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Depression and Outcome of Fear of Falling in a Falls Prevention Program

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Running title: Depression and Fear of Falling
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ABSTRACT

Objective: To examine whether depression predicts less improvement in fear of falling and falls efficacy in older adults attending a falls prevention program (FPP). Design: Prospective observational design. Setting: Academic medical center. Participants: Sixty-nine non-demented adults aged 55 years or older (mean age 77.8 ± 8.9 years) who had experienced at least one fall in the previous year and who attended the FPP. Measurements: The primary outcome variable was change in severity of fear of falling during the FPP. Secondary outcome variables were change in falls efficacy and fear-related restriction of activities during the FPP. Independent variables were baseline depressive disorders and depressive symptom severity. Results: Twenty-one of 69 (30.4%) study participants had a depressive disorder at baseline. Depressive disorder and depressive symptoms were not associated with change in severity of fear of falling or restriction of activity. On the other hand, depressive disorder was associated with improvement in falls efficacy, although this finding was not significant in multivariate analysis. Among participants with a depressive disorder, improvement in falls efficacy was significantly correlated with improvement in depressive symptoms. Conclusions: There was no association between baseline depression and change in fear of falling in this FPP. The correlation between improvement in depressive symptoms and improvement in falls efficacy raises the question as to whether a cognitive behavioral intervention that simultaneously targets both depression and falls efficacy would be a useful component of a FPP.
INTRODUCTION

Fear of falling is a common and potentially serious complication of falling. Approximately 50% of older persons who fall develop fear of falling (1-3) and 25% of fallers will restrict activities because of this fear (1, 4). Fear of falling can also occur in individuals who have not fallen. Fear of falling and the associated avoidance of activities can result in deconditioning, functional decline, risk of future falls, social isolation, and impaired quality of life (5, 6).

The most common strategies used to manage fear of falling are balance training, low intensity exercise, and attention to fall risk factors (7, 8). These interventions are often administered together in a falls prevention program (FPP) (9, 10). However, whilst these strategies have been found to improve a person's falls self-efficacy and balance confidence, they have little or inconsistent impact on the fear itself (7, 8). Moreover, even if the fear does improve, the improvement is usually not sustained once the intervention ends (11, 12).

Fear of falling is strongly associated with depressive symptoms and depressive disorders (5, 13-15). Gagnon et al. (14) found that 37.5% of older fallers with moderate or severe fear of falling had a current depressive disorder and depression accounted for more of the explained variance in fear of falling than other known risk factors for this fear. Depression can be associated with persistence of anxiety (16, 17): in community samples, depression has been found to predict the persistence of both fear of falling (3) and fear-related activity restriction (1). This raises the question as to whether the lack of improvement in fear of falling in treatment programs is attributable, at least in part, to a moderating effect of depression. To address this issue, we examined whether depressive disorders and depressive symptom severity predict less improvement in fear of falling in a FPP.
METHODS

Study Design

This was a prospective study of patients enrolled in a hospital-based FPP in Toronto from September 2010 to July 2012. FPP participants were approached by the research team to participate in this study after having been independently assessed and selected for FPP attendance by the inter-professional falls clinic staff. Research subjects were assessed at three time points: 1) baseline (within 2 weeks of starting the FPP), 2) midpoint (at the 6th FPP session), and 3) final (within 2 weeks of completion of the FPP). Research assessments were scheduled to take place at the hospital, but if subjects were unable or unwilling to come to the hospital, home visits were offered. Research assessments were completed by a psychiatrist (AI) and trained research assistant, neither of whom were involved in the delivery of the FPP.

Fall Prevention Program

The FPP was based at two University of Toronto-affiliated hospitals, the University Health Network (UHN) (18) and Sunnybrook Health Sciences Centre (SHSC) (19). The study was approved by the institutional review boards of each hospital. Individuals are typically referred to the FPP by their family physician or by emergency physicians after a fall. The FPP consists of an inter-professional falls clinic assessment, followed by a 12-session program of group education and exercise. The falls clinic assessment is used to exclude individuals who are too medically unstable, cognitively impaired, sensory impaired, or unable to sufficiently communicate in English to benefit from the FPP. Screening for cognitive impairment at the time of assessment for the FPP involves administration of the Mini-Mental State Examination.
(MMSE) (20) followed by further assessment of persons with a score of <24 on the MMSE to establishe if they can follow multi-level commands and retain sufficient information to benefit from the program.

**Research Participants**

Inclusion criteria for this research study were individuals aged 55 years or older who had met criteria for admission to the FPP (as described above) and who had experienced at least one fall in the previous 12 months. An occasional individual with poor English skills or dementia was allowed to participate in the FPP with assistance from family members; these individuals were not included in the research study (Figure 1). All participants in the study gave written informed consent prior to the initiation of any research assessments.

**Measures**

The primary dependent variable was change in fear of falling. Subjects were asked to rate their fear of falling on an ordinal scale, “not at all afraid, slightly afraid, moderately afraid, or very afraid” in response to the question “Are you afraid of falling?” A single question regarding fear of falling has been found to have high test–retest reliability and high concurrent validity with continuous measures of fear of falling (14, 21). Participants also completed the modified Falls Efficacy Scale (mFES) (22), whereby they rate on a 10-point scale their confidence in performing indoor and outdoor activities without falling. The mFES score is averaged to give a score out of 10, with higher scores indicating greater confidence. Falls efficacy is a related but distinct construct from fear of falling (23). Restriction in activities due to fear of falling was measured with the Survey of Activities and Fear of Falling in the Elderly (SAFFE) (21), which
assesses 11 common activities: scores can range from 0 (no avoided activities) to 11 (all activities avoided).

The primary independent variables were 1) baseline depressive disorders, and 2) baseline depressive symptoms. The presence of a DSM-IV depressive disorder (any of: major depression, minor depression, dysthymic disorder, mixed anxiety-depression, or adjustment with depressed mood) was determined using the Structured Clinical Interview for DSM-IV (SCID) (24). The Hospital Anxiety and Depression Scale (HADS) (25) was administered to measure self-rated severity of depressive symptoms. The HADS depression subscale has been shown to be a valid and reliable measure of change in the severity of depressive symptoms in older adults (16, 26).

Variables known to be associated with fear of falling (27-29) were assessed at baseline for inclusion as potential covariates in statistical analyses, to allow us to examine the independent effect of depression on change in fear of falling in the FPP. Sociodemographic data were age, gender and whether the person was living alone. Falls history during the previous 12 months included: number of falls, any fall requiring medical attention, any fall resulting in a fractured bone, ≥ 1 minute delay in rising from the ground after a fall, and use of a walking aid at the time of the baseline research assessment. The Cumulative Illness Rating Scale for Geriatrics (CIRS-G) (30) quantified medical burden. Dizziness was measured on a 10 cm visual analogue scale modeled on the style of the first 4 questions of the Philadelphia Geriatric Center pain intensity scale (31). Visual impairment was measured while wearing corrective lenses and was defined as 10/25 or worse vision in at least one eye. Grip strength, as a measure of muscle strength, was assessed using a JAMAR dynamometer with the best of 3 attempts by the dominant hand recorded. Balance and mobility were assessed with the Berg balance scale (32) and the Timed
Up and Go (TUG) test (33), respectively. The total number of prescription medications being taken at study entry was recorded. Global cognitive function was evaluated using the MMSE (20). Mastery was evaluated with the Pearlin Mastery Scale (designed to measure the extent to which individuals perceive themselves in control of forces that significantly impact their lives), which has 7-items, each rated on a 5-point scale, with higher scores indicating greater sense of mastery (34).

The dependent variables were administered at each of the three assessment time points of the study, whereas the independent variables and potential covariates were measured at baseline only.

**Data Analysis**

A series of stepwise regression models were used to examine the independent association of i) baseline depressive disorders and ii) baseline depressive symptoms with change in fear of falling, as well as with change in falls efficacy and change in fear-related restriction of activities. For research participants who completed the FPP, change scores were calculated between the baseline and final visit assessments. For research participants who did not complete the FPP, change scores were calculated between the baseline and mid-point assessments. Change scores for the mFES were calculated as the difference between the baseline mean score and the final (or where applicable, mid-point) mean score. For logistic regression, change in fear of falling and change in activity restriction were divided into three categories: improved, unchanged, and worse. Selection of covariates for the regression models that included depressive disorders involved comparing subjects with and without a depressive disorder using Student’s t-tests and chi-square tests as appropriate. Selection of covariates for the regression models pertaining to
depressive symptoms involved examining correlations between each potential covariate and baseline HADS depression score. Variables with a p value <0.1 were selected for inclusion in the relevant regression models. For all analyses, findings were considered statistically significant if two-tailed alpha was <0.05.

RESULTS

Study Sample

A total of 125 individuals who had been accepted into the FPP were contacted for research participation, of whom 37 declined to participate and 19 were excluded from the study (Figure 1). Thus, sixty-nine persons consented to participate in the study and completed the baseline research assessment. There was no difference between research participants and those who declined to participate in the research, respectively, in age (77.8±8.9 years vs. 80.6±6.8 years, t=1.7; df=104; p=0.09) or gender (70% vs. 64% female; X² = 0.454, df=1, p=0.5). Those enrolled in the research study were predominantly Caucasian (93%), female (64%) and had at least a high-school level of education (88%). Seven study participants did not complete the FPP but 2 of these individuals provided mid-point data, allowing for inclusion of data from 64 participants in the regression analyses (Figure 1).

Participants had a mean (± SD) TUG score of 17.7 ± 9.3, which is consistent with independence in basic transfers in community-dwelling older adults (33). Most participants (71%) had more than one fall in the previous year. Fifty one percent of participants reported either moderate or severe fear of falling. Sixty eight percent of participants avoided one or more activities because of the fear (range 1-4), but the mean number of avoided activities for the entire group was low
(1.3 ± 1.1). Twenty one (30.4%) participants met DSM-IV criteria for a depressive disorder at baseline (n=10 major depression; n=2 dysthymic disorder; n=6 minor depression; n=3 adjustment disorder with depressed mood). Compared with participants who did not have a depressive disorder, depressed participants were younger, more likely to have experienced a fall in which they were on the ground for more than one minute, slower on the TUG, and had more severe dizziness, more severe anxiety, lower self-mastery, lower falls-related confidence, and greater restriction of activities due to fear of falling (Table 1). A significantly greater proportion of depressed than non-depressed participants were prescribed an antidepressant at the time of baseline assessment (57.1% versus 20.8%, X² =8.9, df=1, p=0.003). By participant self-report, no antidepressant medication was newly initiated after baseline, although there was one dose increase and one antidepressant switch in individuals with depressive disorders. The depressed participants reported greater severity of fear of falling at baseline than participants without a depressive disorder (Mann-Whitney U=274.5, p=0.002; Figure 2). Baseline depressive disorder did not predict completion versus non-completion of the FPP (Fischer exact test, p=0.667). In addition, there was no significant difference between depressed and non-depressed participants in the mean number of FPP sessions that they attended (8.9 ± 3.3 vs. 9.8 ± 3.2 respectively, df=67, p=0.25).

**Change in Dependent Variables**

In the study group as a whole, there was statistically significant improvement between the baseline and final assessments, respectively, in fear of falling (51% with moderate or severe fear at baseline versus 34% at final assessment; Wilcoxon signed rank test T=112.5, p=0.003) (Figure 2) and falls efficacy (mean mFES score: 7.4±2.0 versus 7.9±1.6; t=-2.3, df=63, p=0.02).
However, there was no statistically significant change in the mean number of fear-related restricted activities (mean SAFFE score: 1.3±1.2 versus 1.1±1.0; t=1.7, df=61, p=0.1).

**Regression Analyses**

For the logistic regression analyses examining change in fear of falling, subjects were divided into three groups: improved (n=23), unchanged (n=32), and worse (n=9). In univariate regression models, neither baseline depressive disorder ($x^2=1.10$, df=1, p=0.30; OR= 0.57, 95% CI 0.20-1.64 ) nor baseline depressive symptoms as measured by the HADS ($x^2=0.84$, df=1, p=0.36; OR =1.06, 95%CI 0.93-1.22) were significantly associated with change in fear of falling. In separate stepwise models that included i) baseline fear of falling, depressive disorders, age, dizziness, mastery, TUG, delay in rising after a fall, and use of a walking aid, and ii) baseline fear of falling, depressive symptoms, age, dizziness, and delay in getting up after a fall, baseline fear of falling was the only variable associated with outcome: more severe baseline fear of falling was associated with an increased odds of improvement in fear of falling ($x^2=21.11$, df=1, p<0.0001; OR=4.22, 95% CI 2.28-7.80).

In a univariate regression analysis, the presence of a baseline depressive disorder was associated with significantly greater improvement in falls self-efficacy (mFES) ($\beta$=1.21 ± 0.46, p=0.01; $R^2$=0.1). Similarly, more severe depressive symptoms at baseline were associated with greater improvement in mFES ($\beta$=0.13 ± 0.06, p=0.03; $R^2$=0.07). In stepwise linear regression analysis examining depressive disorder and adjusting for baseline mFES, age, dizziness, mastery, TUG, delay in rising after a fall and use of a walking aid, depressive disorder was not retained in the model. Higher baseline mFES ($\beta$=-0.60 ± 0.09, p<0.0001) and baseline use of a walking aid ($\beta$=0.85 ± 0.38, p<0.03) were associated with less improvement in mFES: the overall model fit
was $R^2=0.43$. In a separate stepwise regression model examining baseline depressive symptoms and adjusting for baseline mFES, age, dizziness, and delay in rising after a fall, depressive symptoms were not retained in the model: only baseline mFES was significantly associated with change in mFES ($\beta=0.53 \pm 0.09$, $p<0.0001$; $R^2=0.38$).

Change in number of activities restricted due to fear of falling was divided into improved (n=19), unchanged (n=33), and worse (n=10). In the univariate regression models, neither depressive disorder ($x^2=0.42$, df=1, $p=0.52$; OR 0.71, 95% CI 0.25-2.03) nor depressive symptoms ($x^2=1.34$, df=1, $p=0.25$; OR 1.08, 95% CI 0.95-1.24) were associated with a change in restricted activities. In stepwise models that included baseline restriction of activities and the aformentioned covariates, baseline TUG was the only variable retained: slower mobility at baseline was associated with a decreased odds of improvement in restricted activities ($x^2=4.1$, df=1, $p<0.05$; OR=0.92, 95% CI 0.85-0.99).

Given the univariate finding of greater improvement in falls self-efficacy in participants with a baseline depressive disorder, we explored whether there was a relationship between improvement in severity of depression during the FPP and improvement in mFES. HADS depression score did not significantly change between baseline and follow-up in either the group as a whole (5.3±3.6 versus 5.1±4.2; t=0.69, df=63, $p=0.5$) or in the subset of participants with a baseline depressive disorder (8.6±2.9 versus 8.4±4.2; t=0.25, df=17, $p=0.81$). Of the 18 depressive disorder participants with follow-up data, HADS depression scores improved in 9 participants and were unchanged or worse in the remaining participants: in these 18 participants, change in mFES was significantly correlated with change in HADS depression scores ($r^2=-0.47$, $p=0.049$) (Figure 3).
DISCUSSION

In keeping with the known associations between falls, fear of falling, and depression (5), 51% of participants had moderate or severe fear of falling and 30% had a DSM-IV depressive disorder. Not all persons in the depressed group had major depression, but other types of depressive disorder such as minor depression are nevertheless clinically significant, with disability and outcomes that are intermediate between those of major depression and no depression (35, 36). Consistent with previous studies (5), participants with a depressive disorder had more severe fear of falling, lower falls efficacy (less confidence), and greater restriction of activities due to fear of falling at baseline assessment. Depressed individuals were also more anxious and had a lower sense of mastery than their non-depressed counterparts.

Prior research in community samples has found that depression can predict the persistence of fear of falling (3) and fear-related activity restriction (1). In the current study, we found no association between either depressive disorder or severity of depressive symptoms and change in fear of falling or change in activity restriction. Thus our findings do not support the hypothesis that depression accounts for, or contributes to, the lack of improvement in fear of falling that has been observed in many treatment programs (7, 8). We did however find that more severe fear of falling at baseline was associated with greater improvement in fear of falling and, conversely, greater baseline falls efficacy (i.e greater confidence in not falling) was associated with less improvement in falls efficacy: these findings presumably reflect the fact that there was more room for improvement in persons with greater fear and less confidence at baseline. Also, we found that use of a walking aid at baseline was associated with less improvement in falls efficacy.
and slower baseline mobility was associated with less likelihood of improvement in activity restriction.

Contrary to our expectations, a depressive disorder was associated with improved falls efficacy over the course of the program, although this finding was not significant when we accounted for baseline falls efficacy and selected covariates. When we explored the univariate association in more detail, we found that the severity of depression improved during the FPP in 50% of participants with a depressive disorder and improvement of depression was significantly correlated with improvement in falls efficacy (Figure 3). The direction of causality between improvement in severity of depression and improvement in falls efficacy is unknown. The group exercise and social interaction in a FPP may improve mood and well-being in some individuals, which may then result in greater confidence that one can perform tasks without falling. Alternatively, the FPP may change negative appraisals of physical capabilities through education and exposure to physical activity or directly improve confidence through improved balance and strength; this improved confidence could then have a positive impact on mood.

Consistent with previous research (8), participation in this FPP was not associated with improvement in depressive symptoms in the group as a whole. Cognitive behavioral therapy is efficacious for fear of falling and the related restriction of activity (37), as well as depression (38). Thus, given the high frequency of both fear of falling and depressive disorders in persons attending FPPs, and the correlation between improvement in depression and improvement in falls efficacy in persons with a depressive disorder, the benefit of incorporating a cognitive behavioral intervention as a component of a FPP warrants investigation.
There are several caveats to our findings. One third of persons accepted into the FPP declined to participate in the research, which could have affected the results if participants and non-participants differed in the frequency and/or severity of the primary dependent and independent variables. Second, outcome assessments were not blind to depression status at baseline. However, in an attempt to minimize bias, all outcome measures were completed before the measures of depression. Third, research participants were free to pursue treatment for depression during the study, which could have potentially affected the result. However, this rarely happened: no antidepressant medication was newly initiated after baseline, although there was one dose increase and one antidepressant switch in individuals with a depressive disorder. Finally, because of the exploratory nature of this study, we did not have a sample size estimate. However, the number of participants exceeded the recommended minimum of 5 participants per variable for regression analysis (39). Strengths of the study are inclusion of non-major depressive disorders, in addition to major depression, which is more representative of the constellation of depressive disorders in older adults (35); the use of a structured psychiatric interview to diagnose depressive disorders; inclusion of relevant potential covariates; and the low rate of attrition of study participants.

To conclude, we found a high frequency of depressive disorders among persons attending a FPP, but depression did not impede improvement in fear of falling. In fact, depressed individuals who experienced improvement in depressive symptoms whilst attending the FPP also experienced improvement in falls efficacy: this raises the question as to whether a cognitive behavioral intervention that simultaneously targets both depression and falls efficacy would be a useful component of a FPP.
REFERENCES


Table 1. Baseline Characteristics of Study Participants by Diagnosis of Depressive Disorder

<table>
<thead>
<tr>
<th>Variable</th>
<th>Depressive disorder (n=21)</th>
<th>No depressive disorder (n=48)</th>
<th>Test statistic (df)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
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</tr>
<tr>
<td>Age, mean ±SD</td>
<td>78.0 ± 6.6</td>
<td>81.7 ± 6.7</td>
<td>t(67)=2.15</td>
<td><strong>0.035</strong></td>
</tr>
<tr>
<td>Female, n(%)</td>
<td>16 (76.2)</td>
<td>28 (58.3)</td>
<td>x^2(1)=2.02</td>
<td>0.15</td>
</tr>
<tr>
<td>Lives alone, n(%)</td>
<td>13 (61.9)</td>
<td>25 (52.1)</td>
<td>x^2(1)=0.57</td>
<td>0.45</td>
</tr>
<tr>
<td><strong>Falls history</strong></td>
<td></td>
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</tr>
<tr>
<td>Number of falls ±SD</td>
<td>4.6 ± 4.3</td>
<td>3.8 ± 7.8</td>
<td>t(67)=0.42</td>
<td>0.67</td>
</tr>
<tr>
<td>Fall-- medical attention, n(%)</td>
<td>15 (71.4)</td>
<td>27 (56.2)</td>
<td>x^2(1)=1.41</td>
<td>0.235</td>
</tr>
<tr>
<td>Fall-- fracture, n(%)</td>
<td>9 (42.8)</td>
<td>13 (27.1)</td>
<td>x^2(1)=1.67</td>
<td>0.20</td>
</tr>
<tr>
<td>Time on ground after fall &gt;1minute, n(%)</td>
<td>19 (90.5)</td>
<td>32 (66.7)</td>
<td>x^2(1)=4.30</td>
<td><strong>0.038</strong></td>
</tr>
<tr>
<td>Walking aid use, n(%)</td>
<td>18 (85.7)</td>
<td>30 (62.5)</td>
<td>x^2(1)= 3.71</td>
<td>0.054</td>
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<tr>
<td><strong>Sensory/Physical impairment</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Visually impaired, n(%)</td>
<td>11 (52.3)</td>
<td>22 (45.8)</td>
<td>x^2(1)=0.11</td>
<td>0.91</td>
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<tr>
<td>Dizziness score, mean ±SD</td>
<td>13.7 ± 9.1</td>
<td>8.6 ± 8.4</td>
<td>t(67)=2.29</td>
<td><strong>0.027</strong></td>
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<tr>
<td>Grip strength (kg), mean ±SD</td>
<td>20.7 ± 7.1</td>
<td>23.3 ± 7.6</td>
<td>t(67)=1.35</td>
<td>0.18</td>
</tr>
<tr>
<td>Berg balance score, mean ±SD</td>
<td>46.3 ± 6.8</td>
<td>48.4 ± 4.6</td>
<td>t(67)=1.48</td>
<td>0.14</td>
</tr>
<tr>
<td>TUG (seconds), mean ±SD</td>
<td>21.3 ± 13</td>
<td>15.8 ± 6.3</td>
<td>t(66)=2.39</td>
<td><strong>0.02</strong></td>
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<td><strong>Medical comorbidity</strong></td>
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<td>CIRS-G score, mean ±SD</td>
<td>13.0 ± 6.2</td>
<td>12.0 ± 4.8</td>
<td>t(67)=0.72</td>
<td>0.47</td>
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<tr>
<td>MMSE score, mean ±SD</td>
<td>28.8 ± 1.2</td>
<td>28.5 ± 1.5</td>
<td>t(67)=0.81</td>
<td>0.42</td>
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<tr>
<td></td>
<td>Mean ± SD</td>
<td>P Value</td>
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<tr>
<td>Total medications, mean ±SD</td>
<td>7.1 ±4.7</td>
<td>6.2 ± 2.7</td>
<td>t(67)=0.96 0.34</td>
<td></td>
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<tr>
<td>Psychological scales</td>
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<tr>
<td>mFES score, mean ±SD</td>
<td>5.5 ± 1.8</td>
<td>8.1 ± 1.6</td>
<td>t(67)=5.93 &lt;0.001</td>
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<tr>
<td>SAFFE activities restricted,</td>
<td>1.8 ±1.2</td>
<td>1.1 ± 1.1</td>
<td>t(67)=2.09 0.041</td>
<td></td>
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<tr>
<td>mean ±SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HADS depression score, mean ±SD</td>
<td>8.2 ± 3.2</td>
<td>4.0 ± 2.9</td>
<td>t(67)=5.43 &lt;0.001</td>
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<tr>
<td>HADS anxiety score, mean ±SD</td>
<td>9.5 ± 4.0</td>
<td>4.5 ± 3.8</td>
<td>t(67)=4.98 &lt;0.001</td>
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<tr>
<td>Mastery score, mean ±SD</td>
<td>21.1 ± 4.5</td>
<td>24.8 ± 4.9</td>
<td>t(67)=2.96 0.004</td>
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</table>

TUG= Timed Up and Go; CIRS-G= Cumulative Illness Rating Scale for Geriatrics; MMSE=Mini Mental State Exam; HADS= Hospital Anxiety and Depression Scale; mFES=Modified Falls Efficacy Scale; SAFFE= Survey of Activities and Fear of Falling in the Elderly
Figure 1. Study Participant Recruitment Flowchart

125 FPP participants contacted

37 Declined to participate
19 Excluded:
  9 No falls in previous year
  4 Dementia
  6 Non-English speaking

69 Completed consent form and initial research visit

64 FPP participants with baseline and follow-up data available

3 Did not attend program and did not complete follow-up visit
2 Attended program but did not complete at least one follow-up visit (1 hospitalized, 1 death)
Figure 2. Fear of Falling at Baseline and Follow-up in Depressed and Non-depressed Study Participants
Figure 3. Correlation Between Change in Modified Falls Efficacy Scale Scores and Change in Depression Scores on the Hospital Anxiety and Depression Scale in Participants with a Baseline Depressive Disorder