oldest old’ compared to the younger old, partially because the risk of depression increases dramatically...
for people with illness, limited functionality and disability, and cognitive impairment. Fifty to 85% of those who experience one episode of depression will continue to experience future episodes as frequently as once or twice a year (NAMI, 2011; CDC, 2009).

Overall, the incidence of clinically significant depressive symptoms is approximately 15% of adults over the age of 65. The rates may be as low as one to five percent in seniors living in the community, but rise for older adults with health problems, to an estimated 5 to 36% of those visiting their physician; 10 to 40% with seniors who require home health care or who are hospitalized; and 12 to 40% or more for residents of long term care facilities. Up to 50% of patients with Alzheimer’s disease or Parkinson’s disease develop depression, and their caretakers are also at high risk. Many more seniors suffer from a lower level of depression, which can have many of the same effects on their quality of life and health (Hinrichsen & Clougherty, 2006; National Institute of Mental Health (NIMH), 2007; Richardson, He, Podgorski, Tu, & Conwell, 2010; Sharp & Lipsky, 2002; U.S. Preventive Services Task Force (USPSTF), 2009).

Estimates of the number of depressed older adults vary widely in the literature for a number of reasons. The definition of depression ranges from mild to severe symptoms, and different measures include differing ranges. There are also, unquestionably, a large number of undiagnosed sufferers (Richardson, et al., 2010).

The good news is that if and when depression is recognized, it can be effectively treated. Up to 80% of those suffering with depression can improve with treatment, usually within weeks (NIMH, 2007).

II. Symptoms of and Risk Factors for Depression in Older Adults

What is Depression?

Depression is not a normal part of aging for the majority. The term depression is commonly used to mean the temporary emotional experiences of “the blues”, sadness, loneliness, grief, and negative reactions to loss and pain that are normal. Clinical depression, however, is much more serious. Clinical depression is a medical illness that can interfere significantly with a person’s ability to function and can affect anyone of any age, gender, race, ethnicity, education, or socioeconomic status. Depression can change the way a person feels, thinks, behaves and interacts with others. It is important to note that depression is not a character flaw or personal weakness.

Depression and other mental disorders have been described and categorized in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM IV (the current, fourth edition) classifies depression as a mood disorder with three main classifications, with the possibility of a fourth being added in the next edition (Smyer & Qualls, 1999; Smith E., 2011; Blazer, 2003).

- Major Depressive Disorder (MDD): persistent and long-lasting depressed mood
- Dysthymic Disorder: low level chronic depressed mood lasting for at least two years
- Adjustment Disorder: time-limited period of depressive symptoms appearing in response to a specific stressor
- Minor Depressive Episodes: the possible fourth category of fewer, but still significant symptoms

Depression at any level involves a number of symptoms, although the particular symptoms may vary from person to person and episode to episode and along a continuum of severity. The criteria and symptoms for the various categories of depression include:

**Primary DSM-IV depression disorders, criteria for adults (USPSTF, 2009, adapted).**

<table>
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<th>Depressive Diagnoses</th>
<th>Symptoms</th>
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<td><strong>Major Depressive Episode:</strong></td>
<td>1) Depressed mood (<em>sadness, despair</em>)</td>
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<td>1. 5 or more depressive symptoms for ≥ 2 weeks</td>
<td>2) Markedly diminished interest or pleasure in most or all activities</td>
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<td>2. Must have either depressed mood or loss of interest/pleasure (<em>symptoms #1 or 2 on right</em>)</td>
<td>3) Significant weight loss (or poor appetite) or weight gain</td>
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<tr>
<td>3. Symptoms must cause significant distress or impairment</td>
<td>4) Insomnia or hypersomnia</td>
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<td>4. No manic or hypomanic behavior</td>
<td>5) Psychomotor retardation or agitation</td>
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<td><strong>Minor Depressive Episode:</strong> (fewer symptoms)</td>
<td>6) Fatigue or loss of energy</td>
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<td>1. 2–4 depressive symptoms for ≥2 weeks</td>
<td>7) Feelings of worthlessness or excessive or inappropriate guilt</td>
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<td>2. Must have either depressed mood or loss of interest or pleasure (<em>symptoms #1 or 2 on right</em>)</td>
<td>8) Diminished ability to think or concentrate, or indecisiveness</td>
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<td>3. Symptoms must cause significant distress or impairment</td>
<td>9) Recurrent thoughts of death (not just fear of dying), or suicidal ideation, plan, or attempt</td>
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<td>4. No manic or hypomanic behavior</td>
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<td><strong>Dysthymic Disorder:</strong> (low-grade, long term)</td>
<td>1) Significant weight loss (or poor appetite) or weight gain (or increased appetite)</td>
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<td>1. Depressed mood for most of the time for at least two years</td>
<td>2) Insomnia or hypersomnia</td>
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<td>2. Presence of 2 or more of symptoms of dysthymia (<em>on right</em>)</td>
<td>3) Fatigue or loss of energy</td>
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<td>3. Never without symptoms for 2 months or more, over 2 year period</td>
<td>4) Low self-esteem</td>
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<tr>
<td>4. Symptoms must cause clinically significant distress or impairment</td>
<td>5) Diminished ability to think or concentrate, or indecisiveness</td>
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<td>5. No major depressive disorder in first two years, no manic, hypomanic, or mixed episodes.</td>
<td>6) Feelings of hopelessness</td>
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The symptoms of major depression are sometimes remembered by the mnemonic SIGECAPS: Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor and Suicidal.

Kroenke (2011), however, suggests that a better representation might be SPACE DIGS:

Adjustment Disorder, in contrast to depression, is a short-term struggle resulting from a stressful event. The depressed mood and emotional and/or behavioral reactions follow major and identifiable stressful life events, such as an illness, major life transition, divorce, conflict, financial difficulty, family crises, experience of failure, etc. Adjustment Disorders may have symptoms very much like depression, including functioning impairment, and feelings of sadness or hopelessness. The DSM IV criterion is for significant distress or functional impairment to occur within three months of the stressor(s) and persist no longer than six months. Note that this diagnosis can qualify a patient for therapeutic treatment under Medicare.

It is important to remember that all of the DSM diagnoses are meant to be used as guidelines for trained clinical professionals and NOT for self-diagnosing and treatment by the general public.

Older persons, their families, and health care professionals may not recognize depression in older adults for a number of reasons:

1) Medical conditions or medications can cause most of the symptoms of depression, be found in conjunction with them, or may exacerbate them.

2) Nonspecific physical symptoms may represent a variety of other treatable medical conditions, as well as depression.

3) Depressive symptoms and complaints may manifest differently in older adults than how they are described in the DSM-IV. Additionally, older patients may describe depressive symptoms quite differently than a younger person. Depressed mood and feelings of guilt tend to be less prominent in older depressed patients, whose primary complaints tend to be physical (USPSTF, 2009).

Depressed older persons are more likely than younger people to exhibit:

- Apathy
- Irritability/restlessness
- Physical complaints, with atypical pain, or generalized discomfort
- Psychomotor disturbances
- Anxiety
- Diminished self care
- Memory problems
- Sleep disturbance
- Fatigue
- Constipation

4) Depressive symptoms may vary by gender. Older women may have more appetite disturbances or anxiety and older men may have more agitation, antisocial behavior disorders, and substance abuse issues. (Preidt, 2011)

**About Suicide:** Late life suicide risk factors include depression, past suicide attempt(s), social isolation, substance abuse and physical illness or disability. Caucasian older men have the highest suicide rates of any group, and older women have higher rates than younger women, although rates among young people have been increasing (see chart below). More women attempt suicide, but men are much more likely to succeed. Men tend to be more aggressive, less socially connected, seek less professional help, and use more lethal means.

The following charts show distribution of suicides rates, as compiled by Bruce (2011) from CDC data and the National Center for Health Statistics:
- Older people use more lethal means (firearms and overdose) and are significantly more successful at completing suicide than younger people.

- Single, widowed and divorced people commit suicide more often than married people.

- Eighty percent of older adults who committed suicide were depressed (Hinrichsen & Clougherty, 2006). According to a 1992 NIH Consensus Development Panel on late-life depression, most were experiencing their first MDD episode, which had gone unrecognized and untreated (USPSTF, 2009).

- Fifty to seventy-five percent of suicides of older adults were preceded by a visit to a doctor within a month before their suicide, and around forty percent were seen during the week prior to their death. This highlights the importance of the identification of depression by healthcare professionals (NIMH, 2007; USPSTF, 2009).

Depression may occur with or be confused with several other conditions, notably:

- **Bereavement:** Symptoms may be identical to depression, with the exception of suicidal ideation, particularly during the first 3 – 6 months or more, and symptoms usually improve without treatment if adequate support is received. Treatment should be sought if suicidal ideation occurs.

- **Anxiety or panic conditions:** Anxiety is common in depressed elderly patients. Anxiety may be produced by and can exacerbate medical conditions and/or physical disabilities. A clinical diagnosis may be required to tease apart depression, anxiety, and medical conditions, in order to appropriately design treatment (Rovinelli Heller & Werkmeister Rozas, 2011).

- **Other conditions** that may occur alongside depression include substance abuse, eating disorders, or chronic post-traumatic stress disorder.

**Causes and Risks of Depression**

Depression results from complex interactions between biological and psychological vulnerabilities and stressful life events. Depression may be triggered by one or more or an interaction of several of the following factors:

- **Genetics:** Depression risk runs in families. Studies have shown that children with depressed biological parents are vulnerable to depression even when raised by adoptive parents. Genetically linked depression often appears earlier in life.

- **Brain Chemistry:** Brain chemical signaling by neurotransmitters (which can be inherited) plays an important role in regulating mood and emotion. Antidepressant drugs work to increase the levels of neurotransmitters. A first episode of depression lays down pathways in the brain which make future episodes more likely (Smith, 2011).

- **Medical Conditions:** Health concerns play an interactive role with depression. Increases in physical symptoms predict decreases in mental health, especially in women (Trotman & Brody, 2002).
Depression on the other hand, increases vulnerability to health problems both by elevating the risk of the onset of new symptoms and by exacerbating existing conditions. Decreased immune function, decreased physical activity, disruptions in eating and sleeping, and not taking medications correctly can all increase the risk of physical difficulties. In addition, physical co-morbidities decrease the chances of recognition of the depression, complicate the medical treatment, aggravate the problem of short health care visits, influence patient-doctor communication, and increase the need for team management (Kroenke, 2011). Specific connections include:

- Hormone imbalances
- Dietary deficiencies
- Some viral infections
- Medications or medication interactions
- Degenerative neurological disorders and dementia
- Chronic diseases, particularly chronic pain, heart disease, diabetes, disability, cancer, vascular brain lesions, strokes, HIV, COPD, and arthritis

- **Psychological, social and interpersonal factors** causing or exacerbating depression may include:
  - Experiences of abuse, particularly as a child.
  - Living under chronically stressful conditions (serious illness, disability, financial stress, divorce, conflict, homelessness, care giving, etc.)
  - Disability or depression in one’s spouse (Waugh, 2011)
  - Lack of social support systems
  - Living alone, particularly for men (Trotman & Brody, 2002)
  - Unresolved anger
  - Substance abuse
  - Negative thought processes, view of self, and world view
  - Feelings of helplessness/lack of control
  - Maladaptive coping strategies
  - Ineffective problem solving skills
  - Perfectionism
  - Adjusting to transitions, such as increased dependency, loss of driving privileges, change of living situation, end of life issues, etc.
  - Bereavement and loss (especially for men losing spouses)
  - Living in a long term care facility (more health problems and disabilities, less life satisfaction, less physical activity, loss of independence, adjustment to group living, lack of mental health treatment)
  - Generational stigma against admitting problems and seeking help with mental health issues, resulting in delayed identification and treatment
The Risks for Depression, then, are a complex interaction and accumulation of many factors: biological, social and psychological. In a meta-analysis in 2003 of 20 research papers about depression in people over 50, Cole & Dendukuri (2003) identified five common risk factors which contribute to a large proportion of depression among elderly people. They are:

1) Bereavement
2) Sleep disturbance
3) Disability
4) Prior depression
5) Female gender

Note that the first three factors are usually treatable (Cole & Dendukuri, 2003). By watching for these factors, steps can be taken to prevent depression before it occurs by more easily identifying people who need assessment and possible treatment for depression. The modification of these risk factors, to say the least, has the potential for significant public health impact (Cole & Dendukuri, 2003). Of course, the presence of these risk factors alone does not necessarily mean the person is depressed.

The good news is that with proper assessment, depression can be identified and with proper treatment, four out of five patients will improve over time.

For more detailed information about depression in older adults, see the Montana Geriatric Education Center module “Late Life Depression”.

III. Screening Tests Commonly Used to Identify Depression in Older Adults

Treatment for depression in older people is usually very effective; therefore it is important that all practitioners develop skills and tools for identifying depression in this population. Older adults often see health professionals frequently, and depression assessments can be performed by a range of health professionals in a variety of settings.

Remember that sadness is a normal and appropriate response to serious losses such as loss of independence, health, function, status, friends, family, spouses, etc. Initially, support and self care should be encouraged. It is only when sadness interferes with daily functioning and continues for an extended period that depression may be present.

A. Informal Interview Assessment

If depression is suspected, three simple questions can initially assess and judge the potential presence and severity of depression including suicidal thoughts or intent. Each question corresponds to a different level of depression diagnostically, mild, moderate or severe. After asking each question, listen
carefully and consider follow up questions, such as the examples given. Caregivers can also be asked similar questions about the patient, and also for themselves.

1) Have you been feeling sad or blue? [Blue is a better word than depressed for this population.] Follow up questions might be: Do you find that you have lost interest in the things you used to love? How often? For how long?

2) Do you feel hopeless? Or guilty, or worthless, or useless, or unlovable, or withdrawn? [If yes, may want to follow up with an assessment instrument.]

3) Do you wish you were dead or think about killing yourself? [ASK, listen carefully, and take statements seriously. If the answer is yes or hesitant, follow up with questions to determine the level of the suicide ideation. See examples below.]

   a. “What’s the point?” “No one would care if I was dead.” “I wish God would just take me.” Many times people may feel relief just expressing these passive suicidal thoughts. [Further depression assessment may be appropriate.]

   b. Ideas of ways to kill oneself, but no intent to actually follow through. [Need to ASK and assess risk. Remember in Montana, people often have access to firearms or drugs, which increases their risk of suicide completion. If suffering from depression or dementia, a client may not remember this conversation, so obtain a release and ask family members or friends to keep in close touch. Make sure possible means of suicide are removed from the home.]

   c. Visualizing acting, making preparations, active thoughts, plans, and means. [Consider hospitalization, ER, or at the minimum, close monitoring 24/7.]

Many depression screening tools do not include a suicide assessment, and so it is important to ask about suicidal thoughts. Asking these questions will NOT “plant” the idea in a person’s head or precipitate suicide. With appropriate action, it may, however, prevent it.

B. The Most Common Depression Screening Tests for Older Adults

Screening tools can be helpful in many ways. They systematically evaluate depressive symptoms using terms which have been tested and found to be understandable and relevant. A screening score may help gauge the severity of a depression, and it can be used a guide for discussions with the client about depression and treatment. The screen also establishes a baseline of symptoms, which can be used for comparison to judge the effectiveness of a treatment (Hinrichsen & Clougherty, 2006).

The most common evidence-based depression screening tests used with older adults are:

- **Geriatric Depression Scale (GDS):** The most universally recommended assessment and most researched scale for older adults. This is a brief, interview-based or self-assessment instrument in a yes or no, 30-item long form (Appendix B) or a 15-item short form (section IV). It was designed in the early 1980s to assess both affective and behavioral symptoms, without the physical (somatic) complaints which prevent other assessments from being as valid with older adults. Both versions scales have established reliability and validity (92% sensitivity and 89% specificity) when evaluated against diagnostic criteria for community, inpatient, outpatient, or
institutional use, and with mild or possibly moderate cognitive impairment. It is not, however, suitable for more severe cognitive impairments. It is interesting to note that those with a formal education (and women in particular) are more likely to score in the depressed range on the GDS short form. The GDS is available at no charge online at http://www.stanford.edu/~yesavage/GDS.html and in other languages and formats (Yesavage, et al., 1983; Gallo, Bogner, & Fulmer, 2006; Kurlowicz & Greenberg, 2007).

- **Beck Depression Inventory (BDI):** A brief 30-minute self-assessment with both long (21-item) and short (13-item) scales. It is widely used by health professionals and is well researched. The BDI is copyrighted and therefore is not free. It is designed for use with individuals 13 or older. The format may be more difficult for seniors and its physical symptom (somatic) content may lead to false positives with older adults who have physical disabilities but are not depressed (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

- **Center for Epidemiological Studies Depression Scale (CES-D):** A scale of 20 questions covering physical, psychological, and behavioral aspects of depression, with less emphasis on somatic symptoms. Although it is designed for different age groups, it requires an estimation of symptom frequency that some seniors find difficult to complete (Radloff, 1977). The CES-D is available at http://www.chcr.brown.edu/pcoc/cesdscale.pdf

- **Cornell Scale for Depression in Dementia (CSDD):** This 19-item scale is a common assessment of depression for patients with dementia; it is usually administered by the patient’s primary caregiver and takes about 20 minutes to complete. The CSDD consists of two interviews, one with the patient and the other with a caregiver, and also includes observations by the interviewer. It has been found to be reliable, is sensitive to mood changes in dementia, and has concurrent validity with the research diagnostic criteria for depression (Sharp & Lipsky, 2002; Alexopoulos, 2002; Osterweil & Brummel-Smith, 2000). The CSDD is available at http://www.scalesandmeasures.net/files/files/The%20Cornell%20Scale%20for%20Depression%20in%20Dementia.pdf

- **Hamilton Rating Scale for Depression (HAM-D or HRSD):** A more extensive screen commonly used by clinicians (not a self-assessment) to rate severity of symptoms and depression changes over time. The HAM-D distinguishes different levels of depression and requires a 30-minute interview. This tool may overemphasize somatic symptoms for the older population and because various versions exist, scores may be confusing (Osterweil & Brummel-Smith, 2000).

- **Patient Health Questionnaire (PHQ-9):** Perhaps the most widely used screening instrument in primary care settings, the PHQ-9 is a valid and reliable screening tool for depressive syndromes among adults, including older persons. It consists of nine questions on a 4-point Likert scale which correspond to the DSM-IV criteria set for major depression and one additional question measuring the degree of impairment. The PHQ-2 is an abbreviated version of the PHQ-9, and may be given in a two-stage process in which only those clients who screen positive on the PHQ-2 (by scoring 2 or more) are administered the PHQ-9 (Richardson, He, Podgorski, Tu, & Conwell, 2010). The PHQ-9 is available on the web at http://www.depression-screening.org/depression_screen.cfm

- **Zung Self-Rating Depression Scale:** A 20 item self-assessment which measures depression on a continuum from mild to moderate to severe, taking around 45 minutes to complete. Mild but
frequent symptoms may score high, giving false positives among the elderly (Osterweil & Brummel-Smith, 2000).

Self assessments are also available. These could be used as a first step in seeking assistance.

- **Online Self Assessments**: Self assessments available for completion online. One example is the National Mental Health Screening Assessment, which is available through the Missoula City-County Health Department website at [http://www.co.missoula.mt.us/healthpromo/SuicidePrevention/index.htm](http://www.co.missoula.mt.us/healthpromo/SuicidePrevention/index.htm)

In 2009, the U.S Preventive Services Task Force (USPSTF) thoroughly reviewed evidence regarding the accuracy of screening instruments in identifying depressed adults. No one screening tool has been proven to be more effective or accurate than others. The USPSTF, therefore, recommends that depression screening tools may be chosen based on personal preference, the practice setting and the patient population served. (USPSTF, 2009).

**C. Physical Exams**

Due to the fact that many physical conditions could be interacting with, or be the cause of depressive symptoms, it is recommended that a thorough physical assessment, including comprehensive screening laboratory tests, be completed whenever depressive or cognitive symptoms are present. A complete battery of tests may cost around $800 and can be covered by Medicare. Until electronic medical records become easily accessible and accurate, it is helpful to ask a patient to bring to the physical assessment a full list of current medical conditions, medications and supplements. Collecting these lists will be helpful for the patient in the future, will save paperwork time, and will focus the interview on current symptoms, history and severity, family medical conditions, habits and lifestyle. Interview questions at the physical should ideally also cover inquiries about possible domestic violence, substance use and abuse, and recent falls or motor vehicle accidents.

**IV. How to Conduct and Score the Geriatric Depression Scale (GDS)**

The GDS is widely used, easily learned, user friendly, has evidenced-based reliability and is therefore the assessment that is the focus of this training.

**Tips for conducting any assessment:**

- Practitioners with limited training in mental health should limit their assessment to screening for symptoms and should refer the person, if depressive symptoms are observed or identified. A screening instrument is **NOT** sufficient in itself to determine a diagnosis. Likewise, a clinical interview to determine a diagnosis is not sufficient to determine the best treatment. The U.S. Preventive Services Task Force recommends screening adults for depression **if and when** staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (USPSTF, 2009). See section V for more information on referrals.
- Although Medicare is considering the coverage of depression screening tools, assessments are currently only covered when administered by a licensed professional.
• Be aware of patient literacy limitations, visual or speech deficits, and cognitive impairment, and be prepared to make appropriate adjustments. For example, pointing is effective if a patient is unable to speak or be understood. Reading the questions to the person may effectively address literacy and/or visual impairments. Use appropriate assistive devices, such as amplifiers, for aiding conversations with hearing-impaired individuals.

• Be aware of cultural differences that may affect assessments. In Montana, training in Native American cultures is recommended. For example, English may be a second language for some elders, and words and concepts may need translation. Questions about the level of activities at different points in time may be more fruitful than questions about current feelings and symptoms.

• Including significant others, especially caregivers, may be helpful, particularly if the person is severely depressed or has cognitive impairment. The caregiver may have a broader perspective and be willing to volunteer information that the person is hesitant to discuss or cannot remember. Always keep HIPPA and privacy issues in mind, appropriately request permission and keep engaged with the older person at all times, not just talking with the family member about them. Most older adults seek mental health assessment at the encouragement of a family member.

• Seniors may not be familiar with psychological terminology or concepts, so give explanations simply and clearly. Asking the patient to re-state what they heard can confirm that they understand.

• When interviewing a person, be aware of two key professional tenants: confidentiality and self-determination. No information from the interview may be shared with others without the specific, and usually written consent of the client, with the exception of when abuse is present. Self-determination means that the client guides the discussion. Anyone may choose not to take an assessment, skip items of the assessment, not discuss the assessment, not take the results with them, or participate only partially (Emlet, 1996).

• Weigh the need for comprehensive assessments against the realities of time and fiscal constraints. Longer appointments may be needed to meaningfully discuss depression. It is important to take the time to establish rapport and trust, and older adults may have extensive medical, pharmaceutical and personal histories. In addition, older adults may have slower processing time and may need written summaries of what has been discussed.

• There are no hard and fast rules about how often to conduct depression screenings. A screening might be administered initially when a provider begins to see a patient. It might be repeated on an annual basis, whenever there is a change in the patient’s situation, or if the patient self-reports depressive symptoms. Assessments can be effectively used as baselines to compare subsequent scores for changes and to check for treatment effectiveness. Recurrent screenings may be most productive with patients with a history of depression, unexplained somatic symptoms, substance abuse, chronic pain or co-morbid psychological conditions such as panic disorder or generalized anxiety (USPSTF, 2009).

The Geriatric Depression Scale (GDS) Short Form: The GDS was created as part of a federal grant and is, therefore, in the public domain (Sheikh & Yesavage, 1986). It is available in many languages and varied formats, many of which are online. Choice of the format depends on personal preference and whether
it is being given as a self-assessment without scoring cues, or in an interview with scoring imbedded to make calculations easier.

It is also possible to copy a form and adapt it for your own use, as has been done here. By adding bold and colored scoring cues, and customizing the top section, one can make the form easier to use. (Or just as easily remove scoring cues for a self-assessment.) See Appendix A for a selection of other short forms on a variety of websites. This particular form (before modification) is available at: http://www.chcr.brown.edu/GDS_SHORT_FORM.PDF

Geriatric Depression Scale (Short Form)

<table>
<thead>
<tr>
<th>Site Name: ______________________</th>
<th>Name: (optional) ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initials of Interviewer: _____ _____ ____</td>
<td>Date: __ ___ / __ ___ / 20___</td>
</tr>
</tbody>
</table>

| 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 things? | □ Yes □ No |
| 10) Do you feel that 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 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 |

Total Score __________________

Score 1 point for each highlighted answer. A score of 5 or more suggests depression.
Notes on the GDS:

- Scoring: Each bolded and highlighted item that is checked receives one point. A score of ≥ 5 points is suggestive of depression and should be followed up with further questions and a referral (see section V). Scores > 10 indicate a high probability of depression. Interestingly, people with formal education are more likely to score in the depressed range on the short form (Kurlowicz & Greenberg, 2007).

- The GDS includes assessment items for anxiety, but does not cover suicidal thoughts, intent or potentially important signals such as sleep or eating disturbances; therefore, these items should be covered with follow up questions. This is true for both the short and long forms.

- In the case of missing/unanswered items:
  - If one or two items are missing (often because they want to answer “sometimes”, not yes or no), further questioning might complete the assessment, such as “What about on most days of this past week?”
  - If three to five items are missing, the scores may be prorated. For example, if 3 of 15 items were missed, and the total score is 4 on the 12 completed items, add 4/12 of the 3 missing points or 1 point for a total score of 4+1 = 5. Round up, if the result is a fraction. Or use the equation 4/12 = X/15... so X = 5. If 5 or more items are missing, the scale could be considered invalid, although even a few items can be informative (Sharp & Lipsky, 2002).

- A free iPhone app is available at [http://www.stanford.edu/~yesavage/iPhone.htm](http://www.stanford.edu/~yesavage/iPhone.htm)

Tips for Interviewing Older Adults:

- It is important to develop good interviewing skills. Most importantly, establish a positive rapport with the client. Briefly, but clearly, state the purpose of the assessment, and conduct the assessment in such a way that it is respectful and mindful of the person’s needs. Listen carefully to what is said, offer to discuss or explain anything, summarize the findings, and, if the person desires, suggest the next steps and referrals (Emlet, 1996; Smith, 2011).

- It is appropriate to ASK what older patients are thinking and feeling, even when these questions may seem intrusive. Despite the cohort’s stoicism, the belief that people aren’t interested may prevent them from expressing themselves and keep them isolated. Many in fact, are pleased and relieved to be asked, and to be given a chance to talk.

- Aging adults may react negatively to the term depression, so refer instead to “the blues”, “low spirits”, accomplishing tasks, activities, pleasure, and one’s outlook on life and the future.

- Be aware that a fear may exist that seeking mental health help is the first step to being institutionalized. Gently address those fears (Hinrichsen & Clougherty, 2006).

- “Stage” your interview to be considerate of working with older adults. Face the person directly, sit somewhat close and do not cover your face with your hands or other objects. Eliminate background noise by turning off the television or radio and, if at all possible, do not interview in rooms with other conversations or background noise. For those with hearing impairments, lower your voice tone and do not shout.
- Slow down your rate of speech and use simple sentences, but do not talk down to the client or change your tone or inflections. Practice reading the questions so that you feel comfortable saying them out loud without embarrassment, with a normal tone of voice, and without any leading inflections.

**Introducing the GDS Interview:**

With practice, you will develop your own words and style when offering, giving and explaining the GDS. Here is a sample introduction (remember to speak slowly and clearly):

"Hello, my name is .... I'm giving the GDS today, which reviews some areas of mood and mental health. The assessment is a short checklist, with just yes and no answers. It only takes about 5 minutes. It asks you about how you've been feeling in the past week. Does that sound ok? [If the person agrees to continue...] Please relax, be honest, and answer the best that you can. This is only a screening, and I'll go over the results with you.

After the screening, your explanation will depend on the scoring. For a score of 5 or more, indicating possible depression, you might say:

"Your score is in the range for possible depression. [Pause for any response or questions.] As I said, this is just a screening, but I would recommend that you take this to your doctor or a counselor to discuss. In particular, you may want to discuss... [review items with positive scores]. Many of these concerns can be successfully treated, and this screening could help that happen sooner rather than later. The doctor may have suggestions for you to feel better. Do you know someone that you would like to take this to to discuss?

To conclude, repeat important points in different words to summarize the results and your recommendation for referral, and thank the person.

"Thank you for taking the time to do this assessment with me. I enjoyed talking with you. Do you have any other questions for me?

**V. Types of Referrals and Referral Sources for Depressed Patients**

Positive screening tests indicate a need for further evaluation by a qualified health care professional who will conduct an appropriate diagnostic interview using standardized diagnostic criteria. This extensive interview can determine whether a depression diagnosis such as MDD or dysthymia is appropriate, and offer a plan to address the level of depression and other co-morbid psychological problems (USPSTF, 2009).

It is important that professionals understand their limits and not treat beyond their skill level, education or qualifications. In general, moderate to severe depression should be referred to a specialist. Referrals require careful consideration, because it is unprofessional to endorse one professional over another and
difficult to “guarantee” the effectiveness of any particular practitioner. Some organizations prohibit specific referral lists. Others encourage developing and maintaining a working knowledge of available local referrals that are appropriate and accessible within a reasonable amount of time. Ask your supervisor for guidance regarding referrals.

**Note to IPHARM students:** A list of local referral sources will be available in communities where you will be administering the GDS.

In addition to local phone books and websites, State Licensing Board websites list names of licensed professionals, as does the Federal Center for Mental Health Services (CMHS) at 1-800-789-2647 or [www.cmhs.samhsa.gov](http://www.cmhs.samhsa.gov).

Often, the ideal treatment is provided by an interdisciplinary team of health care and mental health professionals who are able to effectively communicate about a patient’s history, condition and needs. It takes organization and time to explain referrals to patients, communicate within the interdisciplinary team, and to follow up with the patient. It is, of course, important to obtain appropriate releases before speaking with other professionals about a patient; confidentiality must be observed.

**Professionals who assess and/or treat depression include:**

- **Community Health Fairs**, workshops or special events may offer free depression and/or cognitive screenings. These screenings may be administered by supervised students or community professionals. The person screened should receive a copy of the assessment results, and if the results indicate, a referral to any of the following should be made immediately. The assessment should be taken to the professional at the follow-up appointment. Students and professionals who wish to improve their assessment skills can often volunteer at events. The repetitive use of an assessment tool can be very instructive for developing effective skills for establishing rapport, wording explanations and follow up questions, and making referrals.

- **Pastors or Pastoral Counselors** may have bachelor, master’s, or doctoral level training. Pastoral training in mental health issues varies considerably, but many do offer counseling and/or referrals. Many people, including older adults, will only consider discussing personal issues with a religious leader.

- **Area Agencies on Aging** serve older adults and caregivers and may have case managers and/or programs to address depression (Richardson, et al, 2010).

- **Primary Healthcare Providers include** Physician’s Assistant (PA), Family Practice Nurse Practitioner (NP), Family Practice or Internal Medicine Physician (MD), Osteopathic Doctor (DO), etc. Primary care practitioners manage almost two thirds of older adults who receive treatment for major depression. They may already have some relationship with the patient, as well as have access to their medical and medication history. They are well situated to assess physical symptoms and conditions, can prescribe medication and make further referrals as needed (USPSTF, 2009).

- **Licensed Professional Counselors** usually have a master’s or doctoral degree, have completed two years of supervised clinical experience, and passed a state credentialing exam. Credentials include Licensed Clinical Professional Counselor (LCPC or LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Addictions Counselor (LAC), Doctor of Education (EdD), or Doctor of Counseling...
Licensing makes a practitioner eligible for insurance coverage, but a patient will need to ask whether a practitioner is a preferred provider for their insurance, or accepts Medicaid or Medicare before making an appointment. Some patients may prefer to be referred to a counselor of the same gender. Counselors may specialize in certain areas such as gerontology, marriage and family therapy, addictions, women’s issues, or prefer certain treatment approaches. They cannot prescribe medications. Public health departments or local chapters of the National Alliance for Mental Health may provide a list of counselors and other mental health resources that can be found in the local community.

- **Licensed Clinical Social Workers** (LCSW) have master's level training from a social work perspective, have obtained two years of supervised clinical experience, and passed a state credentialing exam. They may have additional training and experience in mental health issues, resource referrals, medical issues and/or addictions. They cannot prescribe medications.

- **Psychiatric Mental Health Nurse Practitioners** (PMHNP) are registered nurses with advanced education at the master’s or doctoral level in a full range of psychiatric services including primary mental health care services. Some PMHNPs specialize in the care of a specific population group such as families, geriatrics or pediatrics. Practitioners pass a national certifying examination and may be licensed at the state level to prescribe medication. Montana allows for prescriptive authority by PMHNPs as an advanced practice registered nurse.

- **Pharmacists** are licensed after earning a doctoral degree and participating in extensive internship hours. These specialists dispense prescription medication, explain the prescribers’ instructions, and can assess drug and supplement interactions.

- **Clinical Psychologists** (PhD) hold doctoral degrees in psychology with several years of supervised practice. They receive specialized training in clinical therapy and counseling, assessment, diagnosis, and treatment, theory and/or research methods. They cannot prescribe medications in most states.

- **Neurologists** are medical doctors or osteopaths trained in the diagnosis and treatment of nervous system disorders, including diseases of the brain, spinal cord, nerves and muscles. They specialize in the treatment of patients with stroke and/or cognitive problems.

- **Psychiatrists** are medical doctors with additional years of specialized mental health training. They specialize in specific physical and mental assessments, medications (especially those that influence the chemistry of the brain) and treatments. They are licensed to prescribe medication and may additionally specialize in Geriatric Psychiatry.

### VI. Overview of Treatment for Depression

Clinical depression cannot typically be simply shaken off or willed away, although many will say it should be that easy. Many patients feel they should be able to handle it on their own, and many try. Sometimes, depression will ease on its own after a period, but it is just as likely to get worse, or return. Up to 80% of depression can improve with treatment and usually within weeks (NIMH, 2007). Depression can be treated effectively with antidepressant drugs, psychotherapy, or preferably a combination of both. Just as depression may be caused by interactions of biological, psychological and social factors, effective treatment should consider and address the role that each factor plays for any...
individual. When it occurs at the same time as other medical illnesses, depression can and should be treated, as untreated depression can delay recovery or worsen the outcome of other illnesses.

Sadly, most depressive disorders go undiagnosed and untreated. In fact, one study found that fewer than half of older adults seen in primary care settings obtained care for depression (Blasinsky, Goldman, & Unutzer, 2006) and non-white or socio-economically disadvantaged individuals receive even less care (Smith, 2011).

Studies show that approximately two-thirds of patients treated for depression achieve remission within one year. Older patients’ statistics are similar or slightly lower, probably due to higher rates of co-morbid medical conditions. Depression, however, is highly recurrent. About half of the patients who achieved remission have a relapse of depression during the subsequent year (USPSTF, 2009). Therefore, timely treatment and consistent follow-up is crucial, with the goal of recovery from the current episode of depression and prevention of relapses or recurrences of depression (Kiosses, 2011).

A. Pharmacologic Treatments

Up to 70% of people with depression respond to antidepressant drugs. Older adults who received antidepressants were twice as likely to have remission from major or minor depression as older adults who received placebo (Pinquart, Duberstein & Lyness 2006). Antidepressant medications affect brain chemicals called neurotransmitters. Since various medications affect different neurotransmitters and each person’s brain chemistry is unique, there is a need for a wide variety of medications.

Antidepressant selection can be based on the patient’s condition, co-morbidities, side effects and cost since there is no conclusive evidence that any one antidepressant is more effective or faster acting than another (Kroenke, 2011). To date, there isn’t a way to predict which medication will work effectively or which will produce side effects for any particular person. Treatment, therefore, is usually done by trial and error, preferably with close supervision and follow-up by the prescriber to assess effectiveness and the presence of any side effects.

Initial dosages for older adults are typically lower than for a younger adult, due to slower drug metabolism. Medications should be started at a low dose, monitored regularly (once a week or every other week at first), and changes should be made slowly. If one medication isn’t effective and/or has problematic side effects, research shows that a different antidepressant might be effective. A period of two to eight weeks is typically required for the medication to take full effect and for initial side effects to subside. Patience, honest communication between the patient and the prescribing health care professional, and persistence is needed.

Keeping in mind that people over age 65 take, on average, five or more medications, possible interactions with other prescriptions must be carefully monitored (Richardson & Barusch, 2006). Antidepressant drugs are not addictive; however, they may produce unwanted side effects.
Patients should not suddenly stop taking an antidepressant. Antidepressant doses should be gradually changed or decreased, or discontinuation symptoms and/or a sudden worsening of depression can result.

To avoid relapse, people usually continue taking an antidepressant for some time after their symptoms improve. Studies have shown that patients over 70 years of age who continued to take their medication for two more years after being symptom-free were 60% less likely to relapse than those who discontinued their medications earlier (NIMH, 2007). Unfortunately, 40% to 67% of patients discontinue their antidepressant medication within three months, and few receive adequate follow-up (USPSTF, 2009).

**Commonly used antidepressant drugs fall into five major classes:** (Mayo Clinic, 2010; USPSTF, 2009; Kroenke, 2011)

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Notes</th>
<th>Side Effects</th>
</tr>
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<tbody>
<tr>
<td>Selective Serotonin Reuptake Inhibitors (SSRIs): citalopram, escitalopram, sertraline</td>
<td>Increase the availability of serotonin; usually 1st choice for older adults for effectiveness and fewer side effects.</td>
<td>Sexual dysfunction, anxiety, jitteriness, restlessness, digestive problems, upper GI bleeding, insomnia, drowsiness, and headaches. Increased fall risk possible initially &amp; when discontinuing.</td>
</tr>
<tr>
<td>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs): venlafaxine, desvenlafaxine, duloxetine</td>
<td>Increase the availability of serotonin and norepinephrine. May also be helpful with anxiety and pain.</td>
<td>Similar to SSRIs; in high doses, can cause increased sweating and dizziness, which adds to fall risks. Increased fall risk initially &amp; when discontinuing.</td>
</tr>
<tr>
<td>Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs): bupropion</td>
<td>Increases the availability of norepinephrine and dopamine. May be helpful with obesity, sexual dysfunction and smoking cessation.</td>
<td>One of the few antidepressants that doesn't cause sexual side effects (except possibly in men); at high doses may increase risk of having seizures. Increased fall risk initially &amp; when discontinuing.</td>
</tr>
<tr>
<td>Tricyclic antidepressants (TCAs): desipramine, nortriptyline</td>
<td>Increases the availability of both serotonin and norepinephrine without the selectivity of newer agents, causing more severe side effects. Can give in smaller doses &amp; pin point accurate dosage with serum levels.</td>
<td>Drowsiness, low blood pressure, fast heartbeat, blurred vision, nausea, insomnia, constipation, urinary retention, weight gain, dry mouth, dizziness upon standing (risk of falls), memory problems, confusion and hallucinations.</td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors (MAOIs): selegiline, phenelzine</td>
<td>Increases the availability of serotonin, norepinephrine, and dopamine through inhibition of MAO, which metabolizes these neurotransmitters.</td>
<td>Similar to tricyclics, plus requires strict dietary &amp; medication restrictions, due to dietary and drug interactions.</td>
</tr>
</tbody>
</table>
Six out of ten people may feel better with the first antidepressant they try; others will need to continue with two or more trials (Agency for Healthcare Research and Quality, 2007). As the dosage is increased to the effective maintenance dose, serious symptoms often will resolve in the reverse order of seriousness, that is, suicidal ideation first, then hopelessness, then the blues. If a person is suicidal, it is important to see improvement quickly, ideally within a week or two.

Medication costs can be difficult for older adults on fixed incomes. Medicare Part D is an add-on prescription drug coverage that must be purchased from an insurance company. Past coverage gaps known as “the donut hole” are gradually being addressed by Health Care Reform. Some corporate pharmacies have low-cost prescription options, and Area Agencies on Aging or social workers may be able to assist with other medication assistance programs.

B. Psychotherapy Treatment

Studies have shown that short-term psychotherapy can relieve mild to moderate depression as effectively as antidepressant drugs. Unlike medication, psychotherapy produces no physiological side effects. In addition, depressed people treated with psychotherapy appear less likely to experience a relapse than those treated only with antidepressant medication. However, psychotherapy usually takes longer to produce benefits.

For many older adults, especially those who are in good physical health, combining psychotherapy with antidepressant medication appears to provide the most benefit. A study showed that about 80 percent of older adults with depression recovered with this kind of combined treatment and had lower recurrence rates than with psychotherapy or medication alone (NIMH, 2007).

Psychotherapy is also known as therapy, talk therapy, counseling or psychosocial therapy. Discussions are guided by a mental health provider exploring the causes of the depression. Together, the client and therapist work to develop a healthier and more satisfying life for the client.

The most effective therapeutic approaches for depression currently are Cognitive Behavioral Therapy, Problem Solving Therapy, Supportive Psychotherapy, Reminiscence Therapy or Life Review, Interpersonal Therapy, Dialectical Behavioral Therapy, Psychodynamic Psychotherapy, and Group Therapy (Kiosses, 2011). Eye Movement Desensitization and Reprocessing (EMDR) can also be effective in certain situations (EMDR Network, n.d.). Each intervention approaches treatment from a specific angle. Therapists may be specifically trained and experienced in one or more of these techniques, and an introductory session to ask a therapist’s approach and to find out if the client feels comfortable with the therapist is always advised.

Another approach is evidence-based depression treatment programs, which may become more available in the coming years. The Healthy Aging Program at the CDC and the National Association of Chronic Disease Directors have identified three evidence-based programs specifically geared for older adults: IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) which is geared for a primary care setting; PEARLS (Program to Encourage Active Rewarding Lives for Seniors) which is a
counseling program; and Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors). Evidenced-based programs usually address a number of risk factors and management techniques and must follow a set curriculum which has been researched and proven effective. Many include Depression Care Management (CDC, 2009).

C. Hospitalization and Residential Treatment Programs

Inpatient hospitalization may be necessary if a patient is in immediate danger of harming his/her self or others, or is unable to provide self care and does not have anyone to assist them. A period of hospitalization may be important in order to assess the severity of depression or suicidal ideation, adjust medications until the danger passes, and/or assess the patient’s environment and social support system. Medicare covers hospitalization if there is a danger to self or others. The goal is to find the least restrictive setting that provides safety.

D. Self Care to Assist with Depression

The following are helpful suggestions when treating clients with any severity of depression and should be encouraged with all patients:

- Stick to the treatment plan. Skipping appointments or medications is counter-productive and can be dangerous.
- Pay attention to what triggers depression symptoms.
- Report any changes in symptoms or side effects.
- Physical activity reduces depression symptoms. For milder cases of depression, regular aerobic exercise may be as effective as psychotherapy or medication. Tai Chi may also be effective.
- Relaxation techniques may be helpful.
- Eat well. Some research suggests good nutrition affects the level of serotonin in the brain. Restrict or eliminate caffeine.
- Avoid alcohol and illicit drugs. It may seem like alcohol or drugs lessen depression symptoms, but in the long run they generally worsen symptoms and make depression harder to treat.
- Aim for seven to nine hours of sleep per night. Trouble sleeping should be discussed with the Primary Care Provider and too much sleep can also be a problem.
- Gradually add back regular social support and pleasurable activities, without making it an onerous burden (Mayo Clinic, 2010).

Barriers in recognizing and effectively treating late-life depression occur on many fronts:

- The current health care system, which includes cost, continuity of care, and availability of services.
- Providers, including lack of training in geriatric care, lack of time and attention.
Patients, including stigma, family reluctance, and the complications of life situations and co-morbid conditions (Richardson, et al, 2010).

Treatment costs, particularly for mental health care, can be a barrier because of Medicare reimbursement limitations (Hinrichsen & Clougherty, 2006). Medicare Part B reimburses mental health services at 80% of the approved amount for the initial assessment visit, and 60% thereafter for most providers, effective 2012. The number of inpatient days that will be reimbursed for an episode of psychiatric illness is also limited. In addition, Medicare will only pay providers who are Medicare-certified and accept Medicare’s rates, which are substantially below most professionals’ rates. Sadly, because of this, fewer and fewer professionals accept Medicare patients, making it difficult to find care, have a choice of providers, and obtain timely appointments. Medigap insurance policies may cover the costs that Medicare doesn’t cover, but many older adults cannot afford the extra premiums. Some very low income older adults may be eligible for Medicaid, the federal and state insurance program for the poor, which can cover mental health services and prescription drugs (Medicare Rights Center, 2011).

For more detailed information about treatment for depression in older adults, see the Montana Geriatric Education Center module “Late Life Depression”.

VII. Depression Screening – Video Review

FOR REVIEW: Watch this 28-minute video from the Hartford Institute for Geriatric Nursing. To view this, you will need the latest version of Adobe Flash Player, plus an audio set up on your computer. This video is a ConsultGeriRN.org Hartford Institute Video, from the “How to Try This Video” series (Vanden Bosch, n.d.).

To view the video, click this link:

The Geriatric Depression Scale (GDS) Short Form Assessment or copy, cut and paste this web address into the internet browser and click on the GDS link (2nd link) on right.

http://consultgerirn.org/resources/media/?vid_id=4200933#player_container

VIII. Depression Web Resources

American Psychological Association’s Depression and Suicide in Older Adults Resource Guide

ConsultGeriRN.org – Try This Resources
http://consultgerirn.org/resources

MTGEC Screening for Depression in Older Adults
Page 31 of 48
MNA CE expiration date: 4/9/2014
Depression and Bipolar Support Alliance
http://www.dbsalliance.org

Federal Center for Mental Health Services (CMHS)’s Substance Abuse and Mental Health Services Administration - http://www.samhsa.gov/ or 1-800-789-2647

Geriatric Depression Scale (GDS)  
http://www.stanford.edu/%7Eeyesavage/GDS.html (or see Appendix B for websites for other forms)

Mental Health America
http://www.nmha.org

Mental Health: A Report of the Surgeon General, 1999:

- http://surgeongeneral.gov/library/mentalhealth/chapter4/sec3.html - Ch. 4 - Adults and Mental Health
- http://surgeongeneral.gov/library/mentalhealth/toc.html#chapter5 - Ch. 5 – Older Adults and Mental Health

Missoula City-County Health Department – online National Mental Health Screening Assessment and list of Missoula counselors
http://www.co.missoula.mt.us/healthpromo/SuicidePrevention/index.htm

National Alliance on Mental Illness (NAMI)  
http://www.nami.org or 1-800-950-NAMI

- Montana – (406) 443-7871 or http://www.namimt.org; e-mail info@namimt.org – local support groups and speakers

National Council on Aging (NCOA) – Center for Healthy Aging Mental Health Resources
http://www.healthyagingprograms.org/content.asp?sectionid=71

National Institute of Mental Health, Depression site

Patient Health Questionnaire (PHQ) Screens
http://www.phqscreeners.com

Web MD/Depression
http://www.webmd.com/depression/default.htm
IX. Depression Glossary

Diagnostic Procedures:

- **CAT or CT scan**: Computed tomography (CT) - An imaging technique that uses x-rays to create a two-dimensional image of the brain or other parts of the body.

- **MRIs**: Magnetic Resonance Imaging, which uses magnetic fields to create a 3-D image of the body while a person lies quietly inside a narrow tube. Particularly useful for brain scans because the image shows contrast with soft tissues. Does not use radiation.

- **EEGs**: An electroencephalogram (EEG) is a test that measures and records the electrical activity of a brain. Electrodes that are attached to the head are hooked by wires for approximately 20-40 minutes for a recording. Often used to diagnose or monitor epilepsy.

**Co-morbid Conditions**: Simultaneous but independent conditions.

**Neurotransmitters**: Substances, such as serotonin, norepinephrine, dopamine, glutamate, or acetylcholine, which transmit nerve impulses across synapses in the brain.

**Psychomotor Retardation or Agitation**: Changes in physical and emotional reactions common with depression, which may be either slowed or agitated.

**Measurement Research Terms**:

- **Reliability**: The measure of how stable, dependable, trustworthy, and consistent a test is in measuring the same thing each time, including interrater or rate-rerate consistency.

- **Sensitivity**: The probability of true positives.

- **Specificity**: The probability of true negatives.

- **Validity**: The degree to which the measure accomplishes the purpose for which it is being used; it’s accuracy.

**Synapse**: The point at which a nerve impulse passes from one neuron to another.

**Somatic Symptoms**: Bodily or physical symptoms, as opposed to mental.

**A selection of other terms or types of depression or related conditions**:

- **Anhedonia**: Marked loss of interest or pleasure in all or nearly all activities.

- **Anxiety or panic conditions**: These include generalized anxiety disorder (GAD), panic disorder (PD), phobias, agoraphobia, post-traumatic stress disorder (PTSD), acute stress disorder, obsessive compulsive disorder and social anxiety disorder.

- **Bipolar Depression**: The depressed phase of bipolar disorder, when a person's mood alternates between depression and mania, defined as unusually and persistently elevated mood or irritability, elevated self-esteem and excessive energy, thoughts and talking.
- **Chronic or Complex Post-Traumatic Stress Disorder (PTSD):** continued or repeated traumas (such as long-term abuse or captivity) or a series of traumas can result in long-lasting changes in a person’s self-concept, social functioning and adaptations to stressful events.

- **Manic Episodes:** A distinct period of elevated, expansive or irritable mood lasting at least one week. **Hypomania** - “below mania” - has similar symptoms, but the person is more able to be fully functioning in daily life (NAMI, 2011). The presence of manic or hypomaniac episodes distinguishes bipolar disorder from depression.

- **Primary Depression:** Depression alone with no other medical illness or disorder.

- **Psychotic Depression:** Depression accompanied by delusions (fixed false beliefs) and/or hallucinations (false sensory perceptions).

- **Seasonal Affective Disorder (SAD):** Mood changes related to changes in daylight. May be related to depression during autumn and winter, when there are fewer hours of daylight and/or mania in spring.

- **Secondary Depression:** Depression that occurs after and related to the onset of another medical illness or disorder.

- **Subsyndromal Depression:** Symptoms that fall short of meeting the full diagnostic criteria for a disorder. This is common among older adults and is associated with an increased risk of developing major depression (NIMH, 2007).

- **Suicidal Ideation:** The desire to be dead, or more severely, the intent to commit suicide with a specific plan or method. One of the symptoms of major depression or bipolar depression.

- **Vascular Depression:** Late-onset depression from vascular lesions in the brain; can be associated with vascular dementia.
X. References


MTGEC Screening for Depression in Older Adults
Page 36 of 48
MNA CE expiration date: 4/9/2014


Vanden Bosch, J. (Producer) & Kany, K (Director) (no date). *Hartford Institute Video: The Geriatric Depression Scale (GDS) Short Form Assessment* [Video]. US:Terra Nova Films. (Available from American Journal of Nursing http://consultgerirn.org/resources/media/?vid_id=4200933#player_container)


XI. Appendix A- Geriatric Depression Scale – alternate formats

A. GDS Short Form websites

Author’s form – circle yes or no

http://www.stanford.edu/~yesavage/GDS.english.short.html (no scoring cues)

http://www.stanford.edu/~yesavage/GDS.english.short.score.html (with scoring cues)

Another form – circle yes or no, lined up at right edge for easier reading

http://www.chcr.brown.edu/GDS_SHORT_FORM.PDF (one form without scoring cues, one with)

Basic form with background information – circle yes or no, with scoring cues (this form is referenced in the video segment):


Form including spaces to record answers not given (with scoring cues)

http://sitemason.vanderbilt.edu/files/gajLGp/4%20Step%201%20Geriatric%20Depression%20Scale.pdf

Form with lines and check boxes make it even easier to read, and a column for scoring (one form with and one without scoring cues)

http://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf

B. GDS Long Form website

### XII. Appendix B: Geriatric Depression Scale (Long Form)

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Answer</th>
<th>Score</th>
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<tbody>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td>YES/NO</td>
<td></td>
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<tr>
<td>2</td>
<td>Have you dropped many of your activities and interests?</td>
<td>YES/NO</td>
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<tr>
<td>3</td>
<td>Do you feel that your life is empty?</td>
<td>YES/NO</td>
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<tr>
<td>4</td>
<td>Do you often get bored?</td>
<td>YES/NO</td>
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<tr>
<td>5</td>
<td>Are you hopeful about the future?</td>
<td>YES/NO</td>
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<tr>
<td>6</td>
<td>Are you bothered by thoughts you can’t get out of your head?</td>
<td>YES/NO</td>
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<tr>
<td>7</td>
<td>Are you in good spirits most of the time?</td>
<td>YES/NO</td>
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<tr>
<td>8</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>YES/NO</td>
<td></td>
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<tr>
<td>9</td>
<td>Do you feel happy most of the time?</td>
<td>YES/NO</td>
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<tr>
<td>10</td>
<td>Do you often feel helpless?</td>
<td>YES/NO</td>
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<tr>
<td>11</td>
<td>Do you often get restless and fidgety?</td>
<td>YES/NO</td>
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<tr>
<td>12</td>
<td>Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>YES/NO</td>
<td></td>
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<tr>
<td>13</td>
<td>Do you frequently worry about the future?</td>
<td>YES/NO</td>
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<tr>
<td>14</td>
<td>Do you feel you have more problems with memory than most?</td>
<td>YES/NO</td>
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<tr>
<td>15</td>
<td>Do you think it is wonderful to be alive now?</td>
<td>YES/NO</td>
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<tr>
<td>16</td>
<td>Do you often feel downhearted and blue?</td>
<td>YES/NO</td>
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<tr>
<td>17</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>YES/NO</td>
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<tr>
<td>18</td>
<td>Do you worry a lot about the past?</td>
<td>YES/NO</td>
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<tr>
<td>19</td>
<td>Do you find life very exciting?</td>
<td>YES/NO</td>
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<tr>
<td>20</td>
<td>Is it hard for you to get started on new projects?</td>
<td>YES/NO</td>
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<tr>
<td>21</td>
<td>Do you feel full of energy?</td>
<td>YES/NO</td>
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<tr>
<td>22</td>
<td>Do you feel that your situation is hopeless?</td>
<td>YES/NO</td>
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<tr>
<td>23</td>
<td>Do you think that most people are better off than you are?</td>
<td>YES/NO</td>
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<td>24</td>
<td>Do you frequently get upset over little things?</td>
<td>YES/NO</td>
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<td>25</td>
<td>Do you frequently feel like crying?</td>
<td>YES/NO</td>
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<td>26</td>
<td>Do you have trouble concentrating?</td>
<td>YES/NO</td>
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<td>27</td>
<td>Do you enjoy getting up in the morning?</td>
<td>YES/NO</td>
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<td>28</td>
<td>Do you prefer to avoid social gatherings?</td>
<td>YES/NO</td>
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<td>29</td>
<td>Is it easy for you to make decisions?</td>
<td>YES/NO</td>
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<tr>
<td>30</td>
<td>Is your mind as clear as it used to be?</td>
<td>YES/NO</td>
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</tbody>
</table>

**TOTAL**
This is the original scoring for the long scale: One point for each of these answers.

**Cutoff:** normal-0-9; mild depressives-10-19; severe depressives-20-30.

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<td>YES</td>
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<td>28</td>
<td>YES</td>
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<td>NO</td>
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XIII. Appendix C: Depression Brochure for Participants of IPHARM/MTGEC Screening Program

Sources of helpful information:
- National Institute of Mental Health
- Depression Symptoms.net
  http://depressionsymptoms.net/

Depression is a disease that causes feelings of sadness, worthlessness, and despair. Many people of all ages and lifestyles experience depression. If you are feeling depressed, there are many people available to help.

- 15 million people in the United States suffer from depression

Signs and Symptoms:
- Lack of sleep or excessive sleep
- Difficulty concentrating
- Feelings of hopelessness and helplessness
- Uncontrollable, negative thoughts
- An increase or decrease in appetite
- Mood swings/irritability
- Lack of energy
- Feelings of worthlessness
- Loss of interest in activities that you used to enjoy
- Suicidal thoughts*

*If you are experiencing any of these symptoms, you may have depression and should seek help.

Causes/Risk Factors:
Depression can be caused by a chemical imbalance in the brain, but can also be influenced by the world around you. Below is a list of risk factors associated with depression.
- Loneliness
- No support system
- Life and work stress
- Family history
- Family/relationship problems
- Finances
- Traumatic childhood experiences
- Alcohol and/or drug abuse
- Health problems/chronic pain

Lifestyle Changes:
There are lifestyle changes and techniques you can learn that may help your depression.
- First, ask for help.
- Exercising and eating healthy can boost your mood.
- Learn relaxation techniques.

Treatments:
There are many different treatment options for depression. Your treatment should be individualized to your needs and the cause of your depression. Treatment options include:
- Medications
- Antidepressants may be helpful on their own but most of the time counseling is needed to fully treat depression. Talk to your healthcare providers about your treatment options.
- Counseling

Meeting with a mental health professional may be beneficial for recovery from your depression. They can assist you with talking through your problems and help you solve them. Mental health professionals can also teach you techniques for combating your depression.

References:

MTGEC Screening for Depression in Older Adults
Page 41 of 48
MNA CE expiration date: 4/9/2014
XIV. **Appendix D: Depression Screening Tool used in IPHARM/MTGEC Screening Program**

**Geriatric Depression Scale (Short Form)**

<table>
<thead>
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<th>Name: (optional) __________________________</th>
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<tr>
<td>Initials of Interviewer: _______</td>
<td>Date: _____ / _____ / 2 0 1 4</td>
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</table>

1. Are you basically satisfied with your life?  
2. Have you dropped many of your activities and interests?  
3. Do you feel that your life is empty?  
4. Do you often get bored?  
5. Are you in good spirits most of the time?  
6. Are you afraid that something bad is going to happen to you?  
7. Do you feel happy most of the time?  
8. Do you often feel helpless?  
9. Do you prefer to stay at home, rather than going out and doing things?  
10. Do you feel that you have more problems with memory than most?  
11. Do you think it is wonderful to be alive now?  
12. Do you feel worthless the way you are now?  
13. Do you feel full of energy?  
14. Do you feel that your situation is hopeless?  
15. Do you think that most people are better off than you are?  

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**Total Score** __________________

Score 1 point for each highlighted answer. A score of 5 or more suggests depression.
XV. Appendix E: Post-test: Screening for Depression in Older Adults

Record responses on examination form.

1) Depression is under-diagnosed and under-treated in older adults for all of the following reasons EXCEPT:
   a) Aging stereotypes: “Older people’s lives are just hard, and sadness is just a normal part of aging.”
   b) Older people believe “Other people (especially doctors) don’t need to hear about my problems.”
   c) It’s difficult to clearly separate medical symptoms, medication problems, and depression symptoms.
   d) Depression screenings are expensive and most people can’t afford them.
   e) Health care professionals don’t have the time to ask about depression.

2) The percentage of men and women over age 65 who are clinically diagnosable as depressed:
   a) Increases with disability.
   b) Is higher than for younger cohorts.
   c) Is higher for men than women.
   d) Is approximately 22-27%.
   e) All of the above.

3) Which of the following is NOT true? The symptoms of diagnosable depression include:
   a) Changes in sleep and appetite.
   b) Slow or agitated movements, speech or thinking.
   c) Suicidal thoughts.
   d) Feelings of guilt.
   e) Lack of pleasure in previously favorite activities.
   f) Intense grief following the death of a loved one.
4) Which of the following is NOT one of the top five most significant risk factors for depression in seniors?
   a) Bereavement
   b) Sleep disturbance
   c) Being unmarried
   d) Disability
   e) Prior depression
   f) Female gender

5) Depression in older people, unlike younger people, often includes:
   a) Less irritability but more memory problems.
   b) More physical complaints and less sadness.
   c) Less anxiety and better self care.
   d) More guilt, but fewer sleep problems.

6) How often should a depression assessment such as the Geriatric Depression Scale be given to someone over 65?
   a) At each visit with a health care provider.
   b) Every five years, or whenever a major medical event occurs.
   c) At the initial visit with a health care provider, and then annually and/or after any major change occurs in his/her mood.
   d) As often as is financially possible.

7) All of the following are well established depression screening tools with researched reliability and validity for the diagnosis of depression EXCEPT:
   a) Geriatric Depression Scale (GDS)
   b) Patient Health Questionnaire (PHQ-9)
   c) Hamilton Rating Scale for Depression (HAM-D)
   d. Mini-Mental Status Exam (MMSE)
   e. Beck Depression Inventory (BDI)

8) Medications to treat depression in older adults
   a) Should be started at higher dosages than with younger people because drugs are metabolized more slowly in older adults.
   b) Are not addictive, but may have side effects.
   c) Are chosen after analyzing blood samples to match the right medication to the most effective antidepressant for that person.
   d) Should be stopped immediately after the depressive symptoms ease.
   e) Should not be prescribed until all other medical conditions have stabilized.

9) Which of the following statements is/are true about suicide?
a) Most older adults who commit suicide visited their doctor during the month before their suicide.
b) More women attempt suicide, but men are more likely to succeed.
c) Older Caucasian men have the highest suicide rate of any group.
d) Asking about suicidal thoughts will not increase the risk of suicide.
e) c and d.
f) All of the above.

10) Effective treatments for late life depression include all of the following EXCEPT:
   a) Hormone replacement therapy (HRT).
   b) A combination of antidepressants and psychotherapy.
   c) Cognitive Behavioral Therapy.
   d) Increased physical activity.
   e) Medications that increase the availability of serotonin in the brain.
**POST-TEST:** Examination Form  

*Screening for Depression in Older Adults*

**Participant Information**

1. Name: ____________________________________________

2. Mailing address: ________________________________

   ____________________________________________

   ____________________________________________

3. Date exam completed ____________________________

**Questions: (Please circle one response per question)**

<table>
<thead>
<tr>
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</tbody>
</table>

For credit, please return this completed page to:

Rachael Zins  
MTGEC/IPHARM  
Skaggs Building Room 317  
University of Montana  
32 Campus Drive  
Missoula MT, 59812-1522  
Phone# (406) 243-2339 & Fax# (406) 243-4353
### XVI. Appendix F: Evaluation for MTGEC Module: Screening for Depression in Older Adults

Please Circle your profession: Dietitian • Nursing Home Administrator • APRN • RN • LPN • Pharmacist • Physical Therapist • Physician • Social Worker • Other_____________________

<table>
<thead>
<tr>
<th></th>
<th>Please circle or underline the appropriate number.</th>
<th>Yes</th>
<th></th>
<th></th>
<th></th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The overall visual presentation of the material enhanced my learning.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>2</td>
<td>The module content was understandable.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>3</td>
<td>The content was presented without bias.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>4</td>
<td>The content will be useful for health-care professionals working with the elderly.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>5</td>
<td>The objectives were clear.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
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<tr>
<td>6</td>
<td>This approach met my learning objectives.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
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<tr>
<td>7</td>
<td>To what extent have you achieved each objective?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>8</td>
<td>The module objectives related well to the overall purpose/goal of the web-based curriculum.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>9</td>
<td>The test questions were unambiguous.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>10</td>
<td>The test questions were appropriate to the module content.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>11</td>
<td>This teaching method was appropriate and used effectively.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>12</td>
<td>I would recommend this course to other health care professionals.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1 X</td>
</tr>
<tr>
<td>13</td>
<td>How did you learn about the modules?</td>
<td></td>
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</tbody>
</table>

14 Describe how you plan to use the information you obtained from these modules:
☐ Establish a new program
☐ Provide patient information
☐ Change your practice with elderly patients
☐ Other: (Describe)

15 How many hours did you take to complete this module including the pretest, posttest, and evaluation? Please use decimals, for example, 2.25 hours.

__________________ Hours

16 Any other suggestions?

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