

Course Materials for Continuing Education Course

10002 Psychologist's Guide for Working with Older Adults with Depression [1 Credit]

Course Syllabus is on Page 2

Course Materials begin on Page 3

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Course Syllabus

Course Description: This online text-based course describes how psychologists can provide evidence-based treatment for older adults with depression. Topics include best practices in screening for and diagnosing depression, choosing and implementing psychological care, and evaluating outcomes. The course concludes by describing how psychologists can use outcome data to implement and assess evidence-based practices (EBPs).

Course Objectives (Learning Outcomes): By successfully completing this course, the learner will be able to:

1. Identify and describe best practices psychologists follow in screening and diagnosing depression in older adults.
2. Identify and describe best practices psychologists follow in treating depression in older adults.
3. Discuss important principles for implementing and evaluating evidenced-based psychological care for older adults.

Course Category: Treatment and Evidence-Based Practice

Credits: 1.0

Fees: \$10.00 to register for CE Credit (Must pass Course Quiz to earn credit). Refund Policy.

Last Revision: February, 2016

Audience, Level, and Course Utility: This course is appropriate for **Psychologists, Mental Health Counselors, Social Workers, and Marriage and Family Therapists** who work with the elderly population, especially those who treat older adults suffering from or at risk of depression and/or dysthymia. This course is considered **introductory** since its focus is on identifying best practices and no prerequisite training is required.

Course Utility and Potential Risks/Conflicts: This course was designed to help practitioners improve the care they provide to individuals within this population by sharing best practices and important principles. It does not constitute clinical training or certification in any of the screening procedures or treatments discussed. This course is not sponsored by any commercial organizations and no potential conflicts of interest are noted.

Course Instructors: This course was developed by Chris Heffner, PsyD, PhD, LP and was reviewed by Catherine Crews, PhD, LP.

Course Materials: The materials for this course were prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates, Inc., and the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, under contract number 280-04-0095 and Westat under contract number 270-03-6005, with SAMHSA, U.S. Department of Health and Human Services (HHS). Pamela Fischer, Ph.D., served as the Government Project Officer.

Publication Date: September, 2011

Format: PDF (CustomCE Course 10002.pdf)

Technical Requirements: Internet Access for Course Quiz, PDF Viewer (e.g., Acrobat Reader) for Course Materials.

Additional Requirements: None

Suggested Prerequisites: None

10002 Course Supplemental

Published course materials can become outdated quickly and new materials take time to develop and publish. To fill this gap, we work to add updates and other important information related to each course as a Course Supplemental. This information, typically in the form of meta-analyses, review articles, and updated assessment or treatment protocols, is provided below in abstract format.

Pickett, Y. R., Bazelaire, K. N., & Bruce, M. L. (2013). Late-life depression in older African Americans: A comprehensive review of epidemiological and clinical data. *International Journal of Geriatric Psychiatry*, 28, 903-913.

The population of older African Americans is expected to triple by 2050, highlighting the public health importance of understanding their mental health needs. Despite evidence of the negative impact of late-life depression, less is known of how this disorder affects the lives of older African Americans. Lack of studies focusing on how depression presents in older African Americans and their subsequent treatment needs lead to a gap in epidemiologic and clinical knowledge for this population. In this review, we aim to present a concise report of prevalence, correlates, course, outcomes, symptom recognition, and treatment of depression for these individuals. We performed a literature review of English-language articles identified from PubMed and Medline published between January 1990 and June 2012. Studies included older adults and contained the key words 'geriatric depression in African Americans', 'geriatric depression in Blacks', and 'geriatric depression in minorities'.

Although in most studies, older African Americans had higher or equivalence prevalence of depression compared with Caucasian Americans, we also found lower rates of recognition of depression and treatment. Many studies reported worse outcomes associated for depression among older African Americans compared with older Caucasians. Serious racial and ethnic disparities persist in the management of older African Americans with depression. Understanding their unmet needs and improving depression care for these individuals is necessary to reduce these disparities.

Polyakova, M., Sonnabend, N., Sander, C., Mergl, R., Schroeter, M. L., Schroeder, J., & Schonknecht, P. (2014). Prevalence of minor depression in elderly persons with and without mild cognitive impairment: A systematic review. *Journal of Affective Disorders*, 152-154, 28-38.

Minor depression (MinD) and mild cognitive impairment (MCI) are common disorders in late life that often coexist. The aim of the present review is to demonstrate prevalence rates of minor depression in older patients with and without MCI. Electronic database searches were performed through Medline, ISI Web of Knowledge, Psycinfo, and Cochrane library. Two independent reviewers extracted the original studies based on inclusion criteria: representative study population aged 55 and older, diagnostics of MinD according to DSM. Data on prevalence rates, risk factors, comorbidity and health care usage were analyzed.

Point prevalence for MinD is higher in medical settings (median 14.4%) than in the community-based settings (median 10.4%) and primary care patients (median 7.7%). Although minor depression is rarely investigated in elderly persons with MCI, nearly 20% of patients with MCI seem to suffer from MinD. No data was found on the prevalence of MCI in patients with MinD. Risk factors associated with MinD include female gender, history of cerebrovascular diseases, generalized anxiety disorder, loneliness, and long-term institutional care. Methodological differences of included studies resulted in a broad range of prevalence rates. No data is shown regarding the prevalence of MCI in MinD group due to insufficient evidence. Our review indicates that MinD is frequent in elderly population. MCI among those subjects has not been sufficiently investigated. Future studies based on clinical structured interviews should be performed in longitudinal design in order to differentiate late-life depression from progressive MCI or early manifestation of Alzheimer's disease.



EVIDENCE-BASED
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KIT

Knowledge Informing Transformation

Guide to EBPs

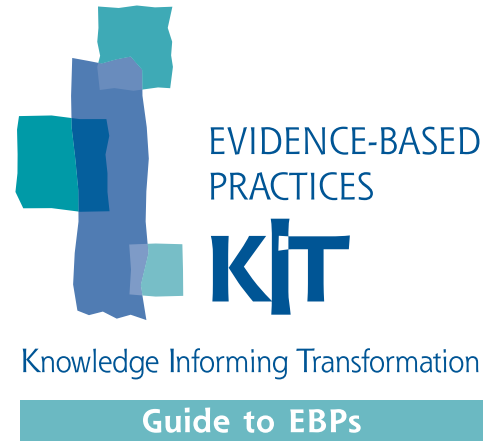
Practitioners' Guide

For Working with
Older Adults
with Depression

**The Treatment
of Depression
in Older Adults**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Recommended Citation

Substance Abuse and Mental Health Services Administration. *The Treatment of Depression in Older Adults: Practitioner's Guide for Working with Older Adults with Depression*. HHS Pub. No. SMA-11-4631, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.

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HHS Publication No. SMA-11-4631
Printed 2011

Practitioners' Guide for Working with Older Adults with Depression

This booklet describes how practitioners can screen for depression, assess and diagnose depression, select an appropriate treatment, deliver care, and evaluate outcomes. It also describes how practitioners can participate in implementing evidence-based practices (EBPs).

The Treatment of Depression in Older Adults

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of The Treatment of Depression in Older Adults Evidence-Based Practices KIT, which includes 10 booklets:

**How to Use the Treatment of Depression in Older Adults
Evidence-Based Practices KIT**

Depression and Older Adults: Key Issues

**Selecting Evidence-Based Practices for Treatment of Depression
in Older Adults**

Evidence-Based Practices Implementation Guides:

Older Adult, Family, and Caregiver Guide on Depression

**Practitioners' Guide for Working with Older Adults
with Depression**

Guide for Agency Administrators and Program Leaders

**Leadership Guide for Mental Health, Aging, and General
Medical Health Authorities**

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP

What's in *Practitioners' Guide for Working with Older Adults with Depression*

| | |
|---|----|
| Why You Should Care About EBPs for Older Adults with Depression | 1 |
| Working with Older Adults | 2 |
| Screening for Depression | 4 |
| Assessing and Diagnosing Depression | 6 |
| Selecting a Treatment | 8 |
| Delivering Evidence-Based Care | 10 |
| Evaluating Care | 22 |
| Implementing EBPs | 22 |

The Treatment of Depression in Older Adults

Practitioners' Guide for Working with Older Adults with Depression

The *Practitioners' Guide for Working with Older Adults with Depression* gives practitioners strategies for providing effective and appropriate care to older adults with depression. Practitioners include people who provide care to older adults with depression. The training and activities of practitioners may differ among the mental health, aging, and general medical health settings. Practitioners may include psychiatrists, psychologists, physicians, nurses, social workers, aging service providers, and other providers of care.

This booklet describes how practitioners can screen for depression, assess and diagnose depression, select an appropriate treatment, deliver care, and evaluate outcomes. It also describes how practitioners can participate in implementing evidence-based practices (EBPs).

Why You Should Care About EBPs for Older Adults with Depression

Demand is growing for mental health services for older adults. Older adults make up 12 percent of the American population, but will grow to 20 percent of the population by 2030.

Although depression is not a normal response to changes that occur in older adulthood, this medical problem affects many older adults. It is widely underrecognized and undertreated.



Depression can impair an older adult's ability to function independently and can contribute to poor health outcomes. It can cause suffering and family disruption. Without treatment, the symptoms of depression can last for years.

Several effective treatments can reduce the symptoms of depression for most older adults. Increasing the availability of these treatments is an important way of improving the quality of care for older adults. Providing EBPs for the treatment of depression can help in these ways:

- Reduce or eliminate the symptoms of depression;
- Lower the risk for suicide;
- Improve physical health; and
- Reduce functional disability.

A variety of skills can help you provide effective depression care to older adults. You can improve delivery of care by strengthening your ability in these areas:

Working with older adults;

- Screening for depression;
- Assessing and diagnosing depression;
- Selecting a treatment;
- Delivering evidence-based care; and
- Evaluating care.

Working with Older Adults

The relationship that you form with an older adult is one of the most important parts of delivering effective care. Building a therapeutic relationship includes showing respect for the older adult, demonstrating your competence in issues of aging and depression, and communicating empathetically with the older adult.

Understanding older adults in terms of their cohort, or age group, is an essential part of developing a therapeutic relationship, especially if you are considerably younger. Each generation can identify cultural norms or historic events that influence their style of coping with problems, family relationships, and outlook on life. Today's older adults grew up during times of racial segregation. Some remember the Great Depression and many served during World War II.

Cultural and generational issues, as well as physical changes associated with aging, may affect the way you interact with older adults. Showing an interest in how older adults view the nature of their problems, and the coping style they are familiar with, can enhance your relationship with them. For important tips for working with older adults, see the next page.

Tips for Working with Older Adults

Communication

- Speak slowly so your words don't run together. Speak in a clear, normal tone. Some pitches are difficult for some older adults to hear.
- Sit directly in front of an older adult so he or she can see your face and lips as you speak. You may also ask if he or she can hear you better out of one ear or the other so you can speak in that direction.
- Provide printed information to older adults. Use large print materials with at least 14-point font size, black print on white, nonglare paper.
- Avoid using slang terms or medical jargon.
- Word choice is crucial. Try to be careful when choosing your words to minimize the effect of mental health stigma, which may prevent an older adult from accepting services.
- Refer to older adults with titles of respect, that is, Mr., Mrs., Miss, Ms, Dr., or other title until given permission to use the first name.
- Depending on the older adult's culture, it may be necessary to communicate directly with family members as well as incorporating family members and caregivers into the treatment plan.
- Encourage the older adult to ask questions.

Privacy

- During in-home visits, be aware that privacy may be an issue. It is often helpful to have family present to help obtain historical information. It also is important to meet with the older adult individually so sensitive information can be shared more comfortably (for example, elder abuse).
- Obtain consent to talk with the older adult's physical health doctor as soon as possible.
- At each contact assure the privacy of the information given.

Assessment

- Take into account literacy and fluency in speaking and understanding English when working with minority older adults.
- Use words that are acceptable and familiar when assessing an older adult's feelings, such as stress, nerves, fatigue, or feeling low or sad.
- Plan more time for assessments than with younger adults. Plan more time for each contact.
- Try not to cut off sentences or fill in words while an older adult is pausing. Some older adults may give useful information in a story format.
- Find out the older adult's beliefs and knowledge concerning depression.
- At times it may be necessary to help older adults refocus. A gentle but decisive approach is needed.
- Never underestimate any inference of feeling worthless or wanting to die. Always indicate your concern and attempt to get more detailed information. Plan to act on that information as indicated.
- While assessing, look at the whole person. Consider whether assistive devices might help older adults stay in their homes longer.
- Ask for a current list of prescription and over-the-counter medications. If an older adult does not have a current list, ask him or her to bring in all medications so a list can be made.

Adapted from *Tips from the Southern Illinois Gero-Psychiatric Specialists*.

Screening for Depression

Screening for depression improves your ability to recognize and diagnose depression, and thereby provide appropriate treatment and improve outcomes of depression. Screening for depression is recommended by the U.S. Preventive Services Task Force (2002) in health care settings where practitioners are prepared to confirm an accurate diagnosis and provide effective treatment and followup.

Several instruments can help you screen for depression in older adults. Two common measures are the Patient Health Questionnaire and the Geriatric Depression Scale. For older adults with a positive screen on either of these measures, you should conduct a full diagnostic evaluation for depression or refer the older adult to a practitioner who can do so. See *Evaluating Your Program* in this KIT for more information about these and other measures for evaluating older adults.

Patient Health Questionnaire (PHQ-2)

The PHQ-2 includes the following two questions. If the answer to either is “Yes,” the older adult should receive further evaluation for depression.

- Over the past 2 weeks, have you felt little interest or pleasure in doing things?
- Over the past 2 weeks, have you felt down, depressed, or hopeless?

Geriatric Depression Scale

The short form of the Geriatric Depression Scale is a 15-item screening tool designed specifically for older adults who may need further evaluation for depression. You can use this scale to screen for depression and to monitor outcomes of depression treatment.

The Geriatric Depression Scale has been translated into multiple languages (for example, Spanish, French, Korean, Chinese, and many others) and is available at <http://www.stanford.edu/~yesavage/GDS.html>.

Geriatric Depression Scale (Short Form)

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

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

Scoring: Score 1 point if you answered NO to Questions 1, 5, 7, 11, 13.

Score 1 point if you answered YES to Questions 2, 3, 4, 6, 8, 9, 10, 12, 14, 15.

Total your points. Total point score: _____

A score > 5 is suggestive of depression and a score > 10 is almost always indicative of depression.

For more information, see “Development and validation of a geriatric depression screening scale: A preliminary report,” by J. A. Yesavage, T. L. Brink, T. L. Rose, O. Lum, V. Huang, M. Adey, and V. O. Leirer, 1983, *Journal of Psychiatric Research*, 17, 37–49.

Assessing and Diagnosing Depression

Depression is often underrecognized and undertreated in older adults. Some reasons include the following:

- Older adults often emphasize physical rather than cognitive and mood complaints, or they may report mild or nonspecific symptoms of depression.
 - Symptoms of depression often overlap with symptoms of physical disorders.
 - Depression may be a side effect of a medication or result from adverse drug interactions.
 - Depression can be mistaken for anxiety, as mixed depression and anxiety is common.
 - A misconception is that depression is a normal or understandable component of aging.
 - Older adults may deny symptoms of depression and refuse to accept the diagnosis because of stigma.
 - Inadequate mental health training exists among practitioners working with older adults.
 - Practitioners may be uncertain of the diagnosis, available treatment, or expected outcomes of treatment.
 - Time limitations in primary care interfere with the practitioner's ability to address both physical health and mental health problems.
- Ensure that the older adult has a recent physical evaluation. Symptoms of depression can be caused by serious (and even life-threatening) undiagnosed medical disorders.
 - Review physical health history. Obtain the older adult's permission to review relevant medical records and communicate directly with the primary care practitioner.
 - Review social history, including personal supports.
 - Assess for the presence of risk factors, including history of depression in the older adult and his or her family members.
 - Ask direct questions about symptoms of depression, thoughts of suicide, psychosis, and recent losses or crises.
 - Review medications.
 - Assess cognitive dysfunction and functional disability.
 - Obtain the older adult's permission to consult family members, if available, to verify information and to provide a different perspective on the older adult's problems.
 - Use a standardized assessment tool to rate the severity of symptoms (for example, Patient Health Questionnaire [PHQ-9], Geriatric Depression Scale-Short Form).

You can improve recognition of depression by conducting a careful evaluation of older adults who screen positive or have risk factors for depression. The goal of an evaluation is to determine the causes of depression and the best course of treatment.

To evaluate depression in older adults, you can perform the following assessments:

Conduct an individualized depression assessment and interview.

Patient Health Questionnaire (PHQ-9)

The nine-item PHQ-9 can help you rate the severity of depressive symptoms and help make a diagnosis of depression. The questions of the PHQ-9 align with the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) diagnostic criteria for depression.

The PHQ-9 has been translated into multiple languages (for example, Spanish, Chinese, and many others). To learn more about the PHQ-9, visit <http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/>

Patient Health Questionnaire (PHQ-9)

Rate question 1 with the following categories:

Not at all (score 0),

Several days (score 1),

More than half the days (score 2), or

Nearly every day (score 3).

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
 - a. Little interest or pleasure in doing things
 - b. Feeling down, depressed, or hopeless
 - c. Trouble falling asleep, staying asleep, or sleeping too much
 - d. Feeling tired or having little energy
 - e. Poor appetite or overeating
 - f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
 - g. Trouble concentrating on things such as reading the newspaper or watching television
 - h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
 - i. Thinking that you would be better off dead or that you want to hurt yourself in some way

Rate question 2 with the following categories:

Not difficult at all,

Somewhat difficult,

Very difficult,

Extremely difficult

2. If you checked off any of these 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?

Total point score (Questions 1a-1i): _____

A score > 10 is indicative of depression when problems are at least somewhat difficult.

For more information, see “Validation and utility of a self-report version of PRIME-MD: The PHQ Primary Care Study,” by R. Spitzer, K. Kroenke, and J. B. Williams, 1999, *Journal of the American Medical Association*, 282, pp. 1737-1744. Copyright 1999 © Pfizer Inc.

Selecting a Treatment

The Institute of Medicine (2001) defines evidence-based practice (EBP) as the integration of the best research evidence with clinical expertise and patient values.

When you select an EBP for a particular older adult, you should consider these factors:

- The older adult's presenting problems and diagnosis, including the severity and duration of depression;
- The older adult's prior history of response to treatments;
- The presence of other health conditions or medications;
- The tolerability of the treatments with respect to side effects or required effort;
- The older adult's access to care;
- The availability of treatment for the older adult, including the preferred setting for the delivery of the service;
 - The older adult's personal preferences and choice in treatment interventions; and
- The ability to finance the treatment.
 - It is important to select the treatment that best fits the needs of the older adults you serve. When selecting an appropriate intervention, you should work with older adults to identify the best available evidence and the expected outcomes of the treatment, and understand their treatment preferences.

Best available evidence

Treatments that have been labeled as EBPs are different from other treatments. EBPs have been rigorously evaluated by scientists (in at least two studies) to determine that they reduce the symptoms of depression in older adults. These evaluations have compared the EBP to a comparison group.

Several effective treatments are available to treat depression in older adults. It is important to implement these EBPs because they are proven to be more effective than usual care, and they are not being implemented broadly in practice. For a description of these EBPs, see *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults* in this KIT.

EBPs for Depression in Older Adults

- Psychotherapy interventions
 - Cognitive behavioral therapy
 - Behavioral therapy
 - Problem-solving treatment
 - Interpersonal psychotherapy
 - Reminiscence therapy
 - Cognitive bibliotherapy
- Antidepressant medications
- Multidisciplinary geriatric mental health outreach services
- Collaborative and integrated mental and physical health care

Several other interventions have been developed to treat depression but lack rigorous testing among older adults. In the future, these promising practices may meet the criteria for an EBP for treating depression in older adults.

Older adult preferences

It is important for you to understand the treatment preferences of older adults. Older adults may have clear preferences for receiving one type of treatment over another.

Preferences may be based on the following factors:

- Side effects of treatment;
- Program expectations;
- Length of treatment;
- Experiences of peers; or
- Perceived stigma.
 - For example, some older adults who are on a large number of medications prefer psychotherapy interventions. Others prefer the convenience of medication over the multiple visits and homework that are part of psychotherapy.

Conversations with older adults can help you identify their preferences and values. You can engage older adults in ongoing discussions that allow them to actively participate in treatment decisions. These discussions can empower the older adult to help decide what type of depression care he or she wishes to receive. This model of care is sometimes called shared decisionmaking and is an important principle identified by the Institute of Medicine (2001).

Shared decisionmaking often represents a different way of thinking for older adults. While some older adults may be hesitant to participate in treatment decisions, you can encourage their participation and use their feedback to guide the selection of the best treatment. For information for older adults on becoming more involved in making treatment decisions, see *Older Adult, Family, and Caregiver Guide on Depression* in this KIT.

Steps You Can Take

- Know how demographic characteristics and cultural beliefs influence perceptions of depression, treatment access, treatment preferences, and desired outcomes.
- Use screening tests and a standard depression evaluation to improve your recognition of depression.
- Understand the treatment preferences and values of older adults and involve them in making treatment decisions.
- Work with practitioners from different disciplines to address the multiple physical health, mental health, and social needs of the older adult.
- Learn specialized skills for communicating and working with older adults with depression.
- Use standardized depression scales (for example, Geriatric Depression Scale, PHQ-9) as outcome measures to evaluate the effectiveness of implementation and treatment.
- Monitor treatment participation and response. Reevaluate older adults (in person or by phone) within the first 2 weeks after beginning treatment and at least every 3 weeks during the first 3 months of treatment.

Delivering Evidence-Based Care

A person-centered approach to delivering care should focus on the goals that are set by the older adult. You are more likely to meet his or her goals with an understanding of the following:

- An array of services is available to older adults;
- Collaboration among practitioners from different disciplines is desirable; and
- Your treatment approach will be guided by understanding key principles of aging.

An array of services is available

Treatment for depression in older adults is not limited to EBPs. EBPs should be one component of a larger continuum of services. Other services may lack the scientific rigor of an EBP but may still be important for older adults.

The effectiveness of EBPs may be improved if you can provide them along with other supportive services. Supportive services can include the following:

Education about depression;

- Support for family members and caregivers;
- Assistance with other health and social concerns;
- Treatment of co-occurring physical or mental disorders; and
- Treatment of co-occurring substance use problems (including problems with alcohol and illicit drug abuse, and medication misuse).

As an example, practitioners who deliver the PATCH (Psychogeriatric Assessment and Treatment in City Housing) model of multidisciplinary community-based outreach comment that their ability to help an older adult is often improved because they can address physical health problems, transportation, housing stability, and assistance with access to medical visits and medications. (For a description of the PATCH model, see *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults* in this KIT.)

Collaborating with other practitioners

Older adults with depression typically need multiple medical and social services. You are more likely to provide comprehensive and effective care by working together with mental health, aging, and general medical health practitioners.

You can achieve effective collaboration in these ways:

- Obtaining the older adult's permission to contact his or her other practitioners;
- Identifying health and social issues that can be addressed together; and
- Establishing a mechanism for clear and frequent communication.

Principles for delivering care to older adults

For those adults who suffer from symptoms of depression, recovery is possible. Effective treatments can help up to 80 percent of older adults feel better.

Remembering several important principles can help you provide more effective care to older adults.

Issue 1: Co-occurring physical illness is the rule, not the exception

A distinguishing feature of old age is the common presence of chronic physical illness. About 80 percent of older adults (over age 65) have at least one chronic physical disorder, and 50 percent have at least two. Some of the most common physical disorders include arthritis and musculoskeletal conditions, and heart disease and other circulatory problems. Despite the high rate of chronic physical disorders, two-fifths of older adults consider their health to be excellent or very good.

Among older adults with depression, approximately one-fifth suffer from heart disease, one-fifth have diabetes, two-fifths have arthritis, and nearly half have hypertension.



Important Issues in Delivering Care to Older Adults

- Co-occurring physical illness is the rule, not the exception. Obtain a recent physical evaluation to rule out potential physical causes or contributors to symptoms of depression.
- Co-occurring anxiety can complicate the course and treatment of depression.
- Cognitive impairment can be both a risk factor and a symptom of depression.
- Older adults take multiple medications and their bodies handle the medications differently than younger bodies. Drug interactions can cause serious medical problems.
- Small amounts of substance use can cause serious problems for older adults.
- Mental and physical functioning varies widely among older adults of the same age.
- Coordination and collaboration among mental health, aging, and general medical practitioners is essential.
- Family members and other social supports are critical to successful treatment.
- Maintaining independence and aging in place are common values of older people.
- Ageism and stigma affect treatment access, expectations, and outcomes.
- Cultural differences can affect perceptions of depression, treatment preferences, and desired treatment outcomes.
- Depression can be prevented.
- Older adult depression is associated with the highest rate of suicide.
- Psychotherapy can be as effective as medications.

Physical disorders complicate the identification, course, and treatment of depression. Therefore, you should simultaneously evaluate physical and mental causes of symptoms. Depression shares symptoms with physical disorders such as congestive heart failure and cancer. These can include low energy, poor appetite, impaired functioning, fatigue, irritability, and feelings of hopelessness. A recent physical evaluation can help you exclude potential physical causes or contributors to symptoms of depression.

When chronic physical illness occurs with depression, physical illness can worsen the course of depression and, conversely, depression can worsen the course of physical illness. In either case, you should provide coordinated and integrated care for both depression and the physical disorder. Approaches that neglect one area at the expense of the other are unlikely to be successful.

Assess and treat co-occurring depression and physical disorders in a coordinated manner. Evidence-based models of collaborative and integrated care are an effective treatment approach for such coordination.

Issue 2: Co-occurring anxiety can complicate the course and treatment of depression

Depression and anxiety commonly occur together in older adults. About one-quarter to one-half of older adults with major depression also have an anxiety disorder. Older adults with mixed anxiety and depression often have more severe symptoms of depression, poorer social functioning, greater use of health care services, more physical health symptoms (for example, chest pain, headaches, sweating, gastrointestinal problems), and more thoughts of suicide. The presence of anxiety with depression makes treatment more difficult because there is an increased risk of missing the diagnosis of depression, a more chronic course of illness, and a greater likelihood that older adults will not respond to treatment or withdraw early from treatment.

In addition, the prescription of anti-anxiety medications known as benzodiazepines can worsen symptoms of depression and increase the risk for confusion and falls. You should periodically assess older adults for possible reduction and discontinuation of benzodiazepine medications to minimize the risk for adverse effects (for example, falls, hip fractures, impaired cognition, and depressive symptoms).

You can help reduce an older adult's anxiety and improve the likelihood of treatment success through these steps:

- Explaining adverse effects of medications and reassuring the older adult that you will be available by phone if problems occur; and
- Providing intensive followup, particularly in the early part of treatment when older adults are most likely to drop out because of anxiety-related medication intolerance.

Older adults with depression and anxiety are more likely to stay in treatment if they are seen frequently and are told that they should call with any concerns related to treatment.

Issue 3: Cognitive impairment can be a risk factor and a symptom of depression

Cognitive impairment (for example, memory loss, disorientation, or confusion) is not an inevitable part of aging. Instead, these problems may be symptoms of a possible dementia, such as Alzheimer's disease. One in 10 adults aged 65 and older and nearly half (47 percent) of adults aged 85 and older have Alzheimer's disease. The second most common cause of dementia is stroke or small blood vessel disease in the brain (also known as vascular dementia).

These cognitive impairment disorders are associated with increased rates of depression. For this reason, your assessment and treatment of depression in older people should include a formal evaluation of cognitive functioning. Common measures for evaluating cognitive functioning include the Mini-Mental State Examination and the Mini-Cog. See *Evaluating Your Program* in this KIT for more information about these measures.

Cognitive problems also can be a symptom of depression. Depression can cause impairment in memory, concentration, and executive functioning (for example, planning, organizing, and initiating purposeful behaviors). Successful treatment of depression can often reverse the cognitive problems associated with depression.

Severe cognitive impairment in an older adult can affect treatment decisions. Older adults with severe cognitive impairment may have a limited ability to benefit from some psychotherapy interventions.

Include a formal evaluation of cognitive functioning when you assess and treat depression in older adults.

Issue 4: Older adults take multiple medications. Their bodies handle the medications differently than younger bodies because of normal metabolic changes of aging

On average, older adults regularly consume two to six prescription medications and one to three over-the-counter medications. Notably, nearly two-thirds of older adults with depression receive five or more prescriptions, compared to only one-third of older adults without depression. Physical and cognitive changes associated with aging can make older adults particularly vulnerable to medication interactions and medication misuse.

Changes in body fat distribution and other physical characteristics change the way that older adults metabolize or break down medications and psychoactive substances. An important principle of treatment is to begin with low medication dosages and increase dosages slowly, as necessary. Once medications are started, it may take much longer for the medication to be eliminated from an older adult's body compared to a younger adult's body.

Several medications for physical disorders can cause, worsen, or mimic symptoms of depression. For example, some medications used to treat high blood pressure or endocrine disorders can cause depression. Side effects of some medications also can include low mood, decreased energy, poor appetite, impaired concentration, lack of interest, fatigue, agitation, and poor sleep.

Some prescribed and over-the-counter medications for common physical disorders can interact with antidepressant medications, causing serious side effects or toxicity. Side effects can include confusion, increased chance of falls, and lower functioning and can result in hospitalizations and even death. For older adults taking multiple medications, you should ask a pharmacist or prescribing practitioner to review the person's prescribed and over-the-counter medications for potential adverse drug interactions or impact on dosage levels.

The high number of medications taken by older adults also can lead to poor medication adherence and medication self-administration errors.

You can increase the safety of older adults who take multiple medications in these ways:

- Reducing the complexity of scheduling times to take medications;
- Recommending the use of medication organizers; and
- Providing educational supports.

For more information about selecting and prescribing antidepressant medications to older adults, see *Selecting Evidence-Based Practices for Depression in Older Adults* in this KIT.

Ask a pharmacist or other prescribing practitioner to review the older adult's prescribed and over-the-counter medications for potential adverse drug interactions or impact on dosage levels.

Issue 5: Small amounts of substance use can cause serious problems for older adults

Problems with either alcohol or medication misuse (overuse, underuse, and irregular use of medications) affect up to one-fifth of older adults.

Compared with younger people, older adults have an increased sensitivity to alcohol, as well as to over-the-counter and prescription medications. Metabolic and physical changes in older adults have implications for alcohol and medication use. These age-related changes can increase the circulating amount of alcohol in the body. Liver enzymes that metabolize alcohol also become less efficient with age. For some older adults, ANY alcohol use with specific over-the-counter or prescription medications can be problematic.

Because of the age-related changes in how alcohol is metabolized, and the potential interactions between medications and alcohol, alcohol use recommendations for older adults are generally lower than those for adults under age 65. The National Institute on Alcohol Abuse and Alcoholism (1995) and the Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol on older adults recommend that adults over age 65 drink no more than one standard drink per day or seven drinks per week. In addition, older adults should not consume more than two drinks on any drinking day. A standard drink is the equivalent of 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of brandy (Center for Substance Abuse Treatment, 1998).

Alcohol and medication misuse and abuse can make treatment of depression more difficult. Compared to older adults with either depression or a substance use disorder alone, those with both disorders have more serious health and social problems:

- More symptoms of anxiety and more frequent sleep disturbances;
- Worse physical health;
- Lower quality of life;
- Lower perceived social support;
- Greater use of inpatient and outpatient services; and
- Greater likelihood of thinking about or attempting suicide.

Regular use of even small amounts of alcohol, pain medications, or other psychoactive substances can cause serious problems for older adults. See *Evaluating Your Program* in this KIT for information on instruments to assess substance use in older adults.

Evaluate the older adult's use of alcohol and psychoactive substances. Treatment should address both depression and substance use problems.



Issue 6: Mental and physical functioning varies widely among older adults of the same age

Chronological age is not a good indicator of a person's physical and mental capacities. A wide range of *normal* functioning exists in the 35-year span between ages 65 and 100.

As people age, variation among age groups increases. For example, a 65-year-old person can have the mental and physical functioning of an 85-year-old and vice versa.

Treating an older adult with depression requires thinking beyond the person's chronological age and assessing his or her actual functional capacities. This includes evaluating daily abilities to care for oneself as well as social, physical, and mental functioning that can change with age.

Evaluating and addressing functioning is the key in developing treatment plans.

Evaluating and addressing functioning is the key in developing treatment plans.

Issue 7: Coordination and collaboration between mental health, aging, and general medical health practitioners is essential

Older adults often benefit from services that are provided by an array of health and social service practitioners. For instance, an older adult may receive diabetes management from a primary care practitioner, bi-weekly medical checks from a home health nurse, weekly home health aid assistance with activities of daily living, daily delivery of meals-on-wheels from an aging services practitioner, and a medication visit every 3 months for a memory-enhancing agent from a psychiatrist. For older adults with depression, another layer of complexity is added by the need to coordinate antidepressant medications or psychotherapy with the above-mentioned services.

Older adults with depression often fail to receive appropriate and effective treatment due to fragmented service delivery systems. Treatment typically occurs across discrete settings that provide either mental health, aging, or general medical health services. These settings can include primary health care clinics, long-term care facilities, and home and community-based care.

These different service systems often have different financing, organization, and delivery models with little or no collaboration among the practitioners. The complexity of receiving care from many practitioners in many settings often leads to a lack of coordinated services.

Integrated services can improve access, coordination, efficiency, and effectiveness of care for older adults with depression. This must occur across mental health, aging, or general medical health service settings and practitioners. Evidence-based models for integrating mental and physical health treatment should be used to provide effective depression treatment to older adults.

Collaboration and integration of services should occur across mental health, aging, or general medical health services to provide the most effective care for older adults with depression.

Issue 8: Engagement of family members and other social support is critical to successful treatment

Many older adults receive support and informal services from spouses, children, friends, neighbors and other people. Family involvement may be particularly important for support issues such as providing transportation, helping with activities of daily living, supporting adherence to prescribed medications, and helping to negotiate the complex system of health care and social services. Social support can help offset the risk of developing depression in older age.

Family members and other social supports are critical to successful treatment. Involve family members in assessment and treatment planning to improve the effectiveness of depression treatment, so long as it is desired by the care recipient.

When desired by the older adult, involve family members and caregivers in assessment and treatment planning.

Issue 9: Maintaining independence and aging in place are common values of older adults

A common goal for many older adults is to remain in their own homes or in supported community settings as long as possible. Maintaining independence contributes to healthy aging and acts as a deterrent for depression. For many older adults, the loss of independence associated with living in a nursing home is a major fear and concern.

Treatment of depression should support the independent community functioning goals of the older adult. In some instances, this may require a discussion with the older adult and family members about the potential risks of continuing to live alone or to live in the home when a supervised setting may be safer.

You can support the older adult in his or her desired living setting and lifestyle in these ways:

- Arranging for in-home health care, homemaker services, home-delivered meals, and access to transportation; and
- Installing medication distribution devices, electronic help alert buttons, automated phone check-ins, telemedicine monitoring devices, and mechanical assistive devices for walking and climbing stairs.

Take a preventive approach in supporting the older adult in his or her desired living setting and lifestyle.

Issue 10: Ageism and stigma affect treatment access, expectations, and outcomes

It is common to hear the statement that “depression is normal in older age.” Alternatively, one hears “if I had all those losses and physical health problems I’d be depressed, too.” These views perpetuate the lack of recognition, diagnosis, and treatment of depression in older adults.

The societal stigma placed on depression can discourage older adults from seeking treatment because they may feel ashamed, that it is their fault, or that they should be able to help themselves feel better.

Only about half of older adults with any mental health disorder receive treatment (Klap, Unroe, & Unützer, 2003). Recognizing ageism and stigma is a critical component of effective depression treatment. Important strategies for reducing ageism and stigma include the following:

- Educating the public about mental health and aging issues; and
- Educating and empowering older adults about treating their depression.

Recognizing and addressing ageism and stigma is a critical component of effective depression treatment.

Issue 11: Cultural differences can affect perceptions of depression, access to treatment, treatment preferences, and treatment outcomes

Cultural and ethnic differences affect older adults’ understanding of depression, feelings of stigma, and incentives to seek and engage in treatment.

Different racial and ethnic minority groups approach and understand treatment for depression in different ways. For example, older African-Americans often seek a remedy for depression through their spiritual communities. Older Asian Americans tend to perceive more stigma from needing or using mental health services than older Caucasian or African American adults. Asian Americans also tend to focus on physical problems, rather than emotional problems, and their use of formal mental health services is relatively low. Latino older adults may report problems with their nerves, which is an indicator of anxiety or depression in their culture, yet it is not a diagnostic symptom of depression.

Cultural expressions and understanding of depression in older adults can serve as barriers to developing and delivering effective treatment if they are not addressed by practitioners. Some ethnic groups may not readily disclose information related to depression and you may need a different approach to interact with them and encourage them to speak up. Training in cultural competency will help you deliver effective depression treatment.

Finally, EBPs for depression in older adults have typically been studied in populations that lack diversity. Very little research has included enough representation of racial and ethnic minority groups. Older adults from racial and ethnic minority groups have more health and social disparities than Caucasian older adults.

These issues, along with different perceptions of depression and treatment seeking behavior, may change the effectiveness of an EBP for older adults from racial and ethnic minority groups. However, the prevailing approach is to assume that if the EBP works for one group of older adults, it should work for another group.

Receive training in cultural competence and provide culturally appropriate care for older adults with depression.

Issue 12: Depression can be prevented

Prevention is not limited to the young. You should identify older adults who are at risk for developing depression and encourage them to participate in effective preventive interventions. Older adults who are at risk for depression include those who have been recently bereaved or who have had recent disabling physical health problems. Loss of vision, a recent stroke, or loss of the ability to walk can be associated with an increased risk for depression.

Existing programs, such as problem-solving treatment and regular exercise, can help prevent the onset of a depressive disorder in some older adults.

When appropriate, encourage older adults who are at risk for depression to participate in a program of problem-solving treatment or regular exercise.

Issue 13: Older adult depression is associated with the highest rate of suicide

Older adults with untreated depression, particularly those who are isolated and have had recent losses, are at high risk for suicide. The rate of suicide among older adults is higher than that for any other age group. The vast majority of older adults who complete suicide are males, especially white males (Miniño, Arias, Kochanek, Murphy, & Smith, 2002; National Center for Injury Prevention and Control, 2008).

Prevention of suicide in older adults is of special importance for several reasons. Older adults are less likely to report suicidal ideation compared to younger adults, and suicide attempts are more likely to be deliberate and lethal. Compared to younger adults, older adults make fewer attempts per suicide (Heisel and Duberstein, 1995).

It is common for older adults who complete suicide to visit a primary care practitioner very close to the time of suicide, yet not disclose their suicide intentions. More than half (58 percent) of older adults (over age 55) contact their primary care practitioner within 1 month of completing suicide. In contrast, only 11 percent of older adults contact a mental health practitioner within one month of completing suicide (Luoma, Martin, & Pearson, 2002). Primary care practitioners should be particularly aware of the need to identify and provide treatment to older adults with thoughts of suicide.

You should carefully assess suicide risk in older adults with depression and implement appropriate precautions and interventions. Screening for depression, psychoeducation, telephone-based support, and group-based activities can reduce the rate of suicide among older adults. Providing EBPs for treating depression can reduce thoughts of death and suicide.

You can access more information on suicide prevention strategies through the Suicide Prevention Resource Center: <http://www.sprc.org/>

Assess suicide risk in older adults with depression and implement appropriate interventions.

Issue 14: Psychotherapy can be as effective as medications

Psychotherapy for older adult depression is effective. However, adaptations and modifications may be necessary, particularly in older adults with cognitive impairment. Important modifications include repetition, breaking down tasks into smaller components, and other individually tailored changes.

Short treatment with therapies such as cognitive behavioral therapy or problem-solving treatment can be very effective for older adults with depression. For some older adults with major depression, the combination of antidepressant medication and psychotherapy is more effective than either approach alone. For older adults with minor depression, psychotherapy may be more effective than medications and is the treatment of choice.

Tailor psychotherapy interventions to address the cognitive, physical, and sensory needs of older adults (for example, repetition and breaking tasks into smaller components). Consider whether the combination of psychotherapy and antidepressant medications will be effective for the older adult.

Steps You Can Take

- Assess and treat co-occurring depression and physical disorders in a coordinated and integrated manner.
- Offer more frequent practitioner appointments and contact to older adults with co-occurring depression and anxiety.
- Include a formal evaluation of cognitive functioning when you assess and treat depression in older adults.
- Ask a pharmacist or other prescribing practitioner to review the older adult's prescribed and over-the-counter medications for potential adverse drug interactions or impact on dosage levels.
- Evaluate the older adult's use of alcohol and psychoactive substances. Treatment should address both depression and substance use problems.
- Evaluate and address functioning, which is key in developing treatment plans.
- Ensure that collaboration and integration of services occur across mental health, aging, or general medical health services to provide the most effective care for older adults with depression.
- When desired by the older adult, involve family members and caregivers in assessment and treatment planning.
- Take a preventive approach in supporting the older adult in his or her desired living setting and lifestyle.
- Recognize and address issues of ageism and stigma.
- Receive training in cultural competence and provide culturally appropriate care for older adults with depression.
- When appropriate, encourage older adults who are at risk for depression to participate in a program of problem-solving treatment or regular exercise.
- Assess suicide risk in older adults with depression and implement appropriate interventions.
- Tailor psychotherapy interventions to address the cognitive, physical, and sensory needs of older adults. Consider whether the combination of psychotherapy and antidepressant medications will be effective for the older adult.

Evaluating Care

You can use outcome data to provide feedback to older adults. This information can be useful in discussions about the effectiveness of treatment and whether treatment goals are being met.

Monitoring the symptoms of depression in your older adults will help you determine the effectiveness of treatment. If the symptoms of depression do not improve after an appropriate course of treatment, it may be time to change your approach and reconsider other treatment options.

For helpful ideas for collecting and evaluating data, see *Evaluating Your Program* in this KIT.

Implementing EBPs

Implementing an EBP can help improve the care that your organization provides to older adults. You have an important role in creating these system changes and helping to develop plans for providing a new EBP. You can support the implementation of a new program in these ways:

- Identifying the characteristics of the older adults you serve and what services are needed;
- Providing recommendations to supervisors or program administrators;
- Participating in an implementation task force or advisory board;
- Receiving training, supervision, and ongoing coaching in the new practice; and
- Using data to monitor and provide feedback on the effectiveness of the program.

Identify characteristics of your older adults and what services are needed

Several characteristics of older adults affect the delivery and effectiveness of programs to treat depression. Gender, age, ethnicity, and health status can influence health beliefs and behaviors and affect how older adults access and respond to depression care.

You can be particularly helpful in identifying the gaps in agency services for older adults with depression by taking these steps:

- Identifying priority problem areas for your older adult population;
- Identifying what existing services can address these identified areas; and
- Identifying new programs that may fill remaining gaps in the services that your agency provides.

For suggestions on how to match EBPs with the characteristics of your older adult population and your organization, see *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults* in this KIT.

Provide recommendations to supervisors or program administrators

After you have identified a program that may be beneficial to your organization and the older adults you care for, you may wish to begin discussions with your supervisor or program administrator.

Be prepared to describe the following:

- The characteristics of the program;
- The areas that the program could improve;
- The fit between the program and the mission of your organization;
- The resources necessary to implement the program; and
- The evidence supporting the new program.

This KIT provides some of this information in the booklet on *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults*.

Participate in an advisory board

Most organizations that choose to implement a new practice will develop an advisory board or an implementation task force. An advisory board may include practitioners, agency and program administrators, older adults and their family members or caregivers, community members, and other important stakeholders.

If your agency develops an advisory board, you can offer to participate. The advisory board can help guide how the EBP fits with the culture of the organization and can identify what changes the organization can make to adopt the new practice.

Receive training, supervision, and ongoing coaching in the new practice

You should expect to receive training, supervision, and ongoing coaching to ensure that you provide the EBP in the correct manner. You also should receive support for training in aging and geriatrics.

Training is essential to successfully implement any EBP. Most practitioners are introduced to the knowledge and skills needed to incorporate EBPs into their own work with older adults through preservice training, inservice training, and other continuing education.

Helpful learning methods include the following:

- Participating in case conferences;
- Modeling of interventions by a trainer or consultant; and
- Job shadowing at model sites.

The most valuable trainings include a demonstration of skills necessary for carrying out an intervention, immediately followed by an opportunity to practice skills and receive feedback.

Skill-based training may be of particular importance if you are new to working with older adults. A lack of training or experience working with older adults can interfere with your ability to communicate or work effectively with this population.

The importance of training practitioners to care for older adults, especially those with depression, was listed as a priority by the White House Conference on Aging (2005). In addition to specific skills needed to implement EBPs, practitioners who care for older adults need training in these key areas:

- Addressing issues that are common or unique to older adults and
- Recognizing, assessing, and treating depression in older adults.

Agency training

At least some portion of your training in the new EBP will be provided by the agency for which you work. Agency training often includes instructions for incorporating the new practice into existing work activities and organizational practices.

Sometimes agencies will send one of their practitioners to receive training in the new EBP. However, simply attending a single workshop is not adequate for mastering an EBP. Practicing the EBP through roleplaying, experience-based learning, and ongoing supervision is critical. Once the EBP is mastered, trained practitioners can then train their colleagues.

Supervisor or coach support

Ideally, training will be accompanied by set-aside time for ongoing supervision from trained practitioners within the agency.

Ongoing supervision and coaching will help you develop and maintain newly learned skills. Once the initial training is completed, you should have routine and ongoing feedback to ensure that the specific EBP is delivered with fidelity. Retraining exercises can reinforce your behaviors and correct problems that result from misinterpretation or poor application of programs. Coaching helps incorporate formal learning with clinical expertise in ways that will help you see how new skills apply to your individual practice.

Accessing training manuals and technical assistance

The availability of training resources varies for the different EBPs for depression in older adults. Some programs offer comprehensive training resources. Some provide manuals for how to deliver the intervention. Other programs may offer no support for training practitioners.

For a description of available training resources and program manuals, see *Selecting Evidence-Based Practices for Treatment of Depression in Older Adults* in this KIT.

Use data to monitor and provide feedback on the effectiveness of the program

You have an important role in assessing both the effectiveness of the implementation process and the effectiveness of the EBP for the older adult.

Data collected over several time points will help you provide feedback and identify the strengths and weaknesses of a program. Evaluations of process and outcome measures can help you monitor the effectiveness of program implementation.

One of the most important reasons that health care organizations support using EBPs for older adults with depression is that these treatments reduce symptoms of depression. This means that, if the EBP is implemented correctly, it should result in fewer symptoms of depression among older adults who receive the treatment.

Sometimes you can use specific process measures called *fidelity instruments* to evaluate whether you are providing the program in a way that is consistent with the core features of the EBP. When fidelity instruments are not available, you can answer other questions to assess the quality of implementation.

By monitoring standardized outcome measures, you can determine an older adult's progress toward desired treatment outcomes. You may already be using standardized outcome measures. If not, you may need support from your supervisor or agency administrators and assistance from your quality assurance or information technology teams to institute these measures.

By continuously monitoring the effectiveness of an EBP for older adults, you can assess how well the EBP has been implemented. If outcome monitoring does not show improvements among older adults who receive the treatment, this may be a sign that the EBP is not fully or appropriately implemented, or that the selected intervention was inappropriate for the older adult. When aggregated, these data can indicate whether there are issues at the program level related to EBP implementation.

If you recognize problems with implementation, you should work with your colleagues, supervisor, coach, and administrators to evaluate the components of the program and determine where improvements are needed.

For helpful ideas for collecting and evaluating data, see *Evaluating Your Program* in this KIT.



Steps You Can Take

- Know the characteristics of older adults who receive treatment at your health care setting or organization and identify common problem areas that they wish to address.
- Identify existing resources that address problem areas.
- Identify additional programs or resources that are needed to address these areas.
- Recommend adopting a specific EBP to your supervisor or program administrator.
- Help guide the process of implementing an EBP by participating on an advisory board.
- Work with agency administrators and program leaders to develop the needed supports for EBP implementation.
- Learn new skills to provide effective depression treatment to older adults.
- Monitor process and outcome measures to evaluate the effectiveness of implementation and treatment.

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