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Making an IMPACT on late-life depression

Partnering with primary care providers can double the effect of treatment

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Few depressed older adults seek help from psychiatrists. Those who receive mental health treatment most likely do so in primary care settings. Yet primary care physicians (PCPs) often are ill-equipped to effectively treat depression while managing older patients' numerous acute and chronic medical conditions.

If depressed older patients won't go to a psychiatrist, why not bring the psychiatrist to the patients? This article describes a clinically tested approach called project IMPACT that links psychiatrists to primary care teams and dramatically improves depression treatment in older adults.

UNTREATED GERIATRIC DEPRESSION

Preference for primary care. Major depression is rare in community-living older adults (1% to 3% prevalence), but:

Box 1

Older adults: Usual patterns of depression treatment

- **Prefer** treatment in primary care instead of mental health settings
- **Only 50%** follow through on mental health referrals
- **Only 20%** improve when treated in primary care without a team approach
- **Chronic** medical illnesses often complicate diagnosis and treatment
- **Often complain** of somatic symptoms of depression
- **May believe** depression is a 'normal' part of aging
- **May receive** subtherapeutic antidepressant dosages because of physician concerns about side effects

Source: References 2-4

Box 2

Double trouble: Medical illness and geriatric depression

Depression is rarely the only illness an older adult is experiencing:

- **10% to 25%** of adults with chronic medical illnesses such as diabetes or heart disease have major depression.
- **Medical illness** is associated with increased rates of depression, and depression is associated with poorer physical health.[6]

Depression diminishes self-care, which is key to managing chronic medical illnesses in late life. Depressed patients have higher rates of obesity and smoking. They are less likely to exercise, eat well, or adhere to complex treatment regimens with oral hypoglycemics, antihypertensives, and lipid-lowering drugs.[7]

Depression also substantially increases total health care costs among older adults.[8]

- 5% to 10% of older primary care patients meet DSM-IV-TR criteria for major depression[1]
- approximately one-half of depressed older adults report a primary care visit when a mental health problem was addressed during the past year.[2]

Only 8% of depressed older adults visit a mental health specialist in a given year, compared with 25% of depressed younger adults.[2] Even when PCPs refer older patients to a mental health specialist, only 50% follow through (*Box 1*).[3,4]

Barriers to effective care. Depression diagnosis and treatment by PCPs has improved, but a recent survey suggests that with usual treatment:

- only 1 in 5 depressed older adults treated in a primary care practice experiences substantial improvement over 12 months
- only 1 in 10 becomes symptom-free.[5]

Many depressed older adults do not realize they have depression and visit their PCPs complaining of physical symptoms (*Box 2*).[6-8] Their limited knowledge about depression or fear of being labeled "mentally ill" deters them from disclosing a depressed mood. They and their PCPs may think depression is inevitable with aging.

PCPs also may lack training to differentiate mood disorders, transitory reactions to life-events, or depression caused by medical illness. Their busy schedules limit time to address and prioritize patient concerns about acute and chronic medical problems (*Box 3, page 88*). Thus depression "falls through the cracks."

Prescribing concerns. PCPs who feel uncomfortable prescribing antidepressants to older patients may be concerned about side effects and maintain dosages at low starting levels instead of titrating up to a therapeutic range.

COLLABORATIVE CARE

One way to overcome these barriers is to integrate mental health providers into primary care to sup-

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Box 3

Why primary care providers may fail to treat late-life depression

- **Concerns** about discussing a socially stigmatized condition with older adults
- **Buying into** the fallacy that depression is 'normal' in late life
- **Missing the diagnosis** because of medical comorbidity and older adults' focus on physical versus emotional symptoms
- **Unfamiliarity** with how to prescribe antidepressants, particularly for patients with complex medical comorbidity
- **Time constraints** may discourage opening 'Pandora's box' of depression

port and augment PCP-prescribed depression treatment. Collaborative care can become an effective, efficient way to provide high-quality depression care to older patients who might otherwise go untreated.[9]

Project IMPACT. One such model—project IMPACT (Improving Mood: Promoting Access to Collaborative Treatment for Late-life Depression)—was developed with support from the John A. Hartford Foundation and California Healthcare Foundation. At its heart is a depression care manager or depression clinical specialist—typically a nurse, social worker, or psychologist—who works in a primary care practice. Other team members include the patient's PCP, the patient, and a consulting psychiatrist.

Training in the IMPACT model is available at workshops and via the Internet

The care manager works closely with the PCP by:

- educating patients about depression
- coaching patients in pleasant events scheduling/behavioral activation
- supporting the PCP's antidepressant management
- offering patients a brief course of evidence-based counseling, such as Problem Solving Treatment in Primary Care[10]
- measuring patients' depressive symptoms at treatment onset and regularly thereafter with a tool such as the 9-item depression scale of the Patient Health Questionnaire (PHQ-9).[11]

Consulting psychiatrist's role. If a patient is not sufficiently improved after 8 to 10 weeks, the care manager works with the PCP and psychiatrist to change treatment according to an evidence-based algorithm (*Figure*).[12] In large health care systems, the psychiatrist meets weekly with the care manager to review treatment plans for approximately 100 depressed older adults, with particular attention to those who are not improving. Psychiatrists may see patients in person or facilitate other specialty mental health treatment, as indicated.

Patients are encouraged to choose an antidepressant prescribed by their PCP, psychotherapy provided by the care manager in the primary care setting, or both. The patient and PCP make treatment decisions with support from the care manager and psychiatrist.

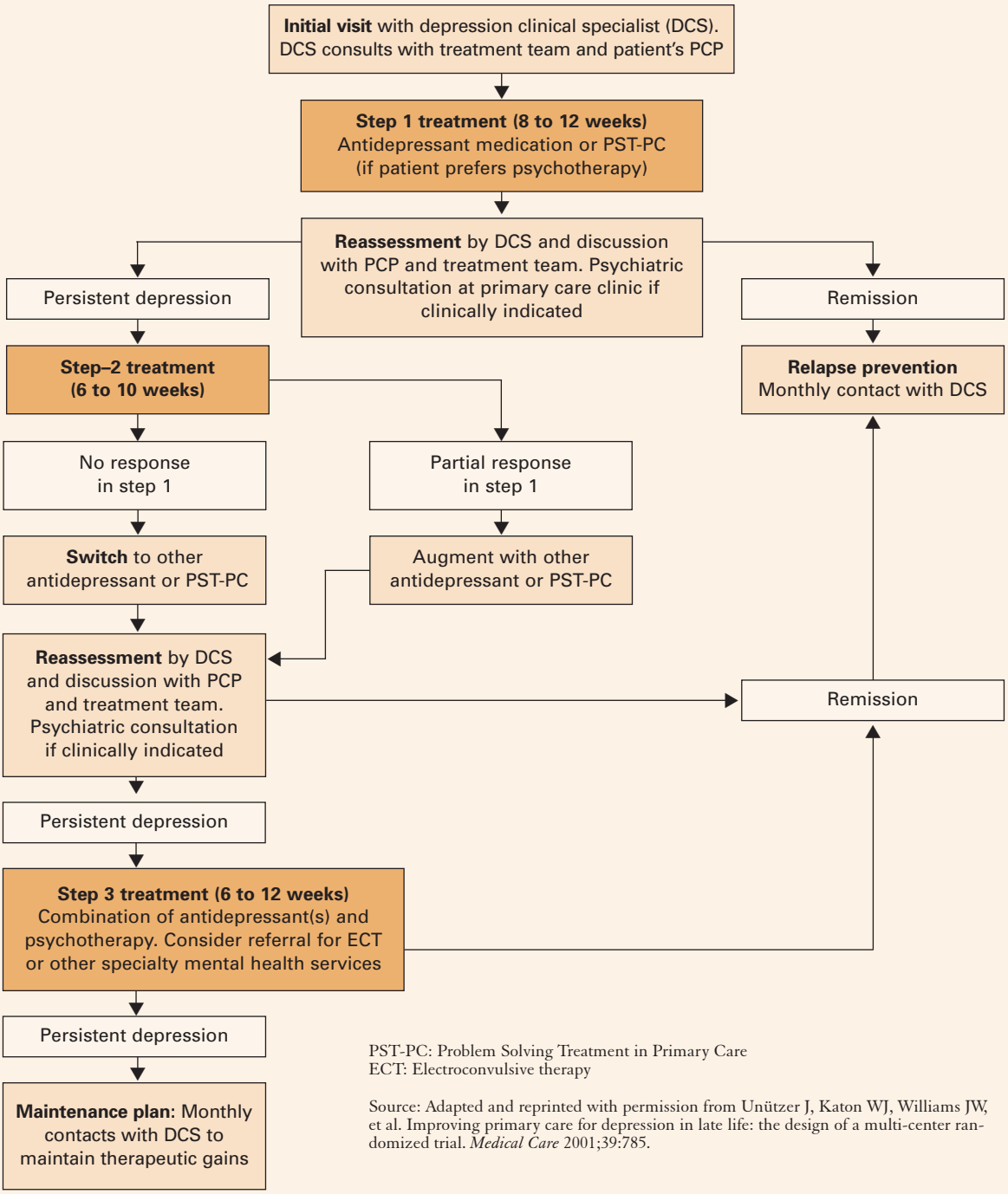
After depressive symptoms remit, the care manager completes a relapse prevention plan with the patient. This includes:

- steps the patient can take to prevent a relapse
- identifying relapse warning signs
- an action plan if depressive symptoms recur.

Training for clinicians in the IMPACT model is available at workshops and on the Internet (*see Related resources*). Successful implementation requires addressing operational and financing issues, and potential funding sources for primary care-based management have been described.[13]

Figure

3-step IMPACT intervention for a typical older patient with depression



PST-PC: Problem Solving Treatment in Primary Care
ECT: Electroconvulsive therapy

Source: Adapted and reprinted with permission from Unützer J, Katon WJ, Williams JW, et al. Improving primary care for depression in late life: the design of a multi-center randomized trial. *Medical Care* 2001;39:785.

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HOW IMPACT WAS TESTED

The IMPACT team care model has been tested in a randomized trial with 1,801 depressed older adults from 18 primary care clinics in 8 U.S. health care organizations. These included fee-for-service plans, health maintenance organizations, and Veterans Affairs clinics with more than 450 PCPs in rural and urban settings.

Patients were randomly assigned to receive IMPACT care for 12 months or care as usual (in usual care, the patient and provider were informed that the patient met diagnostic criteria for major depression or dysthymia). Patients assigned to usual care could engage in any depression treatment the provider normally used, including referral to specialty mental health services.[14]

IMPACT-treated patients gained >100 depression-free days, compared with usual care

Result: Better outcomes. IMPACT was more effective than usual care for late-life depression in all 8 organizations over 2 years.[15,16] Overall, IMPACT doubled the effect of usual care. IMPACT patients:

- experienced >100 additional depression-free days[17]
- showed substantial improvements in physical and social functioning[15,17] and quality of life,[15] even 12 months after IMPACT resources were withdrawn[18]
- experienced less pain and pain-related functional impairment[19]
- had significantly less suicidal ideation.[20]

IMPACT care also was more cost-effective than usual care for depression in older adults with and without comorbid medical illnesses.[17]

FROM RESEARCH TO PRACTICE

Based on the robust study outcomes, researchers received a grant from the John A. Hartford Foundation to provide materials, training, and technical assistance to organizations interested in adopting IMPACT. More than 20 health care organizations have used IMPACT, and several have completed program evaluations showing outcomes matching the original IMPACT trial's.

Kaiser Permanente of Southern California serves 3 million members. Before adopting collaborative care for depression, Kaiser conducted a pilot study of the project IMPACT model modified to fit its health care system. Adaptations included:

- expanding the program to serve depressed adults of all ages
- adding medical assistants to the care team to help with patient follow-up
- adding a "depression class" to offer group-based patient education
- providing psychiatric consultation to the care manager and primary care providers by telephone.

Kaiser investigators compared the outcomes of 300 patients who experienced the adapted program with outcomes in 140 usual-care patients and 140 intervention patients in the original IMPACT study. The effects on depression symptoms were equal to those achieved in the original IMPACT study, with 68% of depressed older adults showing substantial improvement (at least a 50% reduction in depression symptoms) at 6 months.[21]

Want to know more?
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www.currentpsychiatry.com
▸ **Late-life depression: Focused interpersonal psychotherapy eases loss and role changes**
NOVEMBER 2005

Related resources

- Project IMPACT. www.impact-uw.org.
- American Association of Geriatric Psychiatry. www.aagpgpa.org.
- Positive Aging Resource Center. http://positiveaging.org.

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Bottom Line

By collaborating with primary care teams, psychiatrists can help improve the diagnosis and treatment of late-life depression in their communities. The IMPACT collaborative care model can double the effectiveness of usual care for depression in older adults.