



Pharmaceutical Assistance  
Contract for the Elderly



# Caring for older adults with depression



# Depression is *not* a normal part of aging, and is often under-treated

Depression is defined as a cluster of symptoms that causes impairment in function and lasts for at least two weeks.<sup>1</sup> It has medical, functional, and social consequences.

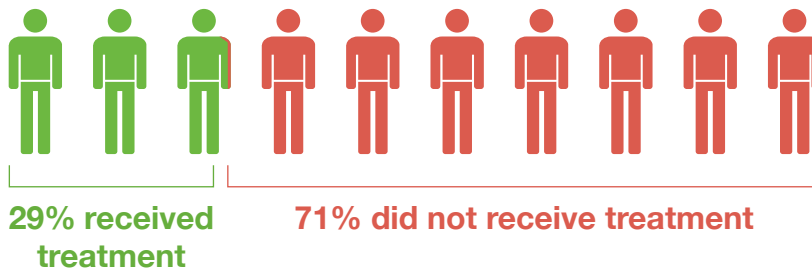
Older patients with depression have worse health outcomes than comparable patients without depression, including:

- increased mortality in patients with coronary heart disease<sup>2</sup>
- elevated risk of suicide<sup>3</sup>
- higher rates of stroke and all-cause mortality<sup>4,5</sup>

Primary care clinicians can help close the care gap for older adults with depression.



**Fewer than 3 in 10 patients received medication, psychotherapy, or both to manage their depression.<sup>6</sup>**



**Of older adults treated for depression, nearly 80% of treatment was provided by their primary care clinician.<sup>7</sup>**



# Identify and diagnose depression

## STEP

# 1

Screen all patients in primary care using the two-question version of the Patient Health Questionnaire (PHQ)-2.<sup>8</sup>

- PHQ-2 identifies the two cardinal symptoms of depression: **low mood** or **anhedonia** (the inability to experience pleasure).
- If the PHQ-2 score is 3 or more, proceed to Step 2.



PHQ-2

## STEP

# 2

Identify whether major depressive disorder is present.

- The criteria for depression in the latest version of the Diagnostic and Statistical Manual (DSM-5-TR) assess functional impairment and symptoms over the prior two weeks, and align with the PHQ-9.<sup>1</sup>
- Depression is diagnosed if **low mood** or **loss of pleasure** is present, **plus at least four of the following, at a level that impairs function:**
  - changes in appetite
  - changes in sleep
  - decrease in concentration
  - changes in activity (e.g., moving slowly or fidgeting)
  - guilt or feelings of worthlessness
  - decrease in energy
  - suicidal thoughts
- A score of 5 or more on the PHQ-9 suggests depression.
- If the patient cannot complete the PHQ-9, use the Geriatric Depression Scale (GDS), which has a yes/no format.



PHQ-9



GDS

## STEP

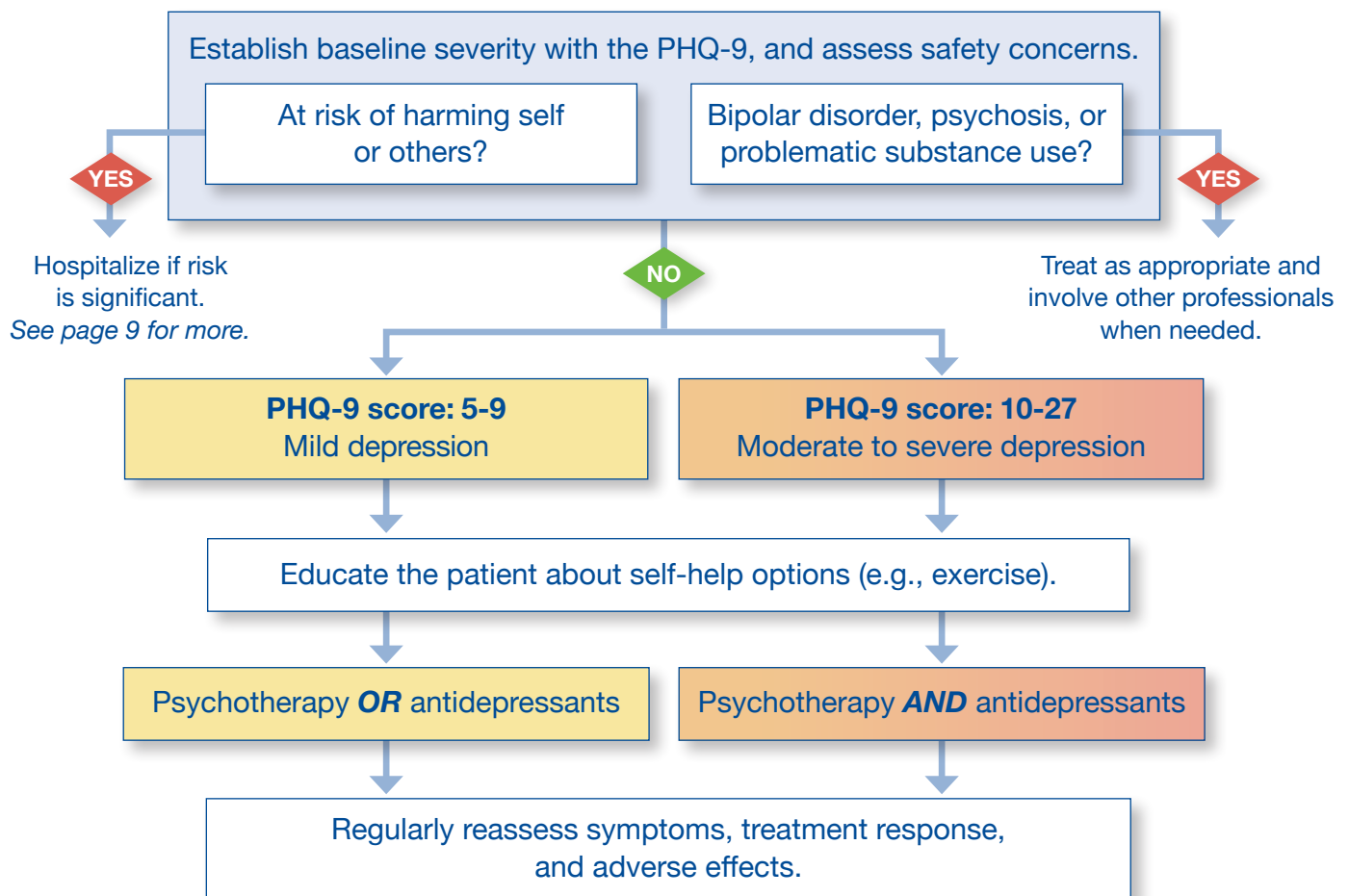
# 3

Evaluate for bipolar disorder.

- Ask patients whether they have a history of mania or hypomania—defined as periods of elevated or irritable mood and increased energy over at least **four days (hypomania)** or **seven days (mania)** **plus at least three of the following:**
  - distractibility
  - indiscretions
  - activity level increased
  - grandiosity
  - flight of ideas
- Typical depression treatment may trigger a manic or hypomanic episode in patients with bipolar disorder and so a different treatment is needed.

# Make a plan for treatment

**FIGURE 1.** An evidence-based approach to depression care



## Identify treatment outcomes

The goal is remission of depressive symptoms, usually with a PHQ-9 score under 5.

### Depression and dementia: evaluating the patient with cognitive impairment

- If there are any concerns about cognition, formally assess with MoCA or MMSE\* and use a tool designed to evaluate for depression in older patients, like the Geriatric Depression Scale (see page 3).
- If the patient has both depression and cognitive impairment, treat the depression.
- Reassess both depression and cognitive impairment after depression treatment is optimized.

\* MoCA: Montreal Cognitive Assessment ([mocacognition.com](http://mocacognition.com)); MMSE: Mini-Mental State Examination ([bit.ly/cogMMSE](http://bit.ly/cogMMSE))

# Offer psychotherapy

Psychotherapy is as effective as medications for patients with mild to moderate depression.<sup>9</sup>

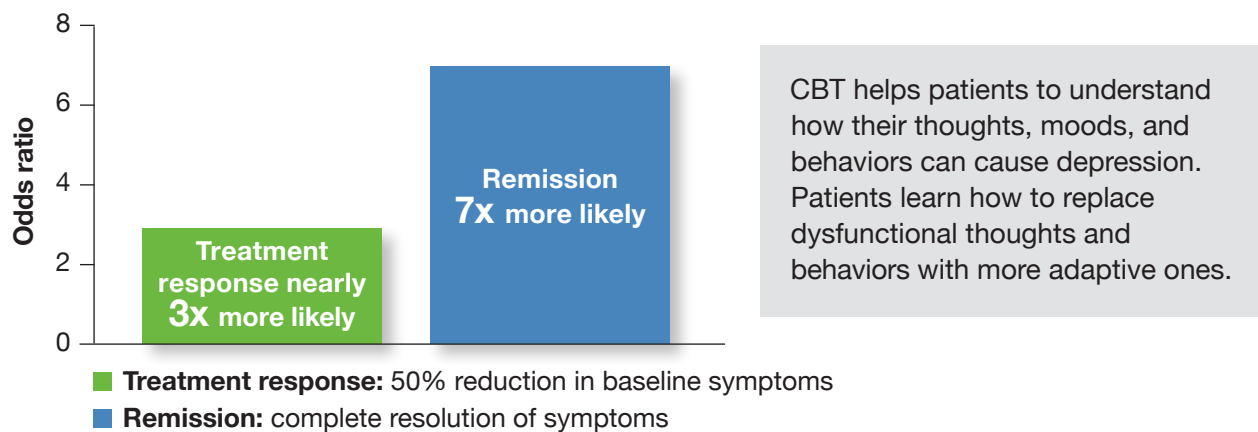


Many psychotherapeutic approaches are similarly effective, including:<sup>9</sup>

- cognitive behavioral therapy (CBT)
- problem solving therapy
- interpersonal therapy
- behavioral activation therapy
- psychodynamic therapy
- dialectical behavioral therapy



**FIGURE 2.** In older adults, CBT improved the likelihood of depression response and remission compared to usual care or wait-list controls.<sup>10</sup>



CBT and other therapies can be adapted for use in primary-care settings by clinical staff members. Links to programs and information: [AlosaHealth.org/Depression](https://AlosaHealth.org/Depression)

## You don't have to be a therapist to be therapeutic.

Talk to patients about participating in activities they enjoy.



Engage in physical activity



Connect with loved ones or a community



Set a goal or learn a new skill



Achievement, Closeness, Enjoyment (ACE) log

Logging activities done with others in an **ACE log** can establish routines and help patients identify and address barriers to engagement.



# Select medications based on patient characteristics

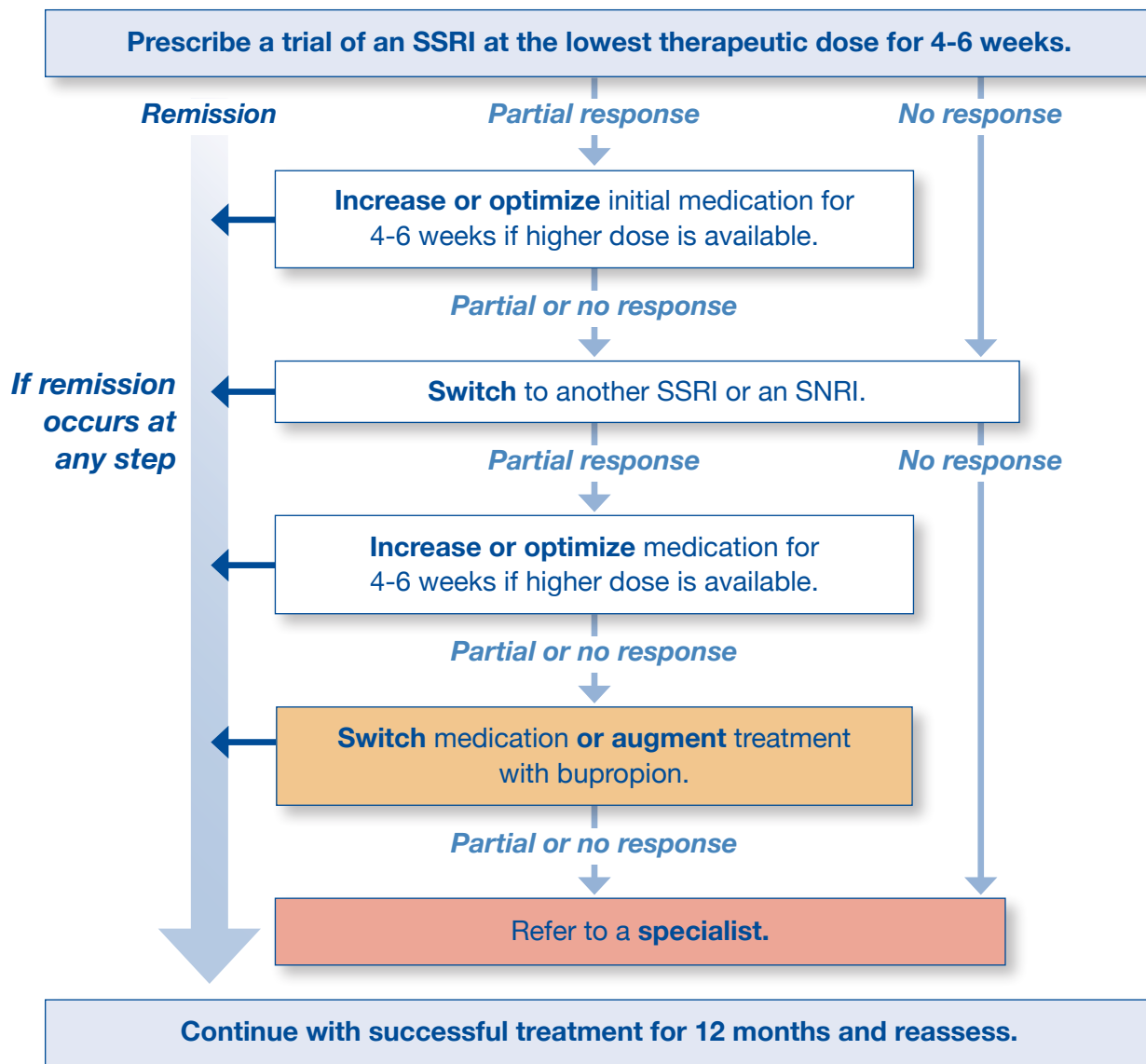
**TABLE 1. Summary of medications effective for the treatment of depression in older adults<sup>11,12</sup>**

MEDICATIONS	STARTING DOSE	THERAPEUTIC DOSE	PRESCRIBING TIPS
Selective serotonin reuptake inhibitors (SSRIs)			
citalopram (Celexa)	20 mg	20 mg	<ul style="list-style-type: none"><li>first-line medications because of a better safety profile compared to other antidepressants<sup>13</sup></li><li>citalopram and escitalopram can cause QTc prolongation</li></ul>
escitalopram (Lexapro)	5-10 mg	10-20 mg	
sertraline (Zoloft)	25-50 mg	50-200 mg	
fluoxetine (Prozac)	10 mg	4-60 mg	<ul style="list-style-type: none"><li>long half-life may lead to accumulation</li></ul>
paroxetine (Paxil)	10 mg	50 mg	<ul style="list-style-type: none"><li>anticholinergic effects limit use in older adults</li></ul>
Serotonin norepinephrine reuptake inhibitors (SNRIs)			
duloxetine (Cymbalta)	20-30 mg	60 mg	<ul style="list-style-type: none"><li>effective for co-occurring neuropathic pain</li></ul>
levomilnacipran (Fetzima)	20 mg	40-120 mg	<ul style="list-style-type: none"><li>monitor for increase in blood pressure</li></ul>
venlafaxine (Effexor)	37.5-75 mg	150-225 mg	
desvenlafaxine (Pristiq)	25-50 mg	50-100 mg	
Atypical antidepressants			
bupropion XL (Wellbutrin XL)	150 mg	300 mg	<ul style="list-style-type: none"><li>can improve energy and concentration</li><li>lowers appetite</li><li>helps with smoking cessation</li><li>avoid in patients with seizure risk</li></ul>
mirtazapine (Remeron)	7.5 mg	30 mg	<ul style="list-style-type: none"><li>can improve appetite and sleep</li><li>may cause thrombocytopenia</li></ul>
Serotonin modulators			
trazodone (Desyrel)	75-150 mg	400 mg	<ul style="list-style-type: none"><li>helps insomnia at low doses</li></ul>
vilazodone (Viibryd)	10 mg	20 mg	<ul style="list-style-type: none"><li>limited data in older adults</li></ul>
vortioxetine (Trintellix)	5 mg	5-20 mg	
Tricyclic antidepressants (TCAs)			
amitriptyline (Elavil)	25 mg	100-300 mg	<ul style="list-style-type: none"><li>may cause QTc prolongation, hypotension</li><li>anticholinergic side effects limit use in older patients</li></ul>
nortriptyline (Pamelor)	25-50 mg	75-100 mg	

**To date, newer medications like vilazodone and vortioxetine offer no advantages over older, generic options for initial treatment.** For the newest medication, dextromethorphan/bupropion (Auvelity), clinical trials did not include adults aged 65 and over.<sup>14,15</sup>

# A roadmap to managing medications

**FIGURE 3. Modified STAR\*D algorithm for medication use in older adults<sup>16</sup>**



■ **Other augmentation strategies:**

- buspirone
- lithium
- antipsychotics

■ **Specialist referral is appropriate for persistent treatment resistant depression or at any stage if:**

- psychotic features
- substance use disorder
- suicidal risk

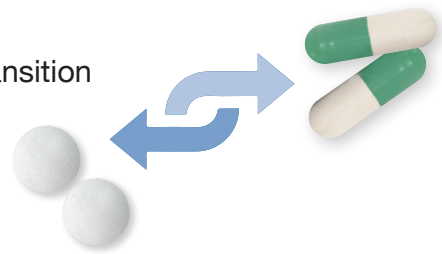
**Augmentation may be selected instead of switching** following an initial partial response.<sup>17</sup>

**Know the risks of antipsychotics.** Monitor for extrapyramidal symptoms, tardive dyskinesia, and metabolic changes.

# Changing therapeutic strategy

## ➡ Switching from one antidepressant to another

- No randomized controlled trials have assessed methods of cross-titration or switching from one antidepressant to another.
- Select the best option for your patient based on:
  - ability to follow-up with the patient throughout transition
  - presence of comorbidities
  - withdrawal-related side effects



## ➡ Stopping therapy

- In patients with a **single episode** of treatment-responsive depression, think about discontinuing treatment after one year if symptoms have been stable and in remission (i.e., PHQ-9 score < 5).<sup>16</sup>
- In patients with **more than one episode** of depression, prolonged treatment may be needed. In a randomized trial of patients who expressed an interest in discontinuing treatment after two or more treated episodes of depression, the risk of symptoms returning was two times higher after discontinuation than if treatment was continued.<sup>18</sup>

## ➡ Consider a specialist referral

### 1. if there is diagnostic uncertainty:

- Refer to a psychiatrist to rule out other mental health diagnoses.
- Refer for neuropsychiatric testing to clarify the role of dementia versus depression in patients with cognitive impairment.

### 2. if there are complicating features (e.g., substance use, psychotic features, suicidality)

### 3. if higher-risk medications are being considered, such as augmentation with an antipsychotic (e.g., risperidone, aripiprazole) or lithium



### What is the role of pharmacogenomic testing?

**Pharmacogenomic testing** can identify how a patient will metabolize a medication. It may aid in the dosing of selected treatments but is not currently recommended for most patients. This testing does NOT indicate whether a medication will be effective or increase the likelihood of achieving remission.<sup>19</sup>



# Talk about suicide

## Older adults have the highest suicide rate of all age groups.

- Patients aged 75 and older have the highest rate of suicide (19.1 per 100,000).<sup>20</sup>
- Men, especially non-Hispanic white men, have particularly high rates among older adults.<sup>20</sup>

The Columbia Suicide Severity Rating Scale (C-SSRS) can help assess self-harm thoughts and behaviors.<sup>21</sup> You can also use SAFE-T.<sup>22</sup>

**FIGURE 4. For patients who express thoughts of self-harm:**<sup>22</sup>

- 1 Identify risk factors** (e.g., untreated mood, anxiety, psychotic or substance use disorders, access to lethal methods, history of attempt).
- 2 Identify protective factors** (e.g., ability to cope with stress, family or social relationships, responsibility for children or beloved pets).
- 3 Ask about suicidal ideation**, plan, behaviors, and intent.
- 4 Determine risk level** and select **one or more** interventions:

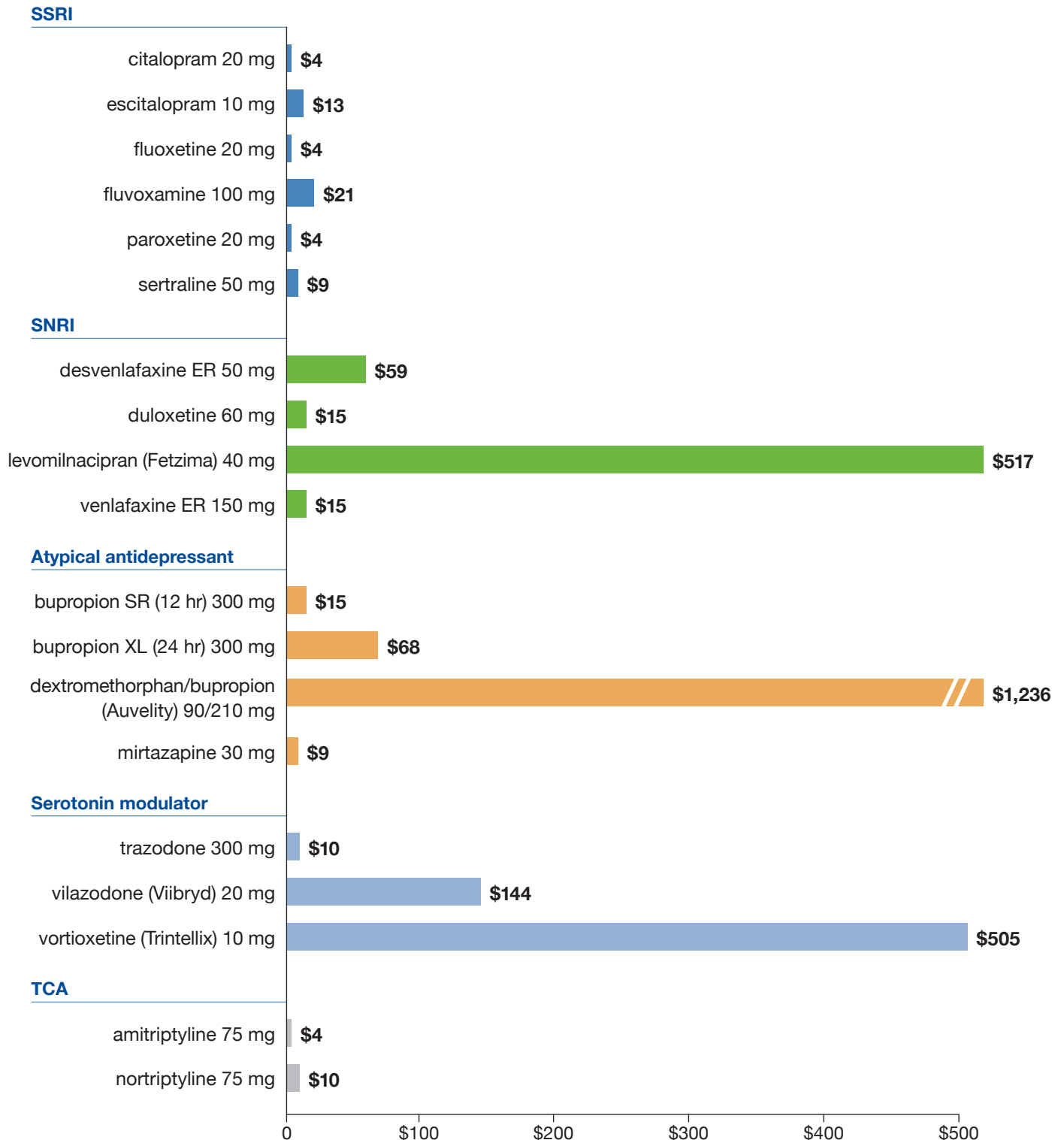
RISK LEVEL	SUICIDALITY	INTERVENTION
HIGH	Suicide attempt or persistent ideation with strong intent or suicide rehearsal	Hospitalization likely indicated; suicide precautions
MODERATE	Suicide ideation with plan, but no intent or behavior	Hospitalization, depending on risk factors. Develop a crisis plan and provide crisis resources.
LOW	Thoughts of death; no plan, intent, or behavior	Outpatient depression treatment. Provide crisis resources and refer to a specialist if needed.
- 5 Document a safety plan.** Provide patients with resources, support, and a plan for how to manage suicidal thoughts at home if appropriate.



**National Suicide Prevention Lifeline**  
Call: 988 / online: [988lifeline.org](https://988lifeline.org)

# Cost chart

**FIGURE 5. Price of a 30-day supply of antidepressant medications**



Pharmacy prices from goodrx.com, January 2023. Listed doses are based on Defined Daily Doses by the World Health Organization. All doses shown are generics when available, unless otherwise noted. These prices are a guide; patient costs will be subject to copays, rebates, and other incentives. These doses should not be used as a guide for treatment.

# Key points

- **Depression is not a normal part of aging and is treatable.**
- **Screen all patients for depression with the 2-question tool (PHQ-2).**  
Follow up a positive screen with the PHQ-9 or Geriatric Depression Scale to confirm the diagnosis.
- **Offer treatment based on severity and patient preference:**
  - Recommend psychotherapy or other behavioral approaches.
  - Prescribe an SSRI or other antidepressant.
- **Monitor response to treatment,** titrate to effective doses, be alert for side effects, and switch therapy if the response is inadequate.
- **In patients who express thoughts of self-harm, evaluate the risk of suicide** and develop a plan for intervention, including hospitalization if needed.
- **Refer to a specialist** if there is continuing treatment resistance.

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**More information is available at [AlosaHealth.org/Depression](https://AlosaHealth.org/Depression)**

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## References:

(1) American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (5th Ed., Text Revision)*. 2022. (2) Barth J, et al. Depression as a risk factor for mortality in patients with coronary heart disease: a meta-analysis. *Psychosom Med*. 2004;66(6):802-813. (3) Conejero I, et al. Suicide in older adults: current perspectives. *Clin Interv Aging*. 2018;13:691-699. (4) Barnes DE, et al. Midlife vs late-life depressive symptoms and risk of dementia: differential effects for Alzheimer disease and vascular dementia. *Arch Gen Psychiatry*. 2012;69(5):493-498. (5) Eurelings LS, et al. Apathy and depressive symptoms in older people and incident myocardial infarction, stroke, and mortality: a systematic review and meta-analysis of individual participant data. *Clin Epidemiol*. 2018;10:363-379. (6) Olsson M, et al. Treatment of Adult Depression in the United States. *JAMA Intern Med*. 2016;176(10):1482-1491. (7) Kessler RC, et al. Age differences in major depression: results from the National Comorbidity Survey Replication (NCS-R). *Psychol Med*. 2010;40(2):225-237. (8) Siu AL, et al. Screening for Depression in Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2016;315(4):380-387. (9) Cuijpers P, et al. Psychotherapies for depression: a network meta-analysis covering efficacy, acceptability and long-term outcomes of all main treatment types. *World Psychiatry*. 2021;20(2):283-293. (10) Gould RL, et al. Cognitive behavioral therapy for depression in older people: a meta-analysis and meta-regression of randomized controlled trials. *J Am Geriatr Soc*. 2012;60(10):1817-1830. (11) Cipriani A, et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. *Lancet*. 2018;391(10128):1357-1366. (12) Tedeschini E, et al. Efficacy of antidepressants for late-life depression: a meta-analysis and meta-regression of placebo-controlled randomized trials. *J Clin Psychiatry*. 2011;72(12):1660-1668. (13) Sobieraj DM, et al. Adverse Effects of Pharmacologic Treatments of Major Depression in Older Adults. *J Am Geriatr Soc*. 2019;67(8):1571-1581. (14) Iosifescu DV, et al. Efficacy and Safety of AXS-05 (Dextromethorphan-Bupropion) in Patients With Major Depressive Disorder: A Phase 3 Randomized Clinical Trial (GEMINI). *J Clin Psychiatry*. 2022;83(4). (15) Tabuteau H, et al. Effect of AXS-05 (Dextromethorphan-Bupropion) in Major Depressive Disorder: A Randomized Double-Blind Controlled Trial. *Am J Psychiatry*. 2022;179(7):490-499. (16) Rush AJ, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR\*D report. *Am J Psychiatry*. 2006;163(11):1905-1917. (17) Canadian Coalition for Seniors' Mental Health. *Canadian guidelines on prevention, assessment and treatment of depression among older adults: 2021 guideline update*. (18) Lewis G, et al. Maintenance or Discontinuation of Antidepressants in Primary Care. *N Engl J Med*. 2021;385(14):1257-1267. (19) Oslin DW, et al. Effect of Pharmacogenomic Testing for Drug-Gene Interactions on Medication Selection and Remission of Symptoms in Major Depressive Disorder: The PRIME Care Randomized Clinical Trial. *JAMA*. 2022;328(2):151-161. (20) Centers for Disease Control and Prevention. Disparities in suicide. 2022; <https://www.cdc.gov/suicide/facts/disparities-in-suicide.html>. Accessed Dec 22, 2022. (21) Posner K, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry*. 2011 Dec;168(12):1266-77. (22) Suicide Prevention Resource Center. Suicide assessment five-step evaluation and triage SAFE-T pocket card. <https://www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card>. Accessed Jan 3, 2023.

## About this publication

**These are general recommendations only; specific clinical decisions should be made by the treating clinician based on an individual patient's clinical condition. More detailed information on this topic is provided in a longer evidence document at [AlosaHealth.org](https://AlosaHealth.org).**



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