

References: Mental Health

REF ID: 1378

Level VI: Opinion

Topic 3: Assessment

Toolkit. screening for and treating male depression.(2004). *Geriatrics*, 59(10), 46.
Journal Article, Protocol

REF ID: 1386

Level VI: Opinion

Topic 4.3: Management-Medication

New guidelines promote drug therapy for depression.(2002). *Senior Care Management*, 5(1), 8-10.
Journal Article, Practice Guidelines

REF ID: 1534

Level VI: Opinion

Topic 4.3: Management-Medication

AbouSaleh, M. T. (2001; 2001). Pharmacological treatment of depression in the elderly. *Arab Journal of Psychiatry*, 12(1), 11-19.

Journal; Peer Reviewed Journal

Discusses pharmacotherapy for depression in the elderly. The author discusses pretreatment consideration, commonly used antidepressant medications and usual doses, choice of specific pharmacological treatment, treatment-resistant depression, and strategies for treatment of failure to respond to pharmacotherapy in the acute phase. The author suggests that a large majority of elderly patients with depression could be treated successfully, particularly with the selective serotonin reuptake inhibitors, due to their favorable side-effect profile and low toxicity in overdose. The challenge with these drugs is drug-drug interactions. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1472

Level VI: Opinion

Topic 6: Comprehensive

Alexopoulos, G. S. (2005; 2005). Depression in the elderly. *Lancet*, 365(9475), 1961-1970.

Journal; Peer Reviewed Journal

In elderly people, depression mainly affects those with chronic medical illnesses and cognitive impairment, causes suffering, family disruption, and disability, worsens the outcomes of many medical illnesses, and increases mortality. Ageing-related and disease-related processes, including arteriosclerosis and inflammatory, endocrine, and immune changes compromise the integrity of frontostriatal pathways, the amygdala, and the hippocampus, and increase vulnerability to depression. Heredity factors might also play a part. Psychosocial adversity--economic impoverishment, disability, isolation, relocation, caregiving, and bereavement--contributes to physiological changes, further increasing susceptibility to depression or triggering depression in already vulnerable elderly individuals. Treatment with antidepressants is well tolerated by elderly people and is, overall, as effective as in young adults. Evidence-based guidelines for prevention of new episodes of depression are available as are care-delivery systems that increase the likelihood of diagnosis, and improve the treatment of, late-life depression. However, in North America at least, public insurance covers these services inadequately. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1623

QM: Quality Measures

Topic 5: Evaluation/Follow-up

American Geriatrics, S., & American Association for Geriatric, Psychiatry. (2003 Sep). The american geriatrics society and american association for geriatric psychiatry recommendations for policies in support of quality mental health care in U.S. nursing homes.[see comment]. *Journal of the American Geriatrics Society*, 51(9), 1299-1304.

Guideline. Journal Article. Practice Guideline

REF ID: 1625

OM: Quality Measures

Topic 5: Evaluation/Follow-up

Andrews, B. C., Kaye, J., Bowcutt, M., & Campbell, J. (2001). Redesigning geriatric healthcare: How cross-functional teams and process improvement provide a competitive advantage. *Health Marketing Quarterly*, 19(2), 33-48.

Evaluation Studies. Journal Article

This study examines the consequences of adding a geriatric subacute unit to the traditional health care mix offered by a nonprofit hospital. Historically, geriatric health care offerings have been limited to either acute care units or long-term care facilities. The study's findings demonstrate that the addition of a subacute unit that is operated by an interdisciplinary team is a competitively rational move for two reasons. First, it provides a continuum of care that integrates services and departments, thereby reducing costs. Second, it provides a supportive environment for patients and their families. As a consequence patients have a higher probability of returning home than patients who are assigned to more traditional modes of care.

REF ID: 1575

Level VI: Opinion

Topic 4.3: Management-Medication

Appelberg, B. (2003). Long term citalopram prevents recurrent depression in the elderly and is well tolerated. *Evidence-Based Mental Health*, 6(1), 24.

Journal Article, Abstract, Commentary

critique of: Original Study: Klysner R, Bent-Hansen J, Hansen H. Efficacy of citalopram in the prevention of recurrent depression in elderly patients: placebo-controlled study of maintenance therapy. *British Journal of Psychiatry* 2002 July; 181: 29-35;

QUESTION: What is the efficacy and long-term tolerability of citalopram for depression in elderly people? **Design** Open-label acute and continuation phase followed by randomised controlled parallel group trial of maintenance therapy (with blinded participants and clinicians). **Setting** Denmark; **March 1996-June 1999.** **Participants** A letter was sent to all people aged over 65 in two Danish municipalities to identify undiscovered depression. People with unipolar major depression were eligible (DSM-IV 296.2x or 296.3x; MADRS score of 22 or above). 230 people received acute treatment and 121 took part in the randomised phase (77% women; mean age 75 years). **Exclusion criteria** were history of mania, schizophrenia, hypomania, epilepsy; drug or alcohol abuse or severe somatic disorders; depressive episode lasting more than 12 months; fluoxetine within 5 weeks or other antidepressants within 3 days; lithium, carbamazepine or valproate within 2 weeks; electroconvulsive therapy within 8 weeks, or a score of 5 or above on the MADRS suicide scale. **Intervention** Participants were treated with 8 weeks of flexible doses of open-label citalopram (10-40mg per day) followed by a stabilisation phase with individual fixed doses for 16 weeks. **Responders** were randomised to continue citalopram or receive placebo for a third period of at least 48 weeks. **Doses** of citalopram were 20, 30 or 40mg per day in the maintenance period. **Concomitant psychotropic medication** was not allowed, except for stable dose benzodiazepines and other hypnotics. **Main outcome measures** Recurrence of depression (MADRS total score \geq 22 confirmed after 3 to 7 days); time to recurrence. **Main results** One third of people receiving citalopram had recurrent depression compared to two thirds receiving placebo. Time to recurrence was significantly longer in the citalopram group (hazard ratio citalopram v placebo 0.32, 95% CI 0.19 to 0.56). The estimated proportion recurrence-free at 48 weeks was 67% for citalopram and 27% for placebo ($p < 0.0001$). Citalopram was well tolerated, although back pain and influenza-like symptoms were more common than in the placebo group. **The study was not powered to analyse dose-response relationships.** **Conclusions** Long-term treatment with citalopram prevents recurrence of depression in the elderly and is well tolerated.

REF ID: 1374

Level I: Systematic Reviews

Topic 1: Risks

Arai, L., & Harding, S. (2004). A review of the epidemiological literature on the health of UK-born black caribbeans. *Critical Public Health, 14(2), 81-116.*

Journal Article, Research, Systematic Review, Tables/Charts

A review of the epidemiological literature on the health of UK-born Black Caribbeans was undertaken. Forty-three papers were found; around half of these were on the incidence of schizophrenia and psychotic conditions in this population. A small number were on autoimmune disorders, sexual health, diet and alcohol intake and children's health. Although there are many methodological limitations with the research on schizophrenia and psychotic conditions, the findings are consistent in that UK-born Black Caribbeans are more likely to be diagnosed with these conditions than Whites, and possibly more so than migrant Black Caribbeans. Poorer sexual health and the high prevalence of some specific autoimmune conditions, such as human T-cell lymphoma/leukaemia (HTLV-1), were also consistent features in the research evidence. The findings from these studies suggest a transmission of risk of these conditions across generations, and that environmental factors, rather than genetic susceptibility, play a major role in outcomes. There was a lack of research investigating generational shifts in risks for major conditions, such as coronary heart disease, lung or breast cancer.

REF ID: 1481

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Arean, P. A. (2004; 2004). Psychosocial treatments for depression in the elderly. *Primary Psychiatry, 11(5), 48-53.*

Journal; Peer Reviewed Journal

Depression in older adults can be treated successfully with psychotherapy. This article reviews the latest information on the effectiveness of two types of psychotherapy for late-life depression, cognitive-behavioral therapy and interpersonal therapy. The reader will learn the theory, structure, and adaptations of these therapies for older adult populations. A case illustration will be briefly discussed to illustrate the application of each therapy. This article is intended to be an introduction to evidence-based psychotherapies for late-life depression and a resource for learning more about these interventions.

(PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1469

Level VI: Opinion

Topic 3: Assessment

Topic 4.2: Management-Behavior Therapy

Arean, P. A., & Ayalon, L. (2005; 2005). Assessment and treatment of depressed older adults in primary care. *Clinical Psychology: Science and Practice, 12(3), 321-335.*

Journal; Peer Reviewed Journal

The purpose of this paper is to describe and discuss both assessment and psychotherapeutic techniques that can be applied in primary-care medicine for older adults seeking mental health services in these settings. Assessment techniques that are amenable to primary-care settings include the Center for Epidemiological Studies Depression Scale, Revised; the Geriatric Depression Scale-15; two and nine-symptom Patient Health Questionnaire; the General Health Questionnaire; the Beck Depression Inventory-II; and the Beck Depression Inventory for Primary Care. Psychotherapeutic interventions that have been created and/or modified for primary-care settings are Problem solving therapy (PST-PC) and interpersonal therapy (IPT-PC). These detection tools and treatments are discussed in the context of primary-care medicine. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1547

Level II: Individual experimental study

Topic 4.1: Management-General

Arean, P. A., Ayalon, L., Hunkeler, E., Lin, E. H. B., Tang, L., & Harpole, L. et al. (2005; 2005). Improving depression care for older, minority patients in primary care. *Medical Care, 43(4), 381-390.*

Journal; Peer Reviewed Journal

Objective: Few older minorities receive adequate treatment of depression in primary care. This study examines whether a collaborative care model for depression in primary care is as effective in older minorities as it is in nonminority elderly patients in improving depression treatment and outcomes. Study Design: A multisite randomized clinical trial of 1801 older adults comparing collaborative care for depression with treatment as usual in primary care. Twelve percent of the sample were black (n = 222), 8% were Latino (n = 138), and 3% (n = 53) were from other minority groups. We compared the 3 largest ethnic groups (non-Latino white, black, and Latino) on depression severity, quality of life, and mental health service use at baseline, 3,6, and 12 months after randomization to collaborative care or usual care. Principal Findings: Compared with care as usual, collaborative care significantly improved rates and outcomes of depression care in older adults from ethnic minority groups and in older whites. At 12 months, intervention patients from ethnic minorities (blacks and Latinos) had significantly greater rates of depression care for both antidepressant medication and psychotherapy, lower depression severity, and less health-related functional impairment than usual care participants (64%, 95% confidence interval [CI] 55-72 versus 45%, CI 36-55, P = 0.003 for antidepressant medication; 37%, CI 28-47 versus 13%, CI 6-19, P = 0.002 for psychotherapy; mean = 0.9, CI 0.8-1.1 versus mean = 1.4, CI 1.3-1.5, P < 0.001 for depression severity, range 0-4; mean = 3.7, CI 3.2-4.1, versus mean = 4.7, CI 4.3-5.1, P < 0.0001 for functional impairment, range 0-10). Conclusions: Collaborative Care is significantly more effective than usual care for depressed older adults, regardless of their ethnicity. Intervention effects in ethnic minority participants were similar to those observed in whites. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1339

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Topic 4.3: Management-Medication

Arean, P. A., & Cook, B. L. (2002; 2002). Psychotherapy and combined psychotherapy/pharmacotherapy for late life depression. *Biological Psychiatry*, 52(3), 293-303.

Over the past 20 yrs, numerous studies have investigated the efficacy of psychotherapy for treating late life depression and, to a lesser degree, the efficacy of psychotherapy combined with antidepressant medication. Of the intervention studies, cognitive-behavioral therapy and interpersonal psychotherapy combined with antidepressant medication have the largest base of evidence in support of their efficacy for late life depression. To a lesser degree, there is support for stand-alone interpersonal psychotherapy, brief dynamic therapy, and life review treatments. The purpose of this review is to present data on the acute and long-term effects of cognitive-behavioral therapy, interpersonal psychotherapy, brief dynamic therapy, and combined antidepressant medication and psychotherapy to discuss the generalizability of these interventions, and to discuss future research directions and the need for increased opportunities for this area of research. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1513

Level VI: Opinion

Topic 3: Assessment

Armstrong, T. D., & Crowther, M. R. (2002; 2002). Spirituality among older african americans. *Journal of Adult Development*, 9(1), 3-12.

Journal; Peer Reviewed Journal

Recent changes in gerontology have drawn attention to the role of spirituality among older adults. Demographic trends suggest that the number of African Americans over the age of 65 is increasing, with the largest shift to occur in persons 85 yrs of age and older. Given the paucity of information available regarding the relationship between spirituality and aging along with the increase in the number of older African Americans, a literature review of these concepts is sorely needed. This paper provides a thorough profile of older African Americans, with a review of historical and cultural factors that have informed the spiritual development of this population. Additionally, attention is given to methodological issues such as definitions, measures, sampling, and research designs at the interface of development and spirituality in this population. The paper also reviews findings to date about the effects of spirituality on

physical and mental health among older African Americans. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1449

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Auquier, P., Robitail, S., Llorca, P., & Rive, B. (2003; 2003). Comparison of escitalopram and citalopram efficacy: A meta-analysis. *International Journal of Psychiatry in Clinical Practice*, 7(4), 259-268.

Escitalopram is a new selective serotonin reuptake inhibitor (SSRI) indicated for the treatment of major depressive disorder (MDD) and panic disorder. Escitalopram is the therapeutically active enantiomer of citalopram. Its efficacy in the treatment of MDD was compared to that of citalopram. A quantitative meta-analysis was applied to 1,262 patients in four randomised clinical trials; the comparison was based on response rate and mean change from baseline in the Montgomery-Asberg depression rating scale (MADRS) total score at week 8. Complementary analyses were performed on early MADRS change from baseline (week 1), in very severely depressed patients (baseline MADRS total score > 35) and on the influence of the level of severity at baseline. Compared with citalopram, escitalopram-treated patients showed significantly higher response rates and increased mean change from baseline in MADRS at weeks 1 and 8. The superiority of escitalopram over citalopram was more pronounced in very severely depressed patients. This superiority was further shown to increase with degree of severity of the depression. The robustness of meta-analysis results was supported by sensitivity analyses... (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1498

Level VI: Opinion

Topic 1: Risks

Bagulho, F. (2002; 2002). Depression in older people. *Current Opinion in Psychiatry*, 15(4), 417-422.

Journal; Peer Reviewed Journal

The present review on depression in older people is occurring at a time when depression is fast becoming a major public health problem throughout the world with a very high prevalence rate in the 65 and over age group. Particular groups at risk will need to be identified so that early detection and interventions can be implemented. The concept of late-onset depression with a possible vascular cause, poor treatment response to antidepressants and a specific disability of executive dysfunction has developed further and has opened the field to the possibility of primary prevention and the opportunity of development of new treatments for this debilitating condition. Much confusion exists about the nature of the association between disability and depression and there is an urgent need for research in this area if we are to understand depression, its disabilities and mortality further. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1528

Level VI: Opinion

Topic 3: Assessment

Baker, F. M. (2001; 2001). Diagnosing depression in african americans. *Community Mental Health Journal*, 37(1), 31-38.

Journal; Peer Reviewed Journal

Since the 1970s, articles have noted the increased presence of psychotic symptoms among depressed African Americans, the presence of diagnostic bias identified when structured clinical interviews are used, and the identification of misdiagnosis of affective illness among chronically, mentally ill, African Americans. This paper reviews this literature and describes three alternative presentations of depressive illness among African Americans that differ from the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) criteria for Major Depressive Disorder: "the stoic believer," "the angry, evil one" with a personality change, and "the John Henry doer." Clinicians are encouraged to recall these presentations of depression when evaluating African American patients. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1385

Level I: Systematic Reviews

Topic 6: Comprehensive

Baldwin, R. C. (2002). Research into depressive disorder in later life: Who is doing what? A literature search from 1998-2001. *International Psychogeriatrics*, 14(4), 335-346.

Journal Article, Research, Systematic Review, Tables/Charts

The International Psychogeriatric Association (IPA) aims to improve the mental health care of older people globally. In order to help clarify what progress has been made, the author conducted a literature review of original **research** subsequent to 3 recent major reviews. A literature search of 4 databases over the period 1998-October 2001 was conducted. Results show that a total of 1,002 publications meeting predefined criteria were located. 59% were cross-sectional studies; less than 10% were randomized controlled studies. The most common themes were depression with comorbidity and etiology, accounting for almost half the papers, with stroke and Parkinson's disease the most frequently **researched** comorbid medical **disorders**, although interest in Alzheimer's disease, heart disease, hip fracture, and chronic lung disease appears to be increasing. There were comparatively few studies of psychological and psychosocial interventions. A quarter of the publications concerned major **depressive disorder**. There were striking variations in the origin of publications with 2 regions, North America and Northern Europe, accounting for 2/3 of all publications but only 13.7% of the world's population aged 65 yrs and over. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1409

Level I: Systematic Reviews

Topic 4.1: Management-General

Ballesteros, J., Gonzalez-Pinto, A., Querejeta, I., & Arino, J. (2004 Jan). Brief interventions for hazardous drinkers delivered in primary care are equally effective in men and women.[see comment]. *Addiction*, 99(1), 103-108.

Journal Article. Meta-Analysis

BACKGROUND: Despite the accumulated evidence on the efficacy of brief interventions in hazardous drinkers some ambiguity remains regarding their differential effectiveness by gender. **METHODS:** Meta-analysis of independent studies conducted in primary health care settings with a follow-up of 6-12 months which report results separately by gender. Two outcome measures were selected: the quantity of typical weekly alcohol consumption and the frequency of drinkers who reported consumption below hazardous levels after the intervention. **RESULTS:** Seven studies were included in the meta-analysis. The standardized effect sizes for the reduction of alcohol consumption were similar in men ($d = -0.25$; 95% CI = -0.34 to -0.17) and women ($d = -0.26$; 95% CI = -0.38 to -0.13). The odds ratios (OR) for the frequency of individuals who drank below harmful levels were also similar (four studies; OR for men = 2.32; 95% CI = 1.78-2.93; OR for women = 2.31; 95% CI = 1.60-3.17). The difference between genders was negligible. **CONCLUSION:** Our results support the equality of outcomes among men and women achieved by brief interventions for hazardous alcohol consumption in primary care settings.

REF ID: 1462

Level VI: Opinion

Topic 4.6: Management-Other

Barbour, K. A., & Blumenthal, J. A. (2005; 2005). Exercise training and depression in older adults. *Neurobiology of Aging*, 26(Suppl1), S119-S123.

Journal; Peer Reviewed Journal

This article provides a review of the evidence supporting exercise as an effective treatment of depression in older adults. Depression is prevalent among older adults and is associated with significant morbidity, increased risk of mortality, and economic burden. Although effective treatments for depression exist (e.g., antidepressant medication, cognitive-behavioral therapy), the disorder remains inadequately treated for many older individuals. Recently, the use of exercise as a treatment for depression has received increased attention. Results of these studies suggest that exercise leads to a reduction in depressive symptoms when compared to wait list, social contact controls, and antidepressant medication. However, many studies have significant methodological limitations. In the

present article, we include discussion of these limitations and provide suggestions for future research. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1400

Level I: Systematic Reviews

Topic 4.1: Management-General

Bartels, S. J., Dums, A. R., Oxman, T. E., Schneider, L. S., Arean, P. A., & Alexopoulos, G. S. et al. (2003 Dec). Evidence-based practices in geriatric mental health care: An overview of systematic reviews and meta-analyses. *Psychiatric Clinics of North America*, 26(4), 971-990.

Journal Article. Meta-Analysis. Review

At least 20% of people over the age of 65 suffer from mental disorders. It is anticipated that the number of older Americans with psychiatric disorders will double over the next 30 years. There is, however, substantial unmet need. The recent Surgeon General's Report on Mental Health, a Report on Mental Health from the Administration on Aging, and an expert consensus statement underscore the need to plan for the challenge of providing services for elderly people with major mental disorders. Among the greatest challenges is the expertise gap that affects clinicians practicing in routine clinical settings. This gap reflects inadequate training in geriatrics and a failure to incorporate contemporary clinical research findings and known evidence-based practices (EBPs) into usual care. This article provides an overview of the emerging evidence-base supporting the efficacy of empirically-validated geriatric mental health interventions for major geriatric mental health disorders, including systematic EBP reviews, meta-analytic studies, and expert consensus statements. Cautions and limitations regarding the reliance on randomized, controlled trials, meta-analyses, and systematic reviews also are presented. [References: 98]

REF ID: 1585

QM: Quality Measures

Topic 5: Evaluation/Follow-up

BatesJensen, B. M., Schnelle, J. F., Alessi, C. A., AlSamarrai, N. R., & LevyStorms, L. (2004). The effects of staffing on in-bed times of nursing home residents. *Journal of the American Geriatrics Society*, 52(6), 931-938.

Journal Article, Research, Tables/Charts

OBJECTIVES: To examine the effect of staffing level on time observed in bed during the daytime in nursing home (NH) residents. **DESIGN:** Descriptive, cross-sectional study. **SETTING:** Thirty-four southern California NHs. **PARTICIPANTS:** A total of 882 NH residents: 837 had hourly observation data, 777 had mealtime observations, 837 completed interviews, and 817 completed a physical performance test. **MEASUREMENTS:** Cross-sectional data collected from participants at each NH site included direct observations (hourly and mealtime), resident interviews, medical record review, and physical performance tests. **RESULTS:** In multivariate analyses, staffing level remained the strongest predictor of time observed in bed after controlling for resident functional measures (odds ratio=4.89; P=.042). Residents observed in bed during the daytime in more than 50% of hourly observations were observed also to experience increased daytime sleeping (P<.001) and less social engagement (P=.026) and consumed less food and fluids during mealtimes than those observed in bed in less than 50% of observations, after adjusting for resident function (P<.001). **CONCLUSION:** In this sample of NHs, resident functional measures and NH staffing level predicted observed time in bed according to hourly observations, with staffing level the most powerful predictor. Neither of these predictors justifies the excessive in-bed times observed in this study. Staff care practices relevant to encouraging residents to be out of bed and resident preferences for being in bed should be examined and improved. Practice recommendations regarding in-bed time should be considered, and further research should seek to inform the development of such recommendations.

REF ID: 1482

Level VI: Opinion

Topic 1: Risks

Beullens, J., & Aertgeerts, B. (2004; 2004). Screening for alcohol abuse and dependence in older people using DSM criteria: A review. *Aging & Mental Health*, 8(1), 76-82.

Journal; Peer Reviewed Journal

Alcohol abuse and dependence in older people are important problems, which frequently remain undetected by health services. Therefore, screening instruments for alcohol abuse and dependence in elderly people would be useful in clinical practice. To assess the quality of screening instruments we performed a literature search in Medline (1966-2002) and PsycINFO (1967-2002). Seven research reports were found. The MAST-G and especially the CAGE appear appropriate. The two questions of Cyr and Wartman, AUDIT and the MAST do not appear appropriate in screening for alcohol abuse and dependence in elderly people in a clinical environment. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1495

Level VI: Opinion

Topic 6: Comprehensive

Blazer, D. G. (2003; 2003). Depression in late life: Review and commentary. *Journals of Gerontology: Series A: Biological Sciences and Medical Sciences*, 58A(3), 249-265.

Journal; Peer Reviewed Journal

Depression is perhaps the most frequent cause of emotional suffering in later life and significantly decreases quality of life in older adults. In recent years, the literature on late-life depression has exploded. Many gaps in our understanding of the outcome of late-life depression have been filled. Intriguing findings have emerged regarding the etiology of late-onset depression. The number of studies documenting the evidence base for therapy has increased dramatically. Here, I first address case definition, and then I review the current community and clinic based epidemiological studies. Next I address the outcome of late-life depression, including morbidity and mortality studies. Then I present the extant evidence regarding the etiology of depression in late life from a biopsychosocial perspective. Finally, I present evidence for the current therapies prescribed for depressed elders, ranging from medications to group therapy. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1371

Level I: Systematic Reviews

Topic 6: Comprehensive

Bould, S. (2005). A population health perspective on disability and depression in elderly women and men. *Journal of Aging & Social Policy*, 17(2), 7-24.

Journal Article, Research, Systematic Review, Tables/Charts

abstract not available

REF ID: 1494

Level VI: Opinion

Topic 4.3: Management-Medication

Bourin, M. (2003; 2003). Use of paroxetine for the treatment of depression and anxiety disorders in the elderly: A review. *Human Psychopharmacology: Clinical and Experimental*, 18(3), 185-190.

Journal; Peer Reviewed Journal

Paroxetine is a potent selective serotonin reuptake inhibitor (SSRI) with indications for the treatment of depression, obsessive-compulsive disorder, panic disorder and social phobia. It is also used in the treatment of generalized anxiety disorder, posttraumatic stress disorder, premenstrual dysphoric disorder and chronic headache. There is wide interindividual variation in the pharmacokinetics of paroxetine in adults as well as in the elderly with higher plasma concentrations and slower elimination noted in the latter. Elimination is also reduced in severe renal and hepatic impairment, however, serious adverse events are extremely rare even in overdose. A Pub Med search was used to collect information on the efficacy and tolerability in elderly patients. There are few studies of depression in the elderly and only one study in the old-old. In anxiety disorders including general anxiety disorder, panic disorder, obsessive-compulsive disorder and social anxiety, there are no studies at all in the elderly. However, the safety of the drug allows its prescription in the elderly. In summary, paroxetine is well tolerated in the treatment of depression in those between the ages of 65 and 75, although few studies have examined its use in those of 75 and older. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1492

Level VI: Opinion

Topic 1: Risks

Braam, A. W., Beekman, A. T. F., & van Tilburg, W. (2003; 2003). Religiosity and depression in later life: A review of recent epidemiological research. *Tijdschrift Voor Psychiatrie*, 45(8), 495-505. Journal; Peer Reviewed Journal

BACKGROUND In psychiatric epidemiology and gerontology it is frequently reported that religious beliefs and the practice of religion protect the elderly from depression. **AIM** To investigate whether certain aspects of religious belief and practice of religiosity are associated with depression and whether explanatory factors such as coping mechanisms can be identified. **METHOD** A Medline literature search was performed for the period 1997-2002, using as key words religion/religious/religiosity/spirituality, in combination with aging/elderly/old/late-life and depressive/depression/mental-health. **RESULTS** In cross-sectional studies church-attendance is consistently associated with lower levels of depression. On the other hand, religiosity in the form of negative, religious emotions (e.g., anger) and negative religious coping strategies (e.g., expectation of punishment) is associated with higher levels of depression. Persons to whom religion is important in everyday life are more likely to recover from depression. So far, there is little empirical support for explanatory or mediating factors. **CONCLUSION** Religiosity can incorporate risk-factors, but more often than not belief in it generates a potential for hope or a propensity for adaptation in later life. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1574

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Brenes, G. A. (2003). Cognitive training may improve targeted cognitive functions in older adults. *Evidence-Based Mental Health*, 6(2), 54. Journal Article, Abstract, Commentary

critique of Original Study: Ball K, Berch D, Helmers K et al. Effects of cognitive training interventions with older adults. A randomized controlled trial. JAMA 2002 Nov

QUESTION: Do interventions targeting memory, reasoning and cognitive speed affect the mental abilities and everyday activities of older adults? **Design:** Randomised controlled trial. Analysts were blind to treatment allocation. **Setting;** 6 cities in the United States; March 1998-December 2001. **Participants:** 2802 older adults recruited from senior housing, community centres, clinics and driver's licence registries. Mean age 73.6 years (range 65-94); 76% women; 73% white. **Exclusion criteria** were age under 65 years; not living independently; recent cognitive training; substantial cognitive decline; Alzheimer's disease; medical conditions with increased risk of functional decline or death, or severe loss of vision, hearing or communicative ability. **Intervention:** Participants received 10 group training sessions in either (1) memory (verbal episodic memory); (2) reasoning (ability to solve problems following a serial pattern); (3) speed of processing (visual search and identification), or were allocated to a non-contact control group. 11 months later, 4 booster sessions were offered to a random sample of 60% of participants. Follow up data were collected from 80% after 2 years. **Main outcome measures:** Cognitive function and cognitively demanding everyday function were measured using composite scores on a variety of tests and the Activities of Daily Living scales. **Main results:** All 3 interventions improved the targeted cognitive ability (memory, reasoning or speed of processing) compared to baseline. Improvements were noted immediately after the intervention and at 2-year follow up. Booster training increased gains in speed and reasoning. At 2 years, the authors did not detect any effects on everyday functioning, likely due to the lack of functional impairment at baseline. **Conclusions:** Poor cognitive function is associated with reduced independent living in older adults. This study suggests that 10 sessions of cognitive training may improve targeted cognitive abilities, but there were no benefits on everyday cognitive functioning after 2 years.

REF ID: 1392

Level IV: Non-experimental study

Topic 1: Risks

Bruce, M. L., McAvay, G. J., Raue, P. J., Brown, E. L., Meyers, & Keohane, D. J. et al. (2002). Major depression in elderly home health care patients. *American Journal of Psychiatry*, 159(8), 1367-1374.

Journal Article, Research, Tables/Charts

OBJECTIVE: Despite the growth of geriatric home health services, little is known about the mental health needs of geriatric patients seen in their homes. The authors report the distribution, correlates, and treatment status of DSM-IV major depression in a random sample of elderly patients receiving home health care for medical or surgical problems. **METHOD:** Geriatric patients newly admitted to a large, traditional visiting nurse agency were sampled on a weekly basis over a period of 2 years. The 539 patients ranged in age from 65 to 102 years; 351 (65%) were women, and 81 (15%) were nonwhite. The Structured Clinical Interview for DSM-IV Axis I Disorders was used to interview patients and informants. The authors reviewed the results of these interviews plus the patients' medical charts to generate a best-estimate DSM-IV psychiatric diagnosis. **RESULTS:** The patients had substantial medical burden and disability. According to DSM-IV criteria, 73 (13.5%) of the 539 patients were diagnosed with major depression. Most of these patients (N=52, 71%) were experiencing their first episode of depression, and the episode had lasted for more than 2 months in most patients (N=57, 78%). Major depression was significantly associated with medical morbidity, instrumental activities of daily living disability, reported pain, and a past history of depression but not with cognitive function or sociodemographic factors. Only 16 (22%) of the depressed patients were receiving antidepressant treatment, and none was receiving psychotherapy. Five (31%) of the 16 patients receiving antidepressants were prescribed subtherapeutic doses, and two (18%) of the 11 who were prescribed appropriate doses reported not complying with their antidepressant treatment. **CONCLUSIONS:** Geriatric major depression is twice as common in patients receiving home care as in those receiving primary care. Most depressions in patients receiving home care are untreated. The poor medical and functional status of these patients and the complex organizational structure of home health care pose a challenge for determining safe and effective strategies for treating depressed elderly home care patients.

REF ID: 1508

Level VI: Opinion

Topic 1: Risks

Bruce, M. L. (2002; 2002). Psychosocial risk factors for depressive disorders in late life. *Biological Psychiatry*, 52(3), 175-184.

Journal; Peer Reviewed Journal

This article summarizes research findings on psychosocial risk factors for late life depressive disorders. The article draws heavily on longitudinal cohort studies of well-defined, population-based samples with diagnostic measures that assess the risk of incident or new-onset depressive episodes. These studies have identified a number of significant psychosocial risk factors for late life depressive disorders, including life events and ongoing difficulties; death of a spouse or other loved one; medical illness and injuries; disability and functional decline; and lack of social contact. Additional evidence suggests that the impact of these psychosocial risk factors on depression can be enhanced or buffered by personal or environmental factors. Although many of these psychosocial risk factors are more prevalent among older than younger adults, it is not clear that their impact on the risk of depression differs by age. Methodological challenges to advancing research on psychosocial risk factors for late life depression are reviewed, including problems related to study designs, sample selection, and measurement. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1557

Level VI: Opinion

Topic 4.1: Management-General

BuistBouwman. (2005). Collaborative care management improves physical functioning in older people with depression. *Evidence-Based Mental Health*, 8(4), 106.

Journal Article, Abstract, Commentary

critique of: Original Study: Callahan CM, Kroenke K, Counsell SR, Hendrie HC, Perkins AJ, Katon W,

Hitchcock P, Harpole L, Hunkeler EM, Unutzer J. Treatment of depression improves physical functioning in older adults. *J AM GERIATR SOC* 2005 Mar; 53(3): 367-73

Does collaborative care management improve physical functioning in older people with depression? Design: Randomised controlled trial. METHODS Allocation: Not clear. Blinding: Not clear. Follow up period: Twelve months. Setting: Eighteen primary care clinics in the USA; recruitment 1999 to 2001. People: 1801 people aged over 60 years with current major depressive or dysthmic disorder (DSM-IV). Interventions: Improving Mood: Providing Access to Collaborative Treatment (IMPACT) intervention or usual care. IMPACT collaborative care management consisted of participant education on late life depression (videotape and booklet) and 12 months' access to a depression clinical specialist who coordinated and monitored care with the participant's primary care physician, a liaison primary care expert, and a psychiatrist. Treatment was provided according to an approved algorithm. Usual care consisted of access to primary care and speciality mental health services. Outcomes: Physical functioning (instrumental activities of daily living (IADL; range 0-7) and physical component summary of the 12 item Short Form (PCS; range 0-100) scores). Higher PCS and lower IADL scores indicate better physical function. Patient follow up: 96% at 12 months' follow up. MAIN RESULTS Collaborative care management significantly improved physical functioning compared with usual care at 12 months (mean PCS scores: 40.91 with collaborative care management v 39.17 with usual care, $p < 0.001$; mean IADL scores: 0.73 with collaborative care management v 0.89 with usual care, $p = 0.04$). CONCLUSIONS Collaborative care management improves physical functioning compared with usual care in older people with depression.

REF ID: 1578

Level VI: Opinion

Topic 4.1: Management-General

Topic 2: Prevention

Burke, D. (2002). A geriatric evaluation and management programme prevented functional decline and reduced depression in high risk older adults. *Evidence-Based Mental Health*, 5(1), 9. Journal Article, Abstract, Commentary

critique of Original Study: Boulton C, Boulton LB, Morishita L, Dowd B, Kane RL, Urdangarin CF. A randomized clinical trial of outpatient geriatric evaluation and management. *J AM GERIATR SOC* 2001 Apr; 49(4): 351-9

QUESTION: Can an outpatient geriatric evaluation and management (GEM) programme prevent functional decline and reduce depressive symptoms and Medicare costs in high risk older adults? Design Randomised (allocation concealed**), blinded (outcome assessors)*, controlled trial with 18 months of follow up. Setting Ramsey County and adjacent zip codes, Minnesota, USA. Patients 568 patients who were ≥ 70 years of age (mean age 79 y 56% men), community dwelling, and Medicare beneficiaries; and were at high risk for hospital admission and functional decline. Exclusion criteria included living in a nursing home, illness requiring frequent physician visits, and communication barriers. Follow up was 97%. Intervention Patients were allocated to GEM ($n=294$), consisting of a home visit by a social worker, 2 visits to the GEM clinic, and 6 months of management by an interdisciplinary team, or usual care ($n=274$) for a mean 6 months. A team comprising a geriatrics nurse practitioner, a geriatrician, a social worker, and a nurse assessed patients, set intervention priorities, created a plan of care, and provided comprehensive care. Patients had monthly clinic visits and regular telephone calls between visits. Main outcome measures Functional ability (Sickness Impact Profile: Physical Functioning Dimension [SIP:PFD], bed disability days [BDDs], and restricted activity days [RADs]); depressive symptoms (Geriatric Depression Scale [GDS]); and use and cost of healthcare services (Medicare payments). Main results Analysis was by intention to treat After 18 months of follow up, the GEM group had fewer BDDs ($p = 3$ point increase in SIP:PF score) and had possible depression (GDS score ≥ 11) (table). After adjusting for baseline use of services, home care use at 12 months was less for GEM than for usual care (adjusted OR 0.60, 95% CI 0.37 to 0.98). Groups did not differ for nursing home use or total Medicare costs (US\$ 11 354 v US\$ 11 786, $p=0.93$). Conclusion A

geriatric evaluation and management programme prevented functional decline and reduced bed disability days, depressive symptoms, and home care use, but did not reduce Medicare costs. *See glossary. ** Information provided by author. ***p Value calculated using data in article.

REF ID: 1443

Level I: Systematic Reviews

Topic 1: Risks

Burke, H. M., Davis, M. C., Otte, C., & Mohr, D. C. (2005; 2005). Depression and cortisol responses to psychological stress: A meta-analysis. *Psychoneuroendocrinology*, 30(9), 846-856.

The purpose of this meta-analysis is to examine the association between depression and cortisol responses to psychological stressors. A total of seven studies comparing plasma or cortisol responses to psychological stressors in clinically depressed (MDD) and non-depressed (ND) individuals (N=196: 98 MDD, 98 ND; 83 men, 113 women; mean age=40 years) were included. Sample size-adjusted effect sizes (Cohen's d statistic) were calculated and averaged across baseline (before stressor onset), stress (stressor onset up to 25 min after stressor offset), and recovery (more than 25 min after stressor offset) periods. Overall, MDD and ND individuals exhibited similar baseline and stress cortisol levels, but MDD patients had much higher cortisol levels during the recovery period than their ND counterparts. There was also a significant time of day effect in which afternoon studies were more likely to reveal higher baseline cortisol levels, blunted stress reactivity, and impaired recovery in MDD patients. This blunted reactivity-impaired recovery pattern observed among the afternoon studies was most pronounced in studies with older and more severely depressed patients. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1548

Level II: Individual experimental study

Topic 4.1: Management-General

Callahan, C. M., Kroenke, K., Counsell, S. R., Hendrie, H. C., Perkins, A. J., & Katon, W. et al. (2005; 2005). Treatment of depression improves physical functioning in older adults. *Journal of the American Geriatrics Society*, 53(3), 367-373.

Journal; Peer Reviewed Journal

Objectives: To determine the effect of collaborative care management for depression on physical functioning in older adults. Design: Multisite randomized clinical trial. Setting: Eighteen primary care clinics from eight healthcare organizations. Participants: One thousand eight hundred one patients aged 60 and older with major depressive disorder. Intervention: Patients were randomized to the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) intervention (n=906) or to a control group receiving usual care (n=895). Control patients had access to all health services available as part of usual care. Intervention patients had access for 12 months to a depression clinical specialist who coordinated depression care with their primary care physician. Measurements: The 12-item short form Physical Component Summary (PCS) score (range 0-100) and instrumental activities of daily living (IADLs) (range 0-7). Results: The mean patient age was 71.2, 65% were women, and 77% were white. At baseline, the mean PCS was 40.2, and the mean number of IADL dependencies was 0.7; 45% of participants rated their health as fair or poor. Intervention patients experienced significantly better physical functioning at 1 year than usual-care patients as measured using between-group differences on the PCS of 1.71 (95% confidence interval (CI)=0.96-2.46) and IADLs of -0.15 (95% CI=-0.29 to -0.01). Intervention patients were also less likely to rate their health as fair or poor (37.3% vs 52.4%, P<.001). Combining both study groups, patients whose depression improved were more likely to experience improvement in physical functioning. Conclusion: The IMPACT collaborative care model for late-life depression improves physical function more than usual care. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1479

Level VI: Opinion

Topic 1: Risks

Camus, V., Kraehenbuhl, H., Preisig, M., Bula, C. J., & Waeber, G. (2004; 2004). Geriatric depression and vascular diseases: What are the links? [references]. *Journal of Affective Disorders*,

81(1), 1-16.

Journal; Peer Reviewed Journal

The aims of this study were to review clinical and epidemiological evidence linking geriatric depression and vascular diseases, and to discuss the potential mechanisms that could underlie this association. Systematic review of the literature of the last 5 years through Medline database search. Papers report the following potential ways of association: (1) there is a direct influence of vascular disease, in particular, arteriosclerosis, on the incidence of depression; (2) depressive disorders have a direct impact on the cardiovascular system; (3) depression and vascular disease share either a common pathophysiological process or genetic determinants. Vascular depression is mostly considered to be the consequence of microvascular lesions on prefrontal and subcortical regions. However, this functional neuroanatomical model offers no explanation for cases where depression has been shown to precede vascular diseases. Since cardiovascular diseases develop in a context of acquired environmental factors together with genetically determined disease, it may be postulated that geriatric depression could both result from brain lesions of vascular origin and also share some pathogenic or genetic determinants. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1473

Level VI: Opinion

Topic 4.1: Management-General

Topic 3: Assessment

Cassidy, E. L., Lauderdale, S., & Sheikh, J. I. (2005; 2005). Mixed anxiety and depression in older adults: Clinical characteristics and management. *Journal of Geriatric Psychiatry and Neurology*, 18(2), 83-88.

Journal; Peer Reviewed Journal

The frequent comorbidity of anxiety and depression, particularly among elderly, is widely recognized by clinicians, but the debate continues as to whether the combined diagnostic designation is merited. This article reviews the debate over the mixed diagnosis, discusses treatment implications, and reviews a small treatment study undertaken with elderly patients. Ten community-dwelling, older adults diagnosed with generalized anxiety disorder and subsyndromal depression (n = 6) or generalized anxiety disorder and major depressive disorder (n = 4) were started on a 12-week, open-label trial of nefazodone. Clinicians' ratings on the Clinical Global Impression of Change and patients' self-ratings of symptoms on the Beck Depression Inventory and the Beck Anxiety Inventory identified statistically significant gains in patients' overall pre/post functioning. Nefazodone was efficacious in symptom alleviation in patients with comorbid anxiety and depression. Further double-blind, randomized investigations with newer antidepressant medications are required to extend these preliminary findings with nefazodone. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1586

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Charbonneau, A., Rosen, A. K., Owen, R. R., Spiro, A. I. I. I., Ash, A. S., & Miller, D. R. et al. (2004). Monitoring depression care: In search of an accurate quality indicator. *Medical Care*, 42(6), 522-530.

Journal Article, Research, Tables/Charts

BACKGROUND: Linking process and outcomes is critical to accurately estimating healthcare quality and quantifying its benefits. **OBJECTIVES:** The objective of this study was to explore the relationship of guideline-based depression process measures with subsequent overall and psychiatric hospitalizations. **RESEARCH DESIGN:** This is a retrospective cohort study during which we used administrative and centralized pharmacy records for sample identification, derivation of guideline-based process measures (antidepressant dosage and duration adequacy), and subsequent hospitalization ascertainment. Depression care was measured from June 1, 1999, through August 31, 1999. We used multivariable regression to evaluate the link between depression care and subsequent overall and psychiatric hospitalization, adjusting for patient age, race, sex, socioeconomic status, comorbid illness, and hospitalization in the prior 12 months. **SUBJECTS:** We studied a total of 12,678 patients from 14

Northeastern VHA hospitals. RESULTS: We identified adequate antidepressant dosage in 90% and adequate duration in 45%. Those with adequate duration of antidepressants were less likely to be hospitalized in the subsequent 12 months than those with inadequate duration (odds ratio [OR], .90; 95% confidence interval [CI], .81-1.00). Those with adequate duration of antidepressants were less likely to have a psychiatric hospitalization in the subsequent 12 months than those with inadequate duration (OR, .82; 95% CI, .69-.96). We did not demonstrate a significant link between dosage adequacy and subsequent overall or psychiatric hospitalization. CONCLUSIONS: Guideline-based depression process measures derived from centralized data sources offer an important method of depression care surveillance. Their accuracy in capturing depression care quality is supported by their link to healthcare utilization. Further work is needed to assess the effect of implementing these quality indicators on depression care.

REF ID: 1493

Level VI: Opinion

Topic 3: Assessment

Topic 4.1: Management-General

Charney, D. S., Reynolds, C. F. I. I., Lewis, L., Lebowitz, B. D., Sunderland, T., & Alexopoulos, G. S. et al. (2003; 2003). Depression and bipolar support alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in late life. *Archives of General Psychiatry*, 60(7), 664-672.

Journal; Peer Reviewed Journal

Reviewed progress made in depression and late-life mood disorders and identified areas of unmet need in health care delivery and research. The Consensus Development Panel (CDP) consisted of experts in late-life mood disorders, geriatrics, primary care, mental health and aging policy research, and advocacy. Evidence were 1) literature reviews addressing risk factors, prevention, diagnosis, treatment, and delivery of services and 2) opinions and experiences of primary care and mental health care providers, policy analysts, and advocates. The final document was reviewed and edited to incorporate input from the entire CDP. Despite the availability of safe and efficacious treatments, mood disorders remain a significant health care issue for the elderly and are associated with disability, functional decline, diminished quality of life, mortality from comorbid medical conditions or suicide, demands on caregivers, and increased service utilization. Discriminatory coverage and reimbursement policies for mental health care are a challenge for the elderly, especially those with modest incomes, and for clinicians. Minorities are particularly underserved. Access to mental health care services for most elderly individuals is inadequate, and coordination of service is lacking. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1467

Level VI: Opinion

Topic 3: Assessment

Chiriboga, D. A., Yee, B. W. K., & Jang, Y. (2005; 2005). Minority and cultural issues in late-life depression. *Clinical Psychology: Science and Practice*, 12(3), 358-363.

Journal; Peer Reviewed Journal

Disparities in the identification and treatment of behavioral health problems such as depression have only recently come to the attention of policymakers, researchers, and practitioners. This paper reviews currently available information on critical elements of cultural competence for clinical practice, including not only organizational standards but also the standards recommended for individual providers. Factors that may distinguish a minority elder from non-Hispanic white clients are discussed, as well as potential problems with psychosocial assessment tools. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1243

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Chow, T. W., & MacLean, C. H. (2001 Oct 16). Quality indicators for dementia in vulnerable

community-dwelling and hospitalized elders. *Annals of Internal Medicine*, 135(8 Pt 2), 668-676.

Journal Article

REF ID: 1394

Level I: Systematic Reviews

Topic 4.1: Management-General

Cole, M. G. (2001). The impact of geriatric post-discharge services on mental state. *Age and Ageing*, 30(5), 415-418.

Journal Article, Research, Systematic Review, Tables/Charts

Objective: to determine the impact of geriatric post-discharge services on mental state. Methods: three computer databases, MEDLINE, HealthSTAR and the Cochrane Database of Systematic Reviews were searched for relevant articles; the bibliographies of retrieved articles were searched for additional references. Results: 11 trials were located that met the four inclusion criteria: (i) original study; (ii) published in English or French; (iii) controlled trial (randomized or non-randomized) of a geriatric post-discharge service; and (iv) including at least one measure of mental state. All trials met most of the validity criteria for intervention studies of the EvidenceBased Medicine Working Group. Three trials reported a small effect on emotional state or self-perceived health and eight trials reported no effect. Conclusion: there is little evidence that geriatric post-discharge services have an impact on the mental state of aged subjects. Future services and studies should be designed to address the issue of mental state outcomes in this population.

REF ID: 1597

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Cole, M. G., & Dendukuri, N. (2004 Nov). The feasibility and effectiveness of brief interventions to prevent depression in older subjects: A systematic review. *International Journal of Geriatric Psychiatry*, 19(11), 1019-1025.

Journal Article. Meta-Analysis. Review

OBJECTIVES: To explore the feasibility and effectiveness of brief interventions to prevent depression in older subjects. METHOD: MEDLINE, PsycINFO and HealthStar were searched for potentially relevant articles published from January 1966 to June 2003, January 1974 to June 2003 and January 1975 to June 2003, respectively. The bibliographies of relevant articles were searched for additional references. Ten studies met the following five inclusion criteria: original research, subjects mean age 50 years or more, controlled trial of a brief (<12 weeks) intervention to prevent depression, determination of depression status 12 months or more after enrolment, use of an acceptable definition of depression. The validity of studies was assessed according to six criteria. To examine feasibility we tabulated study enrolment, completion and compliance rates. To examine effectiveness we tabulated differences in depression symptom outcome scores between intervention and control groups or, when possible, absolute (ARR) and relative (RRR) risk reductions for depression. RESULTS: Only two of the ten trials met all of the validity criteria. Study enrolment rates were 21 to 100% (median 72.5%); study completion rates were 46% to 100% (median 85%); compliance rates were 29% to 100% (median 87%). Five of the ten trials had positive results: in two trials there were statistically significant differences in depression symptom outcome scores favoring the intervention group; in three trials ARR were 2.3% to 45% (median 17%); RRRs were 45% to 71% (median 61%). CONCLUSIONS: Some types of brief interventions appear to have the potential to prevent depression in older subjects. Despite the methodologic limitations of the trials and this systematic review, these findings may guide efforts to develop and evaluate brief interventions to prevent depression in this population. Copyright 2004 John Wiley & Sons, Ltd. [References: 39]

REF ID: 1379

Level I: Systematic Reviews

Topic 1: Risks

Cole, M. G., & Dendukuri, N. (2003). Risk factors for depression among elderly community subjects: A systematic review and meta-analysis. *American Journal of Psychiatry*, 160(6), 1147-1156.

Journal Article, Research, Systematic Review, Tables/Charts

OBJECTIVE: The goal of this study was to determine risk factors for depression among elderly community subjects. **METHOD:** MEDLINE and PsycINFO were searched for potentially relevant articles published from January 1966 to June 2001 and from January 1967 to June 2001, respectively. The bibliographies of relevant articles were searched for additional references. Twenty studies met the following six inclusion criteria: original research reported in an English or French publication, study group of community residents, age of subjects 50 years or more, prospective study design, examination of at least one risk factor, and use of an acceptable definition of depression. The validity of studies was assessed according to the four primary criteria for risk factor studies described by the Evidence-Based Medicine Working Group. Information about group size at baseline and follow-up, age, proportion of men, depression criteria, exclusion criteria at baseline, length of follow-up, number of incident cases of depression, and risk factors was abstracted from each report. **RESULTS:** Follow-up of the inception cohort was incomplete in most studies. In the qualitative meta-analysis, risk factors identified by both univariate and multivariate techniques in at least two studies each were disability, new medical illness, poor health status, prior depression, poor self-perceived health, and bereavement. In the quantitative meta-analysis, bereavement, sleep disturbance, disability, prior depression, and female gender were significant risk factors. **CONCLUSIONS:** Despite the methodologic limitations of the studies and this meta-analysis, bereavement, sleep disturbance, disability, prior depression, and female gender appear to be important risk factors for depression among elderly community subjects.

REF ID: 1442

Level I: Systematic Reviews

Topic 1: Risks

Cole, M. G. (2005; 2005). Evidence-based review of risk factors for geriatric depression and brief preventive interventions. *Psychiatric Clinics of North America*, 28(4), 785-803.

This review identifies the risk factors for depression among elderly community subjects and explores the feasibility and effectiveness of brief preventive interventions. The review process involved a systematic selection of articles on each topic, an assessment of validity, the abstraction of data, and the examination of results. The review is presented in two parts (risk factors for depression and brief preventive interventions) and is followed by an overall discussion of the findings and proposals for a research agenda. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1521

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Cole, M. G., Elie, L. M., McCusker, J., Bellavance, F., & Mansour, A. (2001; 2001). Feasibility and effectiveness of treatments for post-stroke depression in elderly inpatients: Systematic review. *Journal of Geriatric Psychiatry and Neurology*, 14(1), 37-41.

Journal; Peer Reviewed Journal

Conducted a systematic review to determine the feasibility and effectiveness of antidepressive treatments for post-stroke depression in elderly medical inpatients. Thirteen reports met the following inclusion criteria: (1) published in English or French; (2) minimum age criterion of 55 yrs and over or mean age 65 yrs and over; (3) post-stroke subjects admitted to a medical, geriatric, or rehabilitation service; (4) used accepted criteria for depression; (5) examined treatment(s) for depression; and (6) reported outcomes as a depression diagnosis and/or symptom level. Data were abstracted independently from each article by 2 reviewers. The limited evidence suggests contraindications to treatment of 83% of a group to receive a heterocyclic antidepressant compared with 11% of a group to receive a selective serotonin reuptake inhibitor (SSRI); rates of discontinuation and study completion are similar for heterocyclics, SSRIs and psychostimulants. All of the treatments appear to be at least modestly effective in the short term. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1558

Level VI: Opinion

Topic 4.1: Management-General

Conn, D. K. (2005). Collaborative care depression management for older adults: Level of

comorbidity does not affect outcome. *Evidence-Based Mental Health*, 8(4), 105.

Journal Article, Abstract, Commentary

critique of: Original Study: Harpole LH, Williams JW Jr., Olsen MK, Stechuchak KM, Oddone E, Callahan CM, Katon WJ, Lin EH, Grypma LM, Unutzer J. Improving depression outcomes in older adults with comorbid medical illness. *GEN HOSP PSYCHIATRY* 2005 Jan-Feb; 27(1): 4-12

Does comorbid medical illness modulate the effectiveness of collaborative care management for depression in older adults? Design: Randomised controlled trial. Allocation: Not clear. Blinding: Single blind (assessors blind to study assignment). Follow up period: Twelve months. Setting: Eighteen primary care clinics in the United States; time period not stated. Patients: 1801 people aged over 60 years old, with current major depression or dysthymia (DSM-IV). Each participant's number of chronic medical comorbidities diagnosed or treated over the previous three years was ascertained. Exclusion criteria included: history of bipolar disorder or psychosis, current treatment by a psychiatrist, current drinking problems or severe cognitive impairment, or acute risk of suicide. Intervention: Improving Mood: Providing Access to Collaborative Treatment (IMPACT) intervention or usual care. Participants receiving IMPACT collaborative care management were assigned a depression clinical specialist (DCS; either a nurse or psychologist) who provided participant education and worked with the participant and healthcare professionals (the participant's physician, a liaison primary care expert, and a psychiatrist) to plan and monitor the participant's care. Treatment followed a stepped care algorithm and could include antidepressants, or psychotherapy provided by the DCS (6--8 sessions of problem solving treatment). The participant had weekly or biweekly contact with the DCS during acute treatment, and monthly thereafter. Outcomes: Severity of depression (Symptom Checklist-90 (SCL-20) score); remission of depression (SCL-20 score \geq 50% decrease in SCL-20 from baseline), and functional status (Mental Component Score of the Short Form 12). Differences between the intervention and usual care were calculated for all participants, and also for the subpopulation with two comorbidities (the first quartile) and the subpopulation with five comorbidities (the third quartile). To assess the effect of comorbidity on treatment effect, between group treatment differences were compared for these two subpopulations. Patient follow up: 83% at 12 months' follow up. MAIN RESULTS Overall, collaborative care management improved depressive symptoms ($p < 0.001$), functional status, and remission and response rates compared with usual care over 12 months. Participants' number of comorbidities had no effect on the efficacy of the intervention at 12 months (comparison of between group differences in subpopulation with two comorbidities v subpopulation with five comorbidities: depressive symptoms $p = 0.45$; remission rate $p = 0.29$; response rate $p = 0.46$; functional status $p = 0.83$). CONCLUSIONS The level of comorbidity in depressed older adults does not modulate the effectiveness of collaborative care management.

Conwell, Y., & Duberstein, P. R. (Eds.). (2001). *Suicide in elders*

REF ID: 1556

Level VI: Opinion

Topic 4.3: Management-Medication

Crystal, S. (2005). Prescription of pharmacotherapy for depression in elderly people varies with age, race, gender, and length of care. *Evidence-Based Mental Health*, 8(4), 117.

Journal Article, Abstract, Commentary

critique of: Original Study: Strothers HS III, Rust G, Minor P, Fresh E, Druss B, Satcher D. Disparities in antidepressant treatment in Medicaid elderly diagnosed with depression. *J AM GERIATR SOC* 2005 Mar; 53(3): 456-61

What is the prevalence of drug treatment for depression in different populations of elderly people insured by Medicaid? METHODS Design: Cross sectional study. Setting: Medicaid claims data from five US states in 1998. Population: 7339 people aged 65--84 years with an outpatient Medicaid claim for depression (international classification of diseases diagnosis). Exclusions: bipolar illness or dysthymia. Assessment Information about Medicaid recipients, including demographics, final action, paid claims, and days in long term care, was obtained from insurance claims data. National drug codes were used to

identify prescriptions for antidepressants. Rates of drug treatment were calculated with 95% confidence intervals. Logistic regression was used to assess the effect of multiple factors on drug treatment. Outcomes: Prevalence of antidepressant prescriptions. MAIN RESULTS In elderly people with depression, 24% received no antidepressant treatment, 26.3% received old antidepressants alone or in combination, 64.3% received new antidepressants alone or in combination, 14.8% received both new and old antidepressants, and 75.8% were treated with any antidepressant (old, new, or both) in the same calendar year. Thirty seven per cent of black people, 22.4% of white people, 13.8% of Asian people and 23.6% of Hispanic people received no drug treatment for depression. Significantly more black, non-Hispanics were receiving no treatment than whites ($p < 0.001$). Other risk factors for no pharmacotherapy were being male, aged 65--74 years and being in long term care (see <http://www.ebmentalhealth.com/supplemental> for table). CONCLUSIONS In the USA, the number of elderly people insured by Medicaid and not receiving drug treatment for their depression is high. Being male, black non-Hispanic, in long term care, and aged 65--74 years old are risk factors for lack of drug treatment. NOTES In this study, "old" antidepressants included tricyclics and mono-amine oxidase inhibitors, and "new" antidepressants were selective serotonin reuptake inhibitors. The study found that State had a significant effect on no drug prescription and on prescription of new antidepressants. State practice may be a confounder in this study. Prevalence studies do not explore causal links, and discrepancies in treatment rates may be due to patient, provider, or system level practice.

REF ID: 1387

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Davidson, K. M. (2003). Evidence-based protocol: Family bereavement support before and after death of a nursing home resident. *Journal of Gerontological Nursing*, 29(1), 10-18.

Journal Article, Practice Guidelines, Questionnaire/Scale, Tables/Charts

Front-line caregivers in nursing homes frequently provide bereavement support to family members before and after the death of a nursing home resident. Use of the evidence-based guideline "Family Bereavement Support Before and After the Death of a Nursing Home Resident" (Davidson, 2002) can reduce uncertainty and increase the confidence of staff providing before and after death care to families, and can ensure all families receive consistent bereavement support.

REF ID: 1389

Level VI: Opinion

Topic 1: Risks

Topic 2: Prevention

Delhougne, D., & Thomson, B. D. (2002). The ADAPT program at geriatrics, inc. *Journal of the American Medical Directors Association*, 3(3), 169-174.

Journal Article, Practice Guidelines, Review

Behavioral problems in elderly patients are stressful for families, long-term care staff and health care providers. The individual patient's quality of life can suffer, and other residents may become fearful when behavioral problems are not appropriately addressed. Management of other issues becomes more difficult. Treatment approaches exist for behavioral problems, but at Geriatrics we found them difficult to apply. In response, we developed and tested our own approach to the behavioral problems of Agitation, Depression, Anxiety, Pain, and Thinking, the ADAPT Program. (This is not to be confused with ADAPT, the Alzheimer's Disease Anti-inflammatory Prevention Trial). The mission of our program is to identify and stratify those behavioral problems that are treatable and then to apply established guidelines for the management of these problems. This goal is accomplished using the tools of (a) word association and (b) probability weighting that involve the entire care team as well as family members.

REF ID: 1594

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Desai, M. M., Rosenheck, R. A., Druss, B. G., & Perlin, J. B. (2002 Sep). Mental disorders and quality of diabetes care in the veterans health administration. *American Journal of Psychiatry*,

159(9), 1584-1590.

Journal Article

OBJECTIVE: The population of persons with mental disorders is potentially vulnerable to poor quality of medical care. This study examined the relationship between mental disorders and quality of diabetes care in a national sample of veterans. **METHOD:** Chart-abstracted quality data were merged with outpatient and inpatient administrative database records for a sample of veterans with diabetes who had at least three outpatient visits in the previous year (N=38,020). Mental health diagnoses were identified by use of the administrative data. Quality of diabetes care was assessed with five indicators by chart documentation: annual foot inspection, pedal pulses examination, foot sensory examination, retina examination, and glycated hemoglobin determination. **RESULTS:** Approximately a quarter of the sample had a diagnosed mental disorder (23.7% with psychiatric disorder only, 1.3% with substance use disorder only, and 2.6% with a dual diagnosis). Overall rates of receipt for the indicators were higher than national benchmarks for all patient subgroups, ranging from 70.8% for retina examination to 95.0% for foot inspection. Rates for both retina examination and foot sensory examination differed significantly by mental health status, mainly because of lower rates among those with a substance use disorder. The associations remained significant in multivariate generalized estimating equation analyses that controlled for demographic characteristics, health status, use of medical services, and hospital-level characteristics. **CONCLUSIONS:** Rates for secondary prevention of diabetes were remarkably high at Department of Veterans Affairs medical centers, although patients with mental disorders (particularly substance use disorders) were somewhat less likely to receive some of the recommended interventions.

REF ID: 1424

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Dunn, C., Deroo, L., & Rivara, F. P. (2001 Dec). The use of brief interventions adapted from motivational interviewing across behavioral domains: A systematic review.[see comment]. *Addiction*, 96(12), 1725-1742.

Journal Article. Review

AIMS: To examine the effectiveness of brief behavioral interventions adapting the principles and techniques of Motivational Interviewing (MI) to four behavioral domains: substance abuse, smoking, HIV risk and diet/exercise. **DESIGN:** We conducted a systematic review of 29 randomized trials of MI interventions. Data on methodological quality were extracted and tabulated. Between-group behavior change effect sizes and confidence intervals were calculated for each study. **FINDINGS:** Due to varying intervention time lengths, targeted problem behaviors, settings and interventionists' backgrounds and skill levels, outcomes were not combined meta-analytically. Sixty per cent of the 29 studies yielded at least one significant behavior change effect size. No significant association between length of follow-up time and magnitude of effect sizes was found across studies. There was substantial evidence that MI is an effective substance abuse intervention method when used by clinicians who are non-specialists in substance abuse treatment, particularly when enhancing entry to and engagement in more intensive substance abuse treatment treatment-as-usual. Data were inadequate to judge the effect of MI in the other domains. Client attribute-treatment interactions were understudied and the sparse and inconsistent findings revealed little about the mechanism by which MI works or for whom it works best.

CONCLUSION: To determine more effectively how well MI works in domains other than substance abuse and for whom it works best in all domains, researchers should study MI with risk behaviors other than substance abuse, while examining both interactions and the theoretical components of MI.

[References: 47]

REF ID: 1457

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Entsuah, A. R., Huang, H., & Thase, M. E. (2001; 2001). Response and remission rates in different subpopulations with major depressive disorder administered venlafaxine, selective serotonin reuptake inhibitors, or placebo. *Journal of Clinical Psychiatry*, 62(11), 869-877.

Compared patient age and gender subpopulations on the basis of remission and response rates associated

with venlafaxine and selective serotonin reuptake inhibitor (SSRI) treatment. A meta-analysis of original data from 8 comparable double-blind, active-controlled, randomized clinical trials was conducted. Antidepressant efficacy was assessed for 2,045 patients (aged 18-83 yrs) who met Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) criteria for major depression or Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) criteria for major depressive disorder and were randomly assigned to receive venlafaxine, 1 of several SSRIs, or placebo for up to 8 wks. Symptoms of depression were assessed using the Hamilton Rating Scale for Depression (HAM-D). Remission was defined as a HAM-D-17 score =50% decrease in HAM-D-21 score, and absence of depressed mood was defined as a HAM-D depressed mood item score of 0. Results show no significant age-by-treatment, gender-by-treatment, or age-by-gender-by-treatment interactions; men and women of different ages within a given antidepressant treatment group exhibited similar rates of remission, response, and absence of depressed mood. Remission rates during venlafaxine therapy were higher than during SSRI therapy. Onset of remission was more rapid with venlafaxine than with SSRI treatment. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1527

Level VI: Opinion

Topic 4.1: Management-General

Freudenstein, U., Jagger, C., Arthur, A., & DonnerBanzhoff, N. (2001; 2001). Treatments for late life depression in primary care--a systematic review. *Family Practice, 18*(3), 321-327.

Journal; Peer Reviewed Journal

Reviews trials of treatments for depression of patients over 60 yrs of age in primary care or population samples. The authors searched Medline, Embase, Cinahl, the Cochrane Library, Psyclit, BIDS--Social Science and BIDS--Science Citation Indices for trials of drug treatment, interpersonal psychotherapy, cognitive behavioural psychotherapy, counselling and social interventions for late life depression in English, French or German published between 1980 and June 1999. Of the studies identified, only 2 were of patients over 60 yrs of age and met all inclusion criteria for content and quality. Three further studies that were not restricted to but included patients over the age of 60 years also fulfilled our criteria. The authors found no studies of psychological therapies for depression in older people. With few exceptions, studies were limited to older people who reached a diagnostic threshold and excluded those with "subcase level depression." There is little evidence of effectiveness for a variety of treatment approaches for depression in older people in primary care, particularly in those with less severe depression. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1608

Level II: Individual experimental study

Topic 4.3: Management-Medication

Fruehwald, S., Gatterbauer, E., Rehak, P., & Baumhackl, U. (2003 Mar). Early fluoxetine treatment of post-stroke depression--a three-month double-blind placebo-controlled study with an open-label long-term follow up. *Journal of Neurology, 250*(3), 347-351.

Clinical Trial. Journal Article. Randomized Controlled Trial

OBJECTIVE: Poststroke depression is a frequent psychiatric complication after stroke that may have strong negative impact on rehabilitation therapy and functional recovery. This study was conducted to show the efficacy and safety of early treatment with the selective serotonin reuptake inhibitor fluoxetine in post-stroke depressed patients. **METHODS:** This double-blind, randomized placebo-controlled study was of patients within two weeks after stroke. Moderate to severe depressed patients (determined by Hamilton Depression Scale (HDS) > 15, the Beck Depression Inventory (BDI) and the Clinical Global Impression (CGI) Scale) were randomized to receive either 20 mg/d fluoxetine or placebo for 3 months. Beside the psychiatric assessment, patients were evaluated by use of the Scandinavian Stroke Scale (SSS), the Mini-Mental-State-Examination (MMSE) and the Barthel-Index (BI). An open-label long-term follow up was done 18 months after the initial assessment. **RESULTS:** 54 depressed patients of an inpatient population of 242 consecutive stroke patients aged 25 to 85 years entered the trial within the first two weeks post-stroke. 50 patients completed the trial per-protocol. The initial severity of depression was comparable in the two groups (mean baseline HDS score 32.8 in the fluoxetine vs. 30.3

in the placebo group), as were neurological symptom severity and demographic parameters. Significant improvement was seen in both groups within 4 weeks of treatment, whereas no advantages of fluoxetine could be observed at this time. This indicates a high degree of spontaneous recovery during early rehabilitation therapy. BDI scores of patients treated with fluoxetine further decreased until the follow-up at 12 weeks, whereas the scores increased again in the placebo group. This depressive relapse of the placebo patients after the end of most rehabilitation efforts was evident at a long-term follow-up 18 months after inclusion, when patients who had been treated with fluoxetine were significantly less depressed. No side effects of fluoxetine treatment were detected. CONCLUSIONS: The advantages of fluoxetine were obvious at the follow-up 18 months after inclusion, but could not be demonstrated within the first three months of controlled treatment. The multitude of therapeutic efforts that take place in the early phase of rehabilitation might have facilitated spontaneous recovery from depression and might have hindered benefits of antidepressant treatment to become obvious. Fluoxetine treatment was well tolerated and safe.

REF ID: 1433

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Furukawa, T. A., Streiner, D. L., & Young, L. T. (2001 Jul). Is antidepressant-benzodiazepine combination therapy clinically more useful? A meta-analytic study. *Journal of Affective Disorders*, 65(2), 173-177.

Journal Article. Meta-Analysis

BACKGROUND: Anxiety frequently coexists with depression, and benzodiazepines are often prescribed together with antidepressants. However, benzodiazepines themselves have little or no antidepressive effects and we lack firm evidence for or against this combination therapy. We therefore conducted a meta-analysis of relevant randomized controlled trials to date. METHODS: All randomized controlled trials that compared antidepressant-benzodiazepine treatment with antidepressant alone for adult patients with major depression were sought by electronic searches of Medline and several other databases (January 1972 to December 1998), combined with hand searching, reference searching and SciSearch. Two reviewers independently assessed the eligibility and quality of the studies. Relative risks were estimated with random effects model. RESULTS: Aggregating nine studies with a total of 679 patients, the combination therapy group was 37% (95%CI: 19-51%) less likely to drop out than the antidepressant alone group. The intention-to-treat analysis showed that the former were 63% (18-127%) to 38% (15-66%) more likely to show response (defined as 50% or greater reduction in the depression scale from baseline) up to 4 weeks. Limitations: None of the included RCTs followed the patients beyond 8 weeks. CONCLUSIONS: The potential benefits of adding a benzodiazepine to an antidepressant must be balanced judiciously against possible harm, including development of dependence and accident proneness, on the one hand, and against continued suffering following no response and drop-out, on the other.

Gatz, M., & Smyer, M. A. (Eds.). (2001). *Mental health and aging at the outset of the twenty-first century*. [references]

REF ID: 1520

Level VI: Opinion

Topic 4.3: Management-Medication

Govoni, S., Racchi, M., Masoero, E., Zamboni, M., & FeriniStrambi, L. (2001; 2001). Extrapyramidal symptoms and antidepressant drugs: Neuropharmacological aspects of a frequent interaction in the elderly. *Molecular Psychiatry*, 6(2), 134-142.

Journal; Peer Reviewed Journal

Depression is the most prevalent functional psychiatric disorder in late life. The problem of motor disorders associated with antidepressant use is relevant in the elderly. Elderly people are physically more frail and more likely to be suffering from physical illness, and any drug given may exacerbate pre-existing diseases, or interact with other drug treatments being administered for physical conditions. Antidepressants have been reported to induce extrapyramidal symptoms, including parkinsonism. These observations prompted us to review the neurobiological mechanism that may be involved in this

complex interplay including neurotransmitters and neuronal circuits involved in movement and emotion control and their changes related to aging and disease. The study of the correlations between motor and mood disorders and their putative biochemical bases, as presented in this review, provide a rationale either to understand or to foresee motor side effects for psychotropic drugs, in particular antidepressants. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1428

Level II: Individual experimental study

Topic 4.1: Management-General

Griffiths, P., Harris, R., Richardson, G., Hallett, N., Heard, S., & Wilson-Barnett, J. (2001 Nov). Substitution of a nursing-led inpatient unit for acute services: Randomized controlled trial of outcomes and cost of nursing-led intermediate care.[see comment]. *Age & Ageing*, 30(6), 483-488. Clinical Trial. Journal Article. Randomized Controlled Trial

OBJECTIVES: To evaluate the outcome and cost of transfer to a nursing-led inpatient unit for 'intermediate care'. The unit was designed to replace a period of care in acute hospital wards and promote recovery before discharge to the community. **DESIGN:** Randomized controlled trial comparing outcomes of care on a nursing-led inpatient unit with the system of consultant-managed care on a range of acute hospital wards. **SETTING:** hospital wards in an acute inner-London National Health Service trust. **SUBJECTS:** 175 patients assessed to be medically stable but requiring further inpatient care, referred to the unit from acute wards. **INTERVENTION:** 89 patients were randomly allocated to care on the unit (nursing-led care with no routine medical intervention) and 86 to usual hospital care. **MAIN OUTCOME MEASURES:** Length of hospital stay, discharge destination, functional dependence (Barthel index) and direct healthcare costs. **RESULTS:** Care in the unit had no significant impact on discharge destination or dependence. Length of inpatient stay was significantly increased for the treatment group ($P=0.036$; 95% confidence interval 1.1-20.7 days). The daily cost of care was lower on the unit, but the mean total cost was pound sterling 1044 higher-although the difference from the control was not significant ($P=0.150$; 95% confidence interval - pound sterling 382 to pound sterling 2471). **CONCLUSIONS:** The nursing-led inpatient unit led to longer hospital stays. Since length of stay is the main driver of costs, this model of care-at least as implemented here-may be more costly. However, since the unit may substitute for both secondary and primary care, longer-term follow-up is needed to determine whether patients are better prepared for discharge under this model of care, resulting in reduced primary-care costs.

REF ID: 1381

Level I: Systematic Reviews

Topic 1: Risks

Grinstead, L. N., Leder, S., Jensen, S., & Bond, L. (2003). Review of research on the health of caregiving grandparents. *Journal of Advanced Nursing*, 44(3), 318-326.

Journal Article, Research, Systematic Review

Aim. To provide a critical review of research literature on the health of grandparents raising grandchildren, and identify directions for future research. **Methods.** Approaches used to access the research studies for this review included a comprehensive search using relevant electronic databases and a thorough examination of the references in each published study. **Findings.** All studies but one were published after 1990. Samples consisted primarily of African-American and Caucasian grandmothers in the United States of America. Earlier studies tended to describe health and other related concepts while more recent studies began to examine relationships between concepts. Most of the studies had a cross-sectional design and only one evaluated interventions. Inconsistencies in the results of these studies were prevalent. **Conclusions.** Evaluation studies, longitudinal designs, and more varied study samples including cross-cultural comparisons are needed to advance knowledge about grandparent caregivers' health.

REF ID: 1475

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Guida, F., Unterbach, A., Tivolacci, J., & Provet, P. (2004; 2004). Residential substance abuse

treatment for older adults: An enhanced therapeutic community model. *Journal of Gerontological Social Work*, 44(1-2), 95-109.

Journal; Peer Reviewed Journal

A review of the epidemiology of substance abuse and corollary treatment capabilities for older adults is summarized. This review demonstrates that there is a growing number of older adults with substance abuse problems, and that a majority of such adults are under-diagnosed and have little access to treatment. Research at Odyssey House, a non-profit, substance abuse and mental health treatment agency based in New York City, where older adults have been treated since 1997 within a discrete residential unit, is reviewed. Findings identify two distinct subgroups among the older adults being treated at Odyssey House: lifelong users (become dependent on drugs during adolescence) and late-in-life users (become dependent on drugs after age 45). Treatment implications are discussed in terms of the provision of special groups, such as trauma and bereavement groups for late-in-life users; and poly-substance abuse and relapse prevention groups for the lifelong users. The Enhanced Therapeutic Community is presented as the primary social group and treatment modality for the effective care of older adults with chemical dependence problems. The community intervention is based on the values and principles of mutual aid and self-help for individuals who are willing and able to share their common experiences while supporting and comforting each other. The Enhanced Therapeutic Community is consistent and contemporary with our social work values and methods of social work with groups today, and is an effective method for the treatment of older adults with substance abuse problems. Two case study vignettes, which mirror the research and group process, are presented. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1546

Level II: Individual experimental study

Topic 4.2: Management-Behavior Therapy

Gum, A. M., Areal, P. A., Hunkeler, E., Tang, L., Katon, W., & Hitchcock, P. et al. (2006; 2006).

Depression treatment preferences in older primary care patients. *Gerontologist*, 46(1), 14-22.

Journal; Peer Reviewed Journal

Purpose: For depressed older primary care patients, this study aimed to examine (a) characteristics associated with depression treatment preferences; (b) predictors of receiving preferred treatment; and (c) whether receiving preferred treatment predicted satisfaction and depression outcomes. Design and Methods: Data are from 1,602 depressed older primary care patients who participated in a multisite, randomized clinical trial comparing usual care to collaborative care, which offered medication and counseling for up to 12 months. Baseline assessment included demographics, depression, health information, prior depression treatment, potential barriers, and treatment preferences (medication, counseling). At 12 months, services received, satisfaction, and depression outcomes were assessed. Results: More patients preferred counseling (57%) than medication (43%). Previous experience with a treatment type was the strongest predictor of preference. In addition, medication preference was predicted by male gender and diagnosis of major depression (vs dysthymia). The collaborative care model greatly improved access to preferred treatment, especially for counseling (74% vs 33% in usual care). Receipt of preferred treatment did not predict satisfaction or depression outcomes; these outcomes were most strongly impacted by treatment condition. Implications: Many depressed older primary care patients desire counseling, which is infrequently available in usual primary care. Discussion of treatment preferences should include an assessment of prior treatment experiences. A collaborative care model that increases collaboration between primary care and mental health professionals can increase access to preferred treatment. If preferred treatment is not available, collaborative care still results in good satisfaction and depression outcomes. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

Hall, M. L. R., & Follette, V. M. (Eds.). (2002). *Substance abuse and interpersonal violence in older adults*

REF ID: 1549

Level II: Individual experimental study

Topic 4.1: Management-General

Harpole, L. H., Williams, J. W. J., Olsen, M. K., Stechuchak, K. M., Oddone, E., & Callahan, C.

M. et al. (2005; 2005). Improving depression outcomes in older adults with comorbid medical illness. *General Hospital Psychiatry*, 27(1), 4-12.

Journal; Peer Reviewed Journal

Background: Depression is common in older adults and often coexists with multiple chronic diseases, which may complicate its diagnosis and treatment. Objective: To determine whether or not the presence of multiple comorbid medical illnesses affects patient response to a multidisciplinary depression treatment program. Design, Setting and Participants: Preplanned analyses of Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), a randomized controlled trial of 1801 depressed older adults (≥ 60 years), which was performed at 18 primary care clinics from eight health care organizations in five states across the United States from July 1999 to August 2001. Intervention: Intervention patients had access for up to 12 months to a depression care manager, supervised by a psychiatrist and a primary care expert, who offered education, care management and support of antidepressant management by the patient's primary care physician, or provided brief psychotherapy (Problem-Solving Treatment in Primary Care). Measurements: Depression, quality of life (QOL; scale of 0-10) and mental health component score (MCS) of the Short-Form 12 assessed at baseline, 3, 6 and 12 months. Results: Patients suffered from an average of 3.8 chronic medical conditions. Although patients with more chronic medical conditions had higher depression severity at baseline, the number of chronic diseases did not affect the likelihood of response to the IMPACT intervention when compared to care as usual. Intervention patients experienced significantly lower depression during all follow-up time points as compared with patients in usual care independent of other comorbid illnesses ($P < .001$). Intervention patients were also more likely to experience substantial response (at least a 50% reduction in depressive symptoms) regardless of the number of comorbidities, to experience improved MCS-12 scores at 3 and 12 months, and to experience improved QOL. Conclusions: The presence of multiple comorbid medical illnesses did not affect patient response to a multidisciplinary depression treatment program. The IMPACT collaborative care model was equally effective for depressed older adults with or without comorbid medical illnesses. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1532

Level VI: Opinion

Topic 4.1: Management-General

Harwood, D. (2001; 2001). Grief in old age. *Reviews in Clinical Gerontology*, 11(2), 167-175.

Journal; Peer Reviewed Journal

Attempts to summarize advances in knowledge on the subject of grief in old age. The differences between normal grief and bereavement-related anxiety, depression, and traumatic grief are discussed. posttraumatic stress disorder (PTSD), alcohol misuse, mortality, suicide, suicidal ideation, prognostic factors, and bereavement in special groups are also discussed. Recommendations for future grief management in older people are offered. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1452

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Hautzinger, M. (2002; 2002). Behavioural therapy with affective and neurological disorders in the elderly. *Verhaltenstherapie & Verhaltensmedizin*, 23(2), 195-212.

Cognitive behavior therapy with older adults is possible, successful, and more and more important. Based on a meta-model of successful aging, psychological interventions for older adults can be developed and implemented. This review describes available cognitive-behavioral interventions for the most prevalent disorders among the elderly, depression, dementia, Parkinson disease, and in addition treatments of caregivers of patients with dementia. Empirical results are scarce and scientific evidence is in its infancy. The few published studies are discussed. It is concluded that currently, only very limited evidence-based recommendations can be given. In the future, more studies will become available, particularly focusing on affective disorders among the elderly. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1415

Level II: Individual experimental study

Topic 4.3: Management-Medication

Hays, J., Ockene, J. K., Brunner, R. L., Kotchen, J. M., Manson, J. E., & Patterson, R. E. et al. (2003 May 8). Effects of estrogen plus progestin on health-related quality of life.[see comment]. *New England Journal of Medicine*, 348(19), 1839-1854.

Clinical Trial. Journal Article. Multicenter Study. Randomized Controlled Trial

BACKGROUND: The Women's Health Initiative (WHI) and other clinical trials indicate that significant health risks are associated with combination hormone use. Less is known about the effect of hormone therapy on health-related quality of life. **METHODS:** The WHI randomly assigned 16,608 postmenopausal women 50 to 79 years of age (mean, 63) with an intact uterus at base line to estrogen plus progestin (0.625 mg of conjugated equine estrogen plus 2.5 mg of medroxyprogesterone acetate, in 8506 women) or placebo (in 8102 women). Quality-of-life measures were collected at base line and at one year in all women and at three years in a subgroup of 1511 women. **RESULTS:** Randomization to estrogen plus progestin resulted in no significant effects on general health, vitality, mental health, depressive symptoms, or sexual satisfaction. The use of estrogen plus progestin was associated with a statistically significant but small and not clinically meaningful benefit in terms of sleep disturbance, physical functioning, and bodily pain after one year (the mean benefit in terms of sleep disturbance was 0.4 point on a 20-point scale, in terms of physical functioning 0.8 point on a 100-point scale, and in terms of pain 1.9 points on a 100-point scale). At three years, there were no significant benefits in terms of any quality-of-life outcomes. Among women 50 to 54 years of age with moderate-to-severe vasomotor symptoms at base line, estrogen and progestin improved vasomotor symptoms and resulted in a small benefit in terms of sleep disturbance but no benefit in terms of the other quality-of-life outcomes. **CONCLUSIONS:** In this trial in postmenopausal women, estrogen plus progestin did not have a clinically meaningful effect on health-related quality of life. Copyright 2003 Massachusetts Medical Society

REF ID: 1551

Level II: Individual experimental study

Topic 4.2: Management-Behavior Therapy

Hegel, M. T., Unutzer, J., Tang, L., Arean, P. A., Katon, W., & Noel, P. H. et al. (2005; 2005).

Impact of comorbid panic and posttraumatic stress disorder on outcomes of collaborative care for late-life depression in primary care. *American Journal of Geriatric Psychiatry*, 13(1), 48-58.

Journal; Peer Reviewed Journal

Objective: Comorbid anxiety disorders may result in worse depression treatment outcomes. The authors evaluated the effect of comorbidpanic disorder andposttraumatic stress disorder (PTSD) on response to a collaborative-care intervention for late-life depression in primary care. **Methods:** A total of 1,801 older adults with depression were randomized to a collaborative-care depression treatment model versus usual care and assessed at baseline, 3, 6, find 12 months, comparing differences among participants with comorbid panic disorder (N=262) and PTSD (N= 191) and those without such comorbid anxiety disorders. **Results:** At baseline, patients with comorbid anxiety reported higher levels of psychiatric and medical illness, greater functional impairment, and lower quality of life. Participants without comorbid anxiety who received collaborative care had early and lasting improvements in depression compared with those in usual care. Participants with comorbid panic disorder showed similar outcomes, whereas those with comorbid PTSD showed a more delayed response, requiring 12 months of intervention to show a significant effect. At 12 months, however, outcomes were comparable. Interactions of intervention status by comorbid PTSD or panic disorder were not statistically significant, suggesting that the collaborative- care model performed significantly better than usual care in depressed older adults both with and without comorbid anxiety. **Conclusions:** Collaborative care is more effective than usual care for depressed older adults with and without comorbid panic disorder and PTSD, although a sustained treatment response was slower to emerge for participants with PTSD. Intensive and prolonged follow-up may be needed for depressed older adults with comorbid PTSD. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1358

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Hill, A., & Brettle, A. (2005). The effectiveness of counselling with older people: Results of a systematic review. *CPR*, 5(4), 265-272.

Journal Article, Research, Systematic Review, Tables/Charts

In 2003 the British Association for Counselling and Psychotherapy (BACP) commissioned a systematic review of the research evidence relating to counselling older people. This paper reports on some of the findings of this review, particularly those which address the effectiveness of counselling with this population. Electronic searches of the research literature spanned six databases and were supplemented by hand-searches of reference lists and key journals, along with an extensive search of the "grey" literature. The location of papers testing interventions which fall within a definition of counselling set out by the BACP, with samples aged 50 years of age or above resulted in the inclusion of 47 relevant studies. Studies investigated a variety of mental health problems in older people, particularly depression, anxiety, dementia and the psychological impact of physical conditions such as chronic obstructive pulmonary disease. Of the 47 studies, eight tested counselling as a generic treatment, 15 tested cognitive behavioural therapy, 13 tested reminiscence therapy, and 11 tested various other specific approaches. The review concluded that counselling is efficacious with older people, particularly in the treatment of anxiety and depression and outcomes are consistent with those found in younger populations. Evidence as to the efficacy of counselling interventions in the treatment of dementia is weak.

REF ID: 1615

Level II: Individual experimental study

Topic 4.3: Management-Medication

Hlatky MA. Boothroyd D. Vittinghoff E. Sharp P. Whooley MA. Heart and Estrogen/Progestin Replacement Study (HERS) Research Group. (2002 Feb 6). Quality-of-life and depressive symptoms in postmenopausal women after receiving hormone therapy: Results from the heart and Estrogen/Progestin replacement study (HERS) trial.[see comment]. *JAMA*, 287(5), 591-597. Clinical Trial. Journal Article. Multicenter Study. Randomized Controlled Trial

CONTEXT: Postmenopausal hormone therapy is commonly used by women for disease prevention, but its effects on quality of life have not been well documented. OBJECTIVE: To determine the effect on quality of life of estrogen plus progestin therapy used as secondary prevention in women with coronary artery disease. DESIGN, SETTING, AND PARTICIPANTS: A total of 2763 postmenopausal women with documented coronary artery disease (mean age, 67 years) in the Heart and Estrogen/Progestin Replacement Study, a randomized, placebo-controlled, double-blind trial conducted from January 1993 to July 1998 at outpatient and community settings at 20 US clinical centers. INTERVENTION: Participants were randomly assigned to receive either 0.625 mg/d of conjugated equine estrogen plus 2.5 mg/d of medroxyprogesterone acetate (n = 1380) or placebo (n = 1383) for 36 months. MAIN OUTCOME MEASURES: Physical activity, measured by the Duke Activity Status Index; energy/fatigue and mental health, measured by RAND scales; and depressive symptoms, measured on the Burnam screening scale, at 3 years of follow-up. RESULTS: In all patients, scores declined significantly over 3 years for physical function (-3.8; P<.001), mental health (-0.6; P =.05), and energy/fatigue (-3.8; P<.001), but depressive symptoms were not significantly changed (P =.20). The effect of hormone therapy on these measures depended on the presence (n = 434) or absence (n = 2325) of flushing at study entry. Women with flushing who were assigned to hormone therapy had improved mental health (+2.6 vs - 0.5; P =.04) and fewer depressive symptoms (-0.5 vs + 0.007; P =.01) over follow-up compared with those assigned to placebo. Women without flushing who were assigned to hormone therapy had greater declines in physical function (-4.2 vs -3.3; P =.04) and energy/fatigue (-4.6 vs -3.1; P =.03) over follow-up. Quality-of-life scores were significantly lower among patients with older age, diabetes, hypertension, chest pain, or heart failure. These differences in quality of life among women classified by clinical characteristics were much greater than the effects of hormone therapy. CONCLUSION: Hormone therapy has mixed effects on quality of life among older women. The effects of hormone therapy depend on the presence of menopausal symptoms; women without flushing had

greater declines in physical measures, while women with flushing had improvements in emotional measures of quality of life.

REF ID: 1588

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Holkup, P. A. (2003). Evidence-based protocol: Elderly suicide -- secondary prevention. *Journal of Gerontological Nursing*, 29(6), 6-17.

Journal Article, Forms, Review, Tables/Charts

REF ID: 1474

Level VI: Opinion

Topic 4.3: Management-Medication

Topic 4.2: Management-Behavior Therapy

Hollon, S. D., Jarrett, R. B., Nierenberg, A. A., Thase, M. E., Trivedi, M., & Rush, A. J. (2005; 2005). Psychotherapy and medication in the treatment of adult and geriatric depression: Which monotherapy or combined treatment? [references]. *Journal of Clinical Psychiatry*, 66(4), 455-468.

Journal; Peer Reviewed Journal

Objective: The authors reviewed the literature with respect to the relative efficacy of medications and psychotherapy alone and in combination in the treatment of depression. Data Sources and Study Selection: Findings from empirical studies comparing medications and psychotherapy alone and in combination were synthesized and prognostic and prescriptive indices identified. We searched both MEDLINE and PsycINFO for items published from January 1980 to October 2004 using the following terms: treatment of depression, psychotherapy and depression, and pharmacotherapy and depression. Studies were selected that randomly assigned depressed patients to combined treatment versus monotherapy. Data Synthesis: Medication typically has a rapid and robust effect and can prevent symptom return so long as it is continued or maintained, but does little to reduce risk once its use is terminated. Both interpersonal psychotherapy (IPT) and cognitive-behavioral therapy (CBT) can be as effective as medications in the acute treatment of depressed outpatients. Interpersonal psychotherapy may improve interpersonal functioning, whereas CBT appears to have an enduring effect that reduces subsequent risk following treatment termination. Ongoing treatment with either IPT or CBT appears to further reduce risk. Treatment with the combination of medication and IPT or CBT retains the specific benefits of each and may enhance the probability of response over either monotherapy, especially in chronic depressions. Conclusion: Both medication and certain targeted psychotherapies appear to be effective in the treatment of depression. Although several prognostic indices have been identified that predict need for longer or more intensive treatment, few prescriptive indices have yet been established to select among the different treatments. Combined treatment can improve response with selected patients and enhance its breadth (IPT) or stability (CBT). (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1363

Level I: Systematic Reviews

Topic 6: Comprehensive

Holman, C., Meyer, J., & Cotter, A. (2004). The complexity of loss in continuing care institutions for older people: A review of the literature. *Illness, Crisis & Loss*, 12(1), 38-51.

Journal Article, Research, Systematic Review

This article analyzes the findings of a literature review undertaken on loss in continuing care institutions. It suggests that research undertaken in continuing care institutions, such as care homes, ignores the complexity and multiplicity of loss, depending on the methodological approach taken (e.g., qualitative field methods, survey research and intervention studies). It argues that different methodological approaches fragment and hide some aspect of loss in these settings. For instance, some methods capture the individual emotional component, while others focus solely on the social dynamic. This fragmentation and hiding of aspects of loss makes research findings of limited value to those working in practice. The article concludes that future studies need to be aware of these tendencies, in order to uncover new meanings of loss more appropriate to the continuing care setting.

REF ID: 1384

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Hsieh, H., & Wang, J. (2003). Effect of reminiscence therapy on depression in older adults: A systematic review. *International Journal of Nursing Studies*, 40(4), 335-345.

Journal Article, Research, Systematic Review, Tables/Charts

The objective of this systematic review is to provide healthcare professionals with information to assist in their decision to utilize reminiscence therapy for depression reduction in older adults outside of the primary care setting. Nine reviewed studies that were randomized controlled trials not only varied in person, outcome measurement, control, and exposure/intervention, the results of these studies were also diverse. About half of these studies showed that reminiscence therapy resulted in statistical significantly decrease in depression. Despite that reminiscence therapy requires further testing, it should be considered as a valuable intervention. Future directions of studies on reminiscence therapy are suggested.

REF ID: 1580

Level VI: Opinion

Topic 4.3: Management-Medication

Hume, W. (2001). Exercise was more effective in the long term than sertraline or exercise plus sertraline for major depression in older adults. *Evidence-Based Mental Health*, 4(4), 105.

Journal Article, Abstract, Commentary

critique of Original Study: Babyak M, Blumenthal JA, Herman S, et al. Exercise treatment for major depression: maintenance of therapeutic benefit at 10 months. *Psychosom Med* 2000 Sep-Oct; 62: 633-8;

QUESTION: Does the therapeutic effect of exercise in older adults with major depression (MD) continue after the intervention period ends? Design Randomised {allocation concealed*}**, blinded {outcome assessors*}, controlled trial with 10 months of follow up. Setting A clinical centre in North Carolina, USA. Patients 156 adults who were {50-77 years of age (mean age 57 y, 72% women)}, met DSM-IV criteria for MD, and scored ≥ 13 on the Hamilton Depression Rating Scale (HDRS). Exclusion criteria were current use of antidepressants, contraindications to exercise or study drugs, current substance abuse, primary axis I psychiatric diagnosis other than MD, high suicide risk, initiation of psychotherapy in previous year, or current regular aerobic exercise. Follow up was 85% at 10 months. Intervention Adults were allocated to exercise {n=53}, sertraline {n=48}, or exercise plus sertraline {n=55} for 4 months. Exercise consisted of 3 supervised 45 minute exercise sessions per week for 16 consecutive weeks. Sertraline was begun at 50 mg/day and titrated up to 200 mg/day. Main outcome measures Rates of remission (no MD according to DSM-IV criteria and HDRS score 7). Main results Analysis was by intention to treat. Groups did not differ for remission rates at 4 months (p=0.89) or for self reported depressive symptoms at 10 months (p=0.13). Depression rates were lower in the exercise group than in the sertraline and sertraline plus exercise groups (p=0.028) (table). Conclusions In older patients with major depression, the therapeutic benefit of exercise continued after the intervention period ended. Depression rates at 10 months were lower for exercise than for sertraline or sertraline plus exercise. * See glossary. **Information provided by author.

REF ID: 1563

Level VI: Opinion

Topic 4.3: Management-Medication

Jacoby, R. (2004). Concomitant loop diuretics and ACE inhibitors increase risk of lithium toxicity in elderly people. *Evidence-Based Mental Health*, 7(4), 120.

Journal Article, Abstract, Commentary

critique of Original Study: Juurlink DN, Mamdani MM, Kopp A, Rochon PA, Shulman KI, Redelmeier DA. Drug-induced lithium toxicity in the elderly: a population-based study. *J AM GERIATR SOC* 2004 May; 52(5): 794-8

In elderly people, is lithium toxicity associated with concomitant use of diuretics, angiotensin

converting enzyme inhibitors, or nonsteroidal anti-inflammatory drugs? METHODS Design: Nested case control study. Follow up period: 10 years (January 1992 to December 2001). Setting: Analysis of linked healthcare databases, Ontario, Canada. People: 10 615 people, aged \geq 66 years (62% women), treated continuously with lithium. Four controls, matched for age, sex, and lithium use were selected (randomly where more than four were identified). Risk factors: Diuretics, including thiazide-type (such as chlorthalidone) and loop diuretics (such as furosemide), angiotensin converting enzyme (ACE) inhibitors or non-steroidal anti-inflammatory drugs (NSAIDs), including selective cyclooxygenase-2 inhibitors, taken concomitantly with lithium. Outcomes: Hospital admission for lithium toxicity (ICD-9 criteria). MAIN RESULTS Over 10 years, 413 people (4%) receiving continuous treatment with lithium were admitted into hospital at least once for lithium toxicity. Of these, 15% required critical care, 3% dialysis, and 5% died before discharge. Existing use of loop diuretics and ACE inhibitors was associated with a modestly increased risk of lithium toxicity. Initiating loop diuretics or ACE inhibitors significantly increased the risk of lithium toxicity: within one month of starting treatment. Hospitalisation was almost six times more likely for people initiating loop diuretics, and four times more likely for those initiating ACE inhibitors compared with case controls (see table). Thiazide diuretics and NSAIDs were not associated with an increased risk of lithium toxicity in both new and existing users. CONCLUSIONS Loop diuretics and ACE inhibitors taken concomitantly with lithium significantly increase the risk of lithium toxicity within one month of beginning treatment.

REF ID: 1589

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Jensdottir, A. B., Rantz, M., Hjaltadottir, I., Gudmundsdottir, H., Rook, M., & Grando, V. (2003). International comparison of quality indicators in united states, icelandic and canadian nursing facilities. *International Nursing Review*, 50(2), 79-84.

Journal Article, Research, Tables/Charts

AIM: To discuss the results of a comparison using minimum data set (MDS)-based quality indicators (QIs) for residents in nursing facilities in three countries (Iceland; Ontario, Canada; and Missouri, United States) together with implications regarding nursing practices and resident outcomes in these countries. METHOD: Data were extracted from databases in each country for four consecutive quarterly periods during 1997 and 1998. All facilities investigated had the required consecutive quarterly data. Analytical techniques were matched to measure resident outcomes using the same MDS-based QIs in the three countries. RESULTS: Similarities among the three countries included the use of nine or more multiple medications, weight loss, urinary tract infection, dehydration, and behavioural symptoms that affect others. Differences among the three countries included bowel and bladder incontinence, indwelling catheter use, fecal impaction, tube feeding use, development of pressure ulcers, bedridden residents, physical restraint use, depression without receiving antidepressant therapy, residents with depression, use of anti-anxiety or hypnotic drugs, use of anti-psychotic drugs in the absence of psychotic and related conditions, residents spending little or no time in activities, and falls. CONCLUSIONS: Comparisons highlighted differences in clinical practices among countries, which may account for differences in resident outcomes. Learning from each other's best practices can improve the quality of care for older people in nursing homes in many countries.

REF ID: 1519

Level VI: Opinion

Topic 1: Risks

Jiang, W., Krishnan, R. R. K., & O'Connor, C. M. (2002; 2002). Depression and heart disease: Evidence of a link, and its therapeutic implications. *CNS Drugs*, 16(2), 111-127.

Journal; Peer Reviewed Journal

Reviews research on the relationship between depression and heart disease (HD) with regard to etiology, disease progression and prognosis, and psychopharmacological treatment of depression. Evidence has suggested that depressive disorder is a risk factor for HDs, etiologically and prognostically. Several large, prospective, longitudinal studies have examined the relationship between depression and development of coronary artery disease (CAD); they reveal that the relationship is significant and

independent of conventional risk factors. Prognostic studies have shown that depression is associated with 2 to 3 times higher mortality after myocardial infarction, unstable angina or coronary artery bypass grafting, and in patients with stable CAD vs such patients without depression. Depression also has increased mortality and morbidity in patients with heart failure, regardless of etiology. However, depressed patients with HD are less likely to be recognized clinically as being depressed than those patients who have depression but no HD. Limited evidence from pharmacological clinical trials raises concern about the safety of antidepressants in CAD and heart failure. No research has addressed whether the treatment of depression in patients with HD will improve their prognosis. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1393

Level VI: Opinion

Topic 6: Comprehensive

Kaldy, J., & Tarnove, L. (2002). A clinical practice guideline approach to treating depression in long-term care. *Journal of the American Medical Directors Association*, 3(2), 103-110.

Journal Article, Practice Guidelines, Review, Tables/Charts

REF ID: 1468

Level VI: Opinion

Topic 3: Assessment Topic 4.2: Management-Behavior Therapy

King, D. A., Heisel, M. J., & Lyness, J. M. (2005; 2005). Assessment and psychological treatment of depression in older adults with terminal or life-threatening illness. *Clinical Psychology: Science and Practice*, 12(3), 339-353.

Journal; Peer Reviewed Journal

Depression decreases the quality of life and hinders efforts to palliate symptoms of adults with terminal or life-threatening illness. Nevertheless, depression often may go undetected and untreated in palliative care and hospice settings due to a number of factors, including the overlap of depressive symptoms with those of serious medical illness and concern that frail elderly patients cannot tolerate psychotherapy or antidepressant treatment. In this paper we review the available research regarding assessment and treatment of depression in older adults with terminal or life-threatening illness, focusing on patients who are seen in palliative care, cancer treatment, or hospice settings. Although the prevalence of depression is relatively high in these settings in mixed-age adult samples, studies focused exclusively on older adults are rare and there appear to be no randomized controlled trials of psychotherapy conducted to date that specifically address their needs. There are, however, promising psychological approaches featured in case reports and pilot studies that are consistent with empirically supported therapies for the general treatment of depression in older adults. Based on these preliminary findings and reports, we offer tentative recommendations for the assessment and treatment of depression in terminally ill older adults. We conclude that controlled research on psychotherapy for late-life depression is both feasible and urgently needed in palliative care, cancer care, and hospice settings. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1533

Level VI: Opinion

Topic 4.3: Management-Medication

Kivela, S. (2001; 2001). Treatment of depressive disorders in old age. *Current Opinion in Psychiatry*, 14(4), 387-393.

Journal; Peer Reviewed Journal

Results indicate that major depressive disorders among the aged can be effectively treated by administration of sertraline fluoxetine, reboxetine, nortriptyline, imipramine, and bupropion sustained release. When secondary outcome measures have been utilized, sertraline has been determined to be superior nortriptyline and fluoxetine in improving cognitive functioning Sertraline may have fewer side effects than nortriptyline. Sertraline, citalopram, and mianserin are effective in reduce depressive symptoms among aged patients with mild or moderate dementia. Imipramine, reboxetine and paroxetine been proven in double-blind studies to reduce depressive symptoms among dysthymic patients or patients with minor depression, and sertraline has been proven to reduce symptoms in an open trial. The

results suggest that maintenance therapy with antidepressants in old age may be safe and effective in preventing recurrences of depression, further studies are needed. Unfortunately, fewer studies have been conducted regarding the effects of psychological treatment of depression in old age. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1484

Level VI: Opinion

Topic 4.1: Management-General

Kohn, R., Goldsmith, E., Sedgwick, T. W., & Markowitz, S. (2003; 2003). In-home mental health services for the elderly. *Clinical Gerontologist*, 27(1-2), 71-85.

Journal; Peer Reviewed Journal

In-home psychiatric services for the elderly are a necessary alternative to traditional forms of mental health care delivery for the comorbid medically ill, the psychiatrically homebound, and those noncompliant with standard outpatient care. This article discusses the different models of in-home psychiatric services. The current Medicare guidelines defining eligibility exclude a sizable proportion of individuals in need of these services. Randomized clinical trials demonstrating the efficacy of in-home psychiatric care in the elderly have not yet been conducted. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1530

Level VI: Opinion

Topic 4.1: Management-General

Kornstein, S. G. (2001; 2001). The evaluation and management of depression in women across the life span. *Journal of Clinical Psychiatry*, 62(Suppl24), 11-17.

Journal; Peer Reviewed Journal

Reviews the literature on special considerations in the evaluation and management of depression in women across the life span. It is argued that depression is more common in women than in men, particularly during the childbearing years, and that women may present with different depressive symptoms than men and may respond differently to antidepressant treatment. The author shows that depression in women can surface in association with specific points in the reproductive cycle, including the premenstrual period, pregnancy, the postpartum period, and the perimenopausal years. It is asserted that antidepressant medications may be used effectively at all stages in a woman's life. In premenstrual dysphoric disorder, serotonergic agents have demonstrated efficacy in both full-cycle and luteal-phase dosing strategies. For depressed women who are pregnant or breastfeeding, the safety data available on antidepressants suggest minimal danger to the fetus or infant, and the risks and benefits to both mother and child must be weighed against the risks of untreated illness. The author suggests that treatment of depression in middle-aged and elderly women should take into account the possible influence of both menopausal status and hormone replacement therapy on antidepressant response. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1454

Level I: Systematic Reviews

Topic 1: Risks

Kraaij, V., Arensman, E., & Spinhoven, P. (2002; 2002). Negative life events and depression in elderly persons: A meta-analysis. *Journals of Gerontology: Series B: Psychological Sciences and Social Sciences*, 57B(1), P87-P94.

In a meta-analysis of 25 studies, the relationship of both specific types of negative life events and the total number of experienced events to depression in old age was studied. Almost all negative life events appeared to have a modest but significant relationship with depression. The total number of negative life events and the total number of daily hassles appeared to have the strongest relationship with depression, whereas sudden unexpected events were the only cluster of negative life events that seemed not to be related to depression scores. These findings suggest that providers and developers of intervention and prevention programs for elderly people should pay attention to the occurrence of negative life events. Special attention should be given to elderly people who have experienced an accumulation of stressful

events and daily hassles, because they seem to be a group at greater risk. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1571

Level VI: Opinion

Topic 4.3: Management-Medication

Kurzthaler, I., & Fleischhacker, W. W. (2004). Sertraline improves depression scores in the elderly in the short term, regardless of medical comorbidity status. *Evidence-Based Mental Health*, 7(3), 82.

Journal Article, Abstract, Commentary

critique of Original Study: Sheikh JI, Cassidy EL, Doraiswamy PM, Salomon RM, Hornig M, Holland PJ, et al. Efficacy, safety, and tolerability of sertraline in patients with late-life depression and comorbid medical illness. *J AM GERIATR SOC* 2004 Jan; 52(1): 86-92

What are the effects of sertraline in elderly people with depression, taking comorbid medical illnesses into consideration? **METHODS:** Design: Randomised, double blind, placebo controlled trial. Allocation: Concealed. Blinding: Participants and assessors blinded. Follow up period: Eight weeks with assessments at baseline and endpoint; the three primary outcome variables were also assessed every 2 weeks. Setting: Multicentre trial in the USA; timeframe not specified. Patients: 752 people, age ≥ 60 years (75% ≥ 65) with major depressive disorder (MDD DSM-IV criteria), and scoring ≥ 18 on the Hamilton Depression Scale (HAMD) with a score ≥ 2 on item 1 (depressed mood), and a minimum of 4 weeks of symptoms. Exclusions: bipolar disorder, schizophrenia, or other psychosis; Mini-Mental State Exam (MMSE) score $\leq 50\%$ in HAMD. Safety and adverse events also assessed. Patient follow up: 97% of participants received at least one dose of study medication and were included in the ITT analysis. Safety: data presented for 80% of participants. **MAIN RESULTS:** The intention to treat analysis included 728 participants. 442 participants had medical comorbidities (vascular disease, diabetes, or arthritis) and were likely to be older, retired, widowed, female, and to have lower ratings of quality of life and functioning than those with no comorbidities (n = 127). Efficacy: at 8 weeks, sertraline significantly improved depression scores compared with placebo for the overall sample (see <http://www.ebmentalhealth.com/supplemental> for table). There were no significant differences in changes of depression score from baseline between people with and without comorbidities for both the placebo and sertraline groups. Adverse events: data presented for 458 participants. More people taking sertraline discontinued the trial compared with placebo; however statistical comparisons between groups are not presented (sertraline: 25/172, 15% v placebo 11/232, 5%). Discontinuation rates were similar for people with and without comorbidities for both the sertraline and placebo groups. **CONCLUSIONS:** Sertraline improved depression scores in elderly people both with and without comorbidities. **NOTES:** Results from the 159 people without vascular disease, diabetes, or arthritis but with a current prescription or hospitalisation in the preceding year are not reported in this study. To be included in the ITT analysis, participants only had to take one dose of medication. More detailed information on the adherence rate, or number of doses taken by participants are not presented. Discontinuation rates are presented for 458/569 (80%) participants.

REF ID: 1369

Level V: Case report

Topic 1: Risks

Topic 2: Prevention

Leff, E. W., & Ryan, S. O. (2005). The role of the home care nurse in suicide prevention. *Home Healthcare Nurse*, 23(9), 566-577.

Journal Article, Case Study, CEU, Exam Questions, Pictorial, Protocol, Tables/Charts

How can you identify your patients who are at risk for suicide? How much can, or should, you do to prevent it? This article provides the basic knowledge and skills you need to confidently answer these questions using OASIS data.

REF ID: 1441

Level I: Systematic Reviews

Topic 1: Risks

Lewis, S. J., Lawlor, D. A., Smith, G. D., Araya, R., Timpson, N., & Day, I. N. M. et al. (2006; 2006). The thermolabile variant of MTHFR is associated with depression in the british women's heart and health study and a meta-analysis. *Molecular Psychiatry*, 11(4), 352-360.

Low dietary folate intake has been implicated as a risk factor for depression. However, observational epidemiological studies are plagued by problems of confounding, reverse causality and measurement error. A common polymorphism (C677T) in MTHFR is associated with methyltetrahydrofolate reductase (MTHFR) activity and circulating folate and homocysteine levels and offers insights into whether the association between low folate and depression is causal. We genotyped this polymorphism in 3478 women in the British Women's Heart and Health Study. In these women, we looked at the association between genotype and three indicators of depression; ever diagnosed as depressed, currently taking antidepressants and the EuroQol mood question. We also carried out a systematic review and meta-analysis of all published studies which have looked at the association between MTHFR C677T genotype and depression. In the British Women's Heart and Health Study, we found evidence of an increased risk of ever being diagnosed as depressed in MTHFR C677T TT individuals compared with CC individuals, odds ratio (OR) 1.35(95% CI: 1.01, 1.80). Furthermore, we identified eight other studies, which have examined the association between depression and MTHFR C677T. We were able to include all of these studies in our meta-analysis together with our results, obtaining an overall summary OR of 1.36 (95% CI: 1.11,1.67, P= 0.003). Since this genotype influences the functioning of the folate metabolic pathway, these findings suggest that folate or its derivatives may be causally related to risk of depression. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1577

Level VI: Opinion

Topic 4.1: Management-General

Lightbody, E., & Baldwin, R. (2002). Inpatient geriatric evaluation and management did not reduce mortality but reduced functional decline. *Evidence-Based Mental Health*, 5(4), 109.

Journal Article, Abstract, Commentary

critique of Original Study: Cohen HJ, Feussner JR, Weinberger M. A controlled trial of inpatient and outpatient geriatric evaluation and management. *N Engl J Med* 2002 Mar 21; 346: 905-12

QUESTION: In frail elderly patients, are inpatient units and outpatient clinics for geriatric evaluation and management (GEM) more effective than usual care? Design 1 year randomised (allocation concealed*), blinded (outcome assessors, except for Physical Performance Test [PPT])*, controlled trial. Setting 11 Veterans Affairs (VA) medical centres. Patients 1388 patients who were ≥ 65 years of age (mean age 74 y, 98% men), were admitted to a medical or surgical ward with an expected length of stay of ≥ 2 days, and were frail (met ≥ 2 of the following: unable to do ≥ 1 basic activity of daily living [ADL], stroke in the previous 3 mo, history of falls, difficulty walking, malnutrition, dementia, depression, ≥ 1 unplanned admission in the previous 3 mo, prolonged bed rest, or incontinence). Exclusion criteria included previous hospital admission in GEM unit, current enrolment in outpatient clinic for GEM, and severe disabling disease or terminal condition. Follow up was 99%. Intervention Patients were allocated to 1 of 4 groups: inpatient care in a GEM unit followed by outpatient care in a GEM clinic (n=346) or usual outpatient care (n=348); or to usual inpatient care followed by outpatient care in a GEM clinic (n=346) or usual outpatient care (n=348). In the GEM unit, a plan of care was developed, and the team met twice weekly to discuss the plan. Main outcome measures Mortality, health related quality of life (Medical Outcomes Study 36-Item Short-Form General Health Survey [SF-36]), and functional status (ability to do ADLs and PPT). Main results The groups did not differ for mortality. The inpatient GEM groups did better on physical functioning, bodily pain, energy, general health, basic ADLs, and physical performance at discharge than the usual inpatient care groups (table). The effect on bodily pain remained at 1 year. The outpatient GEM groups had better scores for energy, mental health, and general health at 1 year than the usual outpatient care groups (table); the effect for mental health remained when scores were compared with scores at discharge. Conclusions In frail elderly patients, inpatient geriatric evaluation and management (GEM) units and outpatient GEM clinics did not reduce

mortality. Inpatient GEM units reduced functional decline, and outpatient GEM clinics improved mental health. *See glossary.

REF ID: 1602

Level II: Individual experimental study

Topic 4.1: Management-General

Topic 1: Risks

Lin, E. H., Katon, W., Von Korff, M., Tang, L., Williams, J. W., Jr, & Kroenke, K. et al. (2003 Nov 12). Effect of improving depression care on pain and functional outcomes among older adults with arthritis: A randomized controlled trial.[see comment][comment]. *JAMA*, 290(18), 2428-2429.

Clinical Trial. Comment. Journal Article. Multicenter Study. Randomized Controlled Trial

CONTEXT: Depression and arthritis are disabling and common health problems in late life. Depression is also a risk factor for poor health outcomes among arthritis patients. **OBJECTIVE:** To determine whether enhancing care for depression improves pain and functional outcomes in older adults with depression and arthritis. **DESIGN, SETTING, AND PARTICIPANTS:** Preplanned subgroup analyses of Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), a randomized controlled trial of 1801 depressed older adults (> or =60 years), which was performed at 18 primary care clinics from 8 health care organizations in 5 states across the United States from July 1999 to August 2001. A total of 1001 (56%) reported coexisting arthritis at baseline. **INTERVENTION:** Antidepressant medications and/or 6 to 8 sessions of psychotherapy (Problem-Solving Treatment in Primary Care). **MAIN OUTCOME MEASURES:** Depression, pain intensity (scale of 0 to 10), interference with daily activities due to arthritis (scale of 0 to 10), general health status, and overall quality-of-life outcomes assessed at baseline, 3, 6, and 12 months. **RESULTS:** In addition to reduction in depressive symptoms, the intervention group compared with the usual care group at 12 months had lower mean (SE) scores for pain intensity (5.62 [0.16] vs 6.15 [0.16]; between-group difference, -0.53; 95% confidence interval [CI], -0.92 to -0.14; P =.009), interference with daily activities due to arthritis (4.40 [0.18] vs 4.99 [0.17]; between-group difference, -0.59; 95% CI, -1.00 to -0.19; P =.004), and interference with daily activities due to pain (2.92 [0.07] vs 3.17 [0.07]; between-group difference, -0.26; 95% CI, -0.41 to -0.10; P =.002). Overall health and quality of life were also enhanced among intervention patients relative to control patients at 12 months. **CONCLUSIONS:** In a large and diverse population of older adults with arthritis (mostly osteoarthritis) and comorbid depression, benefits of improved depression care extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status and quality of life.

REF ID: 1611

Level II: Individual experimental study

Topic 4.2: Management-Behavior Therapy

Lincoln, N. B., & Flannaghan, T. (2003 Jan). Cognitive behavioral psychotherapy for depression following stroke: A randomized controlled trial. *Stroke*, 34(1), 111-115.

Clinical Trial. Journal Article. Randomized Controlled Trial

BACKGROUND AND PURPOSE: There is inconclusive evidence of the effectiveness of psychological interventions for depression after stroke. We report the results from a randomized controlled trial of cognitive behavioral therapy (CBT). **METHODS:** Stroke patients admitted to hospital were invited to complete mood questionnaires 1, 3 and 6 months after stroke. Patients who were depressed were invited to take part in a trial and randomly allocated to receive CBT (n=39), an attention placebo intervention (n= 43), or standard care (n=41). Outcome assessments were undertaken at 3 and 6 months after recruitment, on the Beck Depression Inventory, Wakefield Depression Inventory, Extended Activities of Daily Living scale, London Handicap Scale, and a rating of satisfaction with care. **RESULTS:** There were no significant differences between the groups in patients' mood, independence in instrumental activities of daily living, handicap, or satisfaction with care. **CONCLUSIONS:** CBT in the treatment of depression following stroke was found to be ineffective in this study. However, because of the small sample size, method of recruitment, and selection criteria, further randomized trials are required.

REF ID: 1579

Level VI: Opinion

Topic 1: Risks

Linden, W. (2001). Depression was associated with increased risk of coronary heart disease and death in older adults. *Evidence-Based Mental Health*, 4(2), 60.

Journal Article, Abstract, Commentary

critique of Original Study: Ariyo AA, Haan M, Tangen CM, Rutledge JC, Cushman M, Dobs A, Furberg CD. Depressive symptoms and risks of coronary heart disease and mortality in elderly Americans. *CIRCULATION* 2000 Oct 10; 102(15)

QUESTION: In older adults, is depression a risk factor for coronary heart disease (CHD) and death? Design 6 year cohort study (Cardiovascular Health Study [CHS]). Setting 4 US communities. Participants 4493 participants who were 65-95 years of age (mean age 72 y, 61% women) and had no cardiovascular disease were recruited from medical eligibility lists from each county. Assessment of risk factors Depression was assessed at baseline and annually thereafter using the modified, shorter version of the Center for Epidemiological Studies' Depression Scale. Potential confounding variables (age at entry, race, sex, education, hypertension, diabetes, smoking status, total cholesterol concentrations, physical inactivity, triglycerides, marital status, and alcohol consumption) were also assessed. Main outcome measures CHD defined as first occurrence of angina, myocardial infarction, angioplasty, coronary artery bypass grafting, or coronary death; and all cause mortality. Main results The mean depression score was assessed for each participant at the time of a (CHI) event or death or for up to 6 years of follow up. Every 5 point increase in mean depression score on a 0-30 point scale was associated with a 15% increase in risk of developing CHI (unadjusted and multivariate analysis, $p=0.006$). Increases of 16% (unadjusted, $p<0.001$) and 29% (multivariate, $p=0.006$) were observed in risk of death. The table gives the adjusted hazard ratios. The findings held equally true for men and women. Conclusions In older adults, depression was an independent risk factor for coronary heart disease and death. The risk increased with higher depression scores.

REF ID: 1554

Level VI: Opinion

Topic 1: Risks

Links, P. S. (2006). History of psychiatric hospital admission increases the risk of suicide less in the very old than in middle aged people. *Evidence-Based Mental Health*, 9(1), 24.

Journal Article, Abstract, Commentary

critique of Original Study: Erlangsen A, Mortensen PB, Vach W et al. Psychiatric hospitalisation and suicide among the very old in Denmark: population-based register study. *Br J Psychiatry* 2005; 187: 43-8

Does hospitalisation for psychiatric disorder increase suicide risk in elderly people? **METHODS** Design: Prospective cohort study based on individual level record linkage. Follow up period: Five years. Setting: General population, Denmark; 1 January 1994 to 31 December 1998. People: All people aged 50 years and over living in Denmark between 1994 and 1998 (1 978 527 people). Data on gender, age, and migration was obtained from the Register of Population Statistics. Risk factors: Hospitalisation for psychiatric causes, identified using the Danish Psychiatric Central Register. Outcomes: Death by suicide (ICD-10), identified using the Registry of Causes of Death. Proportional hazards models were used for event history analysis to calculate relative risk for suicide. **MAIN RESULTS** Over the five year period, 2323 people over 50 years old died by suicide. People with a history of psychiatric hospital admission were more likely to commit suicide than people who had no history of psychiatric hospital admission (see <http://www.ebmentalhealth.com/> supplemental for table). In middle aged people (50-64 years old) a history of psychiatric hospital admission increased risk of suicide more than in older people (50-64 year olds: ninefold increase in risk in men, 18-fold in women; >80 year olds: fourfold increase in risk in men, fivefold in women). **CONCLUSIONS** People over 50 years old with a history of psychiatric hospital admission are more likely to commit suicide than those who have never been admitted. The increase in risk is less in elderly people (>65 years old) than in middle aged people (50-64 years old). **NOTES** Authors note that limitations of the study included the small numbers of suicides on which some of the

hazard model estimates are based; the inclusion of only psychiatric hospitalisation in analyses, rather than all people with psychiatric disorders; and the inability to identify unregistered suicides.

REF ID: 1450

Level I: Systematic Reviews

Topic 4.3: Management-Medication

MacGillivray, S., Arroll, B., Hatcher, S., Ogston, S., Reid, I., & Sullivan, F. et al. (2003; 2003). Efficacy and tolerability of selective serotonin reuptake inhibitors compared with tricyclic antidepressants in depression treated in primary care: Systematic review and meta-analysis. *BMJ: British Medical Journal*, 326(7397), 1014-1017.

Presents a meta-analysis of randomized controlled trials comparing the efficacy and tolerability of tricyclic antidepressants with selective serotonin reuptake inhibitors in depression in primary care patients (aged 18-70 yrs). 11 studies (2,951 Ss) compared a selective serotonin reuptake inhibitor with a tricyclic antidepressant. Efficacy between selective serotonin reuptake inhibitors and tricyclics did not differ significantly. Significantly more patients receiving a tricyclic withdrew from treatment and withdrew specifically because of side effects. Most studies included were small and supported by commercial funding. Many studies were of low methodological quality or did not present adequate data for analysis, or both, and were of short duration, typically 6-8 wks. It is concluded that the evidence on the relative efficacy of selective serotonin reuptake inhibitors and tricyclic antidepressants in primary care is sparse and of variable quality. The study setting is likely to be an important factor in assessing the efficacy and tolerability of treatment with antidepressant drugs. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1461

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Mackin, R. S., & Arean, P. A. (2005; 2005). Evidence-based psychotherapeutic interventions for geriatric depression. *Psychiatric Clinics of North America*, 28(4), 805-820. Journal; Peer Reviewed Journal

Since 1991, when the National Institutes of Health consensus statement on the treatment of late-life depression ranked psychotherapy as the third-line treatment option, numerous articles have reviewed the evidence base for psychotherapy research in older adults and have evaluated the efficacy of psychotherapy as a treatment for late-life depression. Most of these studies have focused on the evaluation of cognitive-behavioral therapy, brief dynamic therapy, interpersonal psychotherapy, reminiscence therapy, and the combination of these interventions with medication management. This updated review systematically evaluates the evidence base for psychotherapy as an empirically supported treatment of late life depression. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1538

Level VI: Opinion

Topic 6: Comprehensive

Malaguarnera, L., Ferlito, L., Imbesi, R. M., Gulizia, G. S., Di Mauro, S., & Maugeri, D. et al. (2001; 2001). Immunosenescence: A review. *Archives of Gerontology and Geriatrics*, 32(1), 1-14. Journal; Peer Reviewed Journal

Aging involves the morphological and functional integrity of all organs, including the cellular and humoral immunological functions. In order to evaluate immunosenescence and the relevant modifications in their complexity, it is necessary to analyze the main alterations of the lymphoid organs and the immune cells in various phases of their maturation, activation, and functional differentiation, as well as their secreted products. This review is intended to point out the most important issues of the present knowledge regarding this field. The main alterations that are discussed include (1) thymic involution, (2) T-cells and aging, (3) natural killer cells, (4) B-lymphocytes, (5) immunoglobulins, (6) accessory cells, (7) cytokines, and (8) other related factors, such as general health conditions, nutritional status, psychological situation, life habits, and hormone levels. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1373**Level III: Quasi-experimental study****Topic 4.1: Management-General**

Marek, K. D., Popejoy, L., Petroski, G., Mehr, D., Rantz, M., & Lin, W. (2005). Clinical outcomes of aging in place. *Nursing Research*, 54(3), 202-211.

Journal Article, Research, Tables/Charts

BACKGROUND: Programs such as Medicaid Home and Community-based Services (HCBS) have provided an alternative to institutionalization through community-based, long-term care services; however, there are limited studies on the clinical outcomes of participants in these programs as compared to nursing home (NH) residents. **OBJECTIVE:** To compare clinical outcomes of individuals in a community-based, long-term care program to individuals of similar case mix in institutional-based, long-term care. **METHODS:** A program called Aging in Place (AIP) was developed by the Sinclair School of Nursing in cooperation with the state of Missouri's HCBS program. The AIP intervention consisted of nurse coordination of the HCBS program and Medicare home health services. A total of 78 AIP participants were matched with 78 NH residents on admission period, activities of daily living (ADLs), cognitive status, and age. The Minimum Data Set (MDS) was collected on the AIP group at admission and every 6 months over a 30-month period. Cognition was measured by the MDS Cognitive Performance Scale (CPS), ADLs by the sum of 5 MDS ADL items, depression by the MDS-Depression Rating Scale, and incontinence by rating on 2 MDS items related to urinary continence. The Cochran-Mantel-Haenszel method was used to test the association between the AIP intervention and clinical outcomes. **RESULTS:** The AIP group clinical outcomes were better at a statistically significant level (less than .05) for the following outcomes: (a) cognition at 6, 12, and 18 months ($p = .00$); (b) depression at 6 and 12 months ($p = .00$); (c) ADL at 6 ($p = .02$), 12 ($p = .04$), and 24 ($p = .00$) months; and (d) incontinence at 24 ($p = .02$) months. In all 4 outcome measures, the AIP group stabilized or improved outcome scores whereas the NH group's outcome scores deteriorated. **DISCUSSION:** Study results suggest that community-based care with nurse coordination enhances clinical outcomes of long-term care participants.

REF ID: 1359**Level III: Quasi-experimental study****Topic 4.1: Management-General**

Marek, K. D., Popejoy, L., Petroski, G., & Rantz, M. (2006). Nurse care coordination in community-based long-term care. *Journal of Nursing Scholarship*, 38(1), 80-86.

Journal Article, Research, Tables/Charts

Purpose: To evaluate the clinical outcomes of a nurse care coordination program for people receiving services from a state-funded home and community-based waiver program called Missouri Care Options (MCO). **Design:** A quasi-experimental design was used to compare 55 MCO clients who received nurse care coordination (NCC) and 30 clients who received MCO services but no nurse care coordination. **Methods:** Nurse care coordination consists of the assignment of a registered nurse who provides home care services for both the MCO program and Medicare home health services. Two standardized datasets, the Minimum Data Set (MDS) for resident care and planning and the Outcome Assessment Instrument and Data Set (OASIS) were collected at baseline, 6 months, and 12 months on both groups. Cognition was measured with the MDS Cognitive Performance Scale (CPS), activities of daily living (ADL) as the sum of five MDS ADL items, depression with the MDS-Depression Rating Scale, and incontinence and pressure ulcers with specific MDS items. Three OASIS items were used to measure pain, dyspnea, and medication management. The Cochran-Mantel-Haenszel (CMH) method was used to test the association between the NCC intervention and clinical outcomes. **Findings:** At 12 months the NCC group scored significantly better statistically in the clinical outcomes of pain, dyspnea, and ADLs. No significant differences between groups were found in eight clinical outcome measures at 6 months. **Conclusions:** Use of nurse care coordination for acute and chronic home care warrants further evaluation as a treatment approach for chronically ill older adults.

REF ID: 1491**Level VI: Opinion**

Topic 1: Risks

Memcott, J. L. (2003; 2003). Social work practice with the elderly substance abuser. *Journal of Social Work Practice in the Addictions*, 3(2), 85-103.

Journal; Peer Reviewed Journal

A surprising number of elderly people suffer from substance-related disorders. Many more are at risk for developing polydrug problems due to their misuse and abuse of alcohol in combination with prescription medications and over-the-counter preparations. The purpose of this article is to update social workers on advances in geriatric addictionology by reviewing current epidemiological studies and extracting practice principles. Particular emphasis is placed on what the social work practitioner needs to know about screening elderly clients for substance abuse. The article concludes with specific recommendations to advance social work education and research in the field of addictions treatment. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1487

Level VI: Opinion

Topic 1: Risks

Topic 3: Assessment

Michael, S. T., Crowther, M. R., Schmid, B., & Allen, R. S. (2003; 2003). Widowhood and spirituality: Coping responses to bereavement. *Journal of Women & Aging*, 15(2-3), 145-165.

Journal; Peer Reviewed Journal

Nearly half of women age 65 or older are widows and nearly 70% of these women live alone. Because older women are three times more likely than their male counterparts to be widowed, widowhood has been labeled a primarily female phenomenon. This review article has two aims: (a) to discuss the impact of widowhood on the lives of older women and (b) to discuss how religion and spirituality may be used as coping methods for conjugal loss. After reviewing the literature the authors conclude that older women use religious coping as well as religious and spiritual beliefs and behaviors to facilitate positive adjustment to the loss of a spouse. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1504

Level VI: Opinion

Topic 3: Assessment

Topic 1: Risks

Mills, T. L., & Edwards, C. D. A. (2002; 2002). A critical review of research on the mental health status of older african-americans. *Ageing & Society*, 22(3), 273-304.

Journal; Peer Reviewed Journal

Summarizes current research on the mental health status of older African-Americans, with a specific focus on late-life depression, one of the most common forms of mental disorder among older persons. Virtually none of the empirical studies reviewed adequately address the historical, biographical, or structural factors related to the mental health status of older African-Americans. The authors suggest that to understand contemporary manifestations of racial presumptions, there must be an appreciation of the historical antecedents. African-Americans live with the corrosive effects of a legacy of slavery that presumed Black inferiority. Also discussed are: the relationship between physical health and psychological well being; socioeconomic status and mental health; and racial disparities in mental health referrals, diagnosis, and treatment. The identification of salient factors of risk and resilience among this population is critical to developing effective intervention and mental health maintenance programs. By emphasizing socio-historical influences on the mental health of older African-Americans, we can develop a greater understanding of this population's mental health needs and thus pave the way for improved mental health services and a reduction in mental health disparities. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1365

Level I: Systematic Reviews

Topic 1: Risks

Topic 3: Assessment

Mitchell, A. J., & Subramaniam, H. (2005). Prognosis of depression in old age compared to middle age: A systematic review of comparative studies. *American Journal of Psychiatry*, 162(9), 1588-1601.

Journal Article, Research, Systematic Review, Tables/Charts

OBJECTIVE: Depression in old age has a poor long-term prognosis; equal evidence shows that the same is true of depression in middle age. The authors sought to identify research that has compared the prognosis of depression in late life with depression in midlife under similar conditions. **METHOD:** The authors separated studies that examined age at presentation/recruitment from studies of age at first episode of depression, studies that examined remission/response from those that examined relapse/recurrence, and those that examined mortality/risk of dementia. **RESULTS:** Evidence suggests that response and remission rates to pharmacotherapy and ECT are not sufficiently different in old-age depression and middle-age depression to be clinically significant. Older patients at study entry appear to have a higher risk of further episodes, which informs the debate about the duration of continuation treatment for depression in older people. However, older patients and patients with late-onset depression are at increased risk of medical comorbidity. Medical comorbidity is a risk factor for inferior treatment response and poor antidepressant tolerability. Elderly patients with early-onset depression are more likely to have had a higher number of previous episodes, which also adversely influences prognosis compared to elderly depressed patients with late onset of illness. **CONCLUSIONS:** With control for confounding variables, remission rates of depression in patients in late life are little different from those in midlife, but relapse rates appear higher. Findings underline the importance of assessing factors related to patient age and not just to age itself in evaluations of risk factors for poor prognosis.

REF ID: 1516

Level VI: Opinion

Topic 4.3: Management-Medication

Montgomery, S. A. (2002; 2002). Late-life depression: Rationalizing pharmacological treatment options. *Gerontology*, 48(6), 392-400.

Journal; Peer Reviewed Journal

Depressive symptoms in late life are a major concern as they increase disability and aggravate existing medical conditions. Also, for various reasons depression is underrecognized and undertreated in the elderly. There is little doubt that effective and well-tolerated antidepressant therapy is required. This paper reviews the antidepressant treatment options for late-life depression (selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants, and mixed noradrenergic and serotonergic agents) in terms of their efficacy, safety, and pharmacokinetics in elderly patients. Meta-analyses of studies show that, in addition to proven efficacy, selection of an antidepressant agent for late-life depression must be based on an understanding of safety and pharmacokinetic issues associated with each agent. Comorbid conditions and lifestyle characteristics of the elderly that are different to those encountered in the younger adult population also should be considered. It is concluded that, to date, published clinical evidence in the elderly suggests that the first-choice agents for treating late-life depression are the SSRIs. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1526

Level VI: Opinion

Topic 1: Risks

Morgan, K. (2001; 2001). Mental health factors in late-life insomnia. *Reviews in Clinical Gerontology*, 11(1), 71-81.

Journal; Peer Reviewed Journal

Discusses the mental health factors associated with insomnia, stating that insomnia is a correlate of psychological well-being. The review builds on earlier work and reconsiders the symptom of insomnia within the context of health and aging and with reference to the epidemiological literature, and addresses the question: to what extent is late-life insomnia attributable to mental health problems, with the main focus being on affective disorders. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1360**Level I: Systematic Reviews****Topic 4.3: Management-Medication**

Mottram, P., Wilson, K., & Strobl, J. (2006). Antidepressants for depressed elderly. *The Cochrane Library*, (1)

Journal Article, Research, Systematic Review

A substantive amendment to this systematic review was last made on 07 November 2005. Cochrane reviews are regularly checked and updated if necessary. Background: Depression is a relatively common experience in older adults. The syndrome is associated with considerable distress, morbidity and service commitment. Approximately two thirds of patients presenting with severe forms will respond to antidepressant treatment and the last twenty years has witnessed a great increase in the number of these drugs. Older, frail people are particularly vulnerable to side effects. Objectives: The aims of this review were to examine the efficacy of antidepressant classes, to compare the withdrawal rates associated with each class and describe the side effect profile of antidepressant drugs for treating depression in patients described as elderly, geriatric, senile or older adults, aged 55 or over. Search strategy: The Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Register (CCDANCTR-Studies) was searched (2003-08-13). Reference lists of relevant papers and previous systematic reviews were hand searched for published reports and citations of unpublished studies. Selection criteria: Only randomised controlled trials were included. Trials had to compare at least two active antidepressant drugs in the treatment of depression. Data collection and analysis: Reviewers extracted data independently. In examining efficacy, the reviewers assumed that people who died or dropped out had no improvement. Withdrawal rates irrespective of cause and specifically due to side effects were compared between drug classes. Relative risk (RR) for dichotomous data and weighted mean difference for continuous data were calculated with 95% confidence intervals (CI). Qualitative side effect data were reported in terms of ratios of side effects and percentage of patients experiencing specific side effects. Main results: A total of 29 trials provided data for inclusion in the review. We were unable to find any differences in efficacy when comparing classes of antidepressants. However, as the trials contained relatively small numbers of patients, these findings may be explained by a type two error. Tricyclic antidepressants (TCAs) compared less favourably with selective serotonin reuptake inhibitors (SSRIs) in terms of numbers of patients withdrawn irrespective of reason (RR: 1.24, CI 1.04, 1.47) and number withdrawn due to side effects (RR: 1.30, CI 1.02, 1.64). Subgroup analyses demonstrated that TCA related antidepressants had similar withdrawal rates to SSRIs irrespective of reason of withdrawal (RR: 1.49, CI 0.74, 2.98) or withdrawal due to side effects (RR: 1.07, CI 0.43, 2.70). The qualitative analysis of side effects showed a small increased profile of gastro-intestinal and neuropsychiatric side effects associated with classical TCAs. Authors' conclusions: Our findings suggest that SSRIs and TCAs are of the same efficacy. However, we have found some evidence suggesting that TCA related antidepressants and classical TCAs may have different side effect profiles and are associated with differing withdrawal rates when compared with SSRIs. The review suggests that classical TCAs are associated with a higher withdrawal rate due to side effect experience, although these results must be interpreted with caution due to the relatively small size of the review and the heterogeneity of the drugs and patient populations. [CINAHL Note: The Cochrane Collaboration systematic reviews contain interactive software that allows various calculations in the MetaView.]

REF ID: 1522**Level VI: Opinion****Topic 1: Risks**

Mozley, C. G. (2001; 2001). Exploring connections between occupation and mental health in care homes for older people. *Journal of Occupational Science*, 8(3), 14-19.

Journal; Peer Reviewed Journal

Connections between occupation and the mental health of elderly care home residents are explored with particular reference to depression and dementia. The paper reviews and discusses some of the literature on the prevalence of these conditions in care homes; on resident occupation or inactivity in UK care homes; on the possible role of occupation or its absence in the onset or exacerbation of mental health

problems; and on the effects of various kinds of activity programme. The problems of understanding the causation of depression in this context are discussed--does lack of occupation contribute to onset or exacerbate depression or is depressive illness, with its associated loss of interest, the cause of observed inactivity? Some findings from a large study of new admissions to care homes in North-West England are described, which offer evidence that opportunities for occupation and pleasure in the home contribute both to survival and to mood state 9 mo after admission. The paper concludes with an outline of a new trial of an occupational therapy intervention and its effects on depression in care home residents, due to begin in early 2002 in 8 homes in 2 areas of North-East England. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1531

Level VI: Opinion

Topic 3: Assessment

Mui, A. C., Burnette, D., & Chen, L. M. (2001; 2001). Cross-cultural assessment of geriatric depression: A review of the CES-D and the GDS. *Journal of Mental Health and Aging*, 7(1), 137-164.

Journal; Peer Reviewed Journal

This article reviews published studies on the utility and psychometric properties of the two most widely used screening instruments for depressive symptomatology among older populations, the Center for Epidemiological Studies-Depression Scale (CES-D) and the Geriatric Depression Scale (GDS). Studies on the CES-D confirm its usefulness for measuring depression in diverse groups of older adults, however, further research examining criterion validity among different cultural groups is needed. Sociocultural and health-related factors appeared to influence differential patterns of item endorsement and factor structures of the CES-D in these studies. The composition and hierarchy of factors varied: the well-being factor was consistently problematic in non-Western cultures, two rather than four factors were a better fit for data on Hispanic elders, the interpersonal problem factor was most salient for African Americans, and depressed affect and somatic factors were conflated for American Indians. Research on the psychometric properties of the GDS suggests that without alterations it may not be sufficiently valid for use in other cultures. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1480

Level VI: Opinion

Topic 3: Assessment

Topic 4.1: Management-General

Murphy, C. F., & Alexopoulos, G. S. (2004; 2004). Cognition and late-life depression. *Primary Psychiatry*, 11(5), 54-58.

Journal; Peer Reviewed Journal

It is not uncommon for older patients to present with symptoms of both depression and cognitive impairment. Proper diagnoses in such cases are complicated by overlapping symptoms, heterogeneity of syndromes, and impaired self-report. What follows is a discussion of the literature on the clinical and etiological association of late-life depressive syndromes, cognitive dysfunction, and dementia. Assessment and treatment strategies are discussed with the recommendation that when presented with a depressed elderly patient with cognitive impairment, the clinician should evaluate both the psychiatric symptoms and signs and the cognitive impairment. Careful tracking of both depressive and cognitive features and well-targeted, long-term pharmacotherapy and psychosocial interventions can help reduce the burden on these compromised patients. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1476

Level VI: Opinion

Topic 4.1: Management-General

Topic 3: Assessment

Myers, J. E., & Harper, M. C. (2004; 2004). Evidence-based effective practices with older adults. *Journal of Counseling & Development*, 82(2), 207-218.

Journal; Peer Reviewed Journal

Older persons constitute an increasingly large population with significant mental health challenges. The authors review outcome research for both diagnosable conditions and late-life transitions as a basis for evidence-based practice with this population. Implications for clinical practice in professional counseling, counselor education and supervision, and research are considered. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1445

Level I: Systematic Reviews

Topic 4.5: Management-Surgery

Netz, Y., Wu, M., Becker, B. J., & Tenenbaum, G. (2005; 2005). Physical activity and psychological well-being in advanced age: A meta-analysis of intervention studies. *Psychology and Aging, 20*(2), 272-284.

A meta-analysis examined data from 36 studies linking physical activity to well-being in older adults without clinical disorders. The weighted mean-change effect size for treatment groups ($d\text{-super}(C) = 0.24$) was almost 3 times the mean for control groups ($d\text{-super}(C) = 0.09$). Aerobic training was most beneficial ($d\text{-super}(C) = 0.29$), and moderate intensity activity was the most beneficial activity level ($d\text{-super}(C) = 0.34$). Longer exercise duration was less beneficial for several types of well-being, though findings are inconclusive. Physical activity had the strongest effects on self-efficacy ($d\text{-super}(C) = 0.38$), and improvements in cardiovascular status, strength, and functional capacity were linked to well-being improvement overall. Social-cognitive theory is used to explain the effect of physical activity on well-being. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1447

Level I: Systematic Reviews

Topic 5: Evaluation/Follow-up

O'Rourke, N. (2004; 2004). Reliability generalization of responses by care providers to the center for epidemiologic studies-depression scale. *Educational and Psychological Measurement, 64*(6), 973-990.

The Center for Epidemiologic Studies-Depression (CES-D) Scale is among the most commonly used measures of depressive symptomatology. Despite this, a paucity of research has been undertaken to examine the psychometric properties of responses to this scale. This meta-analytic study examined previously published studies of caregiving to identify factors that predict variance in reliability estimates (i.e., reliability generalization). The results suggest that the type of care recipient, the relationship to the care recipient, and CES-D Scale length each statistically affect reliability estimates. Only the number of items, however, appears to have a substantive effect. It is thus recommended that the original 20-item scale be used. Overall, it appears that responses to the CES-D Scale by care providers are largely reliable across these populations. The findings of an informal survey of authors suggest an incomplete awareness and appreciation for issues regarding reliability induction. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1581

Level VI: Opinion

Topic 4.1: Management-General

Ortiz, I. E. (2002). Review: Geriatric health services after discharge do not improve mental state in elderly people. *Evidence-Based Mental Health, 5*(2), 45.

Journal Article, Abstract, Commentary

critique of Original Study: Cole MG. The impact of geriatric post-discharge services on mental state. *AGE AGEING* 2001 Sep; 30(5): 415-8

QUESTION: In elderly people, do geriatric health services after discharge improve mental state? Data sources Studies were identified by searching Medline (1975 to May 2000), HealthSTAR (1975 to May 2000), and the Cochrane Database of Systematic Reviews (2000, issue 1). Bibliographies of relevant articles were also searched for additional references. Study selection Studies published in English or French were selected if they were original research, randomised or nonrandomised controlled trials of a

geriatric post discharge service, and ≥ 1 measure of mental state was reported. Data extraction Data were extracted on country, study design, sample size, subject selection, key components of the intervention, duration of follow up, quality of the study, and outcomes. Outcomes included depression, morale, life satisfaction, contentment, emotional function, social activities, and self perceived health or cognition. Main results 11 randomised controlled trials (3814 patients, ≥ 60 y of age in 9 trials) met the selection criteria. Interventions included patient assessment and follow up by a multidisciplinary team (physician, nurse, physiotherapist, occupational therapist, social worker or support workers) (5 trials), patient assessment and follow up by a nurse (3 trials), help provided by a home aide or attendant (2 trials), and visitation by a volunteer (1 trial). Small improvements in morale, contentment, emotional function, life satisfaction, and self perceived health were reported in 3 trials. The intervention and control groups did not differ for any of the outcomes in 8 trials. Conclusion In elderly people, geriatric health services after discharge do not improve mental state.

REF ID: 1501

Level VI: Opinion

Topic 3: Assessment

Topic 4.1: Management-General

Osgood, N. J., & Manetta, A. A. (2002; 2002). Physical and sexual abuse, battering, and substance abuse: Three clinical cases of older women. *Journal of Gerontological Social Work*, 38(3), 99-113.

Journal; Peer Reviewed Journal

Women born before 1945 are the older women of today. Many of these women were subjected to childhood physical and sexual abuse and spouse battering at a time where there were no laws to protect them and few people discussed such subjects. Some of these women became substance abusers or lived with substance abusers. While there are retrospective studies on the experiences of adult women who suffered abuse in the family, little is known about the experiences of women over the age of 60 years. Similarly, there is information on substance abuse among young and middle-aged women, but very little information on or about older women's experiences with substance abuse. In this study, we review the literature on abuse and substance abuse. We present three clinical cases of older women who have experienced various forms of abuse and who in turn abuse substances. The cases are analyzed.

Assessment, treatment, and evaluation methods for social workers are discussed. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1553

Level VI: Opinion

Topic 3: Assessment

O'Shea, R. (2006). Cognitive function is not a prognostic factor for long term functional status in older people. *Evidence-Based Mental Health*, 9(2), 37.

Journal Article, Abstract, Commentary

critique of Original Study: van Hooren SAH, van Boxtel MPJ, Valentijn SAM, Bosma H, Ponds RWH, Jolles J. Influence of cognitive functioning on functional status in an older population: 3- and 6-year follow-up of the Maastricht Aging Study. *INT J GERIATR PSYCHIATRY* 2005 Sep; 20(9): 883-8

Is cognitive function related to functional status in older people? **METHODS** Design: Prospective cohort study. Setting: Family practices in the Netherlands (Maastricht Aging Study); 1993 to 2001. Population: 485 people aged 60 or over. Exclusion criteria: clinical diagnosis of depression or dementia; cognitive function impairment due to a medical condition. Prognostic factors: Sensorimotor speed, memory, and executive functioning, (compound scores derived from the relevant sections of the Stroop Colour-Word test, Concept Shifting Task, and Visual Verbal Learning Test). Analyses were adjusted for age, gender, educational level, length of follow up, and cognitive function at baseline. Outcomes: Functional status (physical and mental components of the SF-36 questionnaire). Follow up period: Three and six years. **MAIN RESULTS** At baseline, higher cognitive function was significantly associated with higher functional status. However, there was no correlation between cognitive function at baseline, and decline in functional status at three years (see

<http://www.ebmentalhealth.com/supplemental> for table) or six years (data not shown). **CONCLUSIONS**

Sensorimotor speed, memory, and executive functioning were not prognostic factors for functional status at three to six years in people over 60 years old.

REF ID: 1459

Level VI: Opinion

Topic 2: Prevention

Topic 4.1: Management-General

Oslin, D. W. (2005; 2005). Evidence-based treatment of geriatric substance abuse. *Psychiatric Clinics of North America*, 28(4), 897-911.

Journal; Peer Reviewed Journal

This article outlines the current state of knowledge regarding the magnitude of late-life addictions and considers interventions that target prevention, early intervention, or treatment. The focus is on late-life alcohol misuse but the discussion also introduces concepts regarding medication misuse and the potential emergence of problems related to illicit substance misuse and nicotine. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1573

Level VI: Opinion

Topic 4.1: Management-General

Oxman, T. E. (2003). Collaborative care may improve depression management in older adults. *Evidence-Based Mental Health*, 6(3), 86.

Journal Article, Abstract, Commentary

critique of Original Study: Unutzer J, Katon W, Callahan CM, Williams JW Jr., Hunkeler E, Harpole L, Hoffing M, Della Penna RD, Noel PH, Lin EHB, Arean PA, Hegel MT, Tang L, Belin TR, Oishi S, Langston C. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA* 2002 Dec 11; 288(22): 2836-45

QUESTION: Does collaborative care management improve late life depression? Design Randomised trial with allocation concealment. Outcome assessors were blind to treatment allocation. Setting 18 primary care clinics from 8 healthcare organisations in 5 US states; July 1999-August 2001. Participants 1801 people aged at least 60 years (mean 71 years) with major depression (17%), dysthymic disorder (30%), or both (53%). 65% were women; 23% were from an ethnic minority. Exclusion criteria were drinking problems; history of psychosis or bipolar disorder; concurrent treatment by psychiatrist; severe cognitive impairment; and acute suicide risk. Intervention Improving Mood Promoting Access to Collaborative Treatment (IMPACT) programme (n=906) or usual care (n=895). The IMPACT group received a video and booklet about late life depression and were encouraged to attend a consultation with a depression care manager at their primary care practice. Care managers were trained nurses or psychologists. For up to 1 year, the IMPACT group had access to a depression care manager who offered education, care management and antidepressant management, worked with the primary care physician and was supervised by a psychiatrist. Main outcome measures Depressive symptoms, depression treatments, satisfaction with care, functional impairment, and quality of life were measured at baseline and at 3, 6, and 12 months. Main results At 12 months, 45% of the IMPACT collaborative care group and 19% of the usual care group had a 50% or greater reduction in depressive symptoms from baseline (P < 0.05). The IMPACT group also had higher rates of depression treatment and greater satisfaction with depression care compared with usual care (see table). The IMPACT group had reduced depression severity, less functional impairment, and improved quality of life (all P < 0.001). Conclusions The IMPACT collaborative care model appears more effective than usual care for reducing depressive symptoms in later life.

REF ID: 991

Level I: Systematic Reviews

Topic 4.6: Management-Other

Peacock, S. C., & Forbes, D. A. (2003). Interventions for caregivers of persons with dementia: A systematic review. *Canadian Journal of Nursing Research*, 35(4), 89-107.

Journal Article, Research, Systematic Review, Tables/Charts

The prevalence of dementia in older adults is increasing. Due to cuts in funding for formal support, many families are having to provide care for a loved one with dementia at home. This systematic review gathered and synthesized information on interventions designed to enhance the well-being of caregivers of people with dementia. A search of the literature resulted in 36 relevant studies. Of these, 11 were rated as strong, 11 as moderate, 13 as weak, and 1 as poor. This paper focuses on the strong studies. No one intervention had an overall significant impact on the well-being of caregivers. Although several interventions have been shown to be of benefit to caregivers, non-significant findings were more common. Further investigation is greatly needed. Systematic reviews are an important means of guiding consumers and practitioners in making evidence-based decisions.

REF ID: 1356

Level I: Systematic Reviews

Topic 4.6: Management-Other

Pedersen, B. K., & Saltin, B. (2006). Evidence for prescribing exercise as therapy in chronic disease. *Scandinavian Journal of Medicine & Science in Sports*, 16(Supplement 1), 3-63.

Journal Article, Research, Systematic Review, Tables/Charts

Considerable knowledge has accumulated in recent decades concerning the significance of physical activity in the treatment of a number of diseases, including diseases that do not primarily manifest as disorders of the locomotive apparatus. In this review we present the evidence for prescribing exercise therapy in the treatment of metabolic syndrome-related disorders (insulin resistance, type 2 diabetes, dyslipidemia, hypertension, obesity), heart and pulmonary diseases (chronic obstructive pulmonary disease, coronary heart disease, chronic heart failure, intermittent claudication), muscle, bone and joint diseases (osteoarthritis, rheumatoid arthritis, osteoporosis, fibromyalgia, chronic fatigue syndrome) and cancer, depression, asthma and type 1 diabetes. For each disease, we review the effect of exercise therapy on disease pathogenesis, on symptoms specific to the diagnosis, on physical fitness or strength and on quality of life. The possible mechanisms of action are briefly examined and the principles for prescribing exercise therapy are discussed, focusing on the type and amount of exercise and possible contraindications. PMID: 16451303 [PubMed - indexed for MEDLINE]

REF ID: 1515

Level VI: Opinion

Topic 3: Assessment

Pessin, H., Rosenfeld, B., & Breitbart, W. (2002; 2002). Assessing psychological distress near the end of life. *American Behavioral Scientist*, 46(3), 357-372.

Journal; Peer Reviewed Journal

Psychological suffering is one of the most significant and potentially remediable impediments to the dying process for terminally ill patients and their families. This article reviews several of the most common psychological disorders that arise in the context of terminal illness, including depression, anxiety, delirium, and suicidal ideation. Issues related to assessment, measurement, and differential diagnosis are reviewed. Case vignettes are presented regarding differential diagnoses of depression, anxiety, and delirium in 3 end-stage cancer patients. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1377

Level I: Systematic Reviews

Topic 1: Risks

Pinquart, M., & Sorensen, S. (2004). Associations of caregiver stressors and uplifts with subjective well-being and depressive mood: A meta-analytic comparison. *Aging & Mental Health*, 8(5), 438-449.

Journal Article, Research, Systematic Review, Tables/Charts

The present meta-analytic study gives a systematic review of research on depression and the subjective well-being of caregivers. We integrate results from 60 studies on informal caregivers' subjective well-being (e.g., positive affect, life-satisfaction) and contrast them with the result of studies on caregiver depression. Analyses were based on a two-factor model of subjective well-being that distinguishes between positive and negative dimensions of well-being (e.g., happiness and depression). The strongest

effects were domain-specific: uplifts of caregiving were associated with subjective well-being and caregiving stressors were associated with depression. In addition, weaker effects that crossed domains were present: uplifts were weakly associated with depressive symptoms. In addition, lower levels of caregivers' subjective well-being were weakly related to care receivers' physical and cognitive impairments, as well as behaviour problems, but not to the amount of caregiving. Type of care recipients' illness and the measure of well-being moderated, in part, the association between stressors/uplifts and subjective well-being.

REF ID: 1455

Level I: Systematic Reviews

Topic 3: Assessment

Pinquart, M. (2001; 2001). Correlates of subjective health in older adults: A meta-analysis. *Psychology and Aging, 16*(3), 414-426.

Age-associated changes of subjective health and associations of subjective health with physical health, functional health, and mental health were meta-analyzed in older adults (mean age > 60 yrs). An age-associated decline of subjective health, which was stronger in old-old samples than in young-old samples, was found. Subjective health was correlated with the indicators of objective health, but the association with physical health was stronger than with functional health. Correlations of subjective health with physical health and functional health were lower in the old-old than in the young-old samples, whereas associations of subjective health with mental health were stronger in older samples. Furthermore, the size of the association between subjective and objective health varied by the method of assessment of objective health, showing highest associations with symptom checklists and results of medical examinations due to strict protocols. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1456

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Pinquart, M., & Sorensen, S. (2001; 2001). How effective are psychotherapeutic and other psychosocial interventions with older adults? A meta-analysis. *Journal of Mental Health and Aging, 7*(2), 207-243.

Conducted a meta-analysis of 122 psychosocial and psychotherapeutic intervention studies of older adults (aged 55-76+ yrs), primarily with depression. Types of interventions included cognitive-behavioral therapy, psychodynamic therapy, reminiscence, relaxation, supportive treatments, control enhancing treatments, psychoeducational treatments, interventions to increase activity and cognitive ability training. Results show that cognitive-behavioral therapy had above-average effects on depression and other self-ratings of subjective well-being (SWB). Control-enhancing interventions had above-average effects on non-depression SWB. Individual interventions were more effective than group interventions, as were interventions with depressed vs non-depressed seniors. A combination of therapists' high general qualification and specialized training in working with older adults was associated with an above-average effect size. Effects of interventions on depression were weaker for older than younger Ss, but improvements in depression were also statistically significant in the oldest group (median age ≥ 77 yrs). There was no age-associated decline in intervention effects on other measures of SWB (life-satisfaction, morale). (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1395

Level VI: Opinion

Topic 3: Assessment

Piven, M. L. S. (2001). Detection of depression in the cognitively intact older adult protocol... copyright (c) [1998] the university of iowa gerontological nursing interventions research center research dissemination core. all rights reserved. republished with permission. *Journal of Gerontological Nursing, 27*(6), 8-14.

Journal Article, Forms, Protocol, Questionnaire/Scale, Tables/Charts

Powers, D. V., Thompson, L., Futterman, A., & GallagherThompson, D. (Eds.). (2002). *Depression in later life: Epidemiology, assessment, impact, and treatment*

REF ID: 1555

Level VI: Opinion

Topic 4.6: Management-Other

Price, J. R. (2006). A structured activity programme reduces depressive symptoms in moderately depressed older men with coronary heart disease, but not women. *Evidence-Based Mental Health*, 9(1), 17.

Journal Article, Abstract, Commentary

critique of Original Study: Salminen M, Isoaho R, Vahlberg T et al. Effects of a health advocacy, counselling, and activation programme on depressive symptoms in older coronary heart disease patients. *Int J Geriatr Psychiatry* 2005; 20: 552-8;

Does a programme of education, physical activity, and social activities for people with coronary heart disease reduce depressive symptoms? **METHODS** Design: Randomised controlled trial. Allocation: Unclear. Blinding: Unblinded. Follow up period: Baseline measurements taken in August 1999, follow up measurements between October 2000 and January 2001. Setting: Lieto, Finland; 1998 to 2001. Patients: 251 home dwelling residents aged 65 and over with coronary heart disease. Subgroup analysis was undertaken in people with moderate or high depressive symptoms at baseline (Zung Self-rating Depression Scale score ≥ 45 ; $n=59$). Intervention: Structured activity programme: 16 month programme consisting of 16 lectures, eight group discussions, six light exercise sessions, and three social events. Sessions aimed to increase awareness of the prevention and treatment of coronary heart disease, social activity and support, and physical activity. Control: usual care (not further defined). Outcomes: Depressive symptoms (Zung Self-rating Depression Scale; ZSDS). Patient follow up: 88%. **MAIN RESULTS** Overall, neither the structured activity programme nor usual care improved depressive symptoms in women or men, with no difference between groups ($p \geq 0.5$). In men with moderate or high depressive symptoms at baseline, the structured activity programme improved symptoms more than usual care (median ZSDS score change: -1.0 with activity programme v +3.0 with usual care, $p = 0.015$). In women with moderate or high depressive symptoms at baseline, symptoms improved with both the structured activity programme and usual care, with no significant difference between groups (median ZSDS score change: -2.0 v -3.0, $p = 0.95$). **CONCLUSIONS** In older people with coronary heart disease as a whole, a structured activity programme did not improve self-rated depressive symptoms. However, the programme improved symptoms more than usual care in the subgroup of men who had at least moderate depressive symptoms at the start of the study. There was no extra benefit from the programme in women. **NOTES** The gender difference in programme effectiveness may be due to differences in pre-existing levels of social activity in these populations, or the more serious coronary heart disease symptoms experienced by male participants.

REF ID: 1565

Level VI: Opinion

Topic 4.6: Management-Other

Raj, A. (2004). PEARLS home based treatment significantly improves depression, dysthymia, and health related quality of life in older people. *Evidence-Based Mental Health*, 7(4), 110.

Journal Article, Abstract, Commentary

critique of Original Study: Ciechanowski P, Wagner E, Schmaling K, Schwartz S, Williams B, Diehr P, Kulzer J, Gray S, Collier C, LoGerfo J. Community-integrated home-based depression treatment in older adults: a randomized controlled trial. *JAMA* 2004 Apr 7; 291(13): 1569-77

How effective is a home based treatment for minor depression and dysthymia in older people with chronic illnesses? **METHODS** Design: Randomised controlled trial. Allocation: Concealed. Blinding: Assessors blinded to treatment. Follow up period: 12 months. Setting: Seattle, Washington, USA; January 2000 to May 2003. Patients: 138 adults with a mean age of 73 years (79% women). Participants had minor depression (51%) or dysthymia (49%) and a mean of 4.6 chronic medical ailments. 72% of

participants also lived alone. People with major depression, bipolar disorder, psychosis, substance abuse, or cognitive impairment were excluded. Intervention: Participants were randomly assigned to usual care or the home based intervention: Program Encourage Active, Rewarding Lives for Seniors (PEARLS). PEARLS involved eight 50 minute problem solving treatment sessions with social and physical activities, over 19 weeks; these sessions were modified to increase social and physical activities. Physical activation began at session 3 or 4 and aimed to encourage regular moderate physical activity for at least 30 minutes, five days a week. Social activation aimed to increase participants' interactions outside the home, with group activities encouraging peer support given highest priority. Each session included selecting pleasant activities to engage in before the next session (from a list of 250). Outcomes: Improvement of depressive symptoms: Hopkins Symptom Checklist 20, (range 1-4, with 1.72 indicating major depression); improvement in health related quality of life (Functional Assessment of Cancer Therapy Scale-General). Patient follow up: 92% at 12 months. MAIN RESULTS At 12 months, PEARLS significantly reduced depressive symptoms compared with usual care (50% or greater reduction in depressive symptoms: 43% v 15%; OR 5.21; 95% CI 2.01 to 13.49). PEARLS significantly increased complete remission compared with usual care (36% v 12%, OR 4.96; 95% CI 1.79 to 13.72). PEARLS significantly improved health related quality of life in the domains of functional wellbeing (p = 0.001) and emotional wellbeing (p = 0.048) compared with usual care. There were no significant differences between groups in social and physical wellbeing. CONCLUSIONS The PEARLS home based treatment significantly reduces symptoms of depression and improves health related quality of life for elderly people with minor depression and dysthymia.

REF ID: 1584

OM: Quality Measures

Topic 5: Evaluation/Follow-up

Rees, A., Richards, A., & Shapiro, D. A. (2004). Utility of the HoNOS in measuring change in a community mental health care population. *Journal of Mental Health, 13*(3), 295-304.

Journal Article, Research, Tables/Charts

Background: Given that, for many community health care teams, the HoNOS is the audit tool of choice, further work is needed to establish the viability of using this instrument to assess health change. Aims: To assess the usefulness of the HoNOS in measuring change in a population on the caseloads of community mental health teams. Method: Key workers or care co-ordinators of 195 selected patients on the caseloads of a national sample of 10 generic community mental health teams rated patients on the HoNOS four times over a period of 4 - 6 months. Patients had previously received a primary diagnosis of anxiety, depression, psychosis, personality disorder, or substance misuse on the Manchester Audit Tool. Results: In this population, the HoNOS marginally discriminated amongst diagnoses, and was associated with severity and complexity but not chronicity. Scores on the HoNOS changed differentially over time according to diagnosis and severity. Conclusion: A change of 3 to 4 points on the HoNOS is small, but statistically significant, and may be a useful basis for tracking the clinical improvement of neurotic patients, and the clinical stability of those with psychosis. Declaration of interest: This study was supported by a grant from the UK Department of Health's Policy Research Branch, Human Resources and Effectiveness Programme, to Michael West, Simon Garrod, and David Shapiro.

REF ID: 1503

Level VI: Opinion

Topic 1: Risks

Reutens, S., & Sachdev, P. (2002; 2002). Homocysteine in neuropsychiatric disorders of the elderly. *International Journal of Geriatric Psychiatry, 17*(9), 859-864.

Journal; Peer Reviewed Journal

This article reviews the literature on the relationship between homocysteine as a risk factor for stroke, dementia, depression, and Parkinson's disease to ascertain if any clinical recommendations can be made. A MEDLINE and EMBASE search was made for English language publications between 1966 and 2002. In addition, individual articles were hand searched for relevant references. Cross-sectional studies consistently suggest that elevated homocysteine increases the risk of stroke, and may also increase the risk of leukoariosis, vascular dementia, cognitive impairment, and Alzheimer's disease. Longitudinal

studies of homocysteine as a risk factor are few and inconsistently supportive of these associations. No intervention trials to determine the effect of lowering homocysteine levels have yet been published. The pathological mechanisms for homocysteine-mediated disease await complete elucidation. Mild hyperhomocysteinemia is common in the elderly population, and folate supplementation can decrease homocysteine levels. It is concluded that screening the population for hyperhomocysteinemia cannot be recommended at this stage, but individuals at increased risk of cerebrovascular disease or cognitive impairment should be investigated and treated for elevated homocysteine levels. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1514

Level VI: Opinion

Topic 4.1: Management-General

Robb, C., Chen, H., & Haley, W. E. (2002; 2002). Ageism in mental health and health care: A critical review. *Journal of Clinical Geropsychology*, 8(1), 1-12.

Journal; Peer Reviewed Journal

Discussions of aging and mental health widely assume that ageism among mental health providers is an important factor limiting access to mental health services for older adults. Given the widespread citation of ageism as a problem, the authors critically review the history of the ageism construct, and evidence for its existence in both mental health and medical professionals. There is surprisingly little empirical evidence for age bias among mental health providers. Considerable evidence does suggest differential medical treatment for older adults in such diverse areas as physician-patient interaction, use of screening procedures, and treatment of varied medical problems, although it is unclear whether age bias accounts for these differences. The authors suggest that innovations in delivery of psychological services, such as collaborative medical/psychological care in primary care settings, may ultimately prove more useful in improving access to mental health services than efforts to combat ageism. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1444

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Roose, S. P., & Schatzberg, A. F. (2005; 2005). The efficacy of antidepressants in the treatment of late-life depression. *Journal of Clinical Psychopharmacology*, 25(4,Suppl1), S1-S7.

This review addresses the question of whether there is evidence that antidepressants are more efficacious than placebo in the treatment of late-life depression and what is the rate of response that physician and patient can expect when antidepressant medication is prescribed in a typical clinical setting. To date, 5 placebo-controlled and 10 comparison trials have study designs of sufficient rigor to provide evidence of antidepressant efficacy and effectiveness in the treatment of late-life depression. The results suggest that antidepressant medications are more effective than placebo. However, placebo-controlled trials are not a simple comparison of only medication versus placebo. Rather, the amount of nonspecific psychosocial interventions included in these trials is considerable and often not systematically measured. Trial design also affects outcome: response and remission rates in comparison trials consistently are 20% to 30% higher than those reported in placebo-controlled trials. Clinical trials do not consistently assess the many moderators that are believed to affect treatment outcome in late-life depression, and therefore, comparisons across studies are problematic because of an inability to determine whether patient samples are truly comparable. For future clinical trials to have maximal relevance, study design should evolve to reflect as closely as possible a typical clinical setting especially with respect to frequency and duration of patient visits. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1366

Level VI: Opinion

Topic 6: Comprehensive

Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. (2004). Australian and new zealand clinical practice guidelines for the treatment of depression. *Australian and New Zealand Journal of Psychiatry*, 38(6), 389-407.

Journal Article, Practice Guidelines, Tables/Charts

BACKGROUND: The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is coordinating the development of clinical practice guidelines (CPGs) in psychiatry, funded under the National Mental Health Strategy (Australia) and the New Zealand Ministry of Health. **METHOD:** The CPG team reviewed the treatment outcome literature, consulted with practitioners and patients and conducted meta-analyses of outcome research. **TREATMENT RECOMMENDATIONS:** Establish an effective therapeutic relationship; provide the patient with information about the condition, the rationale for treatment, the likelihood of a positive response and the expected timeframe; consider the patient's strengths, life stresses and supports. Treatment choice depends on the clinician's skills and the patient's circumstances and preferences, and should be guided but not determined by these guidelines. In moderately severe depression, all recognized antidepressants, cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT) are equally effective; clinicians should consider treatment burdens as well as benefits, including side-effects and toxicity. In severe depression, antidepressant treatment should precede psychological therapy. For depression with psychosis, electroconvulsive therapy (ECT) or a tricyclic combined with an antipsychotic are equally helpful. Treatments for other subtypes are discussed. Caution is necessary in people on other medication or with medical conditions. If response to an adequate trial of a first-line treatment is poor, another evidence-based treatment should be used. Second opinions are useful. Depression has a high rate of recurrence and efforts to reduce this are crucial.

REF ID: 1420

Level II: Individual experimental study

Topic 1: Risks

Sailer, M., Fuchs, K. H., Fein, M., & Thiede, A. (2002 Sep). Randomized clinical trial comparing quality of life after straight and pouch coloanal reconstruction.[see comment]. *British Journal of Surgery*, 89(9), 1108-1117.

Clinical Trial. Journal Article. Randomized Controlled Trial

BACKGROUND: Functional results after rectal resection with straight coloanal anastomosis are poor. While most functional aspects are improved with coloanal J pouch anastomosis, it is still unclear whether this translates into better quality of life. The aim of this trial was to investigate health-related quality of life as a primary endpoint in patients undergoing sphincter-saving rectal resection. **METHODS:** Sixty-four patients were randomized to either straight (n = 32) or coloanal J pouch (n = 32) anastomosis. Patients were studied before operation, at the time of stoma reversal and at 3-month intervals for 1 year thereafter. Quality of life was measured using two generic (Gastrointestinal Quality of Life Index and European Organization for Research and Treatment of Cancer (EORTC) QLQ-C30) and one disease-specific (EORTC QLQ-CR38) instruments. Functional results using a standardized score as well as manometric variables were recorded. **RESULTS:** Thirty-nine patients (19 with a pouch and 20 with a straight anastomosis) completed the trial. There was a marked difference between the two groups with regard to quality of life profile. Patients with a pouch reconstruction had a significantly better quality of life, particularly in the early postoperative period. **CONCLUSION:** Patients undergoing low anterior rectal resection and coloanal J pouch reconstruction may expect not only better functional results but also an improved quality of life in the early months after surgery compared with patients who receive a straight coloanal anastomosis.

REF ID: 1506

Level VI: Opinion

Topic 4.3: Management-Medication

Topic 4.5: Management-Surgery

Salzman, C., Wong, E., & Wright, B. C. (2002; 2002). Drug and ECT treatment of depression in the elderly, 1996-2001: A literature review. *Biological Psychiatry*, 52(3), 265-284.

Journal; Peer Reviewed Journal

A computer-based literature search of all antidepressant and electroconvulsive therapy (ECT) treatment studies published between 1995 and September 2001 was conducted. In addition, a review of published chapters, review articles, and metaanalyses was also conducted. Articles were categorized into those

reporting comparative studies, those in which the therapeutic agent was not compared with another, articles about ECT, and review articles. These recent publications support the conclusions from prior reviews that antidepressants and ECT are effective and safe treatments for depressed elderly patients. Differences in efficacy and side effects appear to be slight among the various types of antidepressants. Research studies of depressed elderly increased markedly since 1995 compared with all previous years although more studies are still necessary. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1535

Level VI: Opinion

Topic 6: Comprehensive

Saz, P., & Dewey, M. E. (2001; 2001). Depression, depressive symptoms and mortality in persons aged 65 and over living in the community: A systematic review of the literature. *International Journal of Geriatric Psychiatry, 16(6), 622-630.*

Journal; Peer Reviewed Journal

Estimated the influence of depression and depressive symptoms on mortality in the older population. Studies that consisted of a majority population of over 65 yrs and were drawn from a community or random sample from Medline, Embase, personal files, and colleagues' records were considered for this review. The author found 21 reports on 23 cohorts using a depression diagnosis. For 15 of these, odds ratios were pooled by using the Greenland method based on confidence intervals, giving an estimated odds ratio for mortality with depression of 1.73. A fixed effects meta-regression of these studies suggested that longer follow-up predicted smaller depression on mortality for women. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1512

Level VI: Opinion

Topic 4.3: Management-Medication

Scalco, M. A. (2002; 2002). Depression treatment of elderly patients using tricyclics, MAOI, SSRI, and other antidepressants. *Revista Brasileira De Psiquiatria, 24(Suppl1), 55-63.*

Journal; Peer Reviewed Journal

Reviews data on the efficacy and safety of antidepressant agents currently available for the treatment of the elderly, including information about the treatment of specific populations such as physically frail patients and those with dementia. Antidepressants are effective in treating depression in the elderly, but treatment response depends on the type and severity of depression, comorbidities, efficacy and tolerability of antidepressants, patient education and treatment compliance. The aging process leads to physiological changes that, in association with concomitant diseases and use of several medications, render the elderly person more vulnerable to the adverse effects of antidepressants and increased risk of drug interactions. It is seen as very important that psychiatrists treating elderly patients be aware of possible adverse effects and drug interactions of different antidepressants. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1511

Level VI: Opinion

Topic 4.3: Management-Medication

Topic 4.2: Management-Behavior Therapy

Scazufca, M., & Matsuda, C. M. C. B. (2002; 2002). Review of the efficacy of psychotherapy vs. pharmacotherapy for depression treatment in old age. *Revista Brasileira De Psiquiatria, 24(Suppl1), 64-69.*

Journal; Peer Reviewed Journal

Reviews existing clinical trials on the efficacy of psychotherapy vs pharmacological treatments, alone or combined, for depression treatment in elderly people. Internet searches of 2 databases (Medline and PsycINFO) were performed for randomized controlled trials, published between 1984 and 2001, examining the efficacy of psychotherapies vs pharmacotherapy for depression in individuals aged 60 yrs or over with a diagnosis of dysthymia, or minor or major depression. The searches resulted in 4 studies. Three studies compared the efficacy of psychotherapy vs pharmacotherapy during the acute and

continuation phase for depression treatment, and another assessed the efficacy of these treatments during the maintenance phase. Treatments that comprised psychotherapy (alone or combined with medication) were more efficacious than pharmacotherapy in the 3 studies of patients with major depression. Psychotherapy was not more efficacious than placebo or antidepressants in the study of patients with dysthymia or minor depression. It is concluded that empirical evidence is scant and inconclusive, suggesting a need for further clinical trials investigating the efficacy of psychotherapy for depression treatment in later life. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1507

Level VI: Opinion

Topic 1: Risks

Schulz, R., Drayer, R. A., & Rollman, B. L. (2002; 2002). Depression as a risk factor for non-suicide mortality in the elderly. *Biological Psychiatry*, 52(3), 205-225.

Journal; Peer Reviewed Journal

Depression can be a consequence of medical illness and disability, yet recent literature suggests it may also influence morbidity and mortality through a variety of behavioral and biological mediators. Relatively little is known about the complex temporal relations among behavior, affect, motivation, and pathophysiology to account for the association between depression and mortality. We performed a systematic review of the recent literature (1997-2001) examining the evidence linking depression to nonsuicide mortality, describe possible mediators of the depression mortality effect, and identify important next steps in this area of research, including (1) the development of well-specified a-priori mediator models that articulate how depression leads to mortality; (2) the conduct of longitudinal studies in which depression and behavioral and pathophysiological mediators are assessed simultaneously; (3) treatment studies for depression that include assessments of associated changes in health-related quality of life, medical morbidity, and mortality; and (4) treatment studies for behavioral risk factors and medical conditions that include assessment of depressive symptoms. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1523

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Scogin, F., Shackelford, J., Rohen, N., Stump, J., Floyd, M., & McKendreeSmith, N. et al. (2001; 2001). Residual geriatric depression symptoms: A place for psychotherapy. *Journal of Clinical Geropsychology*, 7(4), 271-283.

Journal; Peer Reviewed Journal

Geriatric depression is a relatively commonly occurring mental disorder. A subpopulation of depressed older adults are those who have engaged in or completed pharmacotherapy, yet continue to experience depressive symptoms. The authors review the prevalence, psychosocial effects, and treatment of residual symptoms of depression in older adults. Data from previous studies conducted by our group are presented to support our contention that residual symptoms of geriatric depression are treatable through psychosocial means. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1471

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Scogin, F., Welsh, D., Hanson, A., Stump, J., & Coates, A. (2005; 2005). Evidence-based psychotherapies for depression in older adults. *Clinical Psychology: Science and Practice*, 12(3), 222-237.

Journal; Peer Reviewed Journal

We conducted an evidence-based review of psychological treatments for geriatric depression using coding criteria, and we identified six treatments to be beneficial: behavioral therapy, cognitive behavioral therapy, cognitive bibliotherapy, problem-solving therapy, brief psychodynamic therapy, and reminiscence therapy. Other interventions were found to be promising but were lacking replication. These findings suggest that (a) there are several treatment choices for consumers and practitioners across a relatively broad range of theoretical orientations and modalities, (b) there needs to be a

recognition of the viability of psychological treatments for depressed elders by other disciplines, and (c) there is an opportunity to provide training in evidence-based treatments for present and future providers to the growing number of older adults. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1477

Level VI: Opinion

Topic 1: Risks

Topic 3: Assessment

Shafer, K. C. (2004; 2004). Trauma and the substance-abusing older adult: Innovative questions for accurate assessment. *Journal of Loss & Trauma*, 9(4), 345-358.

Journal; Peer Reviewed Journal

In the last decade, scholarly research has dramatically increased its focus on the impact of trauma events and substance abuse. Despite the vast knowledge of the effects on health and social functioning, how substance abuse and trauma are defined and assessed with older adults in the literature remains minimally addressed and quite controversial. Alcohol, illicit drug, and prescription medication addiction is a hidden epidemic in aging. Additionally, untreated childhood trauma can create serious mental and physical complications later in life. Aging baby boomers will represent one third of the population in the United States by 2030. This article addresses the integration of content related to aging, trauma, and addiction in professional training, assessment and scale development, and prevention research. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1460

Level VI: Opinion

Topic 4.3: Management-Medication

Shanmugham, B., Karp, J., Drayer, R., Reynolds, C. F. I. I., & Alexopoulos, G. (2005; 2005). Evidence-based pharmacologic interventions for geriatric depression. *Psychiatric Clinics of North America*, 28(4), 821-835.

Journal; Peer Reviewed Journal

Late-life depression is under-recognized and under-treated in older adults. Although the existing empirical treatment literature is limited, published studies and expert consensus recommendations find that antidepressants are effective. Treatment of psychotic depression has not been investigated adequately in older adults, although common practices include treatment with a selective serotonin reuptake inhibitor or serotonin-Norepinephrine reuptake inhibitor in conjunction with an atypical antipsychotic. Treating with antidepressants augmented by psychotherapy can minimize relapse and disability in depressed patients. Continuation and maintenance treatment at an adequate dose and for an adequate length of time is critical in minimizing relapse. Empirical trials are needed that evaluate the selection and effectiveness of pharmacologic combination therapy and other treatment strategies for treatment resistant and partially responsive major depressive disorder in older adults. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1621

Level II: Individual experimental study

Topic 4.2: Management-Behavior Therapy

Sharpe, L., Sensky, T., Timberlake, N., Ryan, B., Brewin, C. R., & Allard, S. (2001 Jan). A blind, randomized, controlled trial of cognitive-behavioural intervention for patients with recent onset rheumatoid arthritis: Preventing psychological and physical morbidity. *Pain*, 89(2-3), 275-283.

Clinical Trial. Journal Article. Randomized Controlled Trial

This study examined the efficacy of a cognitive and behavioural intervention (CBT) for patients with recent onset, seropositive rheumatoid arthritis. Fifty-three participants with a diagnosis of classical or definite rheumatoid arthritis, who were seropositive and had less than 2 years of disease history were recruited into the trial. All participants received routine medical management during the study, although half were randomly allocated to receive an adjunctive psychological intervention. All pre- and post-treatment assessments were conducted blind to the allocation. Analyses were conducted of treatment completers and also by intention-to-treat. Significant differences were found between the groups at both

post-treatment and 6-month follow-up in depressive symptoms. While the CBT group showed a reduction in depressive symptoms, the same symptoms increased in the Standard group. At outcome but not follow-up, the CBT group also showed reduction in C-reactive protein levels. However, the CBT group did show significant improvement in joint involvement at 6-month follow-up compared with the Standard group, indicating physical improvements above those achieved with standard care. These results indicate that cognitive-behavioural intervention offered as an adjunct to standard clinical management early in the course of RA is efficacious in producing reductions in both psychological and physical morbidity

REF ID: 1582

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Sherman, A. M., Shumaker, S. A., Kancler, C., Zheng, B., Reboussin, D. M., & Legault, C. et al. (2003). Baseline health-related quality of life in postmenopausal women with coronary heart disease: The estrogen replacement and atherosclerosis (ERA) trial. *Journal of Women's Health (Larchmont)*, 12(4), 351-362.

Journal Article, Clinical Trial, Research, Tables/Charts

OBJECTIVES: This study examined the baseline health-related quality of life (HRQL) of 301 postmenopausal women with heart disease enrolled in the Estrogen Replacement and Atherosclerosis (ERA) trial. **METHODS:** The primary measure of HRQL was the Medical Outcomes Study Short Form-36 (MOS SF-36). The SF-36 was augmented with secondary assessments, including measures of depressive symptoms, life satisfaction, urinary incontinence, sleep disturbance, and physical symptoms. Multiple regression analyses were used to test hypotheses regarding the contribution of positive (social support) and negative (social strain) aspects of social relations after accounting for other correlates of HRQL and heart disease. **RESULTS:** Results indicate that social support was positively associated with better functioning for all measured outcomes (all $p < 0.05$) except symptom frequency and severity. Social strain was negatively associated with HRQL functioning (all $p < 0.05$) except overall physical functioning, sleep disturbance, and urinary incontinence. In addition, several comorbid conditions were negatively associated with HRQL outcomes. In particular, chest pain was significantly associated with worse functioning on all HRQL outcomes except urinary incontinence. **CONCLUSIONS:** These data suggest that both clinical status variables (particularly chest pain) and the psychosocial context (represented by dimensions of relationship quality) influenced HRQL in this cohort. Thus, interventions that combine medical treatments with psychosocially based interventions may be most effective for women at risk for impaired HRQL.

REF ID: 1622

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Simmons, S. F., Cadogan, M. P., Cabrera, G. R., Al-Samarrai, N. R., Jorge, J. S., & Levy-Storms, L. et al. (2004 Aug). The minimum data set depression quality indicator: Does it reflect differences in care processes? *Gerontologist*, 44(4), 554-564.

Journal Article

PURPOSE: The objective of this work was to determine if nursing homes that score differently on prevalence of depression, according to the Minimum Data Set (MDS) quality indicator, also provide different processes of care related to depression. **DESIGN AND METHODS:** A cross-sectional study with 396 long-term residents in 14 skilled nursing facilities was conducted: 10 homes in the lower (25th percentile: low prevalence 0-2%) quartile and 4 homes in the upper (75th percentile: high prevalence 12-14%) quartile on the MDS depression quality indicator. Ten care processes related to depression were defined and operationalized into clinical indicators. Measurement of nursing home staff implementation of each care process and the assessment of depressive symptoms were conducted by trained research staff during 3 consecutive 12-hr days (7 a.m. to 7 p.m.), which included resident interviews (Geriatric Depression Scale), direct observations, and medical record review using standardized protocols. **RESULTS:** The prevalence of depressive symptoms according to independent assessments was significantly higher than prevalence based on the MDS quality indicator and

comparable between homes reporting low versus high rates of depression (46% and 41%, respectively). Documentation of depressive symptoms was significantly more common in homes reporting a high prevalence rate; however, documentation of symptoms on the MDS did not result in better treatment or management of depression according to any care-process measure. Psychosocial prevention and intervention efforts, such as resident participation in organized social group activities, were not widely used within either group of homes. **IMPLICATIONS:** The MDS depression quality indicator underestimates the prevalence of depressive symptoms in all homes but, in particular, among those reporting low or nonexistent rates. The indicator may be more reflective of measurement processes related to detection of symptoms than of prevention, intervention, or management of depression outcomes. A depression quality indicator should not be eliminated from MDS reports because of the importance and prevalence of the condition. However, efforts to improve nursing home staff detection of depressive symptoms should be initiated prior to the use of any MDS-based depression indicator for improvement purposes. Homes that report a low prevalence of depression according to the nationally publicized MDS quality indicator should not be regarded as providing better care.

REF ID: 1569

Level VI: Opinion

Topic 3: Assessment

Snowden, M. B. (2004). The minimum data set depression rating scale (MDSDRS) lacks reliability for identifying depression among older adults living in nursing homes. *Evidence-Based Mental Health*, 7(1), 7.

Journal Article, Abstract, Commentary, Tables/Charts

critique of Original Study: Anderson R, Buckwalter KC, Buchanan RJ, et al. Validity and reliability of the minimum data set depression rating scale (MDSDRS) for older adults in nursing homes. *AGE AGING* 2003; 32: 435-8

Does the MDSDRS reliably detect depression in older adults living in nursing homes? **METHODS:** Design: Prospective cohort study. Setting: Three nursing homes in Iowa, USA; timeframe not specified. Patients: 145 nursing home residents, aged ≥ 60 years (mean age 84 years, 63% women) with complete Minimum Data Set (MDS) information. 21% were diagnosed with dementia, and 28% with depression. Test: The MDSDRS was completed from the MDS. The MDSDRS scores the following 7 mood items: resident made negative statements; persistent anger and irritability; expressions of seemingly unrealistic fears; repetitive health complaints; repetitive anxious complaints; sad, pained, or worried facial expressions, and crying or tearfulness, on a scale from 0 (not exhibited in the preceding 30 days) to 2 (exhibited daily or almost daily). Diagnostic standard: Research staff assessed all participants with the Hamilton Depression rating scale (HDRS) and the Geriatric Depression Scale (GDS). Outcomes: Correlation between each of the 7 items comprised within the MDSDRS and the HDRS, the GDS and chart diagnoses of depression. **MAIN RESULTS:** When validated against the HDRS and GDS, the MDSDRS did not perform well. At all cut off scores, sensitivity rates and correlations with HDRS and GDS were low, although the specificity was acceptable (see table). **CONCLUSIONS:** The MDSDRS may not be the most appropriate scale for identifying depression among older people living in nursing homes.

REF ID: 1624

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Solberg, L. I., Fischer, L. R., Rush, W. A., & Wei, F. (2003 Feb). When depression is the diagnosis, what happens to patients and are they satisfied? *American Journal of Managed Care*, 9(2), 131-140.

Journal Article

OBJECTIVES: To understand the process, outcomes, and patient satisfaction of usual primary care for patients given a diagnostic code for depression. **STUDY DESIGN:** Health plan data were used to identify patients with a diagnostic code for depression (and no such diagnosis in the preceding 6 months). Patients were surveyed by mail soon after the coded visit and again 3 months later about the

care they had received; their charts were also audited. **METHODS:** The 274 patients in 9 primary care clinics who responded to both surveys reported on their personal characteristics, depression symptoms and history, the care received in that initial visit, and the follow-up care during the next 3 months. They also reported on their satisfaction with various aspects of that care. **RESULTS:** These patients were likely to be given antidepressant medications as their main or only treatment. Referral for mental health therapies was not used often, even though referral is readily available in this setting; other types of self-management recommendations and support were even less frequent. Patient outcomes and levels of satisfaction during a 3-month follow-up period were unimpressive. **CONCLUSIONS:** To successfully maintain a key role in the care of this important problem for their patients, primary care physicians may need to incorporate a more comprehensive and systematic approach to management that involves other team members and is more satisfying to patients.

REF ID: 1524

Level VI: Opinion

Topic 1: Risks

Sowdon, J. (2001; 2001). Is depression more prevalent in old age? [references]. *Australian and New Zealand Journal of Psychiatry*, 35(6), 782-787.

Journal; Peer Reviewed Journal

Examined the prevalence of depression in old age and reviewed cross-age studies that reported age-related differences in prevalence. Reports of studies that included data on the prevalence of depression in old age were reviewed, and conclusions from review articles were considered. Findings have been inconsistent, but majority opinion holds that depression (especially "subsyndromal") is common in old age. There may be 2 peaks in the prevalence rate of major depression, one in late old age and the other in middle age or earlier. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1510

Level VI: Opinion

Topic 4.3: Management-Medication

Spear, J. (2002; 2002). How long should older people take antidepressants to prevent relapse? [references]. *Revista Brasileira De Psiquiatria*, 24(Suppl1), 70-73.

Journal; Peer Reviewed Journal

Reviews the evidence from randomized clinical trials and open label trials of the effectiveness of maintenance antidepressant therapy for older adults with depressive disorder. The focus was on whether relapse of depressive disorder can be prevented or delayed. The review also examined the evidence for the effectiveness of psychosocial and psychotherapeutic interventions. Recommendations for clinical practice and future research are included. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1591

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Spencer, J. (2002). Social activity: A key indicator of well being. *Nursingmatters*, 13(8), 1, 12.

Journal Article

REF ID: 1490

Level VI: Opinion

Topic 3: Assessment

Stergiopoulos, V., & Herrmann, N. (2003; 2003). Old and homeless: A review and survey of older adults who use shelters in an urban setting. *Canadian Journal of Psychiatry*, 48(6), 374-380.

Journal; Peer Reviewed Journal

This paper reviews the available literature and presents findings of a Toronto survey in an effort to describe the demographics of homeless seniors, their level of impairment, and their mental and physical health needs. We searched the Medline, AgeLine, and PsycINFO databases, using the following key words: elderly homeless, elderly hostel users, and urban geriatrics. To better describe the service needs of the elderly homeless, we obtained demographic data from the Community and Neighbourhood Services Department and distributed a survey questionnaire to 11 Toronto hostel directors. The

questionnaire elicited data relating to reasons for shelter use, problem behaviours, and mental health needs of those over age 65 years. Although seniors represent a small percentage of the homeless population, their numbers are growing. The available literature suggests a high prevalence of psychiatric disorders and cognitive impairment in this population, with a greater proportion of older women than men having severe mental illness. The homeless elderly are the most vulnerable of this impoverished population. Geriatric psychiatrists could play a significant role in evaluating and treating this population more comprehensively. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1368

Level I: Systematic Reviews

Topic 3: Assessment

Topic 1: Risks

Stevenson, J. S. (2005). Alcohol use, misuse, abuse, and dependence in later adulthood. *Annual Review of Nursing Research*, 23, 245-280.

Journal Article, Research, Systematic Review

Considerable research has focused on alcohol problems in older adults, but the clinical utilization of this knowledge has lagged at least 3 decades behind the scientific developments. This unfortunate situation takes on added significance as the "baby boomer" generation ages because more of them drink more often in larger quantities than previous generations. This chapter focuses more on the ramifications of use, misuse, and abuse than on chronic dependence because the prevalence in the former categories far outweighs the latter. Older alcohol misusers and abusers are at excess risk for myriad physical problems and premature death because alcohol interacts with the natural aging process in negative ways to increase risks for injuries, hypertension, cardiac dysrhythmic events, cancers, gastrointestinal problems, neurocognitive deficits, bone loss, and emotional challenges, most notably depression. Low volume and less than daily alcohol consumption appear to be protective against blood clots in the coronary and brain vessels, bone loss and falls, and cognitive decline compared with current abstainers. At higher levels, alcohol has the opposite effect. Research findings strongly support positive outcomes of case finding, referral, and treatment of older adults who are misusing or abusing alcohol. However, there is ample evidence that health care providers across the spectrum of primary, acute, and long-term care ignore the signs and symptoms of alcohol misuse and abuse in their older patients and treat symptoms and sequelae of the abuse rather than confronting the abuse itself. Recommendations for changes in practice are made together with ideas for additional research in several areas where the current state of knowledge is inadequate, conflicting, or based on narrowly homogeneous samples.

REF ID: 1408

Level I: Systematic Reviews

Topic 4.1: Management-General

Stoltz, P., Uden, G., & Willman, A. (2004 Jun). Support for family carers who care for an elderly person at home - a systematic literature review. *Scandinavian Journal of Caring Sciences*, 18(2), 111-119.

Journal Article. Review

Family carers are a major source of help and assistance to the persons they provide care for. They are also major contributors to the welfare system, balancing the national health care expenditure. Increasing attention, in research as well as government policy, is being paid to their role as informal caregivers. Support to family carers seems to be a new 'buzzword' in Swedish Government policy. However, supporting family carers may prove to be a more complex endeavour than one initially might be led to believe. Support could here be understood as any services, assistances, education, information, attitudes, and lay or professional person's provision for the benefit of the family carer. The aim of this systematic review was to identify modes of, and scientific evidence on, support for family carers of cohabiting elderly persons. The method followed a seven-step model: a focused research question was formulated creating a base for deriving search words and inclusion and exclusion criteria for studies. Systematic database searches identified several studies some of which were retrieved, critically appraised and classified by two independent reviewers. A total of 26 articles were finally included, revealing that family carers fear social isolation and wish to network in groups with peers, either for social or for

learning needs purposes. Family carers also desire respite care. However, it is unclear whether they actually benefit from any of the above or how service provision should be attempted. [References: 54]

REF ID: 1422

Level I: Systematic Reviews

Topic 4.6: Management-Other

Stuck, A. E., Egger, M., Hammer, A., Minder, C. E., & Beck, J. C. (2002 Feb 27). Home visits to prevent nursing home admission and functional decline in elderly people: Systematic review and meta-regression analysis.[see comment]. *JAMA*, 287(8), 1022-1028.

Journal Article. Meta-Analysis. Review

CONTEXT: The effects of home visitation programs to prevent functional decline in elderly persons have been inconsistent, and the value of these programs is controversial. OBJECTIVE: To evaluate the effect of preventive home visits on functional status, nursing home admission, and mortality. DATA SOURCES: Studies published in English, French, German, Italian, or Spanish reporting randomized trials of the effects of preventive in-home visits in older people (mean age >70 years) living in the community were identified through searches of MEDLINE, PSYCHINFO, and EMBASE (January 1985--November 2001). We also searched the Cochrane Controlled Trials Register, checked reference lists of earlier reviews and book chapters, searched conference proceedings and specialty journals, and contacted experts. STUDY SELECTION: We screened 1349 abstracts and excluded those that did not test in-home interventions or in which the mean age of the study population was younger than 70 years. After further exclusions, 17 articles describing 18 trials were analyzed. DATA EXTRACTION: Two reviewers independently screened abstracts. Discrepancies were resolved by consensus with a third reviewer. For each included trial, we extracted data on the study population and the characteristics of the intervention. Two of us extracted information on 3 end points: nursing home admissions, mortality, and functional status. One of us assessed trial quality, including an examination of the method of randomization, blinding of caregivers and research staff ascertaining outcomes, and proportion of patients included in analyses of the 3 end points. DATA SYNTHESIS: The 18 trials included 13 447 individuals aged 65 years and older. The effect on nursing home admissions depended on the number of visits performed during follow-up. The pooled relative risk (RR) was 0.66 (95% confidence interval [CI], 0.48-0.92) for trials in the upper tertile (>9 visits) but was 1.05 (95% CI, 0.85-1.30) in the lower tertile (0-4 visits). Functional decline was reduced in trials that used multidimensional assessment with follow-up (RR, 0.76; 95% CI, 0.64-0.91) but not in other trials (RR, 1.01; 95% CI, 0.92-1.11). Functional decline was reduced (RR, 0.78; 95% CI, 0.64-0.95) in trials with a control group mortality rate in the lower tertile (3.4%-5.8%) but not (RR, 0.98; 95% CI, 0.84-1.13) in those with a control-group mortality rate in the upper tertile (8.3%-10.7%). A beneficial effect on mortality was evident in younger study populations (RR, 0.76; 95% CI, 0.65-0.88 for ages 72.7-77.5 years) but not in older study populations (RR, 1.09; 95% CI, 0.92-1.28 for ages 80.2-81.6 years). CONCLUSION: Preventive home visitation programs appear to be effective, provided the interventions are based on multidimensional geriatric assessment and include multiple follow-up home visits and target persons at lower risk for death. Benefits on survival were seen in young-old rather than old-old populations. [References: 43]

REF ID: 1619

Level II: Individual experimental study

Topic 4.6: Management-Other

Sumaya, I. C., Rienzi, B. M., Deegan, J. F., 2nd, & Moss, D. E. (2001 Jun). Bright light treatment decreases depression in institutionalized older adults: A placebo-controlled crossover study.

***Journals of Gerontology Series A-Biological Sciences & Medical Sciences*, 56(6), M356-60.**

Clinical Trial. Journal Article. Randomized Controlled Trial

BACKGROUND: An important parallel exists between patients with seasonal affective disorder and institutionalized older adults. Many older patients, as a result of global physical decline and immobility, are confined to their rooms, experiencing little natural sunlight. Thus, institutionalized older adults are at risk for chronic light deprivation. Testing the hypothesis that chronic light deprivation might be responsible, at least in part, for some depression among institutionalized older adults, the aim of this study was to investigate the efficacy of morning bright light treatment on depression among older adults

residing in a long-term care facility. **METHODS:** In a placebo controlled, crossover design, participants (N = 10, six women and four men; M age = 83.8) received each of the following: (i) 1 week (5 days) of 10,000 lux (therapeutic dose); (ii) 1 week (5 days) of 300 lux (placebo); or 1 week of no treatment (control). Each week of light treatment was 5 consecutive days, 30 minutes daily, with a wash-out period consisting of 1 week between conditions. **RESULTS:** Geriatric Depression Scale (GDS) scores at baseline during all treatment conditions were positively correlated ($r = .81, p < .01$) with months of institutionalization, where participants with higher GDS scores experienced more time institutionalized. Scores on the GDS remained unchanged during the placebo and control conditions, but depression scores decreased significantly during the 10,000 lux treatment (pretest GDS M = 15 vs posttest GDS M = 11, $p < .01$). After the 10,000 lux treatment, 50% of the participants no longer scored in the depressed range. Improvement during the 10,000 lux condition was positively correlated ($r = .62, p < .05$) to baseline GDS scores, where participants with higher GDS scores experienced greater improvement following the 10,000 lux treatment. **CONCLUSIONS:** The results of the present study suggest that bright light treatment may be effective among institutionalized older adults, providing nonpharmacological intervention in the treatment of depression. Furthermore, the length of institutionalization may play an important role in determining the efficacy of bright light treatment for older adults in the nursing-home setting.

REF ID: 1593

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Teno, J. M., Mor, V., Ward, N., Roy, J., Clarridge, B., & Wennberg, J. E. et al. (2005 Nov).

Bereaved family member perceptions of quality of end-of-life care in U.S. regions with high and low usage of intensive care unit care. *Journal of the American Geriatrics Society*, 53(11), 1905-1911.

Journal Article

OBJECTIVES: To compare the quality of end-of-life care of persons dying in regions of differing practice intensity. **DESIGN:** Mortality follow-back survey. **SETTING:** Geographic regions in the highest and lowest deciles of intensive care unit (ICU) use. **PARTICIPANTS:** Bereaved family member or other knowledgeable informants. **MEASUREMENTS:** Unmet needs, concerns, and rating of quality of end-of-life care in five domains (physical comfort and emotional support of the decedent, shared decision-making, treatment of the dying person with respect, providing information and emotional support to family members). **RESULTS:** Decedents in high- (n=365) and low-intensity (n=413) hospital service areas (HSAs) did not differ in age, sex, education, marital status, leading causes of death, or the degree to which death was expected, but those in the high-intensity ICU HSAs were more likely to be black and to live in nonrural areas. Respondents in high-intensity HSAs were more likely to report that care was of lower quality in each domain, and these differences were statistically significant in three of five domains. Respondents from high-intensity HSAs were more likely to report inadequate emotional support for the decedent (relative risk (RR)=1.2, 95% confidence interval (CI)=1.0-1.4), concerns with shared decision-making (RR=1.8, 95% CI=1.0-2.9), inadequate information about what to expect (RR=1.5, 95% CI=1.3-1.8), and failure to treat the decedent with respect (RR=1.4, 95% CI=1.0-1.9). Overall ratings of the quality of end-of-life care were also significantly lower in high-intensity HSAs. **CONCLUSION:** Dying in regions with a higher use of ICU care is not associated with improved perceptions of quality of end-of-life care.

REF ID: 1470

Level VI: Opinion

Topic 4.2: Management-Behavior Therapy

Teri, L., McKenzie, G., & LaFazia, D. (2005; 2005). Psychosocial treatment of depression in older adults with dementia. *Clinical Psychology: Science and Practice*, 12(3), 303-316.

Journal; Peer Reviewed Journal

Depression and dementia commonly coexist and are associated with higher rates of behavioral and functional problems. Caregivers of these individuals report higher levels of physical and mental distress, as well. Effective treatment, therefore, has the potential to help both the older adult and their caregiver. This article provides an overview of the current literature on treatment of depression in demented older

adults, with particular emphasis on providing guidelines for evidence-based clinical care. Eleven randomized controlled clinical trials were identified following an extensive review of the literature. These studies are reviewed with particular attention to the methodological issues of most relevance to clinicians attempting to use the findings from these studies to guide their practice. Issues of particular relevance when working with this population are also addressed, including (a) for assessment-differential and coexistent diagnosis of depression in dementia, use of collateral informants, self-report and interviewer-obtained information; and b) for treatment-the need for caregiver involvement, individualizing of goals, and planning for future deterioration of cognitive function. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1463

Level VI: Opinion

Topic 4.1: Management-General

Tew, J. D. J. (2005; 2005). Post-hospitalization transitional care needs of depressed elderly patients: Models for improvement. *Current Opinion in Psychiatry*, 18(6), 673-677.

Journal; Peer Reviewed Journal

Purpose of review: In the weeks immediately following psychiatric hospital discharge, severely depressed elderly patients are at risk of 'falling through the cracks' in a complex health care system: becoming lost to follow-up, receiving inadequate care, or requiring prompt readmission. The purpose of this review is to highlight recent literature on the comorbid physical health problems and complex care needs of elderly patients hospitalized for depression. This paper will also review recent initiatives to improve the quality of care transitions for elderly patients discharged from medical hospitals that may be adaptable to a severely depressed population. Recent findings: Due to shorter hospital stays, comorbid physical health problems, and limitations in functional capacity, severely depressed elderly patients discharged from psychiatric hospitals have complex service needs and numerous barriers to care, immediately following hospital discharge. There is a lack of research specifically addressing the transitional care needs of this population. Improvement interventions assigning transitional care providers to chronically medically ill elderly patients immediately after medical hospital discharge have shown decreased rates of rehospitalization and emergency services utilization, and appear to be cost-effective. Summary: Further research is needed to adapt successful transitional care interventions targeting chronically ill elderly patients in medical hospitals to severely depressed elderly patients being discharged from psychiatric hospitals. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 979

Level I: Systematic Reviews

Topic 4.1: Management-General

Tilly, J., & Reed, P. (2005). Interventions that optimize quality dementia care: A comprehensive literature search selects the best evidence-based interventions to improve quality dementia care in LTC facilities. *Canadian Nursing Home*, 16(3), 13-21.

Journal Article, Research, Systematic Review

What interventions are most likely to improve quality care for residents with dementia? Starting with over 300 research articles, the authors whittled down these sources to a number that best represent interventions that provide optimum quality care for nursing home residents with dementia.

REF ID: 1500

Level VI: Opinion

Topic 1: Risks

Topic 2: Prevention

Topolski, J. M., Gotham, H. J., Klinkenberg, W. D., O'Neill, D. L., & Brooks, A. R. (2002; 2002). Older adults, substance use, and HIV/AIDS: Preparing for a future crisis. *Journal of Mental Health and Aging*, 8(4), 349-363.

Journal; Peer Reviewed Journal

Notes that as people in the baby boom generation age, they continue to abuse substances at a greater rate than the previous generation. Substance abuse places many older adults at risk for contracting

HIV/AIDS and other infections as a result of risky sexual behavior and injection drug use. This article has 4 goals: (1) to bring this approaching problem into the awareness of behavioral health professionals, (2) to identify key issues related to substance abuse and HIV/AIDS in older adults, (3) to offer a model for preparing relevant service sectors to respond to the needs of these older adults, and (4) to draw implications for behavioral health professionals. The article builds on the experiences of the authors and a review of the literature in aging, substance abuse, and HIV/AIDS programming. The authors conclude that an integrated response by 5 key service sectors is needed to prepare for this future crisis.

(PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1497

Level VI: Opinion

Topic 3: Assessment

Townsend, B. A., Petrella, J. R., & Doraiswamy, P. M. (2002; 2002). The role of neuroimaging in geriatric psychiatry. *Current Opinion in Psychiatry*, 15(4), 427-432.

Journal; Peer Reviewed Journal

Reviews neuroimaging advances that have occurred over the past year, of relevance to Alzheimer's disease and late-life depression. In Alzheimer's disease, the advances offer promise in early diagnosis, disease monitoring and drug development. Magnetic resonance imaging, positron emission tomography and functional magnetic resonance imaging studies have revealed hippocampal and entorhinal cortex abnormalities in early dementia and in patients with mild cognitive impairment. Serial imaging techniques, such as voxel compression mapping or spectroscopy, can be used to monitor dementia progression, estimate longitudinal change rates, or used in combination to enhance specificity and sensitivity. Techniques to image amyloid as well as the acetylcholinesterase enzyme have been studied in clinical samples. In late-life depression, neuroimaging advances have offered insights into pathophysiology and identified a subtype, vascular depression, characterized by white matter ischemic changes. The impact of such vascular changes on cognitive and therapeutic outcomes of late-life depression is being studied in a large prospective trial. Significant progress has been made in our ability to incorporate neuroimaging into medical management of psychiatric diseases; but research must continue. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1552

Level II: Individual experimental study

Topic 4.1: Management-General

Unutzer, J., Katon, W., Callahan, C. M., Williams, J. W. J., Hunkeler, E., & Harpole, L. et al. (2002; 2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA: Journal of the American Medical Association*, 288(22), 2836-2845.

Journal; Peer Reviewed Journal

Examined the effectiveness of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) collaborative care management program for late-life depression. Participants were 1,801 patients aged 60 yrs or older with major depression, dysthymic disorder, or both, from 18 primary care clinics across 5 states. Patients were randomly assigned to the IMPACT intervention or to usual care. Intervention patients had access for up to 12 months to a depression care manager who was supervised by a psychiatrist and a primary care expert and who offered education, care management, and support of antidepressant management by the patient's primary care physician or a brief psychotherapy for depression, Problem Solving Treatment in Primary Care. At 12 months, 45% of intervention patients had a 50% or greater reduction in depressive symptoms from baseline compared with 19% of usual care participants. Intervention patients also experienced greater rates of depression treatment, more satisfaction with depression care, lower depression severity, less functional impairment, and greater quality of life than participants assigned to the usual care group. The IMPACT collaborative care model appears to be feasible and more effective than usual care for depression in primary care settings.

(PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1376

Level I: Systematic Reviews

Topic 4.2: Management-Behavior Therapy

Topic 4.1: Management-General

Van Citters, A. D., & Bartels, S. J. (2004). A systematic review of the effectiveness of community-based mental health outreach services for older adults. *Psychiatric Services, 55*(11), 1237-1249.

Journal Article, Research, Systematic Review, Tables/Charts

OBJECTIVES: Psychiatric outreach services that provide mental health assessment and treatment to older adults in their homes or communities are widely promoted as improving access and outcomes for older adults. However, a systematic review of the efficacy of these services has not been done. This review evaluates the evidence base for the effectiveness of outreach services for older adults with mental illness in noninstitutional community settings. End points of interest include the ability of the outreach program to increase access to mental health services and improve psychiatric outcomes.

METHODS: MEDLINE, CINAHL, PsycINFO, and Web-of-Science databases were searched for articles in English that were indexed through May 2004. Studies were included if they evaluated face-to-face psychiatric services provided to adults aged 65 and older with mental illness and if they were randomized controlled trials, quasi-experimental outcome studies, uncontrolled cohort studies, or comparisons of two or more interventions. Articles were excluded that evaluated interventions that were provided in institutional settings or that focused on persons with dementia or their caregivers.

RESULTS: Fourteen studies matched all the inclusion criteria. Two studies (one controlled prospective study and one study that used a comparison group) found support for the use of gatekeepers-nontraditional referral sources-in identifying socially isolated older adults with mental illness. Twelve studies (five randomized controlled trials, one quasi-experimental study, and six uncontrolled cohort studies) found that home and community-based treatment of psychiatric symptoms were associated with improved or maintained psychiatric status. All randomized controlled trials reported improved depressive symptoms, and one reported improved overall psychiatric symptoms. **CONCLUSIONS:** Limited data supported the effectiveness of outreach services in identifying isolated older adults with mental illness. A more substantial evidence base indicated that home-based mental health treatment is effective in improving psychiatric symptoms. Studies are needed that apply more rigorous methods evaluating the efficacy of case identification models and subsequent treatment for older persons with a variety of psychiatric diagnoses.

REF ID: 1488

Level VI: Opinion

Topic 4.5: Management-Surgery

van der Wurff, F. B., Stek, M. L., Hoogendijk, W. J. G., & Beekman, A. T. F. (2003; 2003). The efficacy and safety of ECT in depressed older adults: A literature review. *International Journal of Geriatric Psychiatry, 18*(10), 894-904.

Journal; Peer Reviewed Journal

Although little doubt exists among practising clinicians in old age psychiatry about the efficacy and safety of ECT in depression, opinions about acceptability differ widely. The objectives of this review were to determine the efficacy and safety of ECT based on both randomised and non-randomised evidence in elderly with a major depressive disorder. Randomised and non-randomised studies on efficacy and safety of ECT in elderly with and without concomitant disorders such as cerebrovascular disorders, Alzheimer's dementia, vascular dementia and Parkinson's disease were selected. Literature was systematically searched in a number of electronic databases. Although 121 studies were included in the review process, only four provided randomised evidence. No negative studies with respect to efficacy were found. ECT is effective in the acute treatment of late life depression. ECT is generally safe, although a number of serious complications possibly related to ECT have been described. Most of the objectives of this review could not be answered or refuted with certainty, because firm randomised evidence on the efficacy and safety of ECT in the depressed elderly is missing. ECT is effective in the acute treatment of late life depression and is generally safe. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

REF ID: 1361

Level I: Systematic Reviews

Topic 4.5: Management-Surgery

Van der Wurff, F. B., Stek, M. L., Hoogendijk, W. L., & Beekman, A. T. F. (2006).

Electroconvulsive therapy for the depressed elderly. *The Cochrane Library*, (1)

Journal Article, Research, Systematic Review

A substantive amendment to this systematic review was last made on 18 February 2003. Cochrane reviews are regularly checked and updated if necessary. Background: Depressive disorders are common in old age, with serious health consequences such as increased morbidity, disability, and mortality. The frailty of elderly people may seriously hamper the efficacy and safety of pharmacotherapy.

Electroconvulsive therapy (ECT) may therefore be an alternative to treatment with antidepressants.

Objectives: To assess the efficacy and safety of ECT (compared to simulated ECT or antidepressants) in depressed elderly people. Search strategy: We searched the CCDANCTR database, Medline 1966-2000, EMBase 1980-2000, Biological abstracts 1985-2000, Cinahl 1982-2000, Lilacs from 1982 onwards, Psyclit 1887-2000, Sigle 1980-2000. The reference lists of relevant papers were scanned for published reports. Hand searching of the Journal of ECT and the Journal of Geriatric Psychiatry was done. Based on the title of the publication and its abstract, non-eligible citations were excluded. Selection criteria: Randomised, controlled trials on depressed elderly people (> 60 years) with or without concomitant conditions such as cerebrovascular disease, dementia of the Alzheimer's type, vascular dementia or Parkinson's disease were included. Data collection and analysis: Data were independently extracted by at least two reviewers. For continuous data weighted mean differences (WMD) between groups were calculated. Main results: Randomised evidence is sparse. Only three trials could be included, one on the efficacy of real ECT versus simulated ECT (O'Leary 1994), one on the efficacy of unilateral versus bilateral ECT (Fraser 1980) and the other comparing the efficacy of ECT once a week with ECT three times weekly (Kellner 1992). All had major methodological shortcomings; reports were mostly lacking essential information to perform a quantitative analysis. Although the O'Leary study concluded that real ECT was superior to simulated ECT, these conclusions need to be interpreted cautiously. Only results from the second trial (unilateral versus bilateral ECT) could be analysed, not convincingly showing efficacy of unilateral ECT over bilateral ECT, WMD 6.06 (CI -5.20,17.32). Randomised evidence on the efficacy and safety of ECT in depressed elderly with concomitant dementia, cerebrovascular disorders or Parkinson's disease is completely lacking. Possible side-effects could not be adequately examined because of the lack of randomised evidence and the methodological shortcomings. Authors' conclusions: None of the objectives of this review could be adequately tested because of the lack of firm, randomised evidence. Given the specific problems in the treatment of depressed elderly, a well designed randomised controlled trial should be conducted in which the efficacy of ECT is compared to one or more antidepressants. [CINAHL Note: The Cochrane Collaboration systematic reviews contain interactive software that allows various calculations in the MetaView.]

REF ID: 1509

Level VI: Opinion

Topic 6: Comprehensive

Van Ness, P. H., & Larson, D. B. (2002; 2002). Religion, senescence, and mental health: The end of life is not the end of hope. *American Journal of Geriatric Psychiatry*, 10(4), 386-397.

Journal; Peer Reviewed Journal

The authors review epidemiological and survey research relevant to the relationships between religiousness/spirituality and mental health in people at the end of life, with the end of helping psychiatrists, psychologists, and other mental health professionals dealing with older Americans. They give special attention to well-being, religious coping, cognitive dysfunction, anxiety, depression, and suicide, and consider the extent to which hope is a mediator of the purported salutary effects of religiousness. Studies were selected from the comprehensive and systematic review of 20th-century scientific literature concerning religion and health. Authors also review current studies relevant to religion and end-of-life issues. Religious persons reported generally higher levels of well-being. The review also found fairly consistent inverse associations of religiousness with rates of depression and suicide. There was some negative association between religious participation and cognitive dysfunction, but the association with anxiety was inconsistent, with some studies showing a correlation between

higher levels of religion and anxiety. Religion's effects on mental health are generally protective in direction but modest in strength. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1391

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Walsh, B. T., Seidman, S. N., Sysko, R., & Gould, M. (2002). Placebo response in studies of major depression: Variable, substantial, and growing. *JAMA: Journal of the American Medical Association*, 287(14), 1840-7, 1875-6.

Journal Article, CEU, Research, Systematic Review, Tables/Charts

REF ID: 1560

Level VI: Opinion

Topic 1: Risks

Washburn, A. M. (2005). Relocation puts elderly nursing home residents at risk of stress, although the stress is short lived. *Evidence-Based Mental Health*, 8(2), 49.

Journal Article, Abstract, Commentary

critique of Original Study: Hodgson N, Freedman VA, Granger DA, Erno A. Biobehavioral correlates of relocation in the frail elderly: salivary cortisol, affect, and cognitive function. *J AM GERIATR SOC* 2004 Nov; 52(11): 1856-62

What are the effects of moving elderly people to a new nursing home? METHODS Design: Randomised controlled trial. Setting: Long term nursing homes in greater Philadelphia and Horsham, Pennsylvania between June 2001 and spring 2002. Population: 77 nursing home residents aged 65 and over. Assessment: Participants were divided into two groups: residents moving to a new nursing home, and residents remaining in the Philadelphia nursing home. Baseline measurements were recorded in July and August 2001. Residents were moved during fall 2001, measurements were taken 1 week before moving, and 1 week and 4 weeks after moving. Outcomes: Mini-Mental State Examination scores, Observed Affect Rating Scale scores, salivary cortisol, blood pressure, and pulse. Follow up period: Outcomes were assessed 1 week before the move, and 1 week and 4 weeks after the move. MAIN RESULTS 1 week before moving: residents moving had a significantly greater increase from baseline in late afternoon cortisol compared with residents remaining ($p = 0.015$) 1 week after moving: residents moving had a significantly greater increase from baseline in early morning cortisol and mild pleasure, although they had a greater reduction in pulse, anxiety, and sadness compared with residents remaining (early morning cortisol: $p = 0.005$; mild pleasure: $p = 0.042$; pulse: $p = 0.002$; anxiety: $p = 0.027$; sadness: $p = 0.003$). 4 weeks after moving: residents moving had a significantly greater reduction from baseline in late afternoon cortisol, pulse, anxiety, and sadness compared with residents remaining (late afternoon cortisol: $p = 0.030$; pulse: $p = 0.002$; anxiety: $p = 0.002$; sadness: $p = 0.005$). CONCLUSIONS Elderly nursing home residents may experience stress before relocation, although the stress is short lived. Quality of care can be improved by preparing residents for relocation, by identifying and alleviating stressors associated with relocation. NOTES Results should be treated with caution. The study conducted multiple analyses for different outcomes, which increases the likelihood that significant results would have arisen by chance.

REF ID: 1600

Level I: Systematic Reviews

Topic 3: Assessment

Watson, L. C., & Pignone, M. P. (2003 Dec). Screening accuracy for late-life depression in primary care: A systematic review.[see comment]. *Journal of Family Practice*, 52(12), 956-964.

Journal Article. Review

OBJECTIVE: To determine the accuracy of depression screening instruments for older adults in primary care. STUDY DESIGN: Systematic review. DATA SOURCES: MEDLINE, PsycINFO (search dates 1966 to January 2002), and the Cochrane database on depression, anxiety and neurosis. We also searched the second Guide to Clinical Preventive Services, the 1993 Agency for Health Care Policy and

Research Clinical Practice Guideline on Depression, and recent systematic reviews. Hand-checking of bibliographies and extensive peer review were also used to identify potential articles. **OUTCOMES MEASURED:** A predefined search strategy targeted only studies of adults aged 65 years or older in primary care or community settings, including long-term care. Articles were included in this review if they reported original data and tested depression screening instruments against a criterion standard, yielding sensitivity and specificity. **RESULTS:** Eighteen articles met criteria and are included in this review, representing 9 different screening instruments. The most commonly evaluated were the Geriatric Depression Scale (30- and 15-item versions), the Center for Epidemiologic Studies Depression Scale, and the SelfCARE(D). Differences in the performance of these 3 instruments were minimal; sensitivities ranged from 74% to 100% and specificities ranged from 53% to 98%. **CONCLUSIONS:** Accurate and feasible screening instruments are available for detecting late-life depression in primary care. More research is needed to determine the accuracy of depression screening instruments for demented individuals, and for those with subthreshold depressive disorders. [References: 40]

REF ID: 1380

Level I: Systematic Reviews

Topic 6: Comprehensive

Watson, R., Stimpson, A., & Hostick, T. (2004). Prison health care: A review of the literature. *International Journal of Nursing Studies*, 41(2), 119-128.

Journal Article, Research, Systematic Review, Tables/Charts

The prison population is increasing and the health problems of prisoners are considerable. Prison is designed with punishment, correction and rehabilitation to the community in mind and these goals may conflict with the aims of health care. A literature review showed that the main issues in prison health care are mental health, substance abuse and communicable diseases. Women prisoners and older prisoners have needs which are distinct from other prisoners. Health promotion and the health of the community outside prisons are desirable aims of prison health care. The delivery of effective health care to prisoners is dependent upon partnership between health and prison services and telemedicine is one possible mode of delivery.

REF ID: 1562

Level VI: Opinion

Topic 4.3: Management-Medication

Wee, R. (2005). Review: Tricyclic related drugs, but not classical tricyclics, are a tolerable alternative to SSRIs in older people with depression. *Evidence-Based Mental Health*, 8(1), 22.

Journal Article, Abstract, Commentary

How do tricyclic antidepressants (TCAs) and TCA related drugs compare with selective serotonin reuptake inhibitors in terms of tolerability in older people with depression? **METHODS** Design: Systematic review with meta-analysis. Data sources: PsycINFO, MEDLINE, EMBASE, CINAHL, SINGLE, National Research Register, Dissertation Abstracts International, Biological Abstracts, Cochrane Controlled Trials Register, and the Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials, searched up to 2002, plus hand searches and contact with authors. Study selection and analysis: Randomised controlled trials (with concealment) comparing selective serotonin reuptake inhibitors (SSRIs) with TCAs in people aged over 60 years with depression. Trials were excluded if participants had other mental disorders or were receiving psychotherapy, except where data on psychotherapy and antidepressants were analysed separately. Two reviewers independently assessed trials, and included studies were meta-analysed for withdrawal rates and adverse effects. Random effects models were used for estimating effect size. Descriptive data were also extracted. **Outcomes:** Total withdrawal rates; withdrawals due to adverse effects. **MAIN RESULTS** Eleven out of 37 identified trials met inclusion criteria (537 people receiving TCAs and 554 receiving SSRIs). Seven RCTs compared classical TCAs with SSRIs; the remaining four RCTs compared TCA related drugs. SSRIs significantly reduced total withdrawal rate and withdrawals due to adverse events compared with TCAs and TCA related drugs (see table). However, subgroup analyses by TCA class found that although classical TCAs significantly increased withdrawal compared with SSRIs, there was no significant difference between TCA related drugs and SSRIs. **CONCLUSIONS** TCA related drugs, but not classical

TCAs, are as well tolerated as SSRIs in older people, and may be used to treat depression in this age group where intolerance to SSRIs develops. NOTES Classical TCAs include doxepin, amitriptyline, imipramine, clomipramine, dothiepin, nortriptyline, trimipramine, desipramine, and nomifensine. TCA related drugs include mianserin, trazadone, maprotiline, viloxazine. SSRIs include paroxetine, fluoxetine, citalopram, fluvoxamine, and sertraline.

REF ID: 1483

Level VI: Opinion

Topic 4.1: Management-General

Wetherell, J. L., & Unutzer, J. (2003; 2003). Adherence to treatment for geriatric depression and anxiety. *CNS Spectrums*, 8(12,Suppl3), 48-59.

Journal; Peer Reviewed Journal

Patient nonadherence to pharmacologic and psychosocial treatments for geriatric depression and anxiety poses a serious barrier to effective clinical care. Rates of nonadherence may be as high as 60% in older adults. Factors associated with nonadherence include lack of information and misperceptions about mental illness and its treatment, stigma, lack of family support, cognitive impairment, adverse events, side effects, cost of treatments, poor physician-patient communication or relationship, and other barriers, such as lack of transportation. Effective interventions to improve adherence are personalized and include both behavioral and educational components. Several current projects that combine pharmacotherapy and psychotherapy for geriatric depression in an integrated care model show promise as interventions to improve rates of treatment and adherence. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1486

Level VI: Opinion

Topic 1: Risks

Whelan, G. (2003; 2003). Alcohol: A much neglected risk factor in elderly mental disorders. *Current Opinion in Psychiatry*, 16(6), 609-614.

Journal; Peer Reviewed Journal

This review will provide an update on the role that alcohol plays in the presentation and management of mental disorders in the elderly. Recent community surveys from several countries have explored the relationship between the level of alcohol consumption or alcohol use disorder and the concurrence of mental health disorders in the elderly. A consistent finding is that mild to moderate alcohol consumption is protective against the development of dementia in the elderly. In other studies very heavy drinking or alcohol use disorders are associated with functional impairment, depression and suicide. Recent reviews indicate that the relationship between levels of alcohol consumption and problems such as falls and cognitive deterioration remains controversial. The elderly appear to respond to relapse prevention strategies and pharmacotherapy equally as well as those in the younger age groups. While mild to moderate levels of alcohol consumption have a protective effect on the occurrence of dementia, the concurrence of alcohol use disorders, depression and suicide in the elderly has important implications for prevention and treatment. Pharmacotherapy and relapse prevention strategies should be made available to the elderly with alcohol use disorders. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1362

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Wilson, K., Mottram, P., Sivananthan, A., & Nightingale, A. (2006). Antidepressants versus placebo for the depressed elderly. *The Cochrane Library*, (1)

Journal Article, Research, Systematic Review

A substantive amendment to this systematic review was last made on 15 October 2000. Cochrane reviews are regularly checked and updated if necessary. Background: Depression warranting intervention is found in ten percent of people over the age of 60. Older depressed people are more likely to die than non-depressed. Relatively few receive therapeutic interventions, and those that do, tend to receive low dose antidepressant therapy. Depression in older people is thought to differ in terms of

aetiology, presentation, treatment and outcome than in younger people. Concomitant physical illness and increasing social, physical and neurophysiological diversity are associated with the ageing process. Consequently drug treatment of older patients is often carried out in institutions and on patients suffering from multiple physical problems. Objectives: To determine the efficacy of antidepressant medication compared with placebo in the treatment of depression in older patients. Search strategy: The search strategy incorporated: electronic literature searches of databases held by the Cochrane Collaboration Depression, Anxiety and Neurosis Review Group (CCDAN) (see Collaborative Review Group Search Strategy). Reference lists of related reviews and references of located studies. Contact was made with authors working in the field. Selection criteria: All randomised, placebo controlled trials using antidepressants in the treatment of the presenting episode of depression in patients described as elderly, geriatric senile or older adult. Data collection and analysis: Two types of data were extracted (if available) from each study. The first type of data was dichotomous data, this consisted of recovered/not recovered. The second, continuous data, included: Hamilton Depression Rating Scale (HAM-D), Montgomery-Asberg Rating Scale (MADRS) and other depression rating scale scores. An analysis using Peto Odds ratios for the dichotomous data and weighted mean difference for continuous data was performed using RevMan 3.1. The presence of heterogeneity of treatment effect was assessed. Main results: Seventeen trials contributed data to the analyses comparing the efficacy of antidepressant treatment and placebo. Analyses of efficacy were based on 245 patients treated with Tricyclic antidepressants (223 with placebo), 365 patients treated with SSRIs (372 with placebo) and 58 patients treated with MAOIs (63 with placebo). The results using a fixed effect model, for the three groups respectively were, TCAs; OR: 0.32 (95% CI: 0.21,0.47), SSRIs; OR; 0.51 (95% CI: 0.36,0.72), MAOIs: OR 0.17 (95% CI: 0.07,0.39). Authors' conclusions: TCAs, SSRIs and MAOIs are effective in the treatment of older community patients and inpatients likely to have severe physical illness. At least six weeks of antidepressant treatment is recommended to achieve optimal therapeutic effect. There is little evidence concerning the efficacy of low dose TCA treatment. Further trials are required before low dose TCA treatment is routinely recommended. [CINAHL Note: The Cochrane Collaboration systematic reviews contain interactive software that allows various calculations in the MetaView.]

REF ID: 1448

Level I: Systematic Reviews

Topic 4.3: Management-Medication

Wilson, K., & Mottram, P. (2004; 2004). A comparison of side effects of selective serotonin reuptake inhibitors and tricyclic antidepressants in older depressed patients: A meta-analysis. *International Journal of Geriatric Psychiatry, 19*(8), 754-762.

Objective: To examine the relative tolerability and side effect profile of tricyclic antidepressants and selective serotonin reuptake inhibitors in older depressed people. Methods: A systematic literature search generated 37 randomised controlled trials of TCAs and SSRIs of which 11 were entered into a meta analysis comparing withdrawal rates and side effect profiles. Results: 537 TCA recipients and 554 SSRI recipients were compared. TCAs had an increased withdrawal rate (RR: 0.24, CI 1.04, 1.47). A similar result was found when comparing classical TCAs (451 patients) (amitriptyline, clomipramine, doxepin and dothiepin) with SSRIs (466 patients) (RR 1.30 CI: 1.02,1.64). These findings were reflected in the increased TCA prevalence of side effects including dry mouth, drowsiness, dizziness and lethargy. No differences were found when comparing TCA related drugs (mianserin and trazadone) with SSRIs (RR 1.07 CI 0.43, 2.70). Conclusions: Despite the relative low prevalence of side effects associated with SSRIs a significant minority of older people find these drugs intolerable and experience nausea, vomiting, dizziness and drowsiness. We conclude that TCA related drugs are comparable to SSRIs in terms of tolerability and may offer an alternative when SSRIs are either contra-indicated or clinically unacceptable. (PsycINFO Database Record (c) 2006 APA, all rights reserved) (journal abstract)

REF ID: 1572

Level VI: Opinion

Topic 4.6: Management-Other

Woods, B. (2004). Review: Reminiscence and life review are effective therapies for depression in

the elderly. *Evidence-Based Mental Health*, 7(3), 81.

Journal Article, Abstract, Commentary

What are the effects of reminiscence and life review in people with late life depression METHODS: Design: Systematic review with meta-analysis. Data sources: PsycINFO (1960-2001), MEDLINE (1966-2001), and dissertation abstracts studies used in four earlier metaanalyses plus hand searches of bibliographies. Study selection and analysis: Eligible studies examined the effects of reminiscence or life experience, reported sufficient pretest and post-test data, included a control or comparison group, and used a measure of depressive symptoms. The reviewers assessed the quality of the studies. For each study, standardised effect sizes were calculated. These were pooled across studies to determine treatment effect using a random effects model, and correction for reliability. Outcomes: Depressive symptoms. MAIN RESULTS: Twenty studies met inclusion criteria (15 RCTs, five comparative studies). Participants had severe depressive symptoms in five studies. In the other 15 studies, participants were not enrolled due to depression per se but had mild or moderate symptoms. Fifteen studies examined reminiscence and seven studies life review. Reminiscence and life review significantly improved depressive symptoms compared with control (large overall mean effect size 0.84, p25%. Also, there were insufficient data available to calculate long term effects.

REF ID: 1583

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Woods, N. F., LaCroix, A. Z., Gray, S. L., Aragaki, A., Cochrane, B. B., & Brunner, R. L. et al. (2005). Frailty: Emergence and consequences in women aged 65 and older in the women's health initiative observational study. *Journal of the American Geriatrics Society*, 53(8), 1321-1330.

Journal Article, Equations & Formulas, Research, Tables/Charts

OBJECTIVES: To define frailty using simple indicators; to identify risk factors for frailty as targets for prevention; and to investigate the predictive validity of this frailty classification for death, hospitalization, hip fracture, and activity of daily living (ADL) disability. DESIGN: Prospective study, the Women's Health Initiative Observational Study. SETTING: Forty U.S. clinical centers. PARTICIPANTS: Forty thousand six hundred fifty-seven women aged 65 to 79 at baseline. MEASUREMENTS: Components of frailty included self-reported muscle weakness/impaired walking, exhaustion, low physical activity, and unintended weight loss between baseline and 3 years of follow-up. Death, hip fractures, ADL disability, and hospitalizations were ascertained during an average of 5.9 years of follow-up. RESULTS: Baseline frailty was classified in 16.3% of participants, and incident frailty at 3-years was 14.8%. Older age, chronic conditions, smoking, and depressive symptom score were positively associated with incident frailty, whereas income, moderate alcohol use, living alone, and self-reported health were inversely associated. Being underweight, overweight, or obese all carried significantly higher risk of frailty than normal weight. Baseline frailty independently predicted risk of death (hazard ratio (HR)=1.71, 95% confidence interval (CI)=1.48-1.97), hip fracture (HR=1.57, 95% CI=1.11-2.20), ADL disability (odds ratio (OR)=3.15, 95% CI=2.47-4.02), and hospitalizations (OR=1.95, 95% CI=1.72-2.22) after adjustment for demographic characteristics, health behaviors, disability, and comorbid conditions. CONCLUSION: These results support the robustness of the concept of frailty as a geriatric syndrome that predicts several poor outcomes in older women. Underweight, obesity, smoking, and depressive symptoms are strongly associated with the development of frailty and represent important targets for prevention.

REF ID: 1375

Level I: Systematic Reviews

Topic 4.6: Management-Other

Zabalegui, A., Juando, C., Izquierdo, Gual, P., GonzalezVelentin, A., & Gallart, A. et al. (2004). Resources and consequences of caregiving for people older than 65: A systematic review [spanish]. *Gerokomos*, 15(4), 199-208.

Journal Article, Research, Systematic Review

Introduction: Caregivers of elderly people are the main support they receive. The fact of giving care affects in different ways every carer and these consequences are deeply described in the literature.

Literature is wide when describing these repercussions of caregiving on caregivers. Methods: A systematic literature review was done in the main international and Spanish data bases about articles focused on interventions and consequences of caregiving on caregivers of older people. Conclusions: Spanish caregivers seem to have diverse support resources for providing care. Literature compile positive and negative outcomes. Among the latter, we found as the most important anxious and depressive status and caregiver burden. However, these consequences seem to interact with positive repercussions. The literature review invites us to confirm that more research is needed to clear the relationship between both poles of caregiving. This abstract was translated into English by the publisher or author.

REF ID: 1367

Level I: Systematic Reviews

Topic 5: Evaluation/Follow-up

Zimmerman, M., Chelminski, I., & Posternak, M. (2004). A review of studies of the Hamilton depression rating scale in healthy controls: Implications for the definition of remission in treatment studies of depression. *Journal of Nervous and Mental Disease, 192(9), 595-601.*

Journal Article, Research, Systematic Review, Tables/Charts

The Hamilton Rating Scale for Depression (HRSD) is the most commonly used symptom severity scale to evaluate the efficacy of antidepressant treatment. On the basis of an expert consensus panel, an HRSD score of ≤ 7 was recommended as a cutoff to define remission. Since that recommendation, little empirical work has been conducted to confirm the validity of this threshold. One approach toward determining a cutoff score for defining remission is to establish the range of values for healthy controls. We therefore conducted a literature review of studies of the HRSD in healthy controls to determine the normal range of values. Studies of the HRSD in healthy control groups were identified in two ways. First, a MEDLINE search for the years 1966 to 2002 was conducted using the key words Hamilton, depression, and controls, and articles were reviewed. Second, the 69 studies included in two review articles written by the authors were examined. We identified 27 studies that included data on the HRSD for 1014 healthy controls. Across all studies, the weighted mean (SD) HRSD score, adjusting for sample size, was 3.2 (3.2; 95% CI, 3.0 to 3.4). HRSD scores were similar in geriatric and nongeriatric samples, and in men and women. Because HRSD scores in healthy controls are more likely to follow a skewed than a normal distribution, based on a mean of 3.2 and a SD of 3.2, at least 84% of healthy controls scored 7 or less on the HRSD, and 97.5% scored 10 or less. Thus, these results can be taken as support for the recommended cutoff of 7 on the HRSD to define remission. The results can also be used for normative comparisons in which posttreatment group mean scores are compared with mean scores from normative samples.

REF ID: 1592

QM: Quality Measures

Topic 5: Evaluation/Follow-up

Zisselman, M. H., Warren, R. S., CuttilloSchmitter, T., & Denman, S. J. (2002). Challenging the quality of the quality indicator, "depression without treatment". *Journal of the American Medical Directors Association, 3(2), 41-45.*

Journal Article, Research

Objective: To assess the validity of the Minimum Data Set (MDS)-based quality indicator, "depression without treatment," and examine whether a nonphysician-based educational intervention can improve the accuracy of MDS questions regarding depression and its treatment. Subjects: All residents of a 538-bed urban, university affiliated, long-term-care (LTC) facility. Nursing and social work staff involved in completing the mood and behavior items on the MDS. Design: Two retrospective chart review of psychotropic medications, psychiatric diagnoses, mental health evaluation, and treatment of all residents who were identified as displaying the MDS quality indicator, depression without treatment, before and 2 months after an educational intervention. The education consisted of three 12-hour sessions led by a psychiatric clinical nurse specialist to educate registered nurse assessment coordinators and social workers about psychotropic medications, clinical characteristics of psychiatric diagnoses, chart review, and coordination of resident medical care. Results: The first MDS identified 66 residents as having

depression without treatment. Clinical record review revealed that 11 of these residents were receiving an antidepressant. Twenty-two others were receiving a psychotropic medication consistent with their psychiatric diagnosis. Twenty-five of the remaining residents had not received mental health assessment for greater than 1 year. Two months after the educational intervention, 36 residents were identified as depression without treatment. Four of these residents were receiving an antidepressant; eight others were receiving a psychotropic medication consistent with their psychiatric diagnosis. Thirteen of the remaining residents had not received mental health assessment for greater than 1 year. Conclusions: This preliminary study reveals that the presence of the quality indicator, depression without treatment, may not accurately capture clinically depressed LTC residents in need of mental health intervention. An educational intervention may be able to assist staff in more accurately completing MDS questions regarding depression and its treatment.