Closing the Mental Health Disparity Gap:

Addressing Depression in Older Adults

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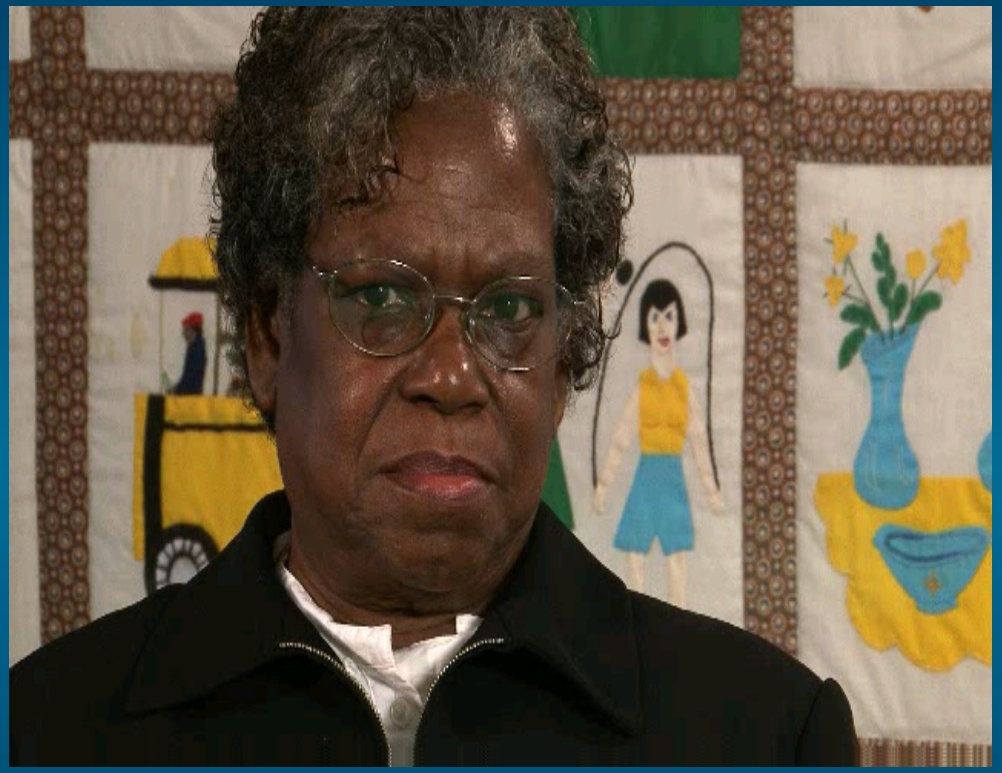
Outline

- Mental health crisis for older adults
- Role of Community-based agencies
- Get Busy Get Better Trial
- Challenges for widespread implementation

Setting the Stage

Mrs. J.

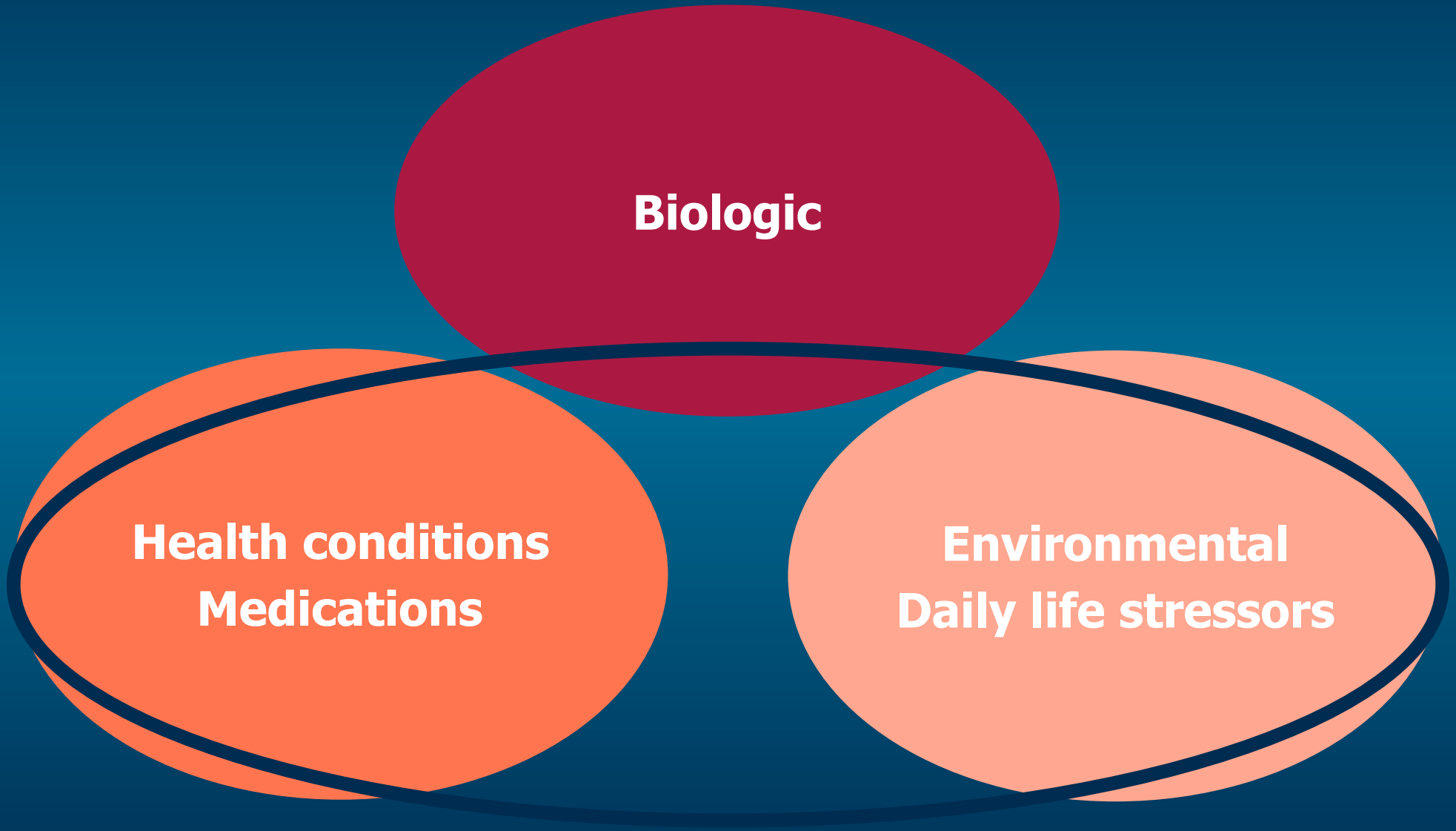
- 68 year old woman with depressive symptoms
- High blood pressure, diabetes, some mobility issues
- Lives in small house in unsafe neighborhood
- Caring for her husband
- Experiencing financial distress, social isolation, anger with grown children who can't help her, anxiety and depressive symptoms



A Global Challenge

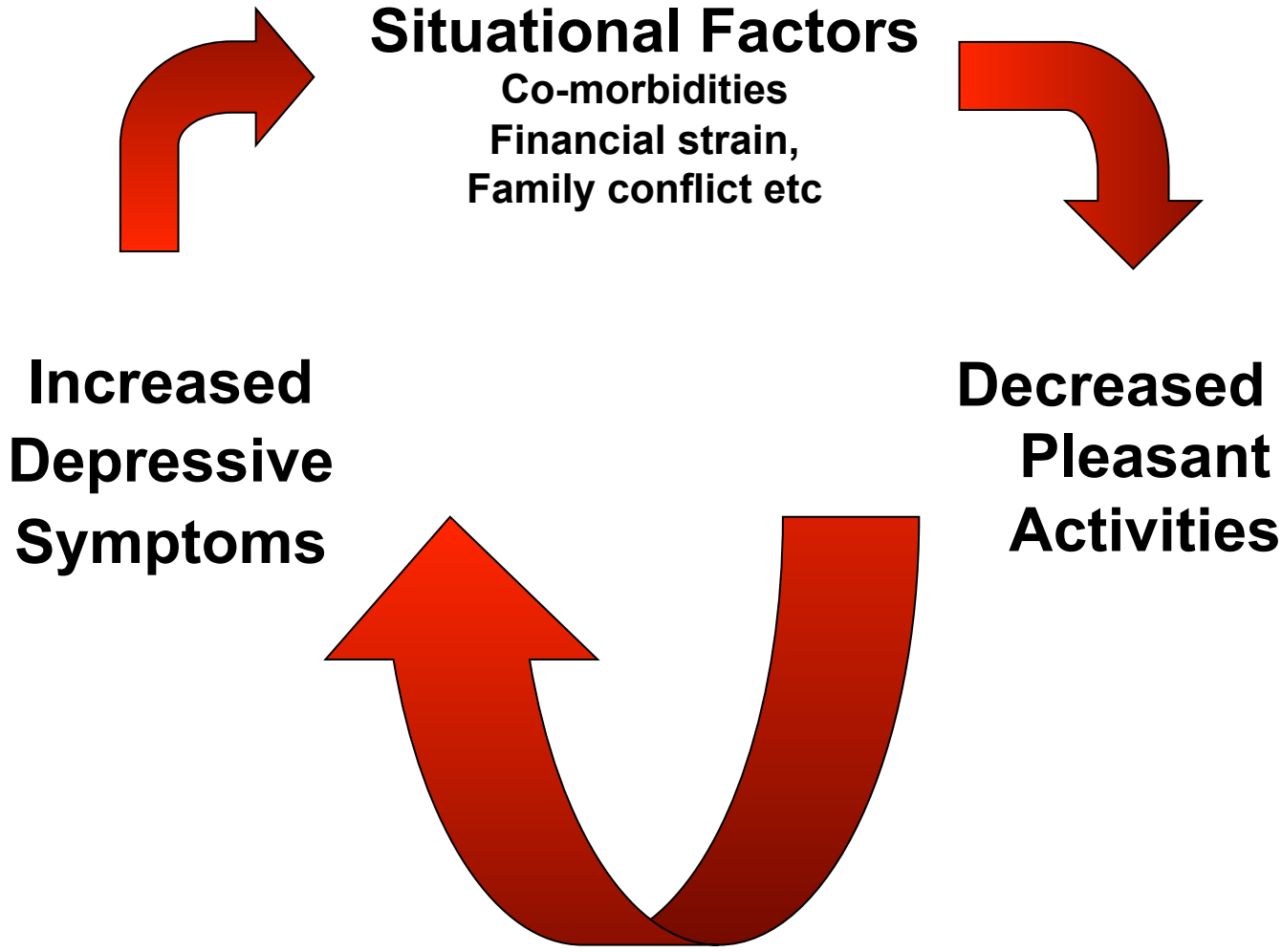
- Common and main cause of disability worldwide
- 400 million of all ages have depression
  - More women than men
- Gap between need for and provision of treatment a global problem
- In low-and middle-income countries 76%-85% do not receive treatment; high income countries, 35%-50% with minorities at a distinct disadvantage
- **WHO Fact Sheet, Oct. 2014**

Social Ecological Framework

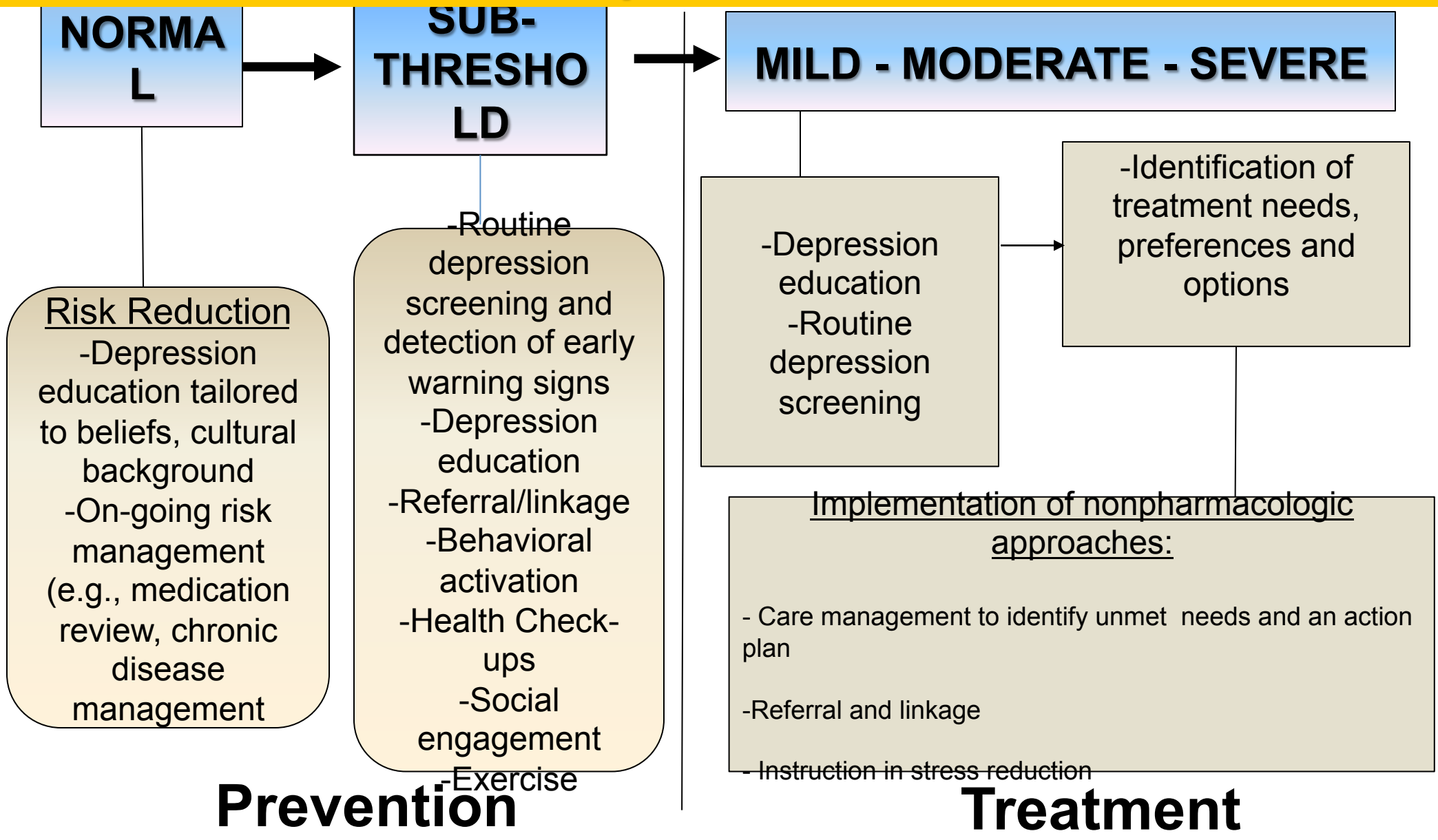


Social Ecological Approach

Contextual factors impinge on mood



Opportunities for Community and Home-based Approaches in Depression Care



Key Advantages of Home and Community-based Models

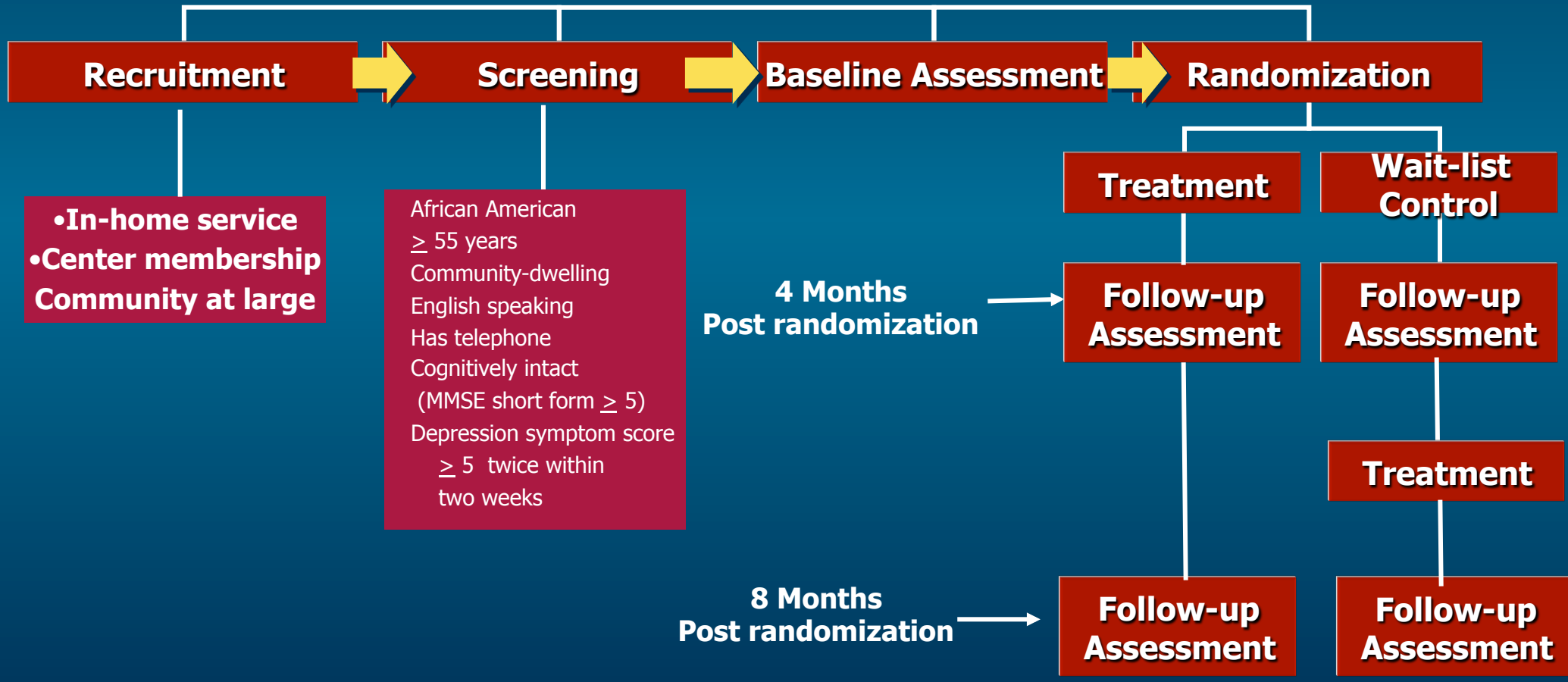
- ❑ Overcome barriers to traditional care (e.g, transportation, mobility, stigma)
- ❑ Provide opportunities for tailoring to care preferences not necessarily afforded in primary care
- ❑ Preference for nonpharmacologic approaches more easily accommodated than in primary care
- ❑ Enable closer examination and management of living contexts and impact on mood and activity
- ❑ Facilitate identification and modification of functional consequences of depressive moods (e.g., reduction in activity and social connectedness)
- ❑ May be less of a tendency to overprescribe medications and try nonpharmacologic approaches as first-line of treatment

Gitlin, L. N. (2014). The role of community and home-based interventions in late life depression. In S. Richards & M. O'Hara (Eds.), *The Oxford Handbook of Depression and Comorbidity* (pp. 511-527).

Get Busy Get Better: Helping Older Adults Beat the Blues

Linking Depression Treatment to Senior Centers

Trial Design (N = 208)



Senior Center Enrollment Outcomes

- 703 initially screened:
  - 390 (55.5%) scored ≥ 5 on PHQ-9 (≥5)
    - 137 (31.1%) of 440 from home program
    - 253 (96.2%) of 263 from community
- Of 390 positive initial screens:
  - 279 (71.5%) successfully screened a second time
    - 241 (86.4%) were eligible
    - 208 (86.3%) willing to participate.

Intervention - 5 Treatment Components

-What is depression
-How to talk to your doctor and a doctor of a different race
-Relationship between mood and activity
-Symptom recognition

--Assessment
-Problem identification/ resolution
- Care coordination

-Role of stress – Common stressors
-Participants' strategies
-Deep breathing, counting
-Guided imagery

-Medication review
-Psychiatric, psychological follow up
Referrals to physician, mental health services

-Identification of valued activities and goals
-Establishment of action plan for goal attainment
-Monitoring of action plan
-On-going goal identification

Up to 10 home visits of 1 hour

Delivered by licensed social workers over 4 months

TRIAL RESULTS

Gitlin et al., 2013, *Annals of Internal Medicine*; Gitlin et al., in press, *The Gerontologist;* Gitlin et al., 2012, *BMC;* Pizzi et al., *JAGS*

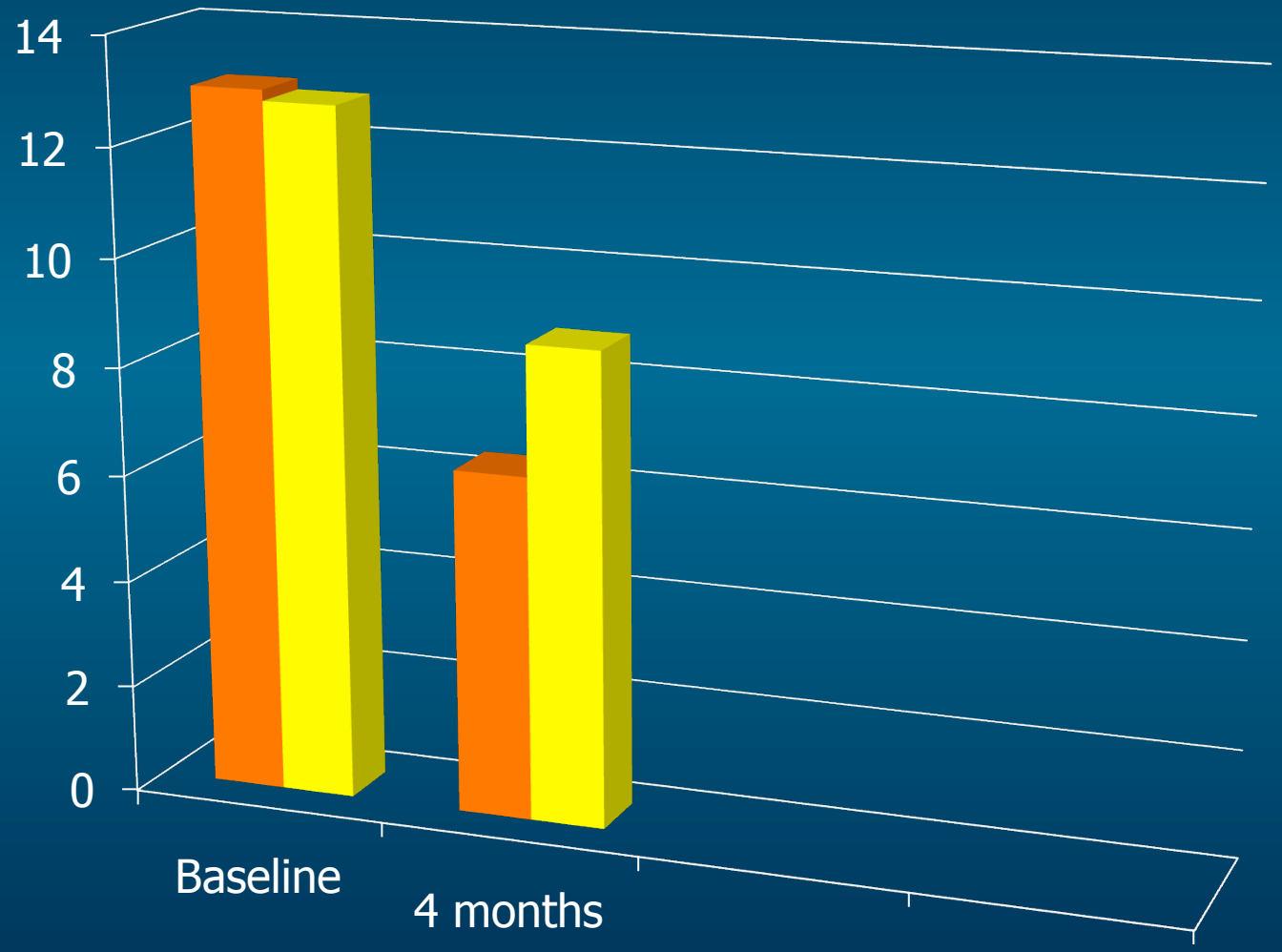
Enrollment Outcomes

- Of 703 initially screened:
  - 390 (55.5%) scored positively on PHQ-9 (≥5)
    - 137 (31.1%) of 440 from IHSP
    - 253 (96.2%) of 263 community members at large
- Of 390 positive initial screens:
  - 279 (71.5%) successfully screened a second time
    - 241 (86.4%) were eligible
    - 208 (86.3%) willing to participate.

BTB Participant Demographics (N=208)

Characteristic	Mean (SD)	%
AGE IN YEARS	69.6 (8.7)	
GENDER		78.9 % FEMALE
EDUCATION		>50% HS/GED
MARITAL STATUS		88% SINGLE
ECONOMIC DIFFICULTY		67.8 %
# HEALTH CONDITIONS	6.6 (3.5)	
MEDICATION USE Anti-depressants Anxiety Pain		 19.2% 16.8% 52.9%
PHQ-9 Score at screen #2 (score ranges = 0-27)	13 (4.9)	72% moderate to severe symptoms (10 - >20)

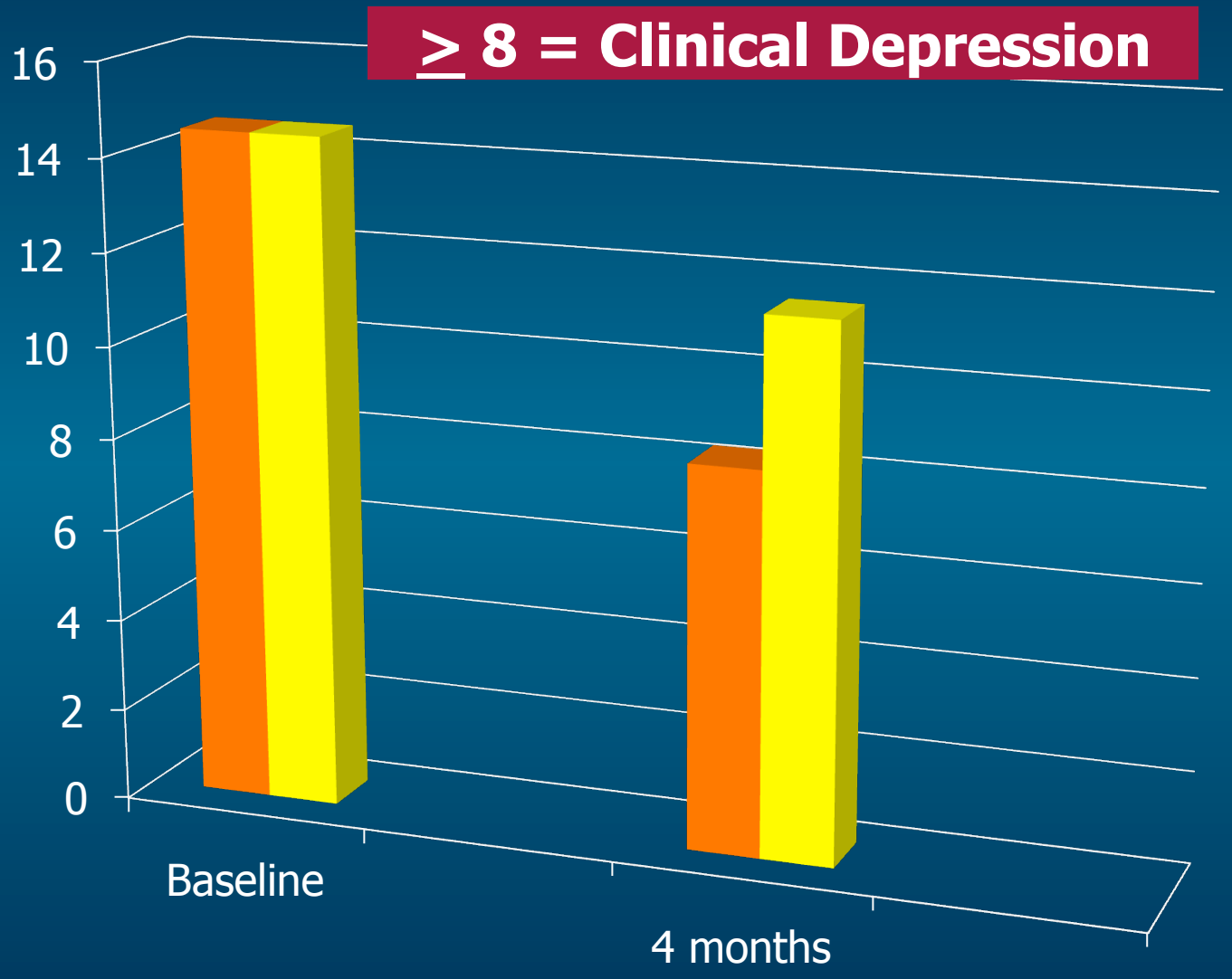
4 Month Outcomes for PHQ-9 Severity Score (N=182)



P=.001

Cohen's d=.47

4 Month Outcomes for CES-D (N=182)



P=.000

Cohen's d=.61

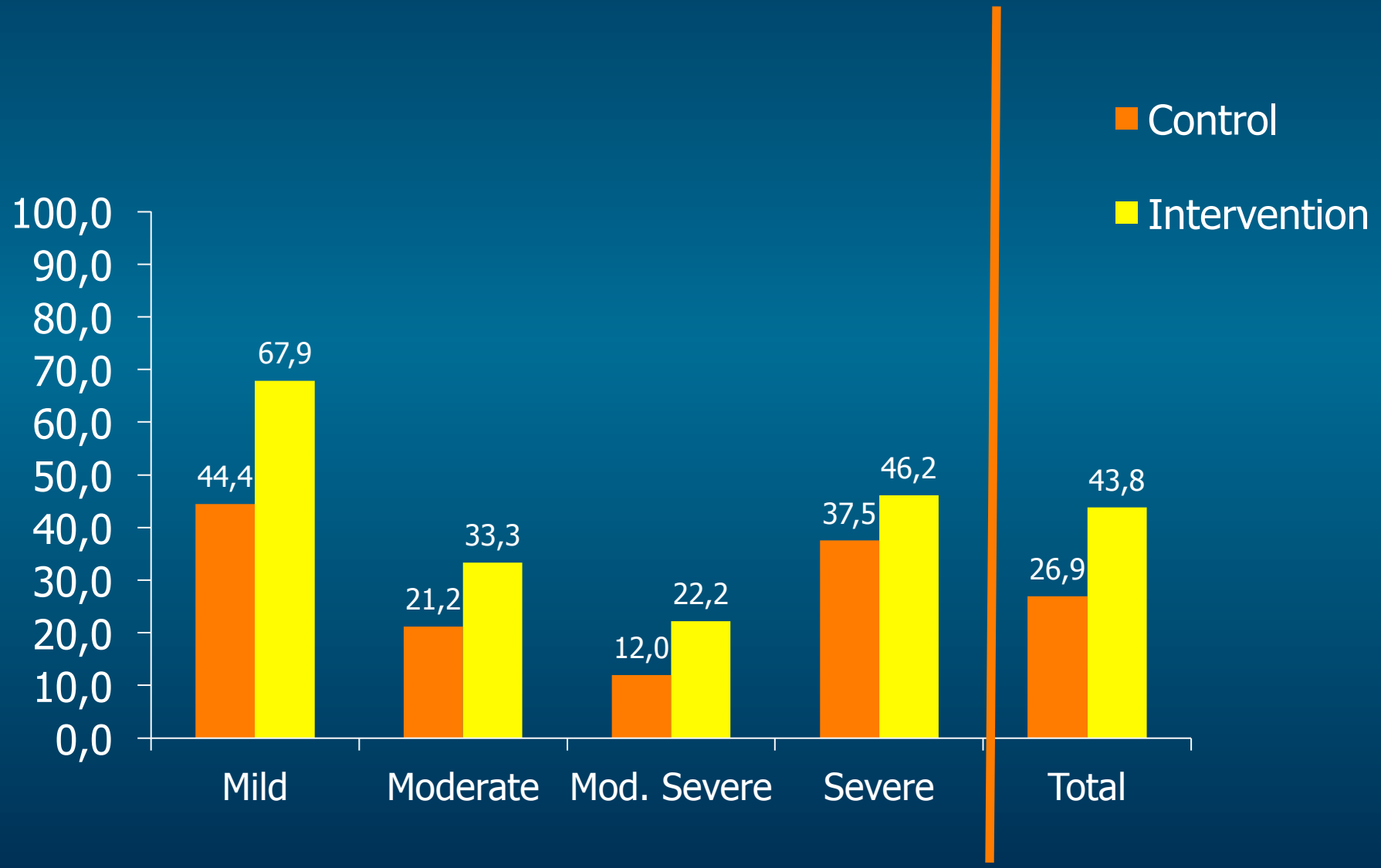
BTB

Control

Secondary 4-Month Outcomes (N=182)

Domain	Difference of adjusted mean	95% Confidence Interval	P- value	Cohen's d
Depression knowledge	0.3	0.2,0.4	**.000**	**.69**
Well-being	0.6	0.4,0.8	**.000**	**.89**
Quality of life	2.9	1.7,4.2	**.000**	**.54**
Behavior activation	0.8	0.5,1.1	**.000**	**.84**
Anxiety	-0.4	-0.6,-0.2	**.000**	**.59**
Functional difficulty	-0.2	-0.3.0.0	**.019**	**.25**

Proportion in Remission at 4-Months by Baseline PHQ-9 (<5)

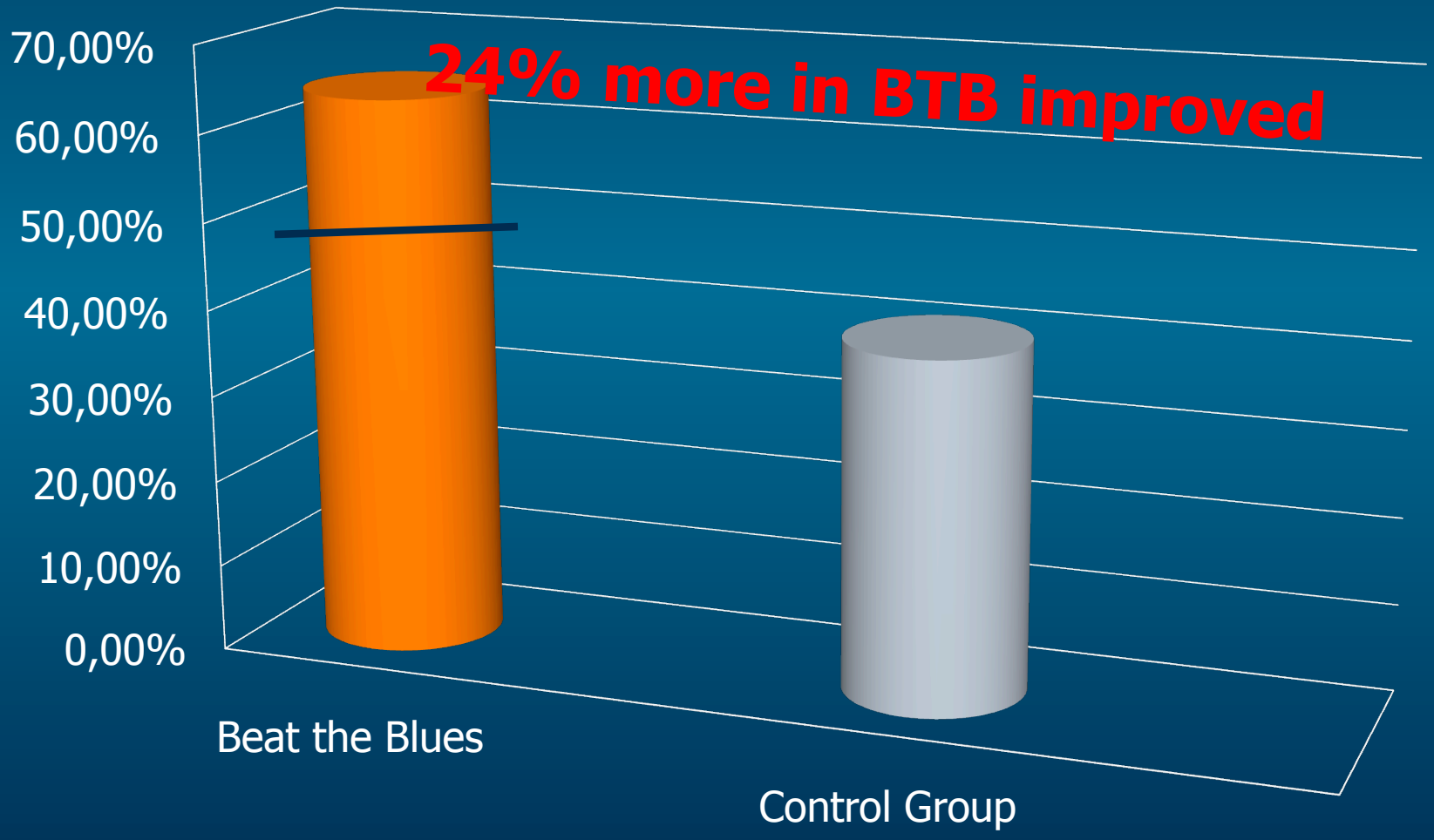


Proportion Improving, Staying Same and Worsening at 4 Months on PHQ-9

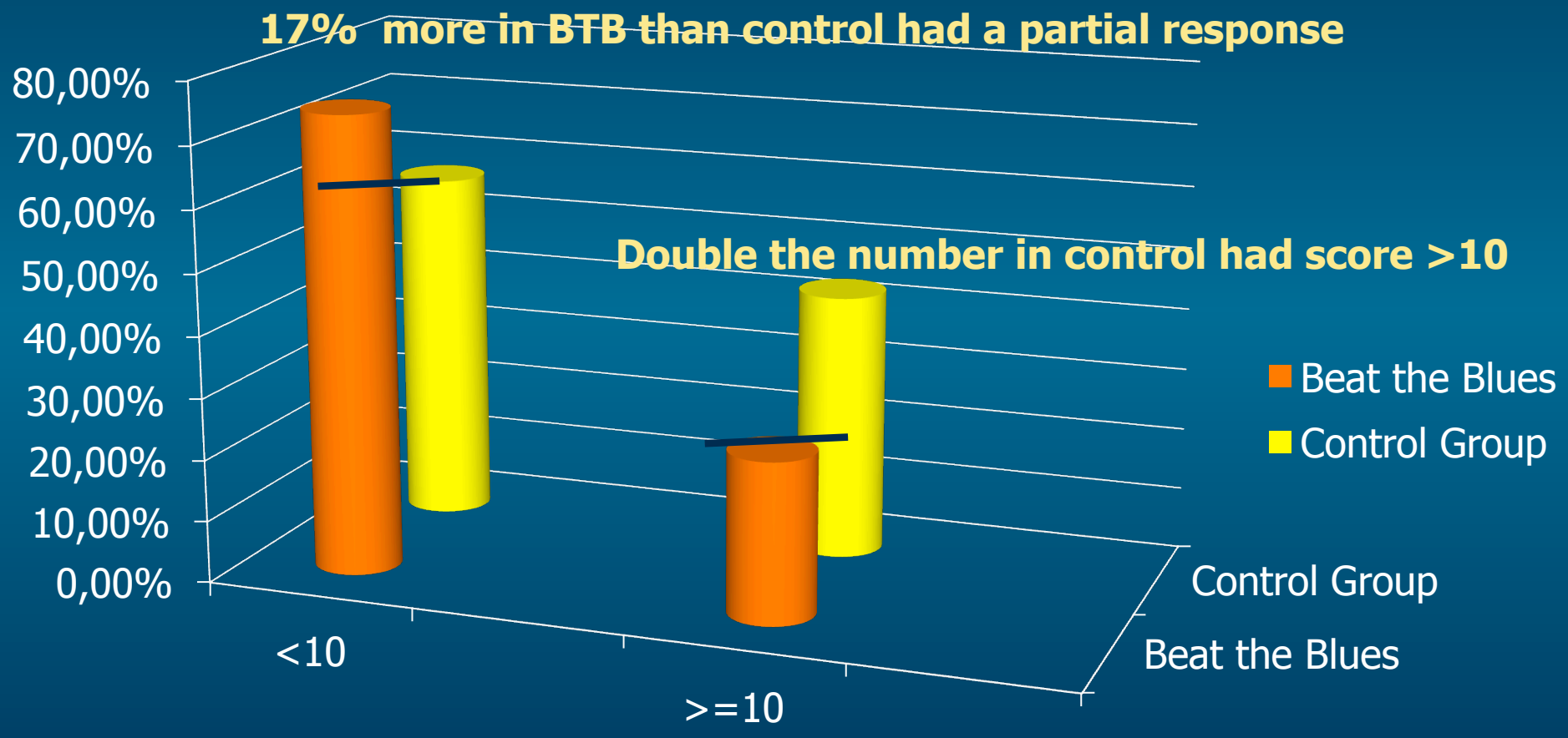
	Improved		Stayed the Same		Worsened	
	N	%	N	%	N	%
Beat the Blues	68	76%	16	18%	5	6%
Control Group	58	62%	24	26%	11	12%

Clinically Significant Improvement

≥ 5 points on PHQ-9 at 4-months



Proportion Scoring <10 on PHQ-9 at 4-months
Partial Response



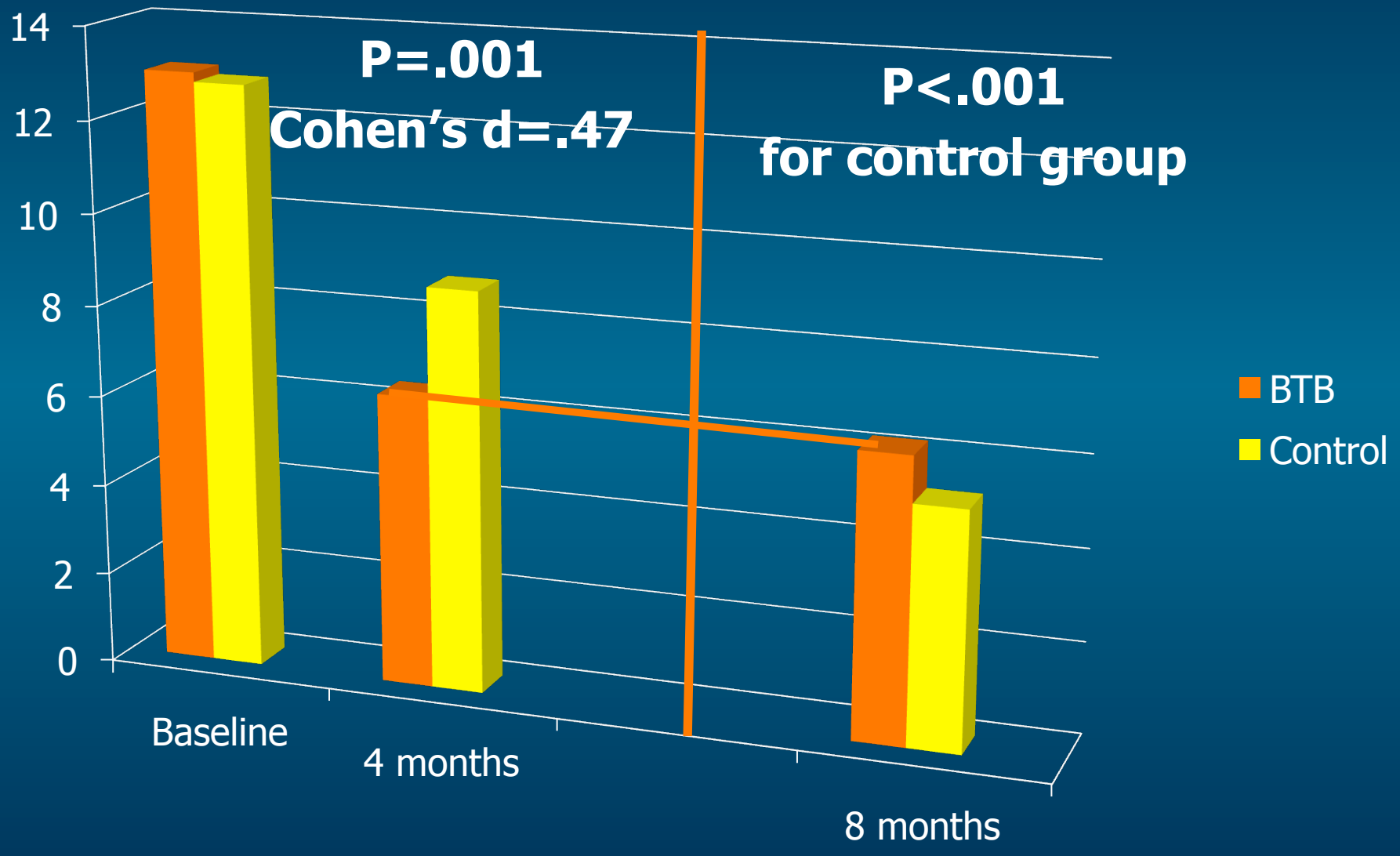
Intervention Costs (Pizzi et al., 2014)

Cost Component	Mean Cost Per Participant (SD), $US 2010
Screening Cost	$2.63 (1.51)
Intervention Delivery Cost per Participant (Cost per Session x Number of Sessions)	$197.31 (133.00)
Interventionist Contact Outside of Sessions	
Total Cost of Participant Contact Outside of Intervention Delivery	$84.00 (60.00)
Travel	
Mileage Reimbursement (Miles X $0.55)	$69.39 (46.88)
Labor Cost of Travel	$141.64 (127.16)
Supervision Costs	
Supervision of Screeners[d]	$4.19 (n/a)
Supervision of Interventionists[e]	$22.33 (n/a)
Training	$0.90 (n/a)
Materials	$61.93 (n/a)
Adverse Events	$0.32 (1.00)
TOTAL COST OF BTB PER PARTICIPANT OVER 4 MONTHS	$584.64

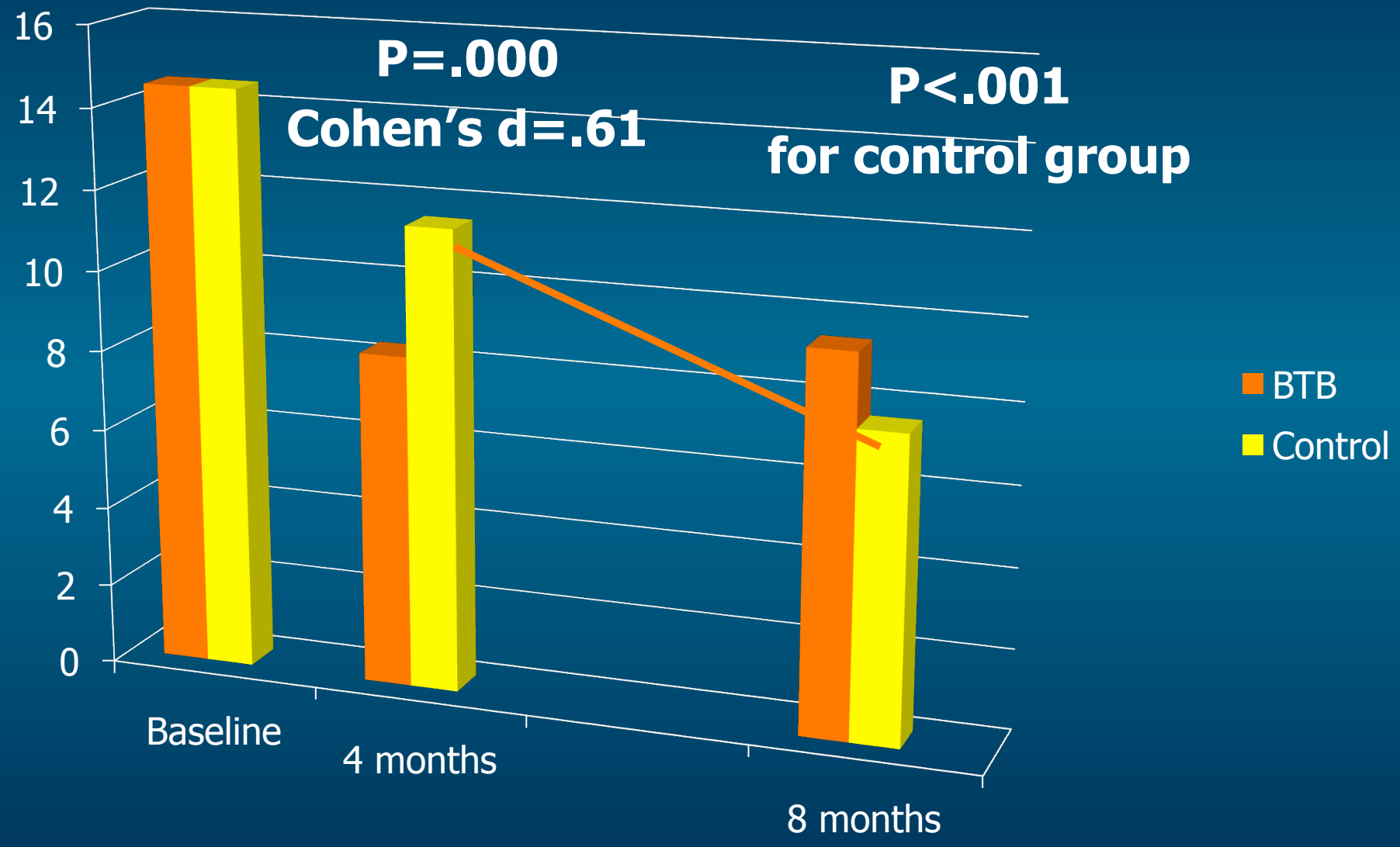
Mean cost of BTB per participant, per month = $146.16

8 Month Outcomes

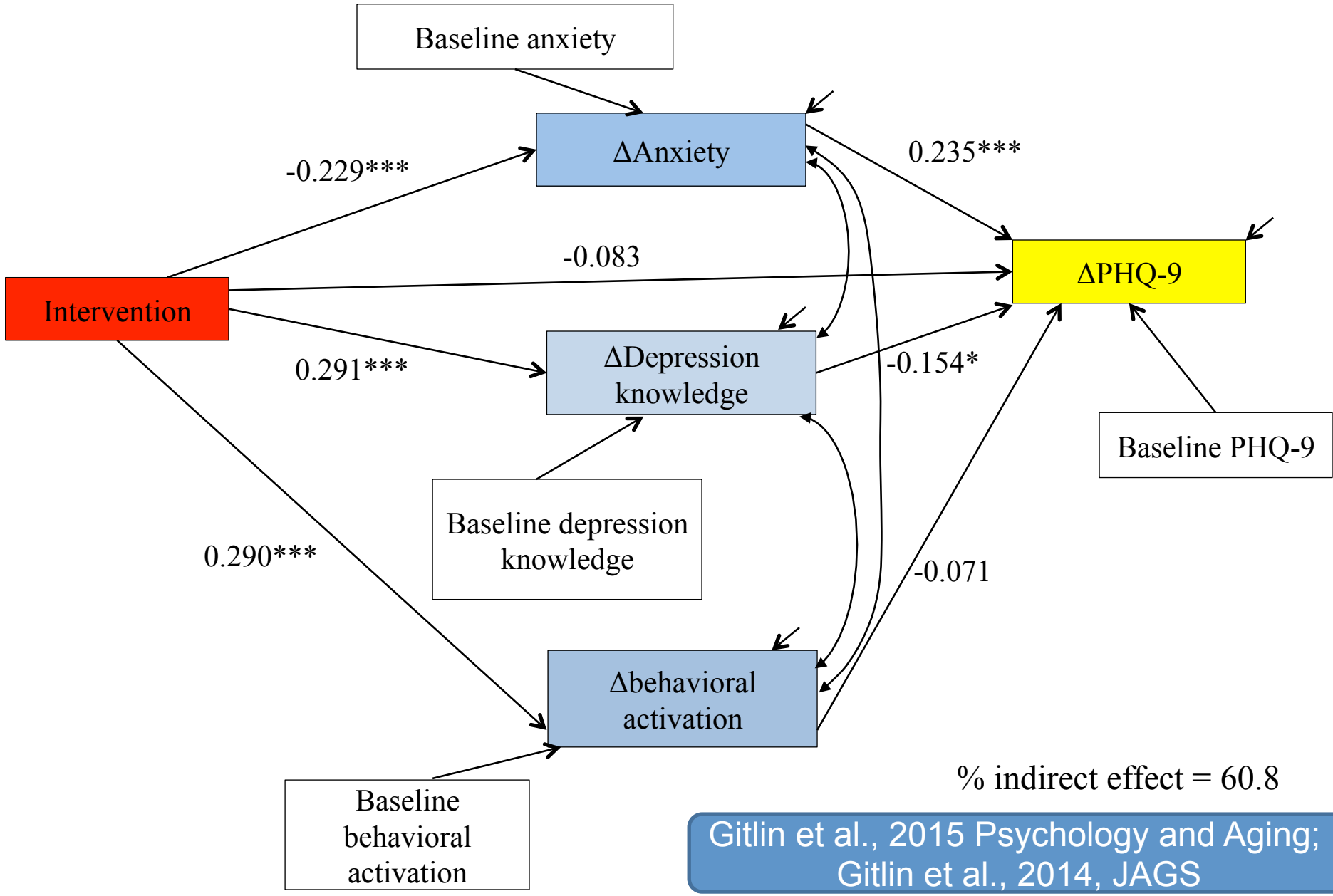
8 Month Outcomes for PHQ-9



8 Month Outcomes for CES-D



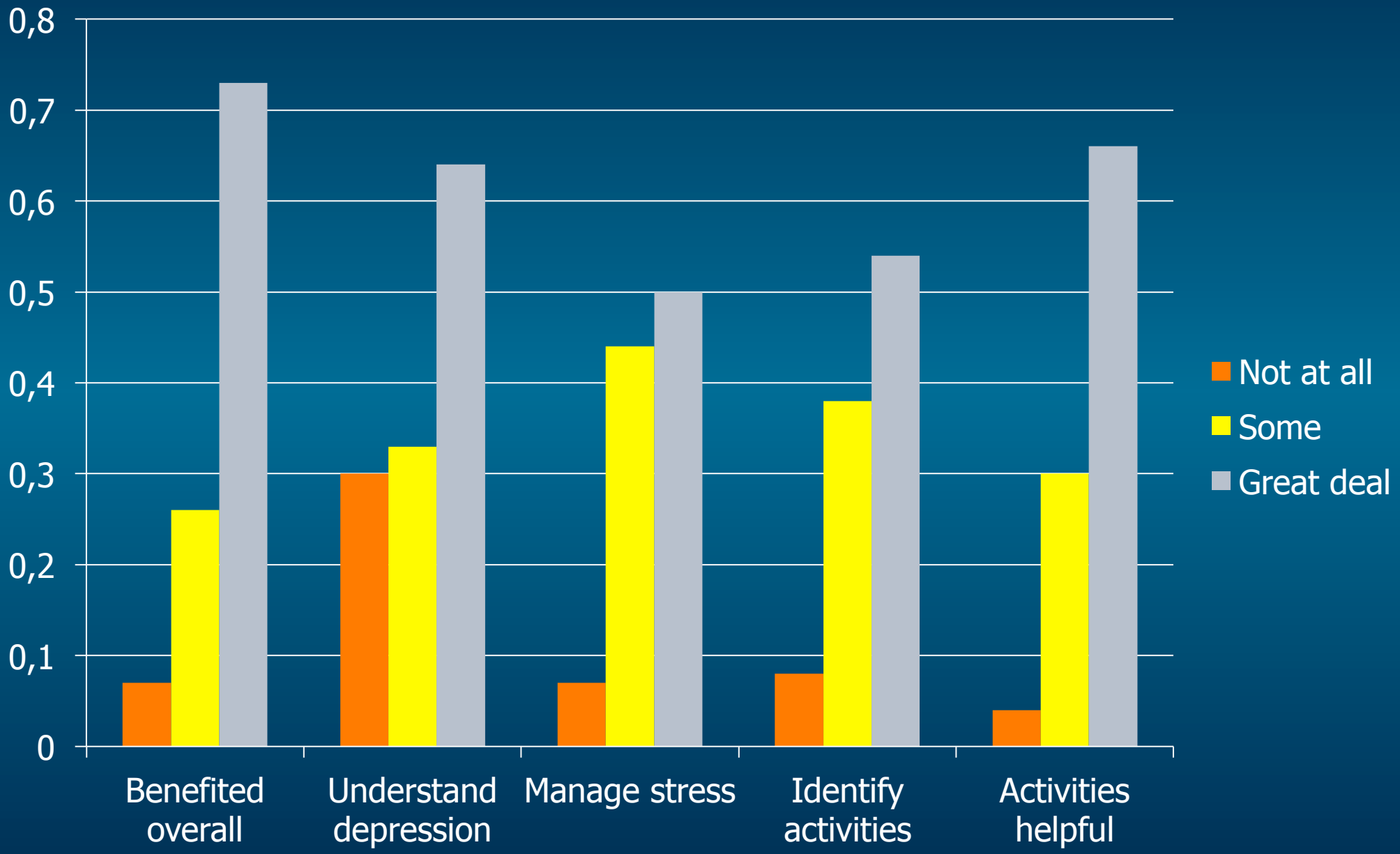
Why is Intervention Effective?
Three-mediator model for intervention effect on PHQ-9 at 4 month



% indirect effect = 60.8

Gitlin et al., 2015 Psychology and Aging; Gitlin et al., 2014, JAGS

Perceived Benefits at 8 Months (N=208)



- “I never realized I was depressed and learned a great deal about depression. I have a new outlook on life and think more positively about things.” Lenny, age 80

- “You not only helped me to recognize that I had symptoms of depression and that having those feelings was a problem, but how to get myself out of it.” Jo, age 61

- “I have a positive outlook for the future, have become more active, and my self-esteem has improved.” Ben, age 75

Conclusions

- Everyone benefits
  - Individuals with mild to severe depressive symptoms
  - Men and women
  - Those with and without financial strain
- Activation preferred vs. problem solving approaches
- Any health and human service provider can provide
- How can program be improved?
  - Better pain management
  - Remote technology for delivery
- Location in community integrates mental health treatment with opportunities for positive aging
- Payment mechanisms unclear

Team Members
Thomas Jefferson University and Johns Hopkins University

- **PI - Laura N. Gitlin, Ph.D.**
- **Project manager - Nancy L. Chernett, MPH,**
- **Intervention coordinator - Laraine Winter, Ph. D.,**
- **Data analysts**
  - Marie Dennis, Ph.D.
  - Edward Hess, MA
- **Statistician – Walter Hauck, Ph.D.**
- **Interviewing staff:**
  - Laura Holbert, MSW
  - Karen Morrison, MSW
  - Barbara Parker
  - Christa Caruso
  - Daneen Whinna
  - Abby Schwartz, MSW
- **Intervention staff:**
  - Laura Holbert, MSW
  - Karen Morrison, MSW
- **IRB coordinator and research assistantship– Lauren Acquarole, MS**
- **Data entry staff:**
  - Mary Barnett
  - Barbara Parker
- **Administrative assistance – Helen Jones**
- **Cost effectiveness Team**
  - Laura Pizzi, PharmD, MPH
  - Eric Jutkowitz
- **Consultants**
  - Nancy Wilson, MSW
  - Melinda Stanley, Ph.D.
  - Barry Rovner, MD
  - Nancy Whitelaw, Ph.D. NCOA
  - Alixe McNeill, MPA, NCOA
- **Data safety and monitoring board members**
  - Neville E. Strumpf, Ph.D., R.N.
  - Kimberly Van Haitsma, Ph.D.
  - Mary D. Sammel, Sc.D.
  - Virginia Smith, Ph.D.
  - Frances Barg, Ph.D.
  - Robin S. Goldberg-Glen, Ph.D.

Team Members – Center in the Park

- Co-investigator - Lynn Fields Harris, MPA
- Co-investigator - Renee Cunningham-Ginchereau, MSS, Co-investigator
- On-site project manager - Megan McCoy, MSS, MLSP
- Recruiter, screener - Erika Barber
- Interventionist supervisor - Barbara R. Davis, A.C.S.W., L.S.W.
- Interventionist - Susan Burgos, MSW, LSW
- Social Services Supervisor – Courtney White
- Intake specialist – Durcas Essilfie
- 17 members of the In-home Care Management staff
- CIP administrative staff