Depression in Post Acute/Long Term Care

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The purpose of this clinical practice link is to outline concepts related to depression in the post acute/long term care setting. The focus will be on prevalence, definition & symptoms, treatment & regulations.

Prevalence

Geriatric depression increases risk of both morbidity and mortality. Among all nursing home residents, 12-14% meet the criteria for Major Depressive Disorder (MDD). The rates of depressive symptoms in general are between 30-45%. For long-term care residents with dementia, the prevalence of clinical depression is estimated to be as high as 63% (Adams-Fryatt, 2010; Espinoza & Unutzer, 2016).

Definition and symptoms

MDD is a condition characterized by the presence of depressed mood or loss of interest or pleasure. Associated symptoms include changes in appetite or weight, sleep, energy, concentration, and psychomotor activity as well as feelings of inappropriate guilt or worthlessness, and recurrent thoughts of death or suicide (Taylor, 2014).

Late-onset depression (depression that occurs after the age of 60 years), often develops as a consequence of accumulating losses (Espinoza & Kaufman, 2014).

To improve assessment of depression, provide privacy and confidentiality and obtain supplemental information from significant others if the patient consents (Espinoza & Kaufman, 2014). The Patient Health Questionnaire 9 is a validated measure that is part of the Minimum Data Set collected by nursing facilities (Taylor, 2014).

Depression tends to present atypically in elderly persons. They are less likely to report sadness or crying spells and more likely to report anorexia, disruption in sleep patterns, and fatigue. Multiple somatic complaints are also common. *Depression is the most common cause of unintentional weight loss in the elderly* (Adams-Fryatt, 2010; Espinoza & Kaufman, 2014; Taylor, 2014).

Suicidal ideation and passive suicide attempts can be found in up to 31% of long-term care (LTC) residents. LTC residents with depression who engage in self-harming behaviors, such as refusing food or medical care, may be expressing a suicide attempt (Adams-Fryatt, 2010).

Chronic medical problems may confer a predisposition to depression, and depression is associated with worse outcomes for some conditions. The elderly patient is more likely to take multiple medications that can cause or contribute to the development of depression (such as beta blockers, benzodiazepines, or opiates). Workup includes laboratory tests to rule out anemia, hypothyroidism, or vitamin B_{12} deficiency (Taylor, 2014).

Treatment

Depression in the elderly can and should be treated. The goal of therapy is complete remission of the depressive episode (Adams-Fryatt, 2010). Treatment modalities include psychotherapy, pharmacotherapy, and/or electroconvulsive therapy (ECT).

Due to favorable adverse-event profiles and low cost, selective serotonin-reuptake inhibitors (SSRIs) are first-line treatment for late-life depression. Serotonin-norepinephrine reuptake inhibitors (SNRIs) are commonly used when remission is not obtained with SSRIs. There is less evidence to support the use of mirtazapine or buproprion. Tricyclic antidepressants (TCAs) are associated with anticholinergic side effects and are not to be used as first-line therapy (Taylor, 2014).

Medications should be started at low dosages and titrated upward slowly (Adams-Fryatt, 2010).
In many elderly persons, an extended trial of 12 weeks is required to observe a full response to an antidepressant before declaring a treatment failure. Once remission is achieved, antidepressant therapy should be continued for six months to one year for the first depressive episode. Elderly persons who have had two or more episodes of depression may benefit from several years to lifelong therapy (Espinoza & Unutzer, 2016).

Psychotherapies are effective treatments for late-life depression and may be considered as first-line therapy. ECT is the most effective treatment for severely depressed patients. ECT should be considered for suicidal patients or those whose depression is resistant to medications and is generally safe in the elderly population (Taylor, 2014).

Regulations
Prescribers of antidepressants in long term care facilities should be aware that guidelines exist that call for attempted tapering of antidepressants, as well as any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders. A provider must document any contraindications against gradual dose reduction (Stefanacci, 2008).

References

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