Meeting Mental Health Needs of Older Adults with Depression: A Resource Guide for Older Adults and Caregivers

by

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Introduction

Depression is the most common emotional disorder of advanced age (Blazer, 1989; Phifer & Murrell, 1986). Its effects can be devastating for older adults as well as for those who care for them. Unfortunately, depression in elderly people is often masked by co-existing medical conditions and/or other stressful life events, making it difficult to detect and treat. In addition, access to mental health services is often a problem for the elderly (Gatz, 1995). A number of barriers have combined to create this problem, including (a) social, cultural, economic, and psychological issues that impact on the use and delivery of services and (b) fragmented and uncoordinated mental health systems and policies for the aged.

Most older adults are healthy, active, independent, and well-integrated in their families and communities. Equating an older population with a "service-needy" group reinforces ageist stereotypes of incompetence and dependency. In fact, studies of the normal aging process have found that later life presents the possibility of growth as well as decline (Baltes, 1987, 1997). Many abilities, once thought to undergo significant decline in adult years (such as some dimensions of memory and intelligence), have been found to be stable or even to improve in some individuals until the 60s and 70s (Schaie, 1995). Depression and other serious illnesses affect only a small minority of the older population and are not intrinsic aspects of the aging process. Nevertheless, as the population ages (particularly with the fast-growing category of persons aged 85 and over, who are the most frail) and as the traditional source of family support dwindles due to smaller family size and increased female labour force participation, there will be a growing need for services by the aged.

Purpose of the Project

The focus of this project was to develop a resource guide, titled, "Understanding Depression: A Resource Guide for Older Adults and Caregivers." (See Appendix B for both the booklet version and the brochure version). The content of the resource guide was based on a review of current literature on depression , and then "field-tested" by service providers in Thunder Bay (e.g. nurse, social worker, psychologist, support service coordinator) to ensure that the content was appropriate and by seniors and caregivers to ensure that it is useful (See Appendix A for a listing of collaborators involved in the review). The resource guide was intended to provide Thunder Bay seniors and caregivers with valuable, accurate information about depression and how it is treated. A self-administrated screening tool enables seniors and caregivers to determine if they are at risk for depression and where they can go for help. By raising the awareness of depression and dispelling myths about aging (e.g. depression is often accepted as a natural part of aging), the resource guide served to assure seniors and caregivers that they are not alone if depressed; it is not their fault to be depressed; and depression can be treated.

Importance of the Project

Demographic Factors

By all accounts, Canada has an aging population. At the beginning of this century, less than 6% of the Canadian population were aged 65 and over. Today, almost 12% fall into this category. This proportion will rise to almost 25% by 2031 (Marshall & McPherson, 1994). Another important trend is that growth in the very advanced ages (80 and over) is happening at a greater rate than among younger old people (ages 65 to 79). This will change after 2010,

however, when the first group of baby boomers start to enter the age 65 category. By 2031, about one in twenty Canadians will be aged 85 or older. Among this aging population, depression has been deemed the most common psychiatric disorder (Blazer, 1989; Blazer, 1993). Estimates of rates of depression among the elderly vary considerably, however, depending on the definition of depression, method of assessment, and particular sample selected. For example, the National (U.S.) Institute of Mental Health Epidemiologic Catchment Area (ECA) study (Myers et al., 1984; Regier et al., 1988), carried out in New Haven, Baltimore, and St. Louis, estimated the prevalence of depression in community-dwelling elderly to be approximately 0.8% to 1%, based upon DSM-III criteria for Major Depressive Disorder (MDD) using the Diagnostic Interview Schedule. In the same ECA study, if one included bereavement and dysthymia as depression diagnoses (as opposed to MDD alone), prevalence rates doubled, using the same sample (Myers et al., 1984). In contrast, self-reported, questionnaire-based ratings of symptomatic depression suggest higher prevalence rates, as high as 15% to 20% in community samples (Blazer, Hughes, & George, 1987). While most of these epidemiologic studies have been completed in the United States, a recent Canadian study suggests that the rate of depression in a community sample of older persons exceeds 11% (Newman, Bland, & Orn, 1998). Furthermore, serious depressive symptoms occur in an additional 15% of community-dwelling elderly, and rates of depression are as high as 50% in nursing home residents (Canadian Association on Gerontology, 1999).

Using these rates of depression (as low as 0.8%, to, as high as 20%) and based upon the 65+ population of 17,725 in Thunder Bay (Northwestern Ontario District Health Council, 1999), one can project that there are anywhere from 142 to 3,545 seniors in the city suffering from some form of depression at any given time. However, with the severe shortage of family physicians in

Thunder Bay where 20 additional family doctors are currently needed (Chronicle Journal [on line]), one would expect that many older adults are without access to proper health care in Thunder Bay. In the meantime, a regional mental health committee report (MH/LTC Interface Working Group, 1997) suggests that seniors are under-represented in the use of community mental health programs. In fact, less than 5% of the clients in the community mental health programs are aged 65+; whereas, individuals aged 65 and over account for 12.5% of the total Northwestern Ontario population. The low rate of use of community mental programs and the lack of access to family physicians suggest that many seniors, who suffer from depression and other serious and chronic illnesses, are not being served in the community. The situation may become even worse when the Lakehead Psychiatric Hospital is closed in Thunder Bay.

In response, the resource guide facilitated early detection of depression by dispelling the misconceptions about depression and providing seniors and caregivers with information about its symptoms and treatments. Furthermore, the resource guide facilitated the linking of seniors with community resources by listing the Community Care Access Centre (CCAC) as the central contact number in the resource guide. As a single access point for services for seniors, the CCAC has received a provincial mandate to coordinate medical, social, and support services for seniors living in the community. This role is particularly important for seniors who do not have access to family doctors or who may be too frail to obtain resources on their own. When a senior contacts the CCAC for help, he/she will be connected to a CCAC Care Coordinator (who is either a trained nurse or a social worker with extensive medical experiences), who will assess the situation and coordinate appropriate medical, social, and support services for the individual. The care coordinator will follow up with the senior to ensure that he/she receives the help needed.

Efficacy of Treatment for Depression

In the past decade, significant progress has been made in understanding the diagnosis and treatment for depression in later life. Safe and effective treatments for depression are available (e.g. improved pharmacotherapy with minimum side effects, psychosocial treatments, electroconvulsive therapy) (Cappeliez, 1993; Fielden, 1992; Zarit & Zarit, 1998). However, a significant proportion of elderly people with depression remain unrecognized and untreated due to a combination of factors (e.g. the unavailability and inaccessibility of services, pessimistic attitudes about the elderly's ability to make progress, unfamiliarity with effective treatments or preventive interventions, and the perceived stigma of depression by the elderly and their families) (Birren, Sloane, & Cohen, 1992).

The failure to recognize and treat depression in elderly people has resulted in many seniors living their final years in despair and suffering without the appreciation of their affliction or the understanding and comfort of those close to them. Depression may trigger a shift from home to a nursing facility or may cause longer hospital stays and exacerbate physical illness. In short, untreated depression can cause suffering to many people who might otherwise find joy in their old age; it also burdens families and institutions caring for those who are needlessly debilitated (Berkman et al., 1986; Mossey, Knott, & Craik, 1990). In addition, problems of depression can place an enormous financial burden on the resources of society (Rice & Miller, 1995). Finally, death by depression-related suicide is a significant risk for older people; the two foremost risk factors for suicide in the elderly are physical illness and depression, typically in combination (Conwell, 1994; Conwell, Duberstein, & Herrmann, 1996). From 1980 to 1992, the suicide rate rose by 9% among those 65 and over and by 35% among those aged 80 to 84 (NAMI

[on line]). In 1996, the suicide rate among "oldest old", white, males (aged 85 and over) was 65.3 per 100,000, six times the rate of the general population (10.8 per 100,000) (NIMH [on line]).

Diagnoses of Depression

According to the DSM-IV (American Psychiatric Association, 1994), the essential diagnostic criteria for a Major Depressive Episode are specified as follows:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day

(3) significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt nearly every day

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day

(9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (p. 327)

One problematic feature of the diagnostic criteria as set out in the DSM-IV is its inclusionary and exclusionary criteria (Gallagher, 1986; Newmann, 1989). For example, only those symptoms that interfere with daily functioning (those causing significant impairments in occupational and other social role performance) are included in a diagnosis. Since older persons generally assume fewer significant occupational and social roles than do younger adults (thereby experiencing fewer dramatic role functioning changes in response to depressive symptoms), this inclusionary rule would make it less likely for an older adult to be diagnosed as depressed. Exclusionary rules require ruling out physical illness, medication, or bereavement as a cause for the depressive symptom. For example, sleep disturbance, appetite loss, and fatigue are excluded as symptoms of depression if there is reason to believe that these symptoms are associated with medications or other medical illnesses. These exclusionary criteria may lead to not diagnosing depression in elderly individuals who experience a depressive response to a debilitating physical illness or following the death of a loved one.

Another problematic feature of the clinical diagnostic criteria in the DSM is the required presence of a dysphoric mood as a necessary condition for a diagnosis of depression disorder (Newmann, 1989). However, there is evidence that elderly depressed people demonstrate a different pattern of symptoms than younger adults who are depressed. For example, Newmann, Engel, & Jensen (1991), in their study of 368 depressed women, between the ages of 51 and 92, have found that the older age cohort suffer more from "the depletion syndrom", which includes "feelings of worthlessness, feeling no interest in things, experiencing a loss of appetite and a general sense of hopelessness, along with thoughts of death or dying. Thus, it differs from a more general and classic depressive syndrome in that symptoms of dysphoric mood, along with feelings of self-blame, are much less prominent in the [elderly] clinical picture." (P. 232) Similarly, Blazer (1993) has argued that dysphoric mood may be a much less central component of depression in elderly persons than vegetative or psychophysiological symptoms, and that minor depression (often referred to as "masked depression"), which does not meet the threshold for major depression or dysthymia, is debilitating nevertheless.

Relevancy to Local Community

A report, prepared by the Regional Mental Health Committee (MH/LTC Interface Working Group Report, 1997), identified that mental illnesses not being detected in older persons is a major problem in the local community. However, no specific recommendations were made to address the issue. The resource guide was developed in response to this local need so that older adults and caregivers can educate themselves about depression, identify their risks for the illness, and take actions to seek appropriate assistance. In another regional survey of 1,502 long-term care providers and elderly care recipients, it was found that printed media (e.g.

pamphlets and brochures) are a major source of educational information for most care providers in the region. In particular, family caregivers and seniors are more likely to use printed media than high-technology equipment (e.g. computers, VCR's, or tape players) as a major source of information due to unfamiliarity with, or lacking access to, the equipment (Kelley et al., 1997). Thus, the current resource guide will serve as an educational tool, through which seniors and caregivers in the community are provided with some "fact sheets" about depression, a short depression self-screening tool, as well as pertinent information and resources to facilitate the early diagnosis and treatment of late-life depression.

Literature Review

Physical Illness and Late Life Depression

Research has demonstrated an association between physical illness, pain, and depression in both young and old people (Katon & Sullivan, 1990) and in outpatient and institutionalized samples of elderly people(Berkman et al, 1986; Parmelee, Katz, & Lawton, 1991; Williamson & Schutz, 1992). Increased severity of illness and pain have been found to be related to the severity of depression (Chochinov et al., 1994; Parmelee, Katz, & Lawton, 1991). For example, prevalence of depression among older persons receiving outpatient care for medical illness has been estimated at 6-9% using the DSM-III criteria for major depressive disorder (Katon & Sullivan, 1990). Among older adults living in residential care facilities due to chronic diseases or disabilities, Parmelee, Katz, and Lawton (1989, 1992) estimated the prevalence of MDD alone to be approximately 15%, with incidence rates increasing over the course of one year. If one includes the clinical depressive symptoms that do not meet the diagnosis of MDD, prevalence estimates are above 20% (Futterman et al., 1995).

Although physical illness and pain are more common in older adults (Katon & Sullivan, 1990), it is not necessarily true that older adults become depressed more often than young adults when confronted with illness. Koenig et al. (1991) examined depressive disorders in young (20-39 years) and old (70-102 years), physically ill, hospitalized men. Major depressive disorder was diagnosed in 22% of the young and only 13% of older patients; minor depression was diagnosed in 18% of the young and 29% of the older patients. While major depressive disorder was also associated with more severe symptoms in the younger men, both groups reported similar patterns of symptoms of prolonged duration. These findings suggest that illness and pain may have similar effects on depression in both young and old, and that medically ill older adults may be no more vulnerable to depression. Additional research to study the relationship between physical illness and depression in older age will shed more light on this issue.

Diagnostic issues.

The longer one lives, the greater the likelihood that medical conditions will develop. For example, while 3% of the people under 45 years of age develop arthritis, 48.4% of those over 65 are afflicted with arthritis (Zisook, & Downs, 1998). Consequently, depressive symptoms in the elderly often will occur in the context of one or more medical conditions. This overlap of depression and medical illnesses constitutes a major diagnostic challenge. Depressed people often report somatic complaints such as disturbed sleep, poor appetite, and fatigue, which may be confounded with symptoms resulting from medical illnesses. In a younger patient with few medical problems, it is easier to establish that these complaints are part of the depressive disorder. The situation is more ambiguous among older people who suffer from a number of health problems which are often chronic in nature. Thus, Koenig and Blazer (1992) distinguish

three patterns of comorbidity in the elderly (1) depression of a psychosocial nature secondary to medical illnesses or disabilities (reactive depression or situational depression), (2) depression that presents with physical symptoms (this is often referred to as masked depression whereby an elderly person with depression will complain of somatic complaints such as difficulty sleeping, loss of energy and appetite, while completely denying a depressed mood), and (3) depression resulting from physical illnesses or medications (depression as a result of physiological or metabolic changes in the body, induced by diseases or drugs). In short, the high probability of symptom overlapping, between depression and medical conditions, often makes the proper diagnosis of depression in the elderly a challenging task.

Gender and Late Life Depression

Major Depressive Disorder appears to be twice as prevalent in women throughout adulthood and old age (Nolen-Hoeksema, 1987). In the elderly, the economic hardships faced by women are augmented by the fact they live seven years longer than men and are much more likely to be widowed, to live alone, to be institutionalized, and to receive lower incomes (Brotman, 1998; Goldstein & Perkins, 1993). For example, in 1981, approximately 31% of Canadian women aged 65 and over lived at or below the poverty line, comparing with 19% for men aged 65 and over. However, women who live in families, especially in families with a male household head, do not have a high poverty rate; it is the unattached elderly persons who are most likely to be poor. Over 60% of unattached women aged 65 and over subsisted at or below the poverty line in 1982. The figure for unattached elderly men is high as well (48.9%), but there are nearly four times more unattached elderly women than men. These unattached elderly women are mostly widows, and their likelihood of being poor increases with advanced age: in

1981, 65% of unattached women aged 70 and over were poor (National Council of Welfare, 1984). While improvements in the last 15 years in the income status of elderly people in Canada have lowered poverty rates for both senior men and women, older women continue to face a higher risk to be poor than older men.

Umberson, Wortman, and Kessler (1992) suggest that widowhood differentially impacts men and women and that the resulting change in financial status is the primary determinant of depression in widows. However, recent studies suggest that gender differences are diminishing or may not exist in older age (Brown, Milburn, & Gary, 1992; Blazer, 1993). The reduced disparity in rates of depression has been attributed to similar risk factors for elderly men and women (e.g. reduced demands of family on women; loss of meaningful roles following retirement for men).

Social Support and Late Life Depression

Much research has focused on social support and its positive impact on both physical and mental health among the elderly in encountering a broad range of common acute and chronic stressors, such as health problems or caregiving (Antonucci, 1990). Caregiver literature, for instance, suggests that, while informal support from families and friends is a major deterrent from premature institutionalization for the frail elderly, the provision of such support can often lead to emotional stress, social isolation, physical exhaustion or illness for caregivers (Aronson, 1994; Ross, Rosenthal, & Dawson, 1997). In a Canadian national study of health and aging (CSHA, 1994), it is estimated that 72% of informal caregivers, caring for demented seniors living in the community, are women, and that 34% of informal caregivers are 70 years of age and over. In addition, among these informal caregivers, over one quarter (25.9%) suffer from significant

depressive symptoms (CSHA, 1994). Although research has begun to focus on the dynamic links between stress, support, coping, and mental health (Thompson et al., 1993), much research remains to be done in this area.

In summary, the incidence and prevalence of depression vary broadly due to subgroup variations among the elderly population (e.g. gender, physical illness, widowhood, poverty, caregiving demands). Continued research on the interplay of these variables in connection to aging will not only present a better understanding of the relationship between aging and depression but also assist in the prevention and treatment of depression in later life.

Patterns of Mental Health Service Utilization by the Elderly

Although the overall number of older adults is increasing, their use of mental health services is much lower than their proportion in the general population. For example, the percentage of visits by older people to community mental health centres (CMHCs) in the United States has remained constant at 6% from 1981 to 1985; at the same time, resources invested in services for the elderly in some CMHCs are as low as 0% and, in 1985, 45% of CMHCs had no specialized services for the elderly (Speer et al., 1991). However, underutilization or underserving of older adults is neither universal nor inevitable. Lebowitz and his colleagues (1987) suggest that CMHCs, that provide specialized services and staff for the elderly and that have cooperative affiliations with local agencies on aging, have higher proportions of older adults in their caseloads. On the other hand, however, Goldstrom et al. (1987) have demonstrated that even when specialized geriatric mental health services and staff are present, the elderly still utilize mental health services at lower rates than younger adults. Three themes are frequently mentioned as sources of older adult resistance to the use of mental health services: (1) the stigma

of mental illness among older adults, (2) the acceptance by the elderly of societal stereotypes about aging in which problems in living are viewed as normal and irreversible results of aging, and (3) the sheer self-reliance ethics of society (NAMI [on line]).

Primary care.

Older adults who seek care for mental health problems are likely to do so outside the mental health sector. Burns and Taube (1990) (cited in Estes, 1995) report that only 56% of the service for the elderly for mental disorders is provided through the mental health sector; 44% is provided in the general health sector. This situation is due, in part, to the comorbidity of physical and mental illness in late life and the fact that many elderly will not consult a professional unless physical manifestations are present (Swan & McCall, 1987). These utilization patterns may have serious implications for older adults: the majority of the elderly who seek care from the general health sector will see family physicians, who typically do not refer patients with mental disorders to mental health professionals. Schurman, Kramer, and Mitchell (1985), for example, report that non-psychiatrist physicians refer only 5% of older patients with psychiatric disorders to psychiatrists; whereas, younger adults with psychiatric illnesses have a 40% chance of being referred to mental health specialists. Many primary care physicians also spend less time with their older patients than their younger patients (Keeler et al., 1982). A report from the National Alliance for the Mentally Ill (NAMI [on line]) indicates that, from 1980 to 1992, the suicide death rate among persons age 65 and over increased 9%. Most striking was a 35% rise in suicide rates for men and women age 80 to 84. The suicide rate among white, "oldest old" males (80 to 84) is six times the rate of the general population. Up to 75% of elderly suicide victims visited their primary care physician within the last month of life; nearly 40% saw their doctors within the

week of committing suicide (Conwell, 1994). However, their depressions were rarely recognized and treated.

Nursing homes.

Burns et al. (1993) found mental illness among elderly nursing home residents at the rate of 66%; however, only about 4.5% received any mental health treatment in a given month. When they did receive treatment, it was likely to be psychotropic medication, which was most often prescribed by general practioners. Few nursing homes employ either mental health professionals or general medical physicians trained to treat mental illness.

In summary, a significant proportion of older adults with mental illness remain undiagnosed and untreated. Even when treatment is rendered, it is highly likely to be offered by general medical practioners rather than mental health professionals. In addition, in contrast to community-based treatment, older adults are more likely to access medical care facilities than community mental health centers. This is, in part, due to the coexistence of physical and mental illness in late life and reflects the fact that many elderly will not consult a professional unless physical symptoms are present. Finally, although nursing homes are a major destination for the mentally ill elderly, most of the services center on medically-based needs rather than mental health needs.

Barriers in Mental Health Services for the Elderly

Ageism, coined by R. N. Butler (1989), is defined as "a systematic stereotyping of and discrimination against people because they are old" (p.139). Attitudes towards aging, in the media and among professional health care providers and older people themselves, have deterred mental health service delivery and use. The concept of being "too old" to benefit from service or

being "that way" because it is a normal part of aging creates a major barrier to service. The fact that the suicide rate for older people is the highest of any age group suggests that this group is substantially under-served.

Unfortunately, the medical profession and other health care professionals are not immune to negative stereotypes about older people. Research indicates that physicians are less responsive to the concerns of older patients; and that they are more respectful, patient, and engaged with younger patients (Greene, Adelman, Charon, & Hoffman, 1986, cited in Wilcox, 1992). Doctors may question why they should even bother treating certain problems of the aged; after all, the patients are old, and their problems are irreversible, unexciting, and potentially less likely to be resolved than those of the younger patient. In addition, the negative bias regarding the benefits that elderly people can derive from psychotherapy is shared by the general public and by clinicians themselves (Zivian et al., 1992, 1994). The ageist attitudes toward older patients is, in part, reflected in that fewer medical school graduates enter Geriatric Medicine (Perrotta et al.,1981, cited in Wilcox, 1992).

Age-related assessment bias.

Unintended assessment bias may also be associated with aging. Using an audiotape of a depressed individual, identified as either middle-aged or elderly, Perlick and Atkins (1984) found that clinical psychologists were more likely to attribute symptoms of depression to organic causes (i.e. dementia); also, there were fewer diagnoses of depression when the patient was described as elderly as opposed to middle-aged. More recently, Wilcox (1992) failed to find an age bias on eighty-eight advanced medical students' responses to an audiotape of a patient with medical complaints and depression. However, in the study of 209 licenced clinical psychologists,

randomly-selected from the membership directory of the Michigan Psychological Association, who read a case vignette of a depressed patient, Wrobel (1993) found that the tendency for an organic diagnosis was more likely as the patient's age increased. Conversely, diagnoses of depression were most likely to be identified in the 45-year-old patient. Similarly, the elderly patient was less likely to be prescribed chemotherapy and/or cognitive-behavioral therapy than the younger patient, and the prognosis for therapy in the elderly was viewed as poorer in comparison to that of the young (Mackenzie, Gekoski, & Knox, 1999; Wrobel, 1993).

Stigma toward mental health services.

Older adults are often more reluctant than younger persons to seek help to deal with psychological difficulties. One reason for this reluctance may be that adults currently over 65 were not socialized to regard confiding with mental health processionals as legitimate coping strategies (Felton and Revenson, 1987). In addition, today's seniors were brought up in an era in which reliance on government services and mental illness were viewed as social stigmas and signs of personal weakness. It is not surprising, therefore, that findings released by the National (Canadian) Advisory Council on Aging, based upon a national sample of 800 seniors and service-providers, indicate that self-reliant strategies were cited as the most frequently used coping strategy in dealing with both physical health problems and emotional/mental problems (National Advisory Council on Aging, 1989; 1990). Furthermore, with respect to physical problems, these self-reliant actions were directed towards solving or mitigating the problem; whereas, in the case of emotional/mental difficulties, the strategies were often intended to alleviate distress (e.g. accept the situation as an inevitable consequence of aging).

Inadequate coordinated, community-based, mental health services for the elderly.

Existing systems that provide support to older adults are not efficient in addressing the mental health needs of older adults. There is an over-reliance on custodial care in nursing homes and long-term care facilities; not enough resources are dedicated to treating the mental health problems of the elderly. Even with the advanced knowledge of the efficacy of treatment (particularly depression) and the evidence of comorbidity of mental illness and physical illness, mental health problems of nursing home residents have been largely ignored.

For those seniors living in the community who are in need of community mental health care, current systems are a far cry from the ideal. For example, the present mental health system (e.g. Canadian Mental Health Association) focuses on the seriously and persistently mentally ill younger person and has limited provision of services for the elderly who are not frequent users of the mental health system. On the other hand, the aging service delivery agencies (e.g. Alzheimer Society) are often reluctant to associate with mental health service networks. Neither the mental health system nor the aging service delivery system has made significant attempts to serve the at-risk older individuals living in the community. In addition, there is an assumption from both the aging and mental health systems that the elderly will self-refer and seek mental health care. This assumption is unrealistic for many elderly, especially those who are frail and isolated. Thus, the resource guide served to promote awareness among service providers (such as homemakers and meals-on-wheels volunteers), so that they can recognize depression in their elderly clients and know where to obtain help for them. The resource guide will be revised regularly by the Northern Education Centre for Aging and Health to ensure that information is up-to-date, and it will be available to community service providers for a nominal fee.

Summary

Mental illness in late life is a serious public health concern. What makes mental illness in the elderly so insidious is that ageist attitudes and stigma often cause the family and health care professionals to accept depression as the normal reaction to the aging process, an attitude often shared by the elderly themselves. This is compounded by the fact that mental disorders commonly coexist with physical illnesses, making differential diagnoses particularly challenging. In addition, from the standpoint of service delivery and availability, the lack of integrated, coordinated, and community-based services often makes it difficult for seniors at risk of mental illness to access services in the community.

A number of strategies may be implemented to improve the mental health service use and delivery for the elderly suffering from depression. For example, policies can be advocated to ensure that adequate resources be directed to mental health screening and treatment in primary care facilities, nursing homes, and in the community. Community mental health systems and aging delivery systems can better coordinate their services to serve the needs of seniors. Gerontological training may be provided to health care professionals, formal and informal care providers, and seniors. Finally, positive aging may be promoted to dispel ageism, while ensuring that older adults and their caregivers are equipped with up-to-date knowledge and resources to access assistance when necessary. The resource guide “Understanding Depression” represents one such intervention strategy: dispelling misinformation about depression in later life, providing a self-administered screening tool, and listing useful community resources for seniors and/or their families.

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Appendix A: Collaborators

The resource guide was developed in collaboration with the Caregivers Support Committee, which include the following member agencies.

	Name	Agency
•	Joan Klemacki	Family Can
•	Fran Adderley	Alzheimer Day Centre
•	Liz Krupa	Central Park Lodge
•	Donna Russell	Community Care Access Centre of the District of Thunder Bay
•	Marie Klassen/ Prue Morton	Community Information and Referral Centre Patients Rights
•	Sandy Isfield	Northwestern Ontario District Health Council
•	Ethyleen Porter-Brysch	Thunder Bay District Health Unit
•	Mirja Hintta	Lakehead Psychiatric Hospital
•	Elizabeth Pim	Meals on Wheels
•	Ruth Wilford	Northern Education Centre for Aging and Health
•	Darlene Harrison	St. Joseph's Care Group
•	Kathy Gibson	Thunder Bay 55+ Centre
•	Lori Ksonzyna	Thunder Bay Regional Hospital
•	Carol Neff	Wesway Inc.
•	Tracy Puurunen	Alzheimer Society
•	Heather Nelson-Clayton	Northwestern Ontario Regional Cancer Centre
•	Joan Williams	Via Vitae

Appendix A (continued):

Also, a number of seniors and caregivers contributed to the final revision of this resource guide. Among them, Ms. Marge Wallington, has kindly agreed to be acknowledged in this manuscript.

In addition, the resource guide was distributed to approximately 15 participants who attended a presentation I made at the Forum for Interdisciplinary Gerontology, NECAH, Lakehead University, September 29, 2000. Participants included social workers, psychologists, educators, seniors, gerontology students, etc. Their feedback and comments were incorporated in the final draft of the resource guide as well.

Appendix B:
Resource Guide (Booklet & Brochure)

A Checklist to Identify Depression

Please answer the following questions to determine if you or someone you know is at risk for depression.

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

Count one point if you answered the following:

1. No	2. Yes	3. Yes	4. Yes	5. No
6. Yes	7. No	8. Yes	9. Yes	10. Yes
11. No	12. Yes	13. No	14. Yes	15. Yes

Geriatric Depression Scale (Sheikh & Yesavage, 1986)

If your score is higher than 5, you may be depressed. **Please contact your family doctor – Take this paper with you. Or, call the Community Care Access Centre and a Care Coordinator will help you to obtain the help you need.**

Older Adults…

Are you feeling constantly tired, sad, or empty?

Are you worried, tense, and irritable?

Are you having trouble sleeping or eating?

It could be depression.

For more information on services and programs available in Thunder Bay and District,

please call:

Community Care Access Centre
(807) 345-7339 or 1-800-626-5406

Developed by NECAH, Lakehead University, (807) 343-2126

What is Depression?

Depression is a whole body illness that can have a devastating effect on all aspects of your life. Sadness and grief are normal reactions to life's stresses and losses. Feeling "the blues" sometimes is natural. Depression is different. It is far more severe and long lasting than the ordinary "down" moods one may experience now and then. Depression is often mistakenly accepted as a natural consequence of aging. Without early detection and treatment, the symptoms of depression may last for months or years.

What Causes Depression?

No clear answer has been found regarding what causes depression. Depression may be related to abnormal brain chemistry or to genetic factors. It may occur with other illnesses or follow a reaction to specific medications, including over-the-counter remedies. Losing a loved one, having money problems, moving to a new place, and caring for a frail family member can lead to depression for some people. The most important thing to remember is that there is help even if you don't know why you are depressed or think you have no reason to be depressed.

If you feel depressed,

you are not alone.

What are the Symptoms of Depression?

If you have, or someone you know has, experienced five or more of the following signs of depression for two weeks or more, a physical and/or a psychological evaluation should be considered.

- ✓ Persistent sadness or anxiety
- ✓ Loss of interest in usual activities
- ✓ Withdrawal from formerly pleasurable activities and /or relationships
- ✓ Decreased energy, fatigue
- ✓ Sleep problems (inability to sleep, oversleeping, early-morning waking)
- ✓ Eating problems (loss of appetite or weight, or weight gain)
- ✓ Memory loss, confusion, or difficulty concentrating
- ✓ Feelings of hopelessness/pessimism
- ✓ Feelings of guilt or worthlessness
- ✓ Irritability
- ✓ Thoughts of suicide

Depression is not your fault

Who is Affected by Depression?

Depression affects men, women, and people of all ages. Experts estimate that 11% of Canadian older adults living in the community suffer from depression and another 15% suffer from at least some depressive symptoms. Shame, fear, and lack of information prevent many people from getting the help they need.

Are Effective Treatments Available?

Yes! The majority of older people suffering from depression can be helped. Being afraid to ask for help and being unable to recognize symptoms prevent people from receiving successful treatment. If you recognize depressive symptoms in yourself or someone you care for, talk to your doctor right away. Many medications, personal counselling, and support groups have proven to be effective in helping people to recover from depression. If one type of therapy does not work for you, don't be discouraged. You may have to try different treatments until you find something that works for you. Be persistent!

If you feel depressed,

treatment brings new hope.

Understanding Depression

A Resource Guide for Older Adults and Caregivers

This guide was developed by
Jane Lam, MSW,
in collaboration with
members of the
Caregivers Support Committee,
seniors, and
community service providers,
as a requirement for
the Master of Social Work Degree,
Lakehead University,
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October 2000

Copies of this guide are available for
$3.00 each from:
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& Health
Lakehead University
955 Oliver Road
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Fax: (807) 343-2104
Email: necah@lakeheadu.ca

Please make cheques payable to
Lakehead University

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INTRODUCTION

Depression among older adults is an often unrecognized and untreated problem that can tarnish the lives of millions of people who might otherwise find joy in later life. Experts estimate that:

- 11% of community-dwelling elderly in Canada suffer from depression and another 15% suffer from at least some depressive symptoms.
- Rates of depression are as high as 50% in nursing home residents.
- As many as 90% of depressed older people are not being treated.

This booklet is intended to answer some of your questions about depression and give you valuable, accurate information about this illness and how it is treated. You may need this information because you suspect depression in yourself, or maybe you want to become more knowledgeable to support a family member, a friend, or someone you care for.

WHAT IS DEPRESSION?

Depression is a whole body illness that can seriously affect the way one feels and thinks. Sadness and grief are normal reactions to life's stresses and losses. Feeling "the blues" sometimes is natural. Depression is different. It is far more severe and long lasting than the ordinary "down" moods one may experience now and then. Without treatment, the symptoms of depression may last for months or years.

Symptoms of Depression

If you have, or someone you know has, experienced five or more of the following signs of depression for two weeks or more, a physical and/or a psychological evaluation should be considered.

- ✓ Persistent sadness or anxiety
- ✓ Loss of interest in usual activities

- ✓ Withdrawal from formerly pleasurable activities or relationships
- ✓ Decreased energy, fatigue
- ✓ Sleep problems (inability to sleep, oversleeping, early-morning waking)
- ✓ Eating problems (loss of appetite or weight, weight gain)
- ✓ Memory loss, confusion, or difficulty concentrating
- ✓ Feelings of helplessness pessimism
- ✓ Feelings of guilt or worthlessness
- ✓ Irritability
- ✓ Thoughts of suicide

CAUSES OF DEPRESSION

Many factors can contribute to depression. Some people become depressed for reasons that may not be obvious. Others become depressed for a combination of reasons. Regardless of the cause, identifying depression correctly means it can be treated.

FACTORS CONTRIBUTING TO DEPRESSION

Some contributing factors that are particularly significant in the development of depression among older adults may include the following:

Other Illnesses

Long-term or sudden illnesses can bring on or aggravate depression. Stroke, cancer, diabetes, Parkinson's Disease, heart disease, and Alzheimer's Disease are examples of illnesses that may be related to depression.

Medications

Some medicines cause depressive side effects. Certain drugs, used to treat high

blood pressure and arthritis, fall into this category. In addition, different drugs, including over-the-counter remedies, can interact in unforeseen ways when taken together. It is important that all the types and dosages of medicine being taken are discussed with a doctor.

Genetics and Family History

Depression can run in families. Children of depressed parents have a higher risk of being depressed themselves. Some people probably have a biological make-up that makes them particularly vulnerable.

Life Events

The death of a loved one, divorce, moving to a new place, money problems, or looking after a frail family member can contribute to depression. People without relatives or friends for support may have even more difficulty coping with loss. Sadness and grief are normal responses to loss, but if they linger or are severe, professional help should be sought as early as possible.

DISPELLING THE MYTHS ABOUT DEPRESSION

Many mistaken beliefs and expectations about depression and aging serve to hinder early recognition and effective treatment. If depression is detected and treated early, older people can have improved physical health and enhanced relationships with family members and friends.

Myth
It is natural to become increasingly depressed with aging.

Fact
Advancing age does not cause depression. Depression is not the outcome of natural processes of aging and should not be considered normal. A majority of older adults lead happy, productive, and fulfilling lives.

Myth
Of course older people are depressed - their spouses and friends are dying all around them.

Fact
The death of spouses, companions, and friends can cause profound sadness and sometimes-even depression, but, at any age, most people manage to find new sources of support and pleasure. Untreated depression often results in social isolation, which can worsen depression.

Myth
Older people have no reason to be depressed. They should be happy about their good fortune. Depression affects only those who cannot manage life's ups and downs. Depression is the result of a character flaw, a personal weakness, or a failure of will power.

Fact
Depression is an illness just like diabetes or arthritis. People with depression cannot change their moods any more than diabetics can use will power to change their blood sugar levels. What a depressed person needs is concern, compassion, and effective treatment.

Myth
Older people are simply too old to benefit from treatment.

Fact
Nearly 80% of people with depression can be treated successfully with medications, psychotherapy, or a combination of both. With proper treatment, even the most seriously depressed person can start to feel better, often in a matter of weeks.

DEPRESSION SHARES SYMPTOMS WITH OTHER MEDICAL CONDITONS

Some symptoms of depression also occur in other medical conditions. For example, weight loss, sleep disturbance, and low energy also occur in people with diabetes and heart disease. Apathy, poor concentration, and memory loss are also found in people with Parkinson's and Alzheimer's Disease and people who have experienced a stroke. Thus, it often presents a diagnostic challenge for physicians to distinguish whether certain symptoms are caused by depression, by

other medical conditions, or by a combination of both. Depression may also be hard to diagnose because some depressed older adults tend to describe physical problems rather than express sadness, anxiety, or hopeless feelings. Careful observation by an informed care provider is essential to recognize a depressed older person.

Depression can also co-exist with other emotional illnesses, especially severe anxiety. In such cases, excessive worrying, nervousness, restlessness, panicky feelings or difficulty falling asleep may be symptoms of both anxiety and depression. Early detection of depression in such cases can result in more effective treatment and a better outcome for the individual.

In addition, misuse of alcohol and/or prescription drugs frequently occurs with depression. If you have concerns about concurrent depression and substance misuse, discuss these issues with a physician and/ or a pharmacist.

DEPRESSION AND SUICIDE

Suicide is a significant risk for older people. The two foremost risk factors for suicide in the elderly are physical illness and depression, typically in combination. The suicide rate among older, white males is six times the rate of the general population. Up to 75% of elderly suicide victims visit their doctors in their last month of life and nearly 40% see their doctors within the week of committing suicide; yet their depressive symptoms are rarely recognized and treated. Education can help to improve care providers' knowledge and skills in earlier detection and treatment.

HELP FOR DEPRESSION

A variety of treatments are available which may be used alone or in combination, depending on a person's condition, diagnosis and personal choice. Nearly 80% of people with depression improve when they receive appropriate treatment such as medication, counselling, and self help.

Medication

Commonly recommended anti-depressants for older adults include tricyclic anti-depressants (TCAs), monoamine oxidase inhibitors (MAOIs), and selective serotonin reuptake inhibitors (SSRIs). While TCAs and MAOIs are effective for many older patients, many physicians now use SSRIs as the first line of treatment because SSRIs tend to have fewer serious side effects than TCAs and MAOIs. Regardless of what medications you may need, all medications have some side effects and you should discuss with your physician or pharmacist if you have any concerns. Commonly prescribed SSRIs include:

- Fluoxetine (Prozac)
- Paroxetine (Paxil).
- Sertraline (Zoloft)

When mediations are used, it is important to consider the following points:

- All anti-depressants alter the imbalance of brain chemicals to improve mood, sleep, appetite, energy levels, and concentration.

- Improvement usually occurs within 6-12 weeks. If symptoms have not improved after several weeks, the treatment plan should be re-evaluated. All possible side effects of medication should be fully discussed with the doctor.

- Different people may need different medications and, sometimes, more than one medication is needed to treat depression. In addition, late life depression is often a chronic illness and tends to recur. To remain well, some older patients may need anti-depressant treatment indefinitely.

Counselling (talk therapy)

Talking with a trained counsellor can also be effective in treating depression. It can be used alone or with medication treatment, depending on the severity of depression. Four basic types of counselling are most often used:

- Brief supportive counselling focuses on present issues, for example, specifically grief, role transitions, and problems with other people.

- Psychodynamic counselling emphasizes resolving inner problems and may take place over many months.

- Behavioural counselling teaches new ways of responding to problems.

- Cognitive therapy focuses on recognizing and changing negative thinking patterns that contribute to depression.

Self-help Groups

Some people find that mutual support groups are helpful, especially when combined with other treatments. Self-help groups can be a valuable resource for people with depression, as well as their families and friends.

Electro-convulsive Therapy (ECT)

ECT is a very effective treatment that is reserved for severe cases of depression when rapid improvement is necessary or when medications cannot be tolerated or have not worked.

A USEFUL TOOL FOR DETECTING DEPRESSION

Please complete the following checklist, based on how you felt over the past week, to determine if you or someone you know may be at risk for depression.

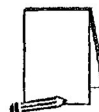
1	Are you basically satisfied with your life?	Yes No
2	Have you dropped many of your activities and interests?	Yes No
3	Do you feel that your life is empty?	Yes No
4	Do you often get bored?	Yes No
5	Are you in good spirits most of the time?	Yes No
6	Are you afraid that something bad is going to happen to you?	Yes No
7	Do you feel happy most of the time?	Yes No
8	Do you often feel helpless?	Yes No
9	Do you prefer staying at home, rather than going out and doing new things?	Yes No
10	Do you feel you have more problems with memory than most people?	Yes No

11	Do you think it is wonderful to be alive?	Yes No
12	Do you feel pretty worthless the way you are now?	Yes No
13	Do you feel full of energy?	Yes No
14	Do you feel that your situation is hopeless?	Yes No
15	Do you think that most people are better off than you are?	Yes No

Adapted from Sheikh & Yesavage, 1986 (Geriatric Depression Scale)

Count one point if you answered the following:

1. No	2. Yes	3. Yes	4. Yes	5. No
6. Yes	7. No	8. Yes	9. Yes	10. Yes
11. No	12. Yes	13. No	14. Yes	15. Yes



Your Score: ______________

If your score is higher than 5, you may be depressed, and you should consider seeing your doctor. Take this paper with you to your doctor's office.

COMMON MISTAKES WE MAKE

Family members, caregivers, and friends sometimes respond to the depressed person in the following well-intentioned but very unhelpful ways:

- "Cheer up"
- "Find something to do"
- "Get out with your friends"
- "Snap out of it"
- "Quit feeling sorry for yourself"
- "You have so much to live for"

These clichés may sound helpful, but they only serve to make a depressed person feel worse.

GETTING HELP

Depression is an illness that can be treated. If you think you have depression or if someone you care for may be depressed, contact your family physician for treatment and/or referrals to specialists. Specialists may include geriatricians, psychiatrists, psychologists, family therapists, social workers, mental health counsellors, and psychiatric nurses. Specialists often work

with family physicians to ensure that patients receive appropriate treatments and follow up.

What do you do if you think an elderly person you care for has depression?

- ✓ Encourage or arrange for an evaluation with a qualified professional to accurately determine the cause of symptoms.
- ✓ Record observations of symptoms to discuss with the professional.
- ✓ Familiarize yourself with medications the person is taking, including over-the-counter and herbal remedies.
- ✓ Provide support and encouragement to offset the individual's loss of self-esteem and to ease his/her sense of isolation.
- ✓ Take an active role in helping the person get assistance. You can help schedule appointments or offer transportation to treatment.

COMMUNITY RESOURCES

For more information on services and/ or programs available in the city and district of Thunder Bay, please call:

Community Care Access Centre
(807) 345-7339 or 1-800-626-5406

The Community Care Access Centre serves as a single point of access providing:

- Information and referral for community care, long-term care, and health care services in the city and district of Thunder Bay
- Coordinated service planning and case management
- Placement services to long term care

You may also call Direct Health if you have a health concern and are unsure about what to do. A nurse is on call 24 hours a day, 7 days a week to assess your symptoms and provide information that will help you decide what to do next.

Direct Health 1-800-480-2808

OTHER RESOURCES

Books

- Conquering Depression: A Guide to Understanding Symptoms, Causes, and Treatment of Depressive Illness, by Dr. R. Joffe and Dr. A. Levitt, Empowering Press, Hamilton, Canada, 1998.
- The Feeling Good Handbook, by Dr. D. D. Burns, Penguin Books, Canada, 1989.

Internet Websites

- www.canadian-health-network.ca
  Funded by Health Canada in partnership with dozens of health organizations across the country, this site lets you search by topic (mental health), by group (seniors, women), by resource type (organizations, health promotions), and by province/ territory.

- www.alzheimer.ca
  This site offers a checklist of the 10 signs of caregiver stress, many of which are related to depression. There is also a caregiver forum for sharing information and experiences.

- www.fhs.mcmaster.ca/direct
  Created by the Faculty of Health Sciences, McMaster University, this site provides information about different types of depression and their treatment options.

- www.hc-sc.gc.ca/seniors-aines/pubs/expression/expintro_e.htm
  Through this site, the National Advisory Council on Aging produces "Expression", a quarterly newsletter on various aspects of the life of aging Canadians.

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