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.

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

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

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Phone (406) 243-2339 & Fax (406) 243-4353
Pre-test: Screening for Depression

Record responses on examination form.

1) 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%.

2) Which of the following is NOT true? The symptoms of major depression include:
   a) Changes in sleep and appetite.
   b) Slow or agitated movements, speech or thinking.
   c) Lack of pleasure in previously favorite activities.
   d) Intense grief following the death of a loved one.

3) Which of the following is NOT one of the top five most significant risk factors for depression in seniors?
   a) Sleep disturbance
   b) Being unmarried
   c) Disability
   d) Prior depression

4) Depression in older adults, unlike younger adults, often includes:
   a) Less irritability but more memory problems.
   b) More physical complaints, including generalized pain
   c) Less anxiety and better self care.
   d) More guilt, but fewer sleep problems.

5) How often should a depression assessment such as the Geriatric Depression Scale be conducted?
   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.

6) 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)

7) 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.
8) 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) Older Caucasian men have the highest suicide rate of any group.
   c) Asking about suicidal thought will not increase the risk of suicide.
   d) All of the above.

9) 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) Increased physical activity.
   d) Medications that increase the availability of serotonin in the brain.

10) Health care practitioners who have limited experience and/or training in working with mental health issues should:
   a) Not perform depression screenings.
   b) Refer all patients to mental health providers for depression screening.
   c) Be aware of patient literacy limitations, visual and speech deficits, and cognitive limitations.
   d) Always include a significant other in the health exam of an older adult.
### Participant Information

1. Name: ________________________________

2. Mailing address: ________________________________
   __________________________________________
   __________________________________________
   __________________________________________

3. Date exam completed ______________________

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

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Montana Geriatric Education Center

Screening for Depression in Older Adults

Diana Reetz-Stacey, MSW
In consultation with Jane C. Wells, MD, MHS

Revised by Diana Reetz-Stacey, MSW

A 2-hour Geriatric Health Screening Module from the

Montana Geriatric Workforce Enhancement Program

A Consortium of:
The University of Montana, Missoula
Mountain Pacific Health, Helena
RiverStone Health, Billings
St. Vincent Healthcare, Billings

Montana Geriatric Education Center Website

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Montana Geriatric Education Center (MTGEC)
Screening For Depression in Older Adults
Disclosures

Montana Geriatric Workforce Enhancement Program Goals/Purpose
Improve health outcomes for older adults in rural Montana via increased knowledge of older adult care and treatment of health problems by health professionals.

Successful completion of this continuing education activity:

- Completion of the Pre-Test
- Reading of text
- Completion of the Post-Test with at least 70% accuracy
- Completion of the module evaluation

Contact Hours: 2

Montana Nurses Association (MNA)
The Montana Geriatric Education Center is an approved provider of continuing nursing education by the Montana Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.
MNA Continuing Nursing Education Expiration Date: 10/09/2017

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

____________________________________

The Montana Geriatric Workforce Enhancement Program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28733, Geriatric Workforce Enhancement Program (GWEP); the total award is $2,143,140 and supports the program 100%. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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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 adults;
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.

Module Purpose:

Upon completion of this module, learners will demonstrate improved knowledge of screening techniques and follow-up for depression in older adults.

Learning Objectives:

Specifically, the learner will:

1. Review the impact of depression in older adults.
2. Describe the procedures for conducting basic depression assessments, including the Geriatric Depression Scale and the PHQ-9.
3. Summarize the need for referral and the treatments for depression.
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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 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 care professionals may not inquire. Even when seniors request help, they tend to receive less care. Health care 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 with other illnesses and to 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 among 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, whose symptoms may not technically qualify as diagnosable depression, suffer from a lower level of depressive symptoms, 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; Federal Interagency Forum on Aging-Related Statistics, 2012).

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 (NAMI, 2009).

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

A. What is Depression?

Depression is not a normal part of aging for the majority of people. 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 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. A major depressive episode, by definition, must include at least five of these symptoms for at least two weeks:

- Persistent sad, anxious or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities, including sex
- Decreased energy, fatigue, feeling "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Low appetite and weight loss or overeating and weight gain
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and pain for which no other cause can be diagnosed.

(Angxiety and Depression Association of America, nd)

Table 1: Acronym to Remember Depression Symptoms

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<thead>
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<th>“SPACE DIGS”</th>
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<td>Related to Medical:</td>
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<tr>
<td>- C oncentration</td>
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Kroenke (2011), however, suggests that a better representation might be SPACE DIGS:

Depression and other mental disorders have been described and categorized in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM-5 (the current fifth edition) was released in 2013 and has 20 categories of disorders, with several important changes in the way depression is classified. The DSM classifies in order to assist with diagnosis; it does not prescribe treatments. Depression is a mood disorder with eight main classifications, two of which do not apply to older adults. There are also several other related classifications. (Smith E., 2011; Morrison, 2014).

In addition to the changes from the DSM-IV to the DSM-5, coding numbers are also in transition. The International Classification of Diseases (ICD) will be switching from the 9th to the 10th revision, known as the ICD-10, beginning on October 1, 2014 in the U.S.

All of the Depressive Mood Disorders in the DSM-5 are characterized by the presence of sadness, emptiness and/or irritable mood, accompanied by physical (somatic) and mental (cognitive) changes that significantly affect an individual’s ability to function. The different classifications describe the duration, timing or causes of the depression. The main classifications of depression in the DSM-5 are:
- **Major Depressive Disorder (MDD):** Consists of at least five depressive symptoms, without manic or hypomanic symptoms, which may occur in single or recurrent episodes.

- **Persistent Depressive Disorder (Dysthymia):** Consists of long-term symptoms, either chronic major depressive disorder or the previous dysthymic (low level but chronic depression) disorder, occurring for most of at least two years. This classification combination is new with the DSM-5, and can be refined with distinct ‘specifiers.’

- **Substance/Medication-Induced Depressive Disorder:** Symptoms are caused by alcohol or other substances – either intoxication or withdrawal.

- **Depressive Disorder Due to Another Medical Condition:** Must have a medical condition which is the direct physiological cause. This diagnosis highlights the importance of evaluating medical conditions when observing depressive symptoms in older adults.

- **Other Specified Depressive Disorder:** Examples include recurrent brief depression, short-duration depressive episode and depressive episode with insufficient symptoms.

- **Unspecified Depressive Disorder**

- **Two other classifications** that don’t apply to older adults are: Disruptive Mood Regulation Disorder (for children) and Premenstrual Dysphoric Disorder (for premenopausal women). Both of these are new in the DSM-5.

- **Co-occurring disorders:** Depression often is present with many other mental disorders including anxiety disorders, obsessive-compulsive disorder, posttraumatic stress disorder, schizophrenia, eating disorders, somatic symptom disorder (SSD), sexual dysfunctions, gender dysphorias, and others (Morrison, 2014).

**Notes on changes in the DSM-5 from the DSM-IV:**

- **Diagnosis notes** should always include the depressive classification, episode type (single or recurrent), severity (mild, moderate, severe), and other specifiers.

- **“Specifier” notes:** May include such things as suicidal thinking, seasonal affective disorder (SAD), mixed symptoms such as manic features with a unipolar depression, and a rating of the severity of anxious distress (American Psychiatric Association, 2013).

- **Adjustment Disorder:** Time-limited period of depressive symptoms appearing in response to a specific stressor. This has been reclassified in the DSM-5 from a Depression classification to a new “Trauma- or Stressor-Related Disorder” classification.

- **Removal of “Bereavement Exclusion”:** In the DSM-IV, even when bereavement symptoms may be identical with depressive symptoms, a major depressive episode could not be diagnosed for up to two months after the death of a loved one. This was removed in the DSM-5 for several reasons. The first is an acknowledgement that the duration of bereavement is far beyond two months – often up to two years. Bereavement is also viewed as a stressor which can precipitate a major depressive episode. In addition, people with a personal or family history of depression...
are more likely to be at risk for a major depressive episode during a period of bereavement. Finally, bereavement symptoms often respond to the same treatments as depression (American Psychiatric Association, 2013).

It is important to remember that all of the DSM-5 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-5. 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: Suicide risk is a concern particularly with older Caucasian men and American Indians. Men 85 and older have a suicide rate that is four times the national average. Montana suicide rates are also some of the highest in the nation. Late life suicide risk factors include depression, past suicide attempt(s), social isolation, a loss of purpose, substance abuse and/or pain, physical illness or disability (Substance Abuse & Mental Health Services Administration [SAMHSA], 2012).

The following charts show distribution of suicides rates from CDC data:

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Chart 1: Suicide Rates by Age from 2000 to 2011

(American Foundation for Suicide Prevention [AFSP], nd) CDC 2011 figures

Chart 2: Rate of Suicide in the U.S. by Sex, Race and Age in 2007

(CDC, 2012)

Chart 3: 2010 Suicide Rates for Ages 65 to 85+

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Older people use more lethal means (firearms and overdoses) and are significantly more successful at completing suicide than younger people (CDC, 2012).

Single, widowed and divorced people commit suicide more often than married people (CDC, 2012).

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 (NAMI, 2009; USPSTF, 2009).

Because suicidal thoughts are so closely related to depression, any depression screen should include direct questions about suicidal thoughts. If present, action should be taken to ensure the immediate safety of the person and that effective follow-up treatment is received.

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

- **Adjustment Disorder with depressed mood**, in contrast to depression, is a short-term episode 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 functional impairment, and feelings of sadness or hopelessness. In the DSM-5, a new “Trauma- or Stressor-Related Disorder” classification has been instituted, and Adjustment Disorder has been moved from the Depression classification into this category. The DSM-5 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.

- **Bereavement and grief:** Symptoms may also be very similar to depression, including intense sadness, fatigue and low energy, appetite and sleep disturbances, difficulty concentrating and loss of pleasure, particularly during the first 3–6 months or more. Usually with grief, unlike depression, there is less isolation and the person may experience occasional pleasure. Symptoms usually improve without treatment if adequate support is received, but in some people grief can trigger a true depressive episode. Treatment should be sought if suicidal ideation occurs.

- **Anxiety or panic conditions:** Anxiety is common in depressed older patients. Anxiety may be produced by and can aggravate 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.

### B. 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 plays an interactive role with depression. Increases in physical symptoms predict decreases in mental health, especially in women (Trotman & Brody, 2002; Sutin et al., 2013). 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.
Depression may decrease immune function, decrease physical activity, disrupt eating and sleeping, and result in not taking medications correctly. In addition, physical co-morbidities decrease the chances that the depression will be recognized, 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). Other specific depression/health links 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, cancer, vascular brain lesions, strokes, HIV, COPD, and arthritis
- Disability

**Psychological, social and interpersonal factors** causing or intensifying 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 (which usually relates to health problems and disabilities, less life satisfaction, less physical activity, loss of independence, adjustment to group living, and 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 older 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 identifying and treating these factors, steps can be taken to prevent depression before it occurs. People with these risk factors should also be assessed 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, once identified, 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 care professionals frequently, and depression assessments can be performed by a range of health care 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, and should be treated.

A. Informal Interview Assessment

If depression is suspected, three simple questions can initially assess and judge the potential presence and severity of depression. 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, both relating to 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, as in these examples:]
   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 to follow up on these expressions of hopelessness.]
   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, referral to the 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 and provide the person with needed help.

**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 as 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 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 (see Appendix A) or a 15-item short form (explained in detail in section V.)
- **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 criteria set for major depression and one additional question measuring the degree of impairment. Section VI below examines this screening tool in detail.

- **Beck Depression Inventory (BDI-II):** A 30-minute self-assessment with both long (21-item) and short (13-item) scales. It is widely used by health care professionals and is well researched. The BDI is copyrighted and therefore is not free. It is designed for use with individuals age 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). Although pirated forms are available on the web, it can be legally ordered at [http://www.beckscales.com](http://www.beckscales.com).

- **Center for Epidemiological Studies Depression Scale (CES-D or CESD-DR):** 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.edwardpierce.net/super/CES-D.pdf](http://www.edwardpierce.net/super/CES-D.pdf). The CES-DR is a 2004 revised version and is available to be taken online at [http://cesd-r.com](http://cesd-r.com).

- **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](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). One version is available at [http://healthnet.umassmed.edu/mhealth/HAMD.pdf](http://healthnet.umassmed.edu/mhealth/HAMD.pdf).

- **PROMIS Emotional Distress—Depression—Short Form:** With the release of the DSM-5, the American Psychological Association (APA) has developed a number of “emerging measures” for further research and clinical evaluation. The DSM-5 Level 2—Depression—Adult measure is the 8-item PROMIS Depression Short Form which focuses on the “pure domain” of depression in individuals age 18 and older. It is a self-assessment evaluating the past 7 days, which has not yet been validated as an informant report scale. Because of its association with the DSM-5, it may become more widely used in the coming years. It is available at [http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures](http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures).

- **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 older adults (Osterweil & Brummel-Smith, 2000). It is available for download at http://library.umassmed.edu/ementalhealth/clinical/zung_depression.pdf and in an online self assessment at http://psychology-tools.com/zung-depression-scale

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. Tips for Conducting a Depression Screening

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 VII for more information on referrals.

- Medicare Part B covers one depression screening per year, in a primary care setting only, usually at the annual “Wellness” visit. It is also included in the “Welcome to Medicare” preventive visit. Depression screenings with licensed mental health care professionals are also covered by Medicare Part B. Screenings provided in other settings by other professionals are not, at this time, covered by Medicare, but may be covered by other supplemental insurance.

- 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 the 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.

- Most older adults seek mental health assessment at the encouragement of a family member. 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 HIPAA and privacy issues in mind and appropriately request permission. When including family member, keep engaged with the older person at all times, that is do not just talk with the family member about them in their presence.

- Older adults 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 on the assessment, not discuss the assessment results, 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 (such as the Medicare annual Wellness visit or at an annual health fair), 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).

**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”, difficulty with 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 Depression Screening Interview:**

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

Hello, my name is …. I’m giving the GDS/PHQ-9 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 5 minutes or less. 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 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?

This training will review in detail two of the most common depression screenings, the Geriatric Depression Scale and the PHQ-9.

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

The GDS is widely used, easily learned, user friendly, and has evidenced-based reliability. 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 the short and long versions 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.

The GDS was created as part of a federal grant and is, therefore, in the public domain (Sheikh & Yesavage, 1986). It is available at no charge, in multiple formats and languages, online at http://www.stanford.edu/~yesavage/GDS.html (Yesavage, et al., 1983; Gallo, Bogner, & Fulmer, 2006; Greenberg, 2012). 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. A free iPhone app is available at https://itunes.apple.com/us/app/geriatric-depression-scale/id433446297?mt=8

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

**Total Score**  __________________

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

- **Scoring:** In this format, 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 VII). Scores > 10 indicate a high probability of depression.

- 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).

VI. **How to Conduct and Score the PHQ-9 Depression Screening**

The Patient Health Questionnaire (PHQ) is a diagnostic tool for mental health disorders used by health care professionals that is quick and easy for patients to complete. It was created in the mid-1990s as a self-administered version of sections of the Primary Care Evaluation of Mental Disorders (PRIME-MD), a diagnostic tool containing modules on 12 different mental health disorders.

There are a number of PHQ variations available for different purposes and in many different languages. They are available for free at [http://www.phqscreeners.com](http://www.phqscreeners.com), along with an instruction manual and an extensive bibliography. Each module can be used alone, in combination, or as part of a complete PHQ screen.

The PHQ-9 scores each of the 9 depression DSM-IV criteria/symptoms. The PHQ-2 is an abbreviated version of the PHQ-9, using only the first two questions of the PHQ-9. These screens can be available as a two-step process for efficiency; if a person screens positive on the PHQ-2, then the PHQ-9 can be given. The PHQ-15 screens for physical symptoms and a ‘Brief PHQ’ is actually a more complete two-page screen. The Generalized Anxiety Disorder 7-item scale (GAD-7) screens for 7 common anxiety symptoms (Richardson, et al., 2010; Pfizer, n.d.). See Appendix B for a more complete list and description of other PHQ screening tools available on their website.

**Notes on the PHQ-9:**

- The advantages of the PHQ-9 are that it is short, but well validated and documented in a variety of populations, including the geriatric population. It can be self-administered, given over the telephone, or done as part of an appointment. The PHQ-9, unlike the GDS, includes a question...
about suicidal thoughts and provides a gauge of symptom severity which facilitates diagnosis of major depression.

- When asking just the first two questions (PHQ-2), a score of 3 or greater indicate that the full PHQ-9 should be administered, as well as a referral for a clinical interview. Because the PHQ-9 is just a screening tool, it is not a substitute for a diagnosis by a trained clinician.

- If a person answers positive to the 9th question assessing suicide ideation, as discussed previously in this module, it is very important to follow up with questions to determine the immediacy of the risk of suicide, make sure the person is safe and that there is a solid plan for follow up treatment and care.

- The final question on the PHQ-9 is a self-assessment of symptom-related impairment. It is not used in calculating the PHQ score, but is useful in the discussion of why a referral for diagnosis and treatment could help a person’s life.

A scoring-friendly PHQ-9 version with details of how to score can be found by following the link and is provided below.
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "*" to indicate your answer)

1. Little interest or pleasure in doing things

2. Feeling down, depressed, or hopeless

3. Trouble falling or staying asleep, or sleeping too much

4. Feeling tired or having little energy

5. Poor appetite or overeating

6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down

7. Trouble concentrating on things, such as reading the newspaper or watching television

8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual

9. Thoughts that you would be better off dead, or of hurting yourself in some way

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
</table>

add columns: + +

TOTAL: (Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at ris@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.
INSTRUCTIONS FOR USE
for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 √’s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. Consider Major Depressive Disorder
   —If there are at least 5 √’s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —If there are 2 to 4 √’s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #16) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up √’s by column. For every √: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients’ files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION
for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every √: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5–9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10–14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15–19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20–27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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VII. 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 be used to determine whether a depression diagnosis is appropriate according to the DSM-5, and to develop a plan to address the level of depression and other co-morbid psychological problems (USPSTF, 2009). Additional factors that clinicians must take into consideration when making a diagnosis and formulating a treatment plan, according to the PHQ instruction manual, are:

- Have current symptoms been triggered by psychosocial stressor(s)?
- What is the duration of the current disturbance and has the patient received any treatment for it?
- To what extent are the patient’s symptoms impairing his or her usual work and activities?
- Is there a history of similar episodes, and were they treated?
- Is there a family history of similar conditions? (Pfizer, n.d.)

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 or PHQ-9.

In addition to local phone books and websites, State Licensing Board websites list names of licensed professionals, and the Federal Center for Mental Health Services (CMHS) keeps lists of treatment facilities at 1-800-789-2647 or http://findtreatment.samhsa.gov/

Often, the ideal treatment is provided by an interdisciplinary team of health care and mental health care 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, masters, 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). Local Area Agencies on Aging can be found at [http://www.n4a.org/about-n4a/?fa=aaa-title-VI](http://www.n4a.org/about-n4a/?fa=aaa-title-VI)

- **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 Psychology (PsyD). 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. As with LCPCs, insurance may cover their therapy and 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. PMHNPs are typically recognized as approved providers for insurance coverage purposes but patients should verify that their particular provider is accepted by their insurance.

- **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 side effects and 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.

VIII. Overview of Treatment for Depression

Clinical depression cannot typically be simply shaken off or willed away, although many may think it should be that easy. Many patients feel they should be able to handle it on their own, and many try. It is true that 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 (NAMI, 2009). 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 an individual. When it occurs at the same time as other medical illnesses, depression can and should be treated. Untreated depression can delay recovery or worsen the outcome of other illnesses and inhibit an older adult’s ability to live independently. Untreated depression is, in fact, the leading cause of disability world-wide.

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. In addition, older adults with cardiovascular diseases or other major illnesses may find that treatment programs for depression may take longer than for other individuals and may not be as successful (Silk, n.d.).

Depression is considered a chronic disease, however, and is highly recurrent. Feeling better is only the first step. 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 goals of recovery from the current episode of depression and prevention of relapses or recurrences of depression (Kiosses, 2011). The greater the number of depressive episodes and the longer the duration of the episodes, the longer the course of treatment is needed (NAMI, 2009).
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. A combination of drugs may also be tried if individual medications are not successful.

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).
### Table 2: Commonly used antidepressant drugs fall into five major classes (Mayo Clinic, 2014; USPSTF, 2009; Kroenke, 2011):

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Notes</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors (SSRIs):</strong> citalopram, escitalopram, sertraline, fluoxetine, paroxetine</td>
<td>Increase the availability of serotonin; usually the first 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><strong>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs):</strong> 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><strong>Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs):</strong> 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><strong>Tricyclic antidepressants (TCAs):</strong> desipramine, nortriptyline, imipramine</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; pinpoint 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><strong>Monoamine oxidase inhibitors (MAOIs):</strong> selegiline, phenelzine, tranylcypromine</td>
<td>Increases the availability of serotonin, norepinephrine, and dopamine through inhibition of MAO, which metabolizes these neurotransmitters. Usually tried when others don’t work.</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 [AHRQ], 2007; Gartlehner et al., 2011) (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 reduced by the Affordable Care Act. 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

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.

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).

Therapy may focus on situational crises, difficult relationships or unresolved issues from a person’s past and/or building social support or coping skills. The most effective therapeutic approaches for depression currently recognized 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. Other Treatments

Complementary and Alternative Medicine

Complementary and alternative medicine depression treatment modalities may be available, including electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), acupuncture, aromatherapy, biofeedback, dietary supplements, hypnosis, massage therapy, meditation and yoga. These may be used in conjunction with standard therapies, but should be monitored, particularly with moderate to severe depression.

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, 2014).
E. Barriers

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

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

Treatment costs, particularly for mental health care, can be a barrier for older adults because of Medicare reimbursement limitations. All insurance coverage of mental health services, including Medicare Part B, has, fortunately, improved in recent years with Mental Health Parity. Since 2008, mental health and addiction services and treatment are required to be covered at equal levels to other medical and surgical benefits within all insurance plans (Employee Benefits Security Administration, n.d.).

Medicare Part B currently reimburses mental health services at 80% of the approved amount for the following services:

- Individual and group therapy
- Family counseling to help with treatment
- Laboratory tests and assessments
- Annual depression screenings received in doctor’s offices or other primary care settings
- Activity therapies, such as art, dance or music therapy
- Occupational therapy
- Training and education (such as training on how to inject a needed medication or education about a condition)
- Substance abuse treatment
- Prescription drugs that must be administered by a practitioner

(Centers for Medicare and Medicaid Services, 2014)

Medicare Part B will cover mental health services received in outpatient hospital programs, a doctor’s or therapist’s office or a clinic. Providers that Medicare will accept include:

- Psychiatrists, although many psychiatrists do not accept Medicare and the patient is then responsible for the full cost of the service.
- Medical doctors, nurse practitioners and physicians’ assistants, including those who do not take Medicare assignment (although the patient may be charged up to 15 percent extra for practitioners who do not accept Medicare assignment).
- Clinical psychologists, clinical social workers and clinical nurse specialists, but only those who are Medicare-certified and accept assignment.

(Centers for Medicare and Medicaid Services, 2014)
Medicare covers up to 190 days of inpatient mental health services in either psychiatric hospitals or in general hospitals over the course of a patient’s life. After 190 days, Medicare may help pay for mental health care at a general hospital (Centers for Medicare and Medicaid Services, 2014).

Medicare supplemental insurance 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”.

IX. Depression Screening – Video Review

FOR REVIEW and to see how depression assessments are done, watch these two videos.

1) The first is **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 this video, click this link:

[The Geriatric Depression Scale (GDS) Short Form Assessment](http://consultgerirn.org/resources/media/?vid_id=4200933#player_container)

2) The second video is a **9.5 minute video** from IMPACT, an evidenced based depression care program. To view this video, you will need an updated version of Real Player, which can be downloaded for free, and an audio set up on your computer.

To view this video, clink this link:

[PHQ-9 Demonstration Video](http://uwaims.org/files/videos/initialvisit.html)
X. For More Information and Resources for Depression

The American Psychiatric Association

The American Psychological Association (APA)

APA’s Depression and Suicide in Older Adults Resource Guide

APA’s Mental and Behavioral Health and Older Adults

CDC Prevention Research Centers Healthy Aging Research Network
Tools and Products on Cognitive Health and Managing Depression: Webinars, Action Briefs and Roadmap to Maintaining Cognitive Health

The Community Guide Mental Health Recommendations

Summary of Community Guide Recommended Strategies: Evidence-Based Strategies to Manage Depressive Disorders

Community Guide News: Collaborative Care Proven Effective for Managing Depressive Disorders

ConsultGeriRN.org – Try This Resources

Depression and Bipolar Support Alliance

Geriatric Depression Scale (GDS) (or see Appendix B for websites for other forms)

Geriatric Mental Health Foundation

Mental Health America

Missoula City-County Health Department – online National Mental Health Screening Assessment and list of Missoula Mental Health Providers

National Alliance on Mental Illness (NAMI) or 1-800-950-NAMI

• NAMI Montana local support groups and speakers: (406) 443-7871 or e-mail info@namimt.org

National Council on Aging (NCOA)’s Center for Healthy Aging Behavioral Health Resources

National Institute on Aging’s Age Page: Depression - free brochures available

National Institute of Mental Health (NIMH) on Depression

NIMH Depression brochures, including one on Older Adults: can order copies

The National Suicide Prevention Lifeline and toll-free 1-800-273-8255

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Patient Health Questionnaire (PHQ) Screens

Older Americans Behavioral Health Issue Brief 4: Preventing Suicide in Older Adults:

Psychiatric Times Charts showing changes from the DSM-IV to DSM-5 and an ICD-10 guide

Substance Abuse and Mental Health Services Administration (SAMHSA) or 1-800-789-2647

National Registry of Evidence-Based Programs and Practices

The Mental Health Services Locator

The Treatment of Depression in Older Adults
XI. 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.

- **MRI**: 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.

- **EEG**: An electroencephalogram (EEG) is a test that measures and records the electrical activity of a brain. Electrodes are attached to the head for approximately 20-40 minutes for a recording of brain activity. 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 inter-rater or rate-rater 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. In the DSM-5, bipolar disorder has been placed in a separate classification.
- **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 hypomanic 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 to 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.
XII. References


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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)

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Appendix A: Geriatric Depression Scale – Alternate Formats

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)

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


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

http://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf
Appendix B: **Geriatric Depression Scale (GDS) Long Form**

Patient’s Name: __________________________ Date: __________________

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

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

2. YES  7. NO  12. YES  17. YES  22. YES  27. NO
3. YES  8. YES  13. YES  18. YES  23. YES  28. YES
4. YES  9. NO  14. YES  19. NO  24. YES  29. NO
5. NO  10. YES  15. NO  20. YES  25. YES  30. NO

### Appendix C: PHQ Screening Tools

The purpose of the different PHQ screening modules are explained in Pfizer’s Instruction Manual: *(Pfizer, n.d.a., p.3)*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRIME-MD</td>
<td>Predecessor of PHQ, now mainly of historical interest.</td>
<td>Combined self-administered patient screener with clinician follow-up questions.</td>
</tr>
<tr>
<td>PHQ</td>
<td>Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating.</td>
<td>Selected (but provisional) DSM-IV diagnoses for all types of disorders except somatoform.</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Depression scale from PHQ.</td>
<td>Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score.</td>
</tr>
<tr>
<td>GAD-7</td>
<td>Anxiety measure developed after PHQ but incorporated into PHQ-SADS.</td>
<td>Seven items, each of which is scored 0 to 3, providing a 0 to 21 severity score.</td>
</tr>
<tr>
<td>PHQ-15</td>
<td>Somatic symptom scale from PHQ.</td>
<td>Fifteen items, each of which is scored 0 to 2, providing a 0 to 30 severity score.</td>
</tr>
<tr>
<td>PHQ-SADS</td>
<td>PHQ-9, GAD-7, and PHQ-15 measures, plus panic measure from original PHQ.</td>
<td>See scoring for these scales above.</td>
</tr>
<tr>
<td>Variants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief PHQ</td>
<td>PHQ-9 and panic measures from original PHQ plus items on stressors and women’s health.</td>
<td>See scoring for PHQ above. Stressor and women's health items are not diagnostic or scored.</td>
</tr>
<tr>
<td>PHQ-A</td>
<td>Substantially modified version of PHQ developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ.</td>
<td>Diagnostic scoring described in manual, available upon request.</td>
</tr>
<tr>
<td>PHQ-2</td>
<td>First 2 items of PHQ-9. Ultra-brief depression screener.</td>
<td>Two items scored 0 to 3 (total score of 0-6)</td>
</tr>
<tr>
<td>GAD-2</td>
<td>First 2 items of GAD-7. Ultra-brief anxiety screener.</td>
<td>Two items scored 0 to 3 (total score of 0-6)</td>
</tr>
<tr>
<td>PHQ-4</td>
<td>PHQ-2 and GAD-2.</td>
<td>See PHQ-2 and GAD-2 above.</td>
</tr>
<tr>
<td>PHQ-8</td>
<td>All items of PHQ-9 except the 9th item on self-harm. Mainly used in non-depression research studies.</td>
<td>Eight items, each of which is scored 0 to 3, providing a 0 to 24 severity score.</td>
</tr>
</tbody>
</table>
Appendix D: Depression Brochure for Participants of IPHARM/MTGEC Screening Program

There is help
Just remember that depression is treatable. If you feel like you need help, there are a lot of people who would be happy to help you. You are not alone.

Sources of helpful information:
- National Institute of Mental Health
- DepressionSymptoms.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.
*If you have suicidal thoughts, please seek help right away from a mental health professional.

Causes/Risk Factors
Depression can be caused by a chemical imbalance in the brain, but can also be influenced by the world around you.
- 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:
Appendix E: Post-test Screening for Depression

Record responses on examination form.

1) The percentage of men and women over age 65 who are clinically diagnosable as depressed:
   a) Increases with disability.
   b) Is higher for younger cohorts.
   c) Is higher for men than women.
   d) Is approximately 22-17%.

2) Which of the following is NOT true? The symptoms of major depression include:
   a) Changes in sleep and appetite.
   b) Slow or agitated movements, speech or thinking.
   c) Lack of pleasure in previously favorite activities.
   d) Intense grief following the death of a loved one.

3) Which of the following is NOT one of the top five most significant risk factors for depression in seniors?
   a) Sleep disturbance
   b) Being unmarried
   c) Disability
   d) Prior depression

4) Depression in older adults, unlike younger adults, often includes:
   a) Less irritability but more memory problems.
   b) More physical complaints, including generalized pain.
   c) Less anxiety and better self care.
   d) More guilt, but fewer sleep problems.

5) How often should a depression assessment such as the Geriatric Depression Scale be conducted?
   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.

6) 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)

7) 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.
8) 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) Older Caucasian men have the highest suicide rate of any group.
   c) Asking about suicidal thought will not increase the risk of suicide.
   d) All of the above.

9) 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) Increased physical activity.
   d) Medications that increase the availability of serotonin in the brain.

10) Health care practitioners who have limited experience and/or training in working with mental health issues should:
    a) Not perform depression screenings.
    b) Refer all patients to mental health providers for depression screening.
    c) Be aware of patient literacy limitations, visual and speech deficits, and cognitive limitations.
    d) Always include a significant other in the health exam of an older adult.
**POST-TEST: Examination Form**

*Screening for Depression*

### Participant Information

1. Name: ______________________________________
2. Mailing address: ______________________________
   ______________________________
   ______________________________
   ______________________________
3. Date exam completed _________________________

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

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
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<td>10</td>
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</tbody>
</table>

For credit, please return this completed page to:

**MTGEC/IPHARM**

Skaggs Building Room 318
University of Montana
32 Campus Drive
Missoula MT, 59812-1522

Phone# (406) 243-2339 & Fax# (406) 243-4353
### Appendix F: Evaluation: Screening for Depression

Please indicate your major

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Based on the module description and stated objectives, this module met my expectations of the content it would deliver.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>2. How effective were the following in helping you understand the material?</td>
<td>Very Effective</td>
<td>Effective</td>
<td>Neutral</td>
<td>Somewhat Effective</td>
<td>Not Effective</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Pre-test</td>
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<td>O</td>
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<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>3. I learned something I can use in my practice/employment or personal setting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide new information to patients/clients</td>
<td>Adjust practices with geriatric patients/clients</td>
<td>New program development or program enhancement</td>
<td>Provide new information to family/friends/co-workers</td>
<td>Train staff or provider</td>
<td>Other implementation*</td>
</tr>
</tbody>
</table>

MTGEC Screening for Depression in Older Adults
Page 56 of 57
MNA CE expiration date: 10/9/2017
4. How do you plan to implement the information from this module to strengthen your practice, employment or personal goals? (check any that apply)

<table>
<thead>
<tr>
<th></th>
<th>&lt;1 hour</th>
<th>1-2 hours</th>
<th>2-3 hours</th>
<th>3-4 hours</th>
<th>4-5 hours</th>
<th>&gt;5 hours</th>
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</tr>
</tbody>
</table>

* Describe 'other' implementation plan here:

5. How long did it take you to complete the module? (including pre-test, module review, post-test and evaluation)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

6. The test questions were relevant to the module content.

7. Please provide suggestions to improve the online learning experience to meet your needs.

8. Please offer ideas or suggestions for new modules.

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