



Joanne Kaldy

Putting A New Face On Depression Treatment

The culture change movement has made long term care facilities rethink how they provide care and services for their residents. Now resident-centered care is helping practitioners and staff alike to improve care for residents with depression. By implementing resident preferences and choices, increasing autonomy, providing consistent staffing, and maximizing personal contact between residents and caregivers, facilities are taking an important step to recognize early signs of depression and tailor individualized care that involves a variety of non-pharmacologic interventions and minimal use of medications.

This innovative approach to addressing depression is putting a new face on an old problem and offering a fresh way to look at how residents' surroundings, interactions, activities, and diet affect their mental health. While most of the data regarding the effectiveness of culture change in improving or staving off depression are strictly anecdotal, many clinicians

are optimistic about the potential for change to have a positive impact on depression.

A Real Phenomenon

"Depression in late life is definitely a real phenomenon that continues to be under-recognized," says G. Allen Power, MD, an Eden mentor and physician at St. John's Home in Rochester, N.Y. In fact, it is the second-most common psychiatric diagnosis in long term care, with prevalence estimated at anywhere from 15 percent to 50 percent, according to researchers E.R. Peskind and M. Snowden *et al.*

The rate of mild depression is the highest. As diabetes, heart attack, stroke, hip fracture, and other conditions and illnesses contribute to depression, it is not surprising that this is a common problem in this setting.

Admission to a long term care facility is a mixed bag when it comes to depression. On the one hand, at least one study suggests that residents are more

While drugs have long been a staple in treating depression, providers are finding resident-centered methods that cater to the individual.



Storytelling helps residents deal with losses in their lives, so attention and interaction are important.

likely to self report depression than their community-dwelling counterparts and are more likely to be prescribed an antidepressant, according to *Science Daily*. At the same time, admission to a facility can contribute to mild or situational depression.

Depression has a profound effect on the elderly population. “If the first instance is after age 65, there is more likely to be a recurrence,” says Power. Suicidal thoughts—and even suicide—are not unknown in elderly long term care residents, especially when one considers that loss of control and feelings of helplessness contribute to a desire for death, according to W. Breitbart.

In fact, white males over age 85 have the highest suicide rate—about 65 per 100,000, according to the Institute on Medicine. The rate of complete suicide among elderly nursing facility residents is fairly low—about 16 per 100,000.

However, “people shouldn’t write off risk of suicide in this population,” says Power. “There have been instances of patients who grab a knife and attempt to stab themselves or slash their wrists, and one patient had a gun smuggled in so he could shoot himself. More often, you see passive suicide attempts where patients stop eating or refuse to take medications.”

There are other potentially serious implications of not treating depression in the elderly. As Power observes, “Untreated depression may be toxic to brain cells. People who get depressed in older age have a higher risk of developing memory loss in the next few years.”

Renovating Recognition

Despite the best efforts of clinicians and caregivers, depression continues to present a diagnostic challenge. “In fact, only about one-fourth of depression in

nursing facility residents is recognized and treated,” says Power.

One challenge, he notes, is that elderly patients often don’t show typical signs of depression. For example, they may not exhibit sad mood. Another challenge is that their symptoms—such as crying, loss of appetite, or social isolation—may be attributed to other conditions such as dementia or dismissed as being a temporary effect of facility admission.

It is important to assess residents on admission, when there are signs or symptoms of depression, and when the individual experiences a loss or change in condition. The Geriatric Depression Scale is useful for residents who do not present with dementia, while the Cornell Scale is considered more effective with residents who have dementia. “There is a good screen with two questions,” says Power. The questions,

posed by M. Ebell, are:

- Have you often been bothered by feeling down, depressed, or hopeless?

- Have you often been bothered by little interest or pleasure in doing things?

Some people still attach a stigma to mental illness, so simply asking a resident, "Are you depressed?" may not be enough. Seniors may hide or deny their depression out of shame or fear, so questions that are specific to symptoms and issues they may be experiencing are important.

When Drugs Are Necessary

"With the newer medications for depression that have a low side-effect profile, we're seeing more physicians using medications to treat depression," says Power.

The American College of Physicians published guidelines in the *Annals of Internal Medicine* in 2008 about the use of antidepressants that make four specific recommendations:

- That when clinicians choose pharmacologic therapy to treat patients with acute major depression, they select second-generation antidepressants on the basis of adverse effect profiles, cost, and patient preference;

- That clinicians regularly assess the patient for status, therapeutic response, and adverse effects starting one to two weeks into therapy;

- That clinicians modify treatment if the response is inadequate within six to eight weeks; and

- That treatment be continued for four to nine months after a satisfactory response in patients experiencing their first episode of major depression or longer for individuals who have had two or more bouts of depression.



'Elders are probably more likely to relapse than younger people, particularly if they've had multiple bouts of depression.'

The guidelines, written by A. Qassem *et al.*, identified 12 specific second-generation antidepressants, including bupropion, fluoxetine, fluvoxamine, mirtazapine, paroxetine, sertraline, and trazodone.

"Newer drugs have comparable effects and fewer side effects, so prescribers may want to look at which of these drugs are on the facility's or drug plan's formulary," Power notes. "Sometimes one drug won't work, and you can get a good response by switching to another product in the same class. If one drug fails, about 50 percent of patients will respond to another one."

Power points to a trend in psychiatry to use antipsychotics to treat major depression. However, he stresses, "I am very reluctant to get on this bandwagon, particularly with elderly patients. There are too many risks."

This approach also could be problematic in light of the implementation of F Tag 329, which is aimed at reducing or even eliminating the use of unnecessary drugs—with a special focus on antipsychotics and other drugs such as antidepressants—on nursing facility residents.

Of course, reducing unnecessary medications in the elderly always should be a priority. As Power observes, "We have to be very careful about every single pill we give our elderly patients.

With each medication, there is a 6 to 7 percent chance of a significant side effect. Additionally, there is some suggestion that for every dollar spent on drugs, the facility spends \$2 to address side effects."

However, he says, medication use has an important role, and an increased use of antidepressants could be a positive sign. "If you are doing a better job of diagnosing and treating depression in a facility, the use of antidepressants may go up for a time. But it is important to monitor these patients for opportunities to reduce dosages and even eliminate the medication altogether when appropriate," he says.

The Dangers Of Reduction

Jules Rosen, MD, a Pennsylvania-based psychiatrist and director of the Clinical Fellowship in Geriatric Psychiatry Program at the University of Pittsburgh Medical College, cautions, "Reduction or elimination of depression could be dangerous in some patients. The risk of relapse is much higher for patients who go off antidepressants too soon."

Texas-based Medical Director David Smith, MD, professor of family medicine at Texas A&M Health Science Center College of Medicine and president of Geriatric Consultants, cautions that reducing or eliminating antidepressants must be done carefully.

"Elders are probably more likely to relapse than younger people, particularly if they've had multiple bouts of depression, and relapse is more damaging in this population," he says. "We can't be eliminating antidepressants simply to save money or simplify the patient's drug regimen."

The general rule of medication administration in long term care, "start low, and go slow," is valid when it comes to antidepressants, but "sometimes we don't give people enough medication," says Power. "We need to give medications and dosages a chance to work, and this takes four to six weeks or more."

While medications—such as antide-



If residents have no families, staff and volunteers need to be part of the social treatment.

pressants—often are necessary and very helpful, many nondrug interventions can be valuable as well. “Clinicians tend to jump to medications right away because they are easy to prescribe and take. However, psychotherapy often is helpful in the elderly,” says Power.

“We say that if patients have physical symptoms, meds are useful, and medication is necessary for patients who have vascular changes in the brain associated with depression, but therapy can help with underlying symptoms.”

Additionally, he suggests, chronic illness, changing lifestyles, and loss of material possessions, loved ones, and independence can contribute to depression, and psychotherapy can deal effectively with these issues. Often, says Power, the combination of medication and nondrug therapies such as psychotherapy produce the best outcomes.

Beyond Meds

Smith stresses that medications never should be used alone, but the nondrug therapies must be tailored to the patient and “match his or her cognitive level and other issues.” He adds, “You need to make sure that psychotherapy is more than just ‘friendly visits.’ The physician should make sure that mental

health professionals have the skills and knowledge necessary to meet the patient’s needs.”

It also is important to set specific goals for therapy. “You need to choose one or more target symptoms with goals of improving them. You need to aim the therapy at those symptoms and track these to see if you are reaching the goals,” Smith says.

A skilled therapist, armed with a knowledge of the patient and his or her interests, hobbies, preferences, and personality, can do much, Power observes. “A good therapist can help the patient work through grief and loss issues, deal with negative feelings, and help arrange an activities or exercise program that will provide engagement, exercise, personal satisfaction and pride, and mental stimulation,” he says.

While psychosocial consultations may not be readily available, the physician and other interdisciplinary team members—including social workers and recreation/activities staff—can work together to identify specific programs, events, and interventions.

“First, get to know the patients. Go beyond routine admission history. Find out their values, what is important to them, and what their passions

are, and bring these to bear in what engages them every day,” Power says. “If caregivers get to know people, every interaction—such as meals—becomes more meaningful. Everything flows from relationships.”

Howard Stein, PhD, professor and special assistant to the chair in the Department of Family & Preventive Medicine at the University of Oklahoma Health Sciences Center, stresses the importance of listening to residents’ stories.

“It’s essential for us to listen to and take an interest in their stories. It also is useful to pair residents with college or high school students who can make these stories part of oral or written histories,” he says. “The attention and interaction are important. There is a circular relationship between feeling like a zombie and being treated like you’re dead.”

At the same time, storytelling helps residents deal with the losses in their lives. Stein notes, “Through storytelling, they can talk about the things in their life that they’ve lost and lovingly let them go. It also lets them distinguish between the things they can keep and the things they must mourn. By facilitating grief, you can help prevent long-term depression.”

Start simple, says Power. “Talk about simple pleasures—moments that bring great joy to the person. These are highly individualized. It might be watching the sun rise over a cup of coffee for one resident, petting a dog or a cat for another, or enjoying a good book and a plate of cookies for still another.

“Once you find out” about the person’s pleasures, when possible, make arrangements to deliver them, he says. He cautions that this may require mobilization of people from several departments, so it is important not to promise things that are too complex.

Role Of Activities

Activities that involve physical exercise can be important for some residents. For years, studies have shown the ben-

efit of exercise in combating depression in the elderly. One early study by J. Blumenthal *et al.* in 1999 showed that physical activity alleviated every major depressive disorder in older patients.

“Exercise has a powerful role to play in mental as well as physical well-being. In fact, recent evidence suggests that the effect of physical activity on serotonin levels lasts longer than drugs,” says Kevin O’Neil, MD, FACP, medical director at Brookdale Senior Living, which operates senior living communities throughout the country.

O’Neil notes that innovative programs can engage residents and alleviate their depressive symptoms. For example, he mentions one such program at Brookdale. Project RISE promotes environmental volunteerism and has been a life-changing experience for some residents. One resident had experienced a stroke and had mild depression. She is a new person now. “She is active and involved and wears makeup and bright colors,” he says.

Rosen stresses that seniors, like their younger counterparts, need activities and events they can look forward to and anticipate. “There are three components to pleasure—anticipation, experience, and memory. And in nursing facilities, residents don’t often have the anticipation,” Rosen says.

“We encourage families and volunteers to plan activities and events with residents that they can look forward to,” he adds. For example, he notes, “If a resident was a concert violinist and loves music, we would encourage his family to make one day a week ‘music day’ where they bring a new CD they can listen to together. Then they can leave the CD with dad, and he can listen to it at leisure. This way, the resident has anticipation, experience, and memory.”

This is part of the “controlled relevance” interventions that Rosen often implements that have proven to positively impact depression. These attend to residents’ personal interests and involve loved ones in providing

Types Of Psychotherapy

TYPE	DEFINITION
Art therapy	Employs creative processes to express thoughts, feelings; involves painting, music, dance, drama, poetry, movement
Behavioral therapy	Focuses on changing behaviors using unwanted or unhealthy behaviors that commonly uses a system of rewards, reinforcing positive behavior, and desensitization
Cognitive therapy	Helps identify and change distorted thought patterns that may exacerbate or encourage troublesome, self-defeating, or self-destructive behaviors and feelings
Cognitive behavioral therapy	Combines cognitive and behavioral therapies to help identify unhealthy, negative beliefs and behaviors and replaces them with healthy, positive ones
Dialectical behavior therapy	A type of cognitive behavioral therapy that primarily is designed to teach behavioral skills to help patients deal with stress, regulate emotions, and improve relationships
Exposure therapy	A type of behavior therapy that exposes the patient to what is upsetting or disturbing them to help them learn to cope with that stressor
Family therapy	Designed to help families or family members understand and improve how they interact, address issues, and resolve conflicts
Group therapy	Involves a small group of people facing a similar illness or issue and brings them together with a professional facilitator
Interpersonal therapy	Therapy that focuses on the patient’s current relationships with others with the goal of improving interpersonal skills
Marriage counseling (or couples therapy)	Couples meet with a professional counselor with the goal of gaining tools to improve communication, negotiate differences, solve problems, and even argue positively
Play therapy	Mainly used with young children at specific developmental levels; employs various play techniques to encourage them to express emotions and feelings that they can’t or won’t with words
Psychoanalysis	In-depth, Freudian-based therapy that guides patients to explore past memories, events, and feelings to understand and change current feelings or behaviors
Psychodynamic psychotherapy	Based on theories of psychoanalysis, this is aimed at increasing awareness of unconscious thoughts and behaviors, developing new insights into motivations, and resolving conflicts
Psychoeducation	Teaches the patient (and sometimes families and friends as well) about the patient’s illness, including treatments, coping strategies, and problem-solving skills

Source: www.mayoclinic.com/health/psychotherapy/MY00186/DSECTION=what-you-can-expect

the intervention. For example, one resident was a Pittsburgh Steelers fan, but he was depressed and no longer enjoyed his favorite pastime. So the facility arranged for his family to come every Sunday with snacks and non-alcoholic beverages to watch the game with him. Before long, his depression dissipated, and he looked forward to Sundays with the Steelers and his family.

Another depressed resident had been an avid card player and missed her regular games. Staff found four other card players at the facility and arranged twice-weekly games. Not only did the resident get to do something she loved but she made new friends and had an ongoing opportunity to socialize and enjoy relationships with people who shared her passion. In a study using such interventions, Rosen and his colleagues saw a complete remission of depression in 50 percent of residents with the condition.

If there is no family, Rosen says, these interventions are still possible. "Facility staff and volunteers need to be part of the social treatment plan and take this role seriously," he says. "By changing care strategies and the environment, a lot of depression can be removed and improved."

Power and Stein stress that all activities and programs must be individualized. Stein observes, "You can't standardize interactions. You have to pay attention to who your residents are and where they come from. If you have a large Mexican population, teaching them to make New York bagels doesn't make sense. The worst thing



'We get people on neighborhood teams to talk about what holidays they celebrate, how they celebrate, and memories they have.'

you can do is develop a one-size-fits-all approach to social activities and recreation."

Culture Change And Depression

Where does culture change come in? It actually—by its very nature—can have a positive impact on mild or situational depression. "When people enter a long term care facility, they often lose control and autonomy, give up their possessions, lose touch with friends and neighbors, and have their routines and daily lives interrupted," Power says.

"In nursing facilities, we often use the diagnosis of 'adjustive disorder.' It isn't a real disorder, but it describes what people experience when they enter the facility." Culture change brings back many of the activities, routines, choices, and relationships they enjoyed before admission, Power says. Residents regain control over their daily lives and enjoy autonomy and choices, and the adjustive disorder dissipates.

Smith agrees that culture change efforts can have an important impact on the mental well-being of residents. However, he cautions about the importance of accurate diagnoses. "It's very important to separate depression from depressed mood—which is a normal phenomenon but not a disease. You don't want to make a pathological diagnosis out of something that is normal."

One aspect of successful culture change that can help prevent or address depression is maximizing resident choice and enabling decision making closer to the resident. For example, Power says, "We get people on neighborhood teams to talk about what holidays they celebrate, how they celebrate, what makes it meaningful for them, and special memories they have. Then we work together to incorporate these into our events."

Stein agrees that involving residents in planning events is key. "When you actively involve people in the planning process, individuals who feel like they are on the short end of the stick will start to feel active and alive again," he says.

Consistent Staffing

Having permanent staffing assignments, another common attribute of culture change, also can contribute to depression treatment. When staff have strong, ongoing relations with residents, they are better positioned to see subtle changes that may be signs of depression. "Permanent staffing can make a big difference. People really get to know residents and can recognize signs that might be missed otherwise," says O'Neil. "The flattened hierarchy that is a hallmark of many culture change initiatives also can help address depression. It benefits residents when staff feel comfortable talking to clinicians about someone they think is depressed and interventions they think might help."

For example, one resident was referred to the RISE project by marketing personnel who knew she had been a surveyor prior to having a stroke and entering the facility. "They recalled how teary she got when she talked about her work and how she missed it. By listening, they had found out something that was an important clue to treating the resident's depression," O'Neil says.

There is a preventive aspect to culture change in regards to depression.

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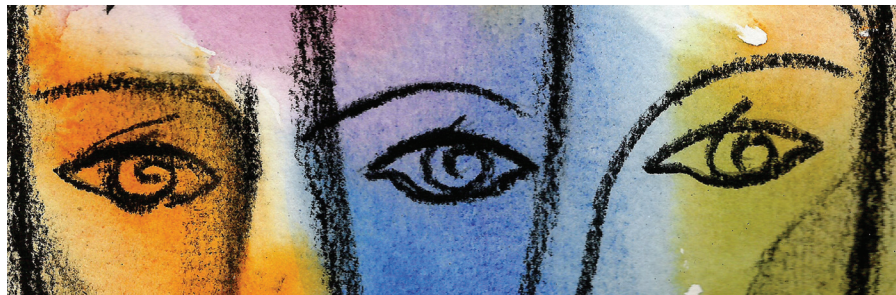
"Living in a group setting with the consistent support of peers and caregivers can enhance socialization and diminish loneliness in a way that can prevent depression in some cases," says Smith. There is no question that depression decreases quality of life, says Power. But can a poor quality of life cause depression? Probably, he suggests. "If a patient moves into a facility that doesn't allow for quality of life, it can contribute to depression."

The holistic approach that culture change efforts take considers the impact of patient happiness on resident health. "One home has wellness plans instead of care plans to take a holistic approach. It makes sure residents have meaningful activities during the day, that they are happy most days, and that they connect with people in a positive way every day," Power notes. The ongoing nature of these activities is key, he says.

"The connection with another living being—whether it is an animal or a person—is essential. This must be provided on an ongoing basis for it to have a positive effect on the person's well-being."

Karen Alizzi, MSW, CEAP, director of social service at the Madlyn and Leonard Abramson Center for Jewish Life in North Wales, Pa., says, "We've incorporated culture change into depression management. We look to initiate activities to address mild depression, and we encourage a higher level of activities." The organization also has an Active Life program that involves a six-week rotation of access to exercise equipment. "We know this can alleviate mood issues."

If these efforts don't help, she says, "we involve social workers and a chaplain to address losses, family issues, unmet needs, and so on." For example, one depressed resident had a son with disabilities who couldn't visit her, so the facility made arrangements for her to go to him. "This really helped her mood and gave her something to look forward to," said Alizzi.



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If this level of intervention doesn't help, the next step involves psychiatric support. "We start out with less invasive approaches and monitor the depression's progress via the Geriatric Depression Scale," says Alizzi.

The Surveyor Situation

When interventions involve resident choice, it is important to weigh risks and benefits. For example, if a resident wants to drink coffee on the patio and watch the sun rise, there is the risk of a burn from spilled coffee. Staff must address such risks by providing adequate supervision, using a no-spill cup, and not serving coffee that is hot enough to cause a burn.

Additionally, all interventions for depression—including medications—must be documented, including the goals of therapy, monitoring activities, efforts to reduce medications or change or add therapies, discussions with the patient and family members, and the reasoning behind non-drug interventions and programs.

"Surveyors don't always understand nontraditional treatments, and it is important to document the rationale for their use and the results," says Alizzi. "If you are doing something really cutting edge, it may be useful to give surveyors a heads-up when they come into the facility so they know what to expect."

The bigger issue with regulators revolves around the fact that autonomy involves personal assumption of some risk in return for being able to make choices, says Power. For instance, he says, "A person who wants to choose their own meals may not get a nutritionally balanced diet. Or a person who wants to decline a medication that bothers them might risk worsening disease. In those cases, the regulators will want to be sure the person has had all of the potential risks explained and is making an informed choice. And if there's any hint of dementia, there's the possibility someone will feel the person isn't capable of exercising that autonomy."

As always, he adds, documentation is key. "This simply may be a record of discussions held but in some situations, liability concerns may even require an informed consent form be signed."

There is much agreement that successful culture change efforts have a positive effect on mental well-being and the treatment and prevention of mild depression and some depressive symptoms. However, Smith observes, "More research is needed in this area."

Nonetheless, it is important to continue to make resident-centered care a priority and implement personalized activities and programs.

As Stein says, "A meaningful life is a powerful antidepressant." ■