Depression, Dementia & Diabetes: A Looming Epidemic – Are You Ready?

Dr. Verna Benner Carson, PMHCNS, BC
President
Katherine J. Vanderhorst, BSN
Vice President
C&V Senior Care Services Inc.
www.cvseniorcare.com
410-336-5408

LET’S TAKE A LOOK AT THE RELATIONSHIP OF THESE THREE SERIOUS CONDITIONS!
It is not immediately obvious
Depression ... an individually unpleasant experience causing intensely unpleasant emotional and perceptual signals SIGNIFICANTLY RELATED TO DIABETES and DEMENTIA

Dementia mimics and overlaps with depression and delirium

Diabetes increases risk of dementia 2 fold in patients w/o Diabetes

What Is Relationship Among These Three D’s In Women?

- With Depression - 17% more likely to develop Type 2 Diabetes than without
- With diabetes 29% more likely to develop depression than women without diabetes
- More severe depression – more likely women would develop diabetes and dementia
- Insulin Dependent - 53% more likely to develop depression during 10 year study
- Women who took antidepressants were 25% more likely than un-depressed women to develop diabetes
3 D’S: KISSIN, CURSIN’ COUSINS

Diabetes known risk factor for Cognitive Dysfunction and Depression

Depression a Risk Factor for Dementia and frequently Masks Dementia

Study of 3,827 primary care patients with diabetes – enrolled in HMO in Washington State – PHQ9 used to assess depression; ICD9 used to identify Dementia diagnoses

NEW DATA ON DEMENTIA AND DEPRESSION

- Midlife or late in life were associated with an increased risk of developing dementia (Archives Genl Psych 2014)
  - Depression in mid and late life had 3x risk vascular dementia
  - Double risk for Alzheimer’s in late life depression
- Timing of the onset of depression (mid-life versus late-in-life) (Archives Genl Psych 2014)
RESEARCH FINDINGS…

- **RESULTS**
  - **OVER 5 YEAR PERIOD**
    - 36 OF 455 (7.9%)
    - WITH MDD AND DM
    - versus 163 with DM alone had one or more ICD-9 diagnoses for Dementia


Physiological findings

- People with depression and diabetes have higher levels of inflammation markers in their blood
- High levels of stress hormones, which are often found in people who are depressed, can lead to problems with glucose and blood sugar metabolism, increased insulin resistance and an accumulation of stomach fat — all risk factors for diabetes
- Damage to hippocampus
DEMENTIA AND LATE LIFE DEPRESSION – KISSIN’, CURSIN’ COUSINS

Why are they related? Lots of theories – one has to do with “damage overlap with hippocampus – store house of short term memories.

<table>
<thead>
<tr>
<th>IS IT DEPRESSION OR DEMENTIA?</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYMPTOMS OF DEPRESSION</td>
</tr>
<tr>
<td>MENTAL DECLINE RELATIVELY RAPID</td>
</tr>
<tr>
<td>Knows correct time, date and where he/she is</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
</tr>
<tr>
<td>Language and motor skills slow but normal</td>
</tr>
<tr>
<td>Notices or worries about memory problems</td>
</tr>
</tbody>
</table>

CHALLENGES POSED FOR HEALTHCARE PROVIDERS

- HEALTH CARE SYSTEM ILL-PREPARED TO DEAL WITH MENTAL HEALTH ISSUES – IN SPITE OF FACT THAT DEPRESSION IS CONSIDERED THE “COMMON COLD” OF PSYCHIATRY
- TODAY FEWER THAN 1800 GERIATRIC PSYCHIATRISTS IN U.S. AND IN 2030 AT THE PEAK OF THE BABY BOOMER EXPLOSION THERE WILL BE ABOUT 1650 – ABOUT 1 PER 6000 OLDER ADULTS WITH MENTAL HEALTH ISSUES
- OLDER ADULTS WITH MENTAL DISORDERS HAVE GREATER DISABILITY THAN THOSE WITH PHYSICAL ILLNESS ALONE – RESULTING IN POORER OUTCOMES, HIGHER RATES OF HOSPITALIZATION AND ER VISITS –RESULTING IN COSTS THAT ARE 47% TO 200% HIGHER. YET MENTAL HEALTH SERVICES ACOUNT FOR ONLY 1% OF MEDICARE EXPENDITURES!
- HOME CARE COULD BE ANSWER BOTH THROUGH A STRUCTURED PSYCHIATRIC HOME CARE PROGRAM AND/OR BY EDUCATING MEDICAL NURSES WHAT INTERVENTIONS ARE WITHIN THEIR SKILL SET.
THE NUMBERS ARE STAGGERING

- ALZHEIMER’S/DEMENTIA-5.4 MILLION Americans
  - 1 out of 9 people aged 65 and older (13%)
  - 70 of people with Alzheimer’s live at home
- DIABETES-25.9% in people 65 and older.
- DEPRESSION-1 in 10 Adults (CDC)
- 25% of People with Alzheimer’s and /or Dementia utilized a home care service

Alzheimer’s, Diabetes and Depression

- Can coexist – Difficult for person with Alzheimer’s or another Dementia to express sadness - and most likely lacks organizational and other cognitive skills needed to manage diabetes!
DEMENTIA AND DEPRESSION

- Patients with Alzheimer’s become depressed;
- Important to pay attention to sad face, change in appetite, change in weight, change in sleep, slow movements, expressions of despair, suicidal talk.
- Untreated depression adds to patient’s confusion.

Patient with Symptoms of Depression, Dementia &/or Non-compliance

Assess with GDS and Mini-Cog
If non-verbal, use Faces

Reassess at 6-8 weeks with Mini-Cog and GDS

GDS Improved Mini-Cog (Still Positive from Initial Assessment)
- Probably Depression
- Refer to MD for the Dementia Assessment
- Do FAST as well

GDS Improved Mini-Cog Improved
- Probably Depression
DISTINGUISHING BETWEEN DEPRESSION AND DEMENTIA

### Geriatric Mood Scale – Short Form

| Patient Name: | ____________________________ |
| Nurse’s Name: | ___________________________________________ |

Choose the best answer for how you felt this past week:

- Are you basically satisfied with your life? Yes / No
- Have you dropped many of your activities and interests? Yes / No
- Do you feel that your life is empty? Yes / No
- Do you often get bored? Yes / No
- Are you in good spirits most of the time? Yes / No
- Are you afraid that something bad is going to happen to you? Yes / No
- Do you feel happy most of the time? Yes / No
- Do you feel that your life is empty? Yes / No
- Do you sleep more than most people? Yes / No
- Do you feel that your life is empty? Yes / No
- Do you often feel helpless? Yes / No
- Do you prefer to stay at home, rather than going out and doing new things? Yes / No
- Do you feel you have more problems with memory than most? Yes / No
- Do you feel full of energy? Yes / No
- Do you feel that your situation is hopeless? Yes / No
- Do you feel that most people are better off than you? Yes / No
- Do you feel pretty worthless the way you are now? Yes / No

**Scoring Key:**

- Score: ______ (number of depressed answers – all bolded answers)
  - Normal 0-4
  - Mildly depressed >5 points suggestive of depression
  - Severely depressed ≥ 10 points is almost always indicative of depression
  - A score of >5 points should warrant a follow-up comprehensive assessment.

---

**MINI-COG – Apple, Table Penny**

**Clock drawing Test**

**IS IT NORMAL OR ABNORMAL AFTER TREATMENT FOR DEPRESSION??**

C & V SENIOR CARE SPECIALISTS, INCa
BATHE -- Assessment

B - Background What’s going on?
A - Affect How does _____ make you feel?
T - Troubles What about it troubles you the most?
H - Help What are you doing to handle it?
E - Empathy I care.. That must be tough...

HOME CARE RESPONSE TO THESE ISSUES

1. EDUCATE ALL PROVIDERS TO ASSESS FOR DEPRESSION, SUICIDALITY AND DEMENTIA GOING BEYOND THE PHQ2 AND PHQ9
   SAVE DEPRESSION QUESTIONS UNTIL END OF OASIS APPROACH THESE QUESTIONS WITH GREAT CONCERN AND EMPATHY
   EX: “As I listen to all that you are dealing with, I have to tell you that I would be surprised if you were not feeling sad and overwhelmed –am I correct? I would like to ask you just a few more questions so that I can really assess how difficult things are for you.”
**SAD PERSONS SUICIDE RISK ASSESSMENT TOOL**

**S: SEX.** Men are more likely to commit suicide than women. *Men kill themselves about four times more often, although females make more attempts.*

**A: AGE.** The ages which are most dangerous to commit suicide vary over time. You should consult current statistics. Currently those between 15-24 have a higher risk – many more attempts made than actual suicides for this group. Males over age of 75 are at high risk. After 65 individuals as a whole have an attempt to completed suicide rate of about 2:1.

Up to age 65, it is about a 7:1 ratio

D: Depression. The suicide rate for those who are clinically depressed is about 20 times greater

Than for the general population. Hopelessness is one aspect of depression that has a close tie to suicide. These two issues, depression and hopelessness, are the strongest predictors of wishes of a hastened death.

P: Prior History. Roughly 80% of completed suicides were preceded by a prior attempt.

E: Ethanol Abuse. Alcohol and/or drug abuse increase risk.

R: Rational Thinking Loss. Psychosis ("I heard a voice saying I should kill myself") increases risk.

Some estimates suggest that 20-40% of those with Schizophrenia make an attempt at some point, and the risk is highest early on in the illness.

S: Support System Loss. Loss of support can vary tremendously. Loss of significant other; Children living in distant place; Loss of friends and acquaintances; Loss of job with accompanying support

O: Organized Plan. This speaks for itself. Having a method in mind creates more risk.

N: No Significant Other. See “S” above

S: Sickness. Terminal illness, such as cancer and AIDS, also carries with it a 20 fold increase in risk of suicide compared to the general population.

---

**PROTOCOL FOR PATIENT WITH DIABETES…**

1. **Assess for depression, dementia and suicidal risk**
   1. Utilize GDS, Mini-Cog and SAD PERSONS scale

2. **Report positive GDS, Mini-Cog and suicidal risk findings to physician.**

3. **Ask for treatment – (antidepressants and if available in agency- psych nursing). Assess medication effectiveness. Assess regularly.**

4. **Modify treatment plan to reflect diagnosis change, etc.**

5. **Patient and Family education** diabetes management
PROVIDE PATIENT/FAMILY EDUCATION/SELF MANAGEMENT SUPPORT

- 1. Value of exercise
- 2. Value of positive self-talk
- 3. Importance of maintaining a healthy diet
- 4. Seeking out companionship
- 5. Identifying friends/family who are supportive
- 6. TAKING MEDICATION AS ORDERED FOR AS LONG AS ORDERED – STOPPING AS SOON AS PATIENT FEELS A LITTLE BETTER ALMOST GUARANTEES A RELAPSE

PROVIDE PATIENT/FAMILY EDUCATION/SELF MANAGEMENT SUPPORT - CONTINUED

- 7. Continue to monitor medication compliance and report to physician improvement and/or lack of improvement – substantiate report with scores on GDS as well as other behaviors – example – if depression is adequately treated the clinician will most likely observe greater compliance with the rest of the treatment plan!
- 8. Provide physician with feedback regarding patient’s response or lack of to medications.
- 9. Provide relapse prevention techniques to patient
- 10. Link to appropriate community agencies for follow up
STOP GAP MEASURES

- Ensure all professional staff are skilled at assessing for depression, cognitive decline, and suicidal risk.
- Ensure that all professional staff know what to do with findings that suggest that depression and/or dementia are complicating factors to diabetes and/or other diagnoses.
- Ensure that all staff are educated on medications for depression.
- Ensure all staff have basic skills in dealing with depression including assessing for suicidal risk and providing supportive interventions.

ULTIMATE ANSWER:

Staff Training
- Depression assessments
- Dementia assessments
- Develop a care plan for treatment that incorporates depression, diabetes, dementia
- Teach staff how to communicate findings to physicians
- Teach staff how to “normalize” depression
- Staff competency
- Patient education resource materials
- Policy development
Treatment for Depression

Non-Pharmacologic:
Psychotherapy: Psychiatrists, Psychiatric Nurses, Social Workers, Cognitive-Behavioral Therapy (CBT)—limited effectiveness in presence of dementia
Electroconvulsive Therapy (ECT)
Exercise/diet
Social Intervention
  Befriending
Spiritual
  Praying
  Involvement in Faith Community

Treatment for Depression

- Psychotropic medications
- Antidepressant Medications
  - Teaching dosing
  - Response time—very important
  - Side-effects
  - What to report to doctor
  - Follow-up Needs