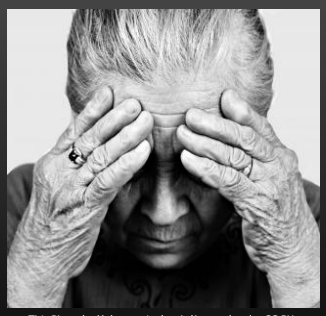
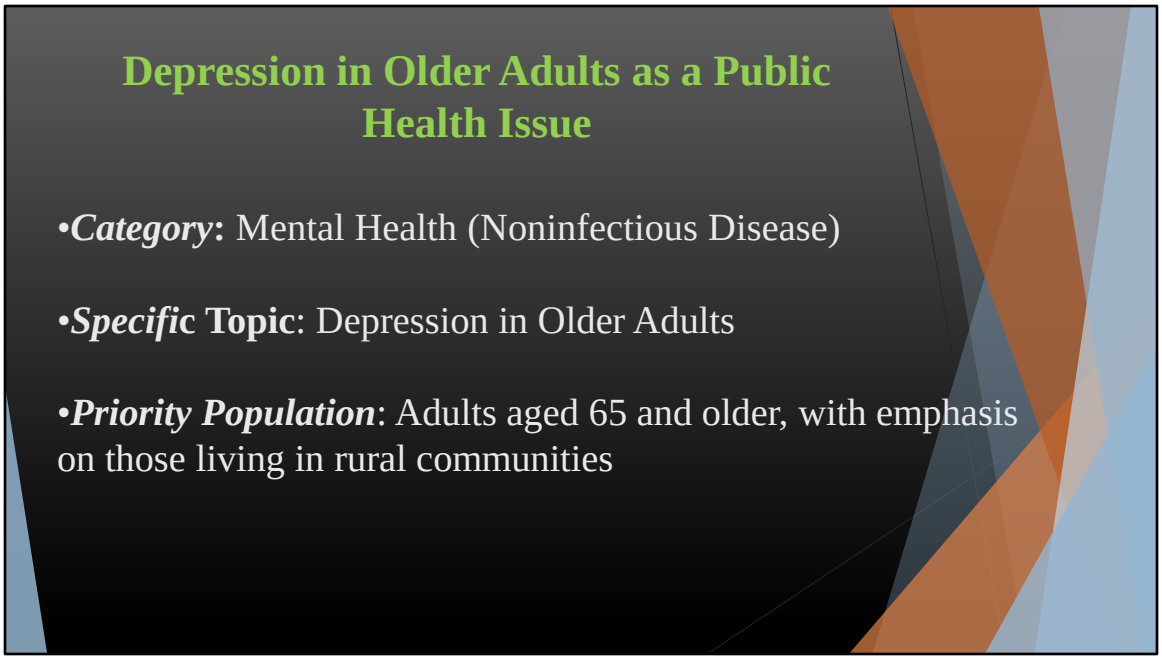
Depression in Older Adults as a Public Health Issue



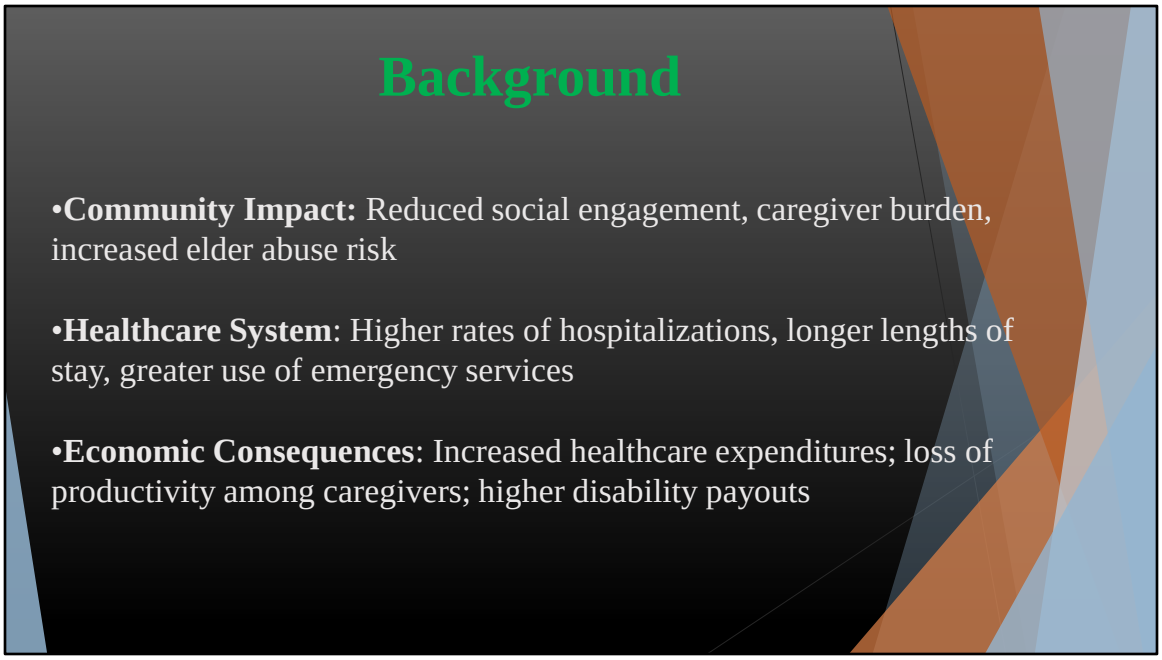
Jessica Stevens
Southern New Hampshire University
PHE 101: Introduction to Public Health

My name is Jessica Stevens, and I am presenting on depression in older adults as a public health issue. Today I will describe the scope of late-life depression, why rural older adults are a priority population, evidence-based intervention options, the public health organizations involved, gaps in the current response, and recommended next steps for stakeholders. By the end of this presentation, I will ask for your support to pilot an integrated, community-based program that links primary care, Area Agencies on Aging, and peer-led healthy aging groups to improve detection, reduce symptoms, and strengthen social supports for adults aged 65 and older in our rural counties.

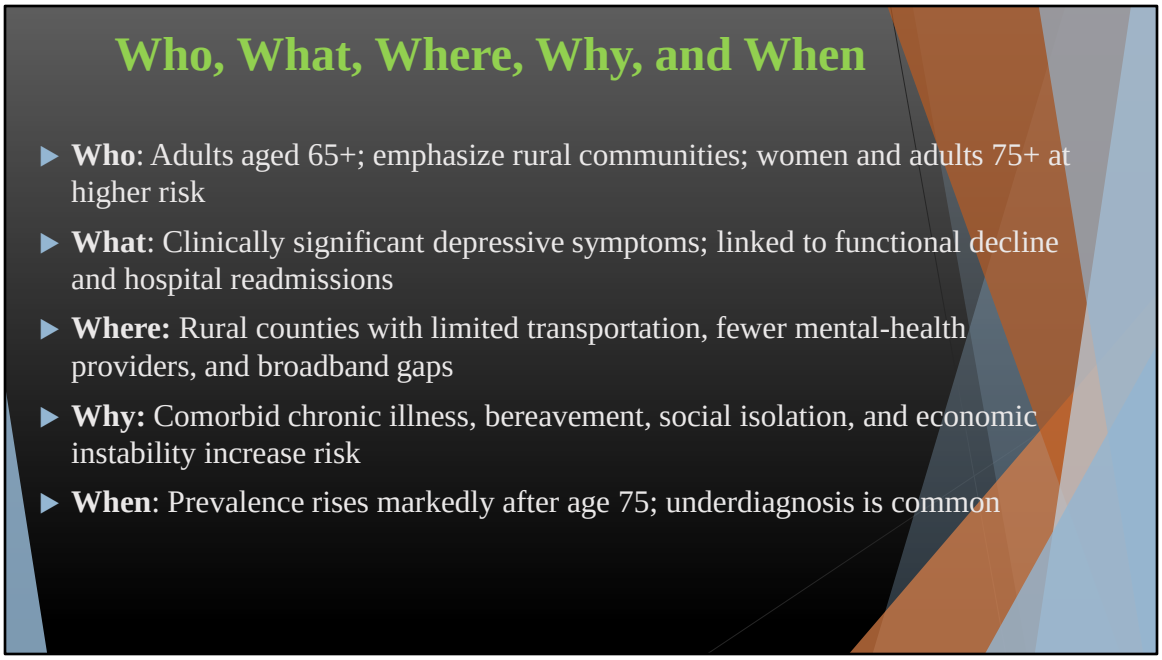


This presentation explores depression among older adults (aged 65 and over) as a key public health concern. We'll examine why late-life depression warrants priority attention, identify who is most at risk, and discuss its broader impacts on communities and healthcare systems. By the end, you'll understand both the scope of the problem and why targeted interventions are essential.

Depression in older adults is often under-recognized and undertreated, especially in rural areas where healthcare access is limited (National Institute of Mental Health, 2024). This project focuses on adults aged 65+ because physiological changes, loss of social supports, and comorbid chronic illnesses increase their vulnerability (Fiske, Wetherell, & Gatz, 2009). Rural populations face additional barriers, long distances to providers, transportation challenges, and stigma, that exacerbate isolation and delay treatment (National Library of Medicine, 2024).



Late-life depression contributes to functional decline and increases the risk of suicide, with older adults accounting for nearly 20% of U.S. suicides despite being only 16% of the population (Kok & Nolen, 2014). Economically, managing depression in this group drives up Medicare spending due to frequent comorbidities and complex medication regimens (Fiske et al., 2009). At the community level, untreated depression leads to caregiver burnout and reduced participation in volunteer and civic activities, weakening rural social networks and community resilience (National Library of Medicine, 2024).

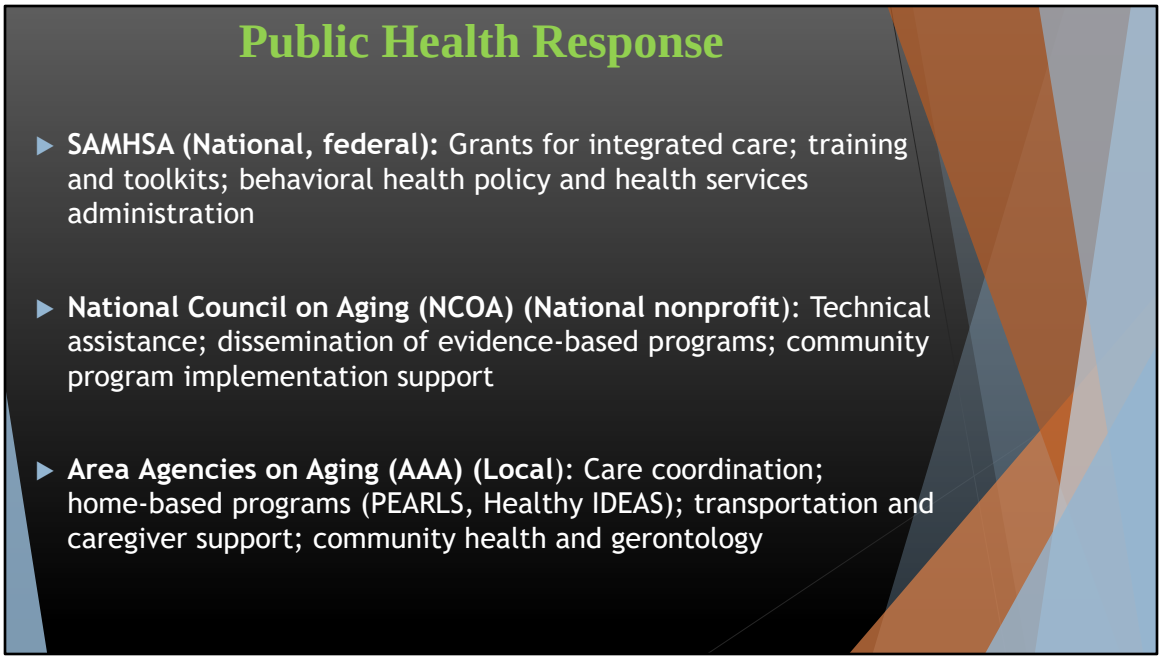


On this slide I summarize who is affected, what the problem is, where it is concentrated, why it develops, and when risk increases. The target population is adults aged 65 and older with a priority focus on rural residents; women and adults aged 75 and older face especially high risk (Kok & Nolen (2014). The issue is clinically significant depressive symptoms that contribute to functional decline and higher rates of hospital readmission (Fiske, Wetherell, & Gatz (2009). Geographically the burden concentrates in rural counties where transportation, provider shortages, and broadband limitations limit access to screening and treatment. Key causes include comorbid chronic illnesses, bereavement, social isolation driven by mobility limits, and economic instability that blocks care access (NIMH, 2024). Finally, risk rises sharply after age 75 and many cases go undetected because symptoms are attributed to medical illness or aging. These patterns point to the need for early detection in primary care, community outreach to reduce isolation, and solutions that remove access barriers such as transportation and telehealth.

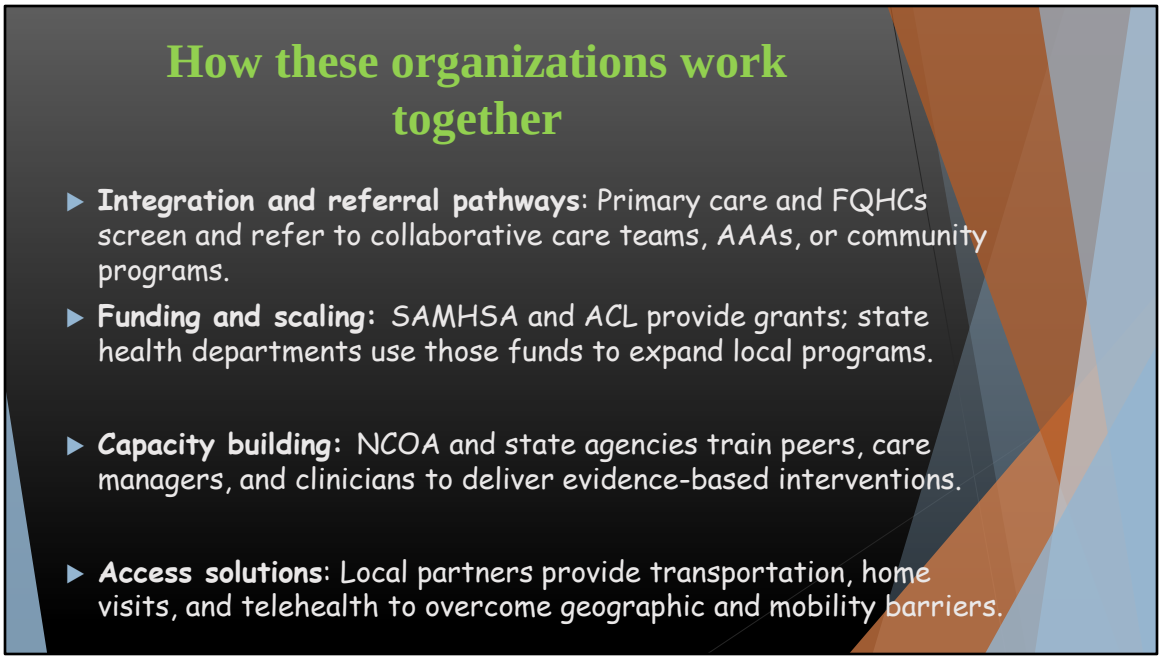
This slide highlights two key social determinants that shape late-life depression and the main disparities they produce. First, the social and community context matters: older adults living in areas with few senior centers, limited peer support, and fewer community programs face higher risk of loneliness and depressive symptoms (Fiske, Wetherell, & Gatz, 2009). Second, economic stability is critical: many older adults live on fixed incomes, and poverty or low income creates financial barriers to accessing psychotherapy, medications, and supportive services (National Institute of Mental Health, 2024). These determinants interact to produce clear disparities. For example, rural older adults often travel substantially farther for mental-health services than urban peers, which reduces treatment uptake and follow-through (Kok & Nolen, 2014). Low-income seniors are more likely to have unmet mental-health needs and to underutilize services, and minority older adults face additional cultural stigma and lack of culturally responsive care that further reduces utilization (Fiske et al., 2009; Kok & Nolen, 2014). Addressing these determinants requires community-based delivery (peer groups, home visits), integration into primary care to lower stigma, and supports such as transportation assistance or telehealth subsidies to reduce financial and geographic barriers.

This slide describes the Collaborative Care model for late-life depression. Core components include the primary care provider, a designated care manager who tracks outcomes and coordinates care, and a psychiatric consultant who advises on diagnosis and treatment; care is measurement-based and follows a stepped approach from brief behavioral interventions to medication management as needed. The model rests on the Chronic Care Model by organizing care around proactive, team-based management and on behavioral activation as an evidence-based behavioral strategy to increase activity and mood. Collaborative Care is primarily a secondary prevention strategy because it focuses on routine screening and early, evidence-based treatment to prevent progression to severe disability. It addresses social determinants by delivering mental-health services in primary care settings that older adults already use, which reduces stigma and transportation barriers and leverages team consultation to extend specialist expertise to rural areas. Implementation studies and secondary analyses show meaningful symptom reductions and improved treatment uptake among older adults receiving collaborative care (Boczor et al., 2025). For stakeholders, the practical asks are supporting training for primary care teams, fund care-manager positions, and trial a measurement system to track PHQ-9 outcomes across participating clinics.

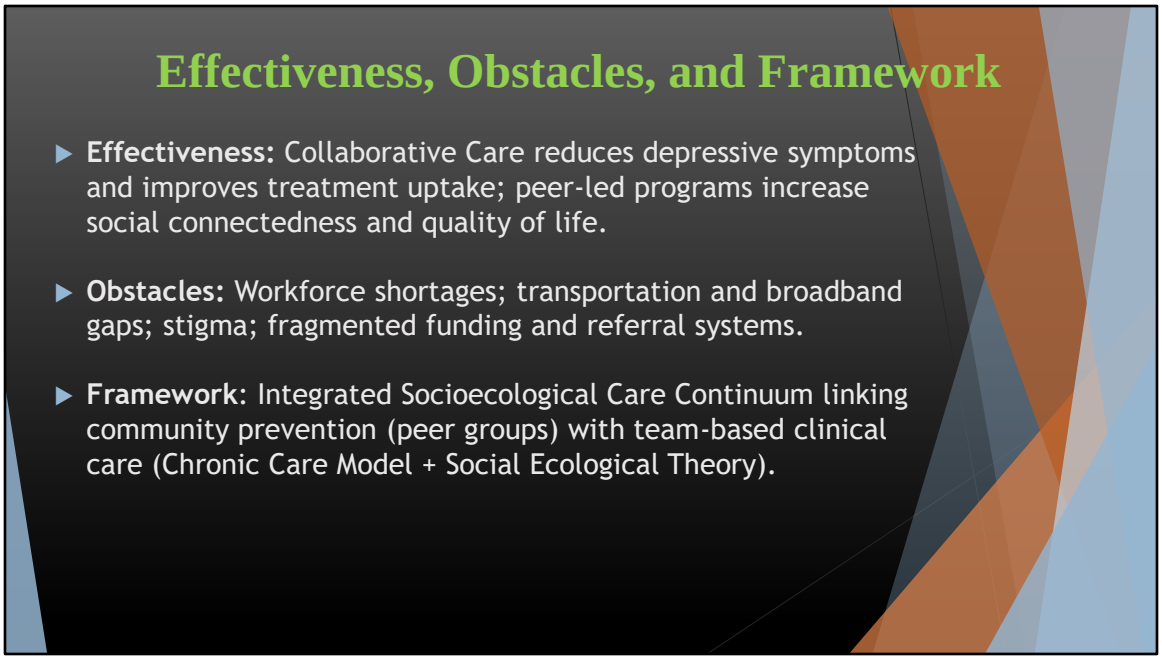
This slide describes peer-led healthy aging programs that use trained older adult leaders to deliver structured group sessions focused on mood, activity scheduling, health promotion, and social engagement. These interventions draw on the Social Ecological Model to intervene at the interpersonal and community levels, Social Support Theory to strengthen ties and reduce loneliness, and Social Cognitive Theory through peer modeling that increases self-efficacy for behavior change (Kim et al., 2025). They function primarily as primary prevention by reducing risk factors such as inactivity and isolation, while also producing secondary benefits when peers screen or refer participants with early depressive symptoms to clinical care. Peer-led programs are low cost and culturally adaptable, which helps address social determinants like economic stability and access to care by bringing services into familiar, local settings such as senior centers, faith communities, or virtual groups. Recent systematic reviews and meta-analytic evidence indicate peer-led healthy aging programs produce moderate improvements in depressive symptoms, quality of life, and social connectedness among community-dwelling older adults (Kim et al., 2025). For stakeholders, recommended actions are to fund peer leader training through local AAAs, integrate referral pathways from peer groups to primary care and collaborative care teams, and support small pilot evaluations that track mood (PHQ-9), attendance, and linkage to services.



This slide summarizes key organizations involved in responding to late-life depression and their core roles. At the national level, the Substance Abuse and Mental Health Services Administration (SAMHSA) funds integrated care models, provides training and implementation toolkits, and leads behavioral health policy and health-services initiatives that support collaborative care adoption (Substance Abuse and Mental Health Services Administration, n.d.). The National Council on Aging (NCOA) functions as a national technical assistant and dissemination partner that helps scale evidence-based programs for older adults and supports implementation of community depression programs (National Council on Aging, n.d.). At the local level, Area Agencies on Aging (AAAs) provide direct care coordination, deliver home-based depression programs such as PEARLS and Healthy IDEAS, offer transportation assistance, and run caregiver education programs; these services fall under community health, gerontology, and health-education subdisciplines (National Institute of Mental Health, 2024). Together these partners create referral pathways from primary care and Federally Qualified Health Centers to community programs and back to specialty consultation when needed. For stakeholder action I ask you to support a pilot that formalizes these referral pathways, funds local AAA peer-leader training, and secures SAMHSA or state grant matching to hire care managers for participating clinics.



This slide is continued from slide #8. This slide just explains how the organizations all work together to make things happen.



This slide summarizes what works, what blocks progress, and the theoretical framework guiding our response. Evidence shows collaborative care models produce meaningful reductions in depressive symptoms and higher treatment uptake among older adults; implementation analyses report improved adherence to measurement-based care and better clinical outcomes (Boczor et al., 2025). Peer-led healthy aging programs provide reliable improvements in mood, social connectedness, and quality of life, and are especially valuable for low-cost, community-based reach (Kim et al., 2025). Major obstacles remain: a shortage of geriatric mental-health specialists and trained care managers; transportation and broadband gaps that limit access to clinic and telehealth services; stigma and low mental-health literacy that reduce help-seeking; and fragmented funding and referral pathways that hinder scale and sustainability (Fiske, Wetherell, & Gatz, 2009; National Institute of Mental Health, 2024). To align evidence and practice I propose the Integrated Socioecological Care Continuum: combine upstream community prevention (peer groups, social supports) with routine primary care screening and downstream collaborative care teams following the Chronic Care Model. This integrated approach leverages population-level prevention while ensuring clinical follow-through for those who need it, addresses social determinants by delivering services closer to home, and creates clearer referral and measurement systems to

evaluate impact. Stakeholder ask fund a 12-month pilot that implements this continuum in two rural counties, measures PHQ-9 outcomes, service linkage rates, and patient-reported social connectedness, and allocates resources to overcome the top two obstacles identified (care manager hiring and transportation/telehealth support).

This slide highlights the ethical dimensions of responding to late-life depression and the concrete action I am requesting from stakeholders. Ethically, the response must prioritize justice and equity by ensuring that low-income, rural, and minority older adults receive the same opportunities for detection and evidence-based treatment as others (Fiske, Wetherell, & Gatz, 2009). Public health interventions that combine community prevention and integrated clinical care improve social conditions and individual outcomes, yet structural barriers; poverty, transportation gaps, limited culturally responsive services, mean benefits are distributed unevenly (National Institute of Mental Health, 2024). My measurable equity objective is to increase access to culturally congruent screening and peer-led supports for disadvantaged older adults by 50% within three years, operationalized by expanding AAA-delivered peer groups, funding care managers in participating clinics, and subsidizing transportation and telehealth access for qualifying seniors. This objective aligns with ethical principles of beneficence and justice because it directs resources toward those with the greatest unmet need and seeks to reduce avoidable disparities (Kok & Nolen, 2014). The specific stakeholder ask is to commit seed funding for a 12-month pilot in two rural counties that (1) hires care managers for participating primary-care clinics, (2) funds peer leader training through AAAs, and (3) provides transportation and telehealth vouchers for low-income older adults. Success will be measured by

PHQ-9 score changes, rates of linkage from peer groups to clinical care, and reach among low-income and minority elders. Scaling these investments will translate program effectiveness into population-level equity gains and fulfill our ethical obligation to protect the most vulnerable older adults (Fiske et al., 2009; National Institute of Mental Health, 2024).

SAMHSA plays a national leadership role in funding and guiding behavioral health services. It supports evidence-based models like Collaborative Care, which integrate mental health into primary care settings, critical for older adults who may not access specialty care. SAMHSA also provides training and resources for screening and referral, helping providers identify depression early (Boczor et al., 2025).

Area Agencies on Aging (AAA) operate locally to connect older adults with services that reduce isolation and improve mental health. Their programs like PEARLS and Healthy IDEAS are tailored for home-based delivery, addressing mobility and transportation barriers. AAA also supports caregivers and offers transportation assistance, which is vital in rural areas (Muhammad & Maurya, 2022).

Public Health Response (cont.)

- **Local Organization**: Area Agencies on Aging (AAA)

(Type: Local, community-based network)

- **Mission:** To connect older adults to services that support independence and well-being
- **Subdisciplines:** Community health, gerontology, health education
- **Services**: Home-based depression programs (PEARLS, Healthy IDEAS)
  - Transportation assistance for medical appointments
  - Caregiver education and support

Continued from the public health responses

These organizations work together through integrated referral pathways. For example, Federally Qualified Health Centers (FQHCs) screen older adults and refer them to AAA programs or peer-led interventions. SAMHSA provides funding to state health departments, which then support local implementation. The National Council on Aging (NCOA) offers training and technical assistance to build capacity for these programs. Local partners help overcome access barriers by offering transportation and telehealth options, especially important in rural communities (Kim et al., 2025).

References

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