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To Activate or Not to Activate: An Integral Question for Self-Guided Behavioral Activation Interventions for Older Adults with Sub-Clinical Depression

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Global statistics suggest that although nearly 15% of older adults by the age of 65 meet criteria for a major depressive episode[1], many other older adults face sub-threshold levels of depression that still cause functional impairment and reduced quality of life. Despite concerns with polypharmacy, psychotropic medications continue to be a widely used intervention for depression among this population[2] even in the presence of effective non-pharmacological evidence-based treatments such as behavioral activation (BA).[3] Therefore, innovation is needed in research aimed at developing, implementing, and evaluating non-pharmacological scalable interventions to treat clinical and sub-clinical depression among older adults with and without comorbidities.

To investigate this important issue, Gilbody *et al.* explored the effectiveness of an unguided self-help behavioral activation intervention (Self-Help for those At Risk for Depression − SHARD) to prevent and or mitigate depressive symptoms in older adults with sub-threshold depression living in the United Kingdom.[4] Participants who met eligibility criteria were randomized to receive either a specifically designed SHARD workbook focused on skills associated with BA or standard of care as usual. Although there were no significant differences in quality-of-life scores at 4 months or 12 months post-intervention between groups, the odds of being depressed were more than halved for older adults who had received the SHARD BA workbook compared to those in the control group at 4 months, but not 12 months post-intervention. Overall, Gilbody *et al.* findings suggest that a brief, modestly supported, unguided self-help BA intervention may be potentially effective in averting clinical levels of depression from developing in older adults with indicated depression.

As more and more people enter into older adulthood, we as a field must strongly consider how unguided self-help interventions like SHARD can be best utilized to treat both clinical and sub-clinical depression among older adults. Although there was no sustained evidence of benefit of the SHARD intervention at 12 months, the strengths of this project including its ease, low-cost, and significant potential for scalability far outweigh its limitations.

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A primary strength of the SHARD intervention is the ease in which the protocol could be implemented. As an unguided, self-help BA intervention, SHARD was able to circumvent some of the more widespread hurdles associated with working with older adults such as reduced mobility/functioning, psychosocial challenges, and structural and technological barriers (e.g., lack of transportation, isolation, lack of internet access, discomfort using technology). Even as the world shifts towards one increasingly focused on tele-health, Gilbody *et al.* removed the potential for technological problems to affect the intervention's efficacy by providing older adults with a physical workbook to help guide their BA activities. Future programs focused on improving mental health outcomes among this population should mirror SHARD and consider alternatives to digitally centered interventions to foster inclusivity and reach as many at-risk older adults as possible.

In an age in which healthcare costs continue to rise, another strength of the SHARD model is its overall cost-effectiveness compared to other mental health interventions. Because of its unguided, self-help approach, there are minimal direct costs associated with implementing SHARD above and beyond disseminating the BA workbook and staffing the various check-in phone calls to participants engaging with the program. It is increasingly important to consider the feasibility of employing mental health interventions for older adults in lower-resource settings or within communities in which socioeconomic inequality persists since data suggests that programs with high overhead or support costs are less likely to get implemented within community settings due to the significant resources required to implement[5]. Additionally, the fact that SHARD applies an indicated prevention approach to preventing the onset of depression among individuals at risk by reason of pre-existing symptoms helps to alleviate long-term costs related to disability-adjusted life years lost and mental health treatment in general. As we know, prevention pays; therefore, we encourage researchers focused on treating depression and other mental health challenges among aging populations to design future interventions with a cost-effectiveness, prevention model in mind.

Perhaps the greatest strength of SHARD is its potential for seamless scalability. Thanks to its unguided approach, SHARD demands only a handful of minimally trained staff and does not require the continued engagement of any type of health provider to be successfully implemented. Essentially, the only person-powered aid outlined by the program are three check-in phone calls from study staff and the mailing of the BA workbooks to older adults participants. It is evident that continued and active support for individuals engaged in BA interventions yields better results[6]; and therefore, increasing the amount of active and engaged support for individual's in the program may yield larger and more durable effects on depression symptomology among older adults engaged without particularly diminishing the program's capacity for continued scalability − an important realization.

With SHARD as a guide, Gilbody *et al.* provide a strong blueprint for future researchers to develop innovative, easily scalable, mental health interventions for aging populations; however, more can and should be done. Integrating a program like SHARD into primary care settings could potentially increase the efficacy and reach of a program like this. Having primary care physicians both present SHARD and provide continued support to their older adult patients would not only help realize the primary goals of the intervention,

but also improve overall coordination of care by overseeing the holistic physical and mental well-being of their older patients. Additionally, adapting SHARD to serve as an unguided group-help BA intervention could help to reduce social isolation, increase motivation to complete BA techniques, and offer a social support network for older adults at risk for depression. This approach has worked for our team with Happy Older Latinos Adults, a physical activity intervention designed to improve cardiometabolic health, reduce social isolation through bolstering social support, and improve mental health outcomes among older Latinos[7].

DISCLOSURE

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