Update on Canadian Guidelines on the Prevention, Assessment and Treatment of Depression among Older Adults

Drs. David Conn & Robert Madan

BrainXchange Webinar

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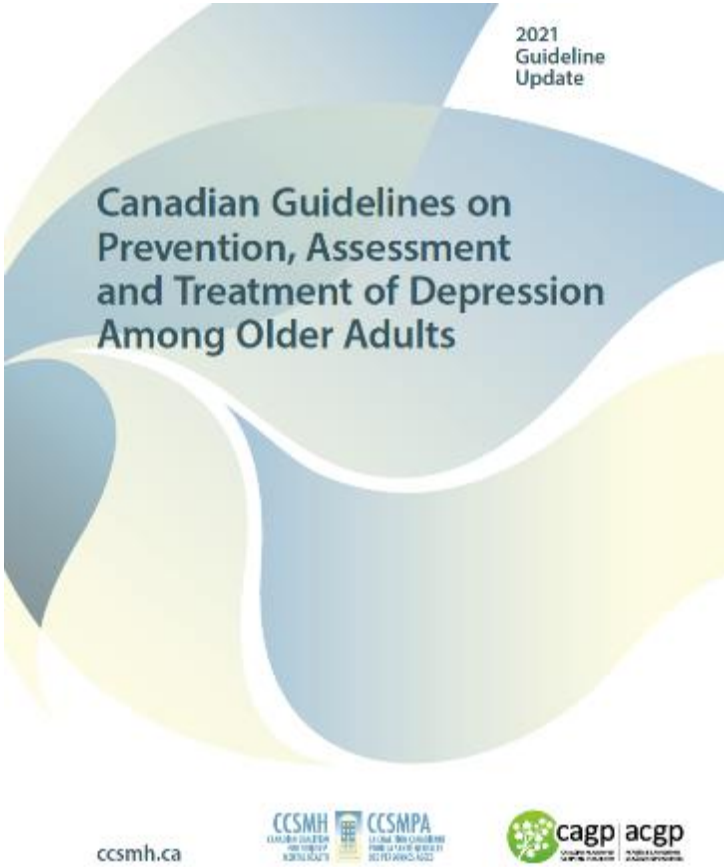
CCSMH CANADIAN COALITION FOR SENIORS' MENTAL HEALTH

CCSMPA LA COALITION CANADIENNE POUR LA SANTÉ MENTALES DES PERSONNES ÂGÉES

cagp CANADIAN ACADEMY OF GERIATRIC PSYCHIATRY | acgp ACADÉMIE CANADIENNE DE GÉRONTOPSYCHIATRIE



2 main sections:

- New or modified recommendations
- Side-by-side comparison of 2006 and 2021 recommendations.
- Ideally readers will review both sections

Topics included

1. Prevention
2. Assessment / Screening
3. Psychosocial interventions and Psychotherapy
4. Pharmacological treatments
5. Somatic Treatments
6. Subtypes of depression
7. Special populations
8. Models of Care

Disclosures

- Drs Conn & Madan have no disclosures related to this presentation

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A systematic search for peer-reviewed scholarly articles was performed in 5 databases including Medline, Embase, HealthStar, Cochrane, and PsychINFO from the beginning of the end date of the literature review from the previous version of the guideline—July 2006—through December 2018. The searches included and were restricted to English papers only and search terms used were the same as for the 2006 Guidelines.

Multiple phases of title and abstract review were conducted by one of the authors to identify 344 full-text articles from an initial yield of 1560 articles from database searches; those were further categorized based on types of study such as controlled trials (especially randomized), meta-analyses, reviews (especially systematic), and practice guidelines or expert committee reports potentially relevant to the subject area. Subsequently, additional relevant articles of which the members were aware were included.

CATEGORIES OF EVIDENCE FOR CAUSAL RELATIONSHIPS AND TREATMENT

Evidence from meta-analysis of randomized controlled trials	Ia
Evidence from at least 1 randomized controlled trial	Ib
Evidence from at least 1 controlled study without randomization	IIa
Evidence from at least 1 other type of quasi-experimental study	IIb
Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies, and case-control studies	III
Evidence from expert committees reports or opinions and/or clinical experience of respected authorities	IV

(Shekelle et al., 1999)

STRENGTH OF RECOMMENDATION

Directly based on category I evidence	A
Directly based on category II evidence or extrapolated recommendation from category I evidence	B
Directly based on category III evidence or extrapolated recommendation from category I or II evidence	C
Directly based on category IV evidence or extrapolated recommendation from category I, II, or III evidence	D

(Shekelle et al., 1999)

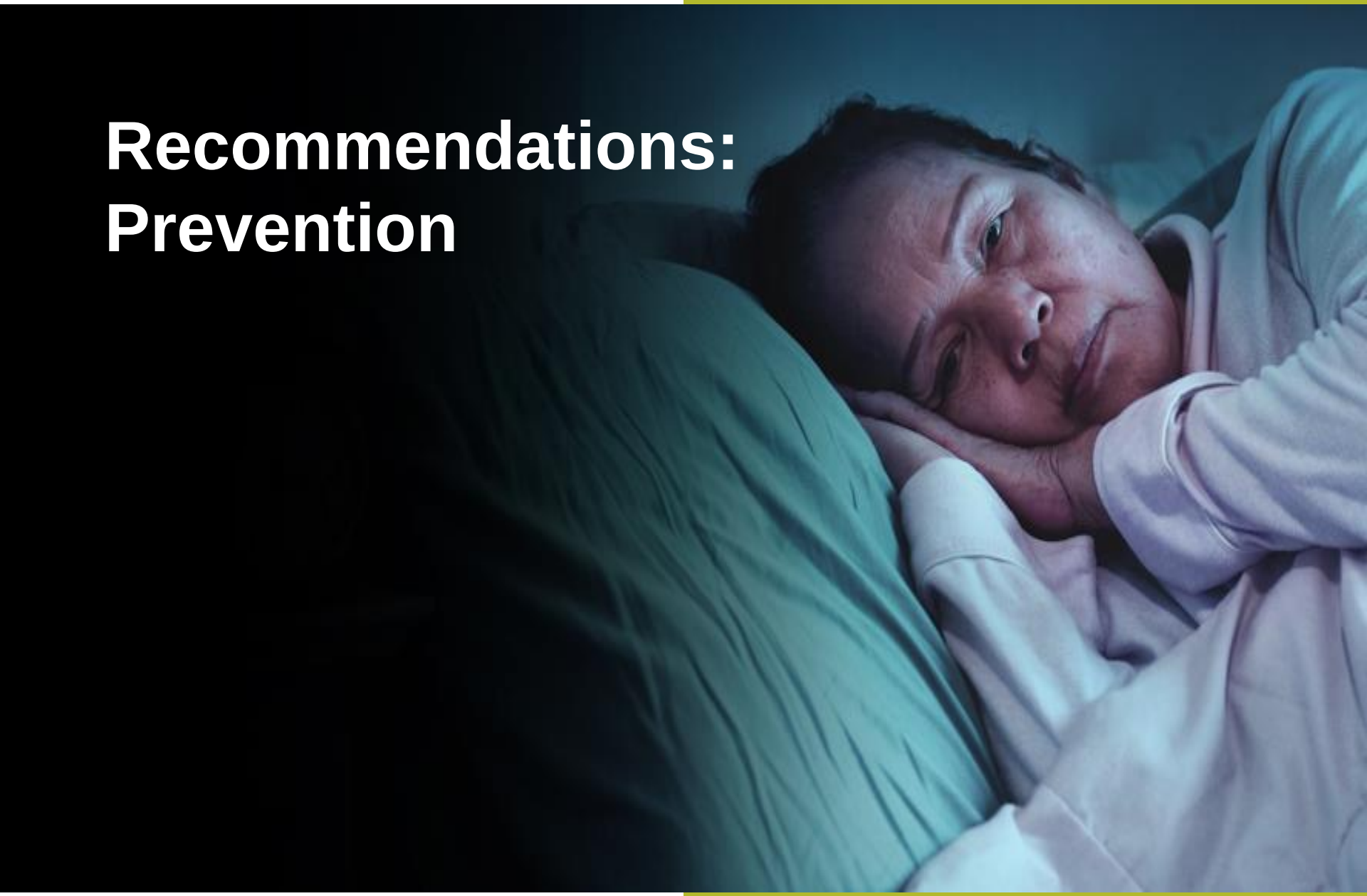
Differential Diagnosis “I feel down…”

- Major Depressive Disorder – Major Depressive Episode
- Bipolar Disorder – Major Depressive Episode
- Persistent Depressive Disorder- pure dysthymic type
- “Minor/subthreshold depression”
- Adjustment Disorder
- Bereavement
- Personality Disorder
- Mood disorder due to a medical condition
- Substances/meds

MDE Symptoms (DSM-5)

- *Depressed/empty
- *Anhedonia
- Sleep (less or more)
- Appetite (less or more)
- Reduced energy
- Poor concentration
- Guilt or worthlessness
- Psychomotor slowing or restlessness
- Thoughts of death or suicide
- Distress or impairment in functioning X 2 weeks
- 5/9 symptoms

Recommendations: Prevention



- Although research on prevention is in its infancy, prevention may be an alternative strategy to further reduce the disease burden of depression, which has been described as a global public health priority (Reynolds et al., 2017).

Universal prevention focuses on the general public or a whole population group regardless of risk status.

Selective prevention targets individuals or subgroups that are at higher risk of developing mental disorders than average individuals or subgroups.

Indicated prevention focuses on individuals who are identified as having prodromal symptoms or biological markers of mental disorders, but who do not yet meet the diagnostic criteria for a full-blown diagnosis.

NEW: PREVENTION

A variety of interventions focused on reducing social isolation and/or loneliness in older adults have demonstrated a reduction in depressive symptoms in addition to reduced loneliness. These interventions were primarily group-based and in long-term care settings. They include reminiscence therapy, physical exercise programs, videoconferences with family, horticultural therapy, and gender-based social groups. [B]

NEW: PREVENTION

Social prescribing, which is defined as, "a means of enabling primary care services to refer patients with social, emotional, or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector", may result in reduced depressive symptoms among older adults who have experienced mild to moderate symptoms of depression, social isolation, or loneliness. [C]

NEW: PREVENTION

A stepped-care approach (e.g., watchful waiting, cognitive behavioural therapy [CBT-based] bibliotherapy, problem-solving therapy, and referral to primary care for antidepressant medication) can reduce the incidence of depressive and anxiety disorders in community-dwelling older adults with subthreshold depression or anxiety. [B]

Van't Veer-Tazelaar et al. (2009) studied the following steps: a watchful waiting approach, CBT-based bibliotherapy, CBT-based problem-solving treatment, and referral to primary care for medication, if required. The intervention group had a 50% reduction in incidence of major depressive disorder or anxiety disorder over a 12-month period compared to usual care.

NEW: PREVENTION

Higher levels of physical activity are consistently associated with lower odds of developing future depression. This finding is consistent across all age groups including older adults. Clinicians should encourage patients with low levels of physical activity to become more active. Tools are available for clinicians to assist patients in setting health-related goals (e.g., Fountain of Health). [B]

Schuch et al. (2018): meta-analysis of 49 studies of physical activity. Compared with people with low levels of physical activity, those with high levels had significantly lower odds of developing depression. Physical activity had a protective effect against the emergence of depression across all age groups including older adults.

NEW: PREVENTION

Clinicians should utilize the instilling of hope and positive thinking as important therapeutic tools in the prevention of depression and in helping individuals with depressive symptoms or disorders. [D]

A review of 9 studies, utilizing such interventions by nurses in patients coping with cancer, concluded that it is possible to increase hope in this group (Li et al., 2018). Moore (2005) suggests that nurses are in key positions to have conversations with their patients about hope and about strategies to find renewed hope in any situation. Although more research is necessary to understand optimal interventions, we would encourage all healthcare staff to reflect on how best to incorporate the instilling of hope into their practices.

Recommendations: Screening and Assessment – Risk Factors

2006 RECOMMENDATIONS	2021 NEW OR UPDATED RECOMMENDATIONS
Health care providers should be familiar with the physical, psychological, and social risk factors for depressive disorders in older adults and include a screening for depression for their clients/ patients who present with some of these risk factors. **[D]**	Unchanged
We recommend targeted screening of those elderly at higher risk for depression due to the following situations: • Recently bereaved with unusual symptoms (e.g., active suicidal ideation, guilt not related to the deceased, psychomotor retardation, mood congruent delusions, marked functional impairment after 2 months of the loss, reaction that seems out of proportion with the loss) • Bereaved individuals, 3 to 6 months after the loss • Socially isolated • Persistent complaints of memory difficulties • Chronic disabling illness • Recent major physical illness (e.g., within 3 months) • Persistent sleep difficulties • Significant somatic concerns or recent onset anxiety • Refusal to eat or neglect of personal care • Recurrent or prolonged hospitalization • Diagnosis of dementia, Parkinson disease or stroke • Recent placement in a nursing/Long Term Care (LTC) home **[B]**	Essentially unchanged, but note that the exclusion of major depression in the first 2 months after the loss and in bereavement was removed in Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V).

Recommendations: Screening and Assessment – Screening and Screening Tools

2006 RECOMMENDATIONS	2021 NEW OR UPDATED RECOMMENDATIONS
Appropriate depression screening tools for elderly persons without significant cognitive impairment in general medical or geriatric settings include the self-rating *Geriatric Depression Scale (GDS)*, *the SELFCARE self-rating scale*, and the *Brief Assessment Schedule Depression Cards (BASDEC)* for hospitalized patients. **[B]**	We recommend using the GDS or the Patient Health Questionnaire-9 (PHQ-9). **[B]**
For patients with moderate to severe cognitive impairment, an observer-rated instrument, such as the Cornell Scale for Depression in Dementia is recommended instead of the GDS. **[B]**	Unchanged

Assessment

- Interview
- Collateral History
- Safety
- Cognitive Assessment
- Physical exam
- Bloodwork
  - CBC, Lytes, Thyroid, B12, Calcium, glucose
- Imaging
- Driving

Recommendations: Psychotherapy and psychosocial interventions

NEW: PSYCHOTHERAPIES AND PSYCHOSOCIAL INTERVENTIONS

There is promising evidence for exercise and mind-body interventions (e.g., tai chi, yoga, and mindfulness-based stress reduction) in reducing depressive symptoms in late-life either alone or in combination with other therapies. Physical activity in the form of exercise is an important non-pharmacological approach to improve mood in older adults. Clinicians should use their judgement in recommending the type of exercise and duration, taking into account comorbidities, physical capacity, and level of motivation. [**B**]

MODIFIED:	PSYCHOTHERAPIES AND PSYCHOSOCIAL INTERVENTIONS

Psychotherapies with the most evidence for effectiveness in older adults include: cognitive behaviour therapies (CBT; individual and group) and problem-solving therapy (PST). PST can be provided to older adults with cognitive impairment and executive dysfunction; CBT and PST have also shown benefit for older adults with depression and medical comorbidity. [**B**]

Psychotherapies and psychosocial treatments should be made available to older adults with depression (symptoms and disorder) in diverse settings (community, hospital, long-term care) across all regions of Canada. [**A**]

There is also evidence to support behaviour therapy, behavioural activation, reminiscence, and other psychotherapies including psychodynamic psychotherapy and interpersonal psychotherapy (IPT). [**B**]

Internet-delivered therapies may be comparable to face-to-face treatment, and may improve access to services for individuals in under-serviced areas and those with mobility issues. [**C**]

Numerous meta-analyses support CBT as an effective treatment for late-life depression (Cuijpers et al., 2006; Pinquart et al.,, 2007; Peng et al., 2009) when provided in both individual and group formats. Some of these meta-analyses also found evidence in support of other psychotherapies such as reminiscence therapy.

Emerging studies also suggest CBT is an effective intervention for depressed older adults with medical comorbidities such as chronic pain (Ehde et al., 2014) and heart failure (Jeyanantham et al., 2017).

Meta-analyses of psychotherapeutic interventions also support the effectiveness of PST for late-life depression showing moderate to high effect sizes (Cuipjers et al., 2014 ; Kirkham et al., 2016), including among frail older adults (Jonsson et al., 2016).

Recommendations: Antidepressant medication

Meta-Analyses

- 2nd generation – effective
  - 44.4% vs 34.7%
- TCA's, SSRIs and other antidepressants were superior to placebo
  - NNT were 14.4 and 6.7 for remission and response
- sertraline, paroxetine, and duloxetine were significantly better than placebo in achieving a partial response
- duloxetine > placebo in achieving remission and response. SSRIs in 3 studies were not significantly better than placebo

Nelson et al. Am J Geriatr Psychiatry 2008; 16:558 –56
Kok et al., Journal of Affective Disorders 141 (2012) 103–115
Thorlund et al., ; J Am Geriatr Soc 63:1002–1009, 2015
Tham et al., Journal of Affective Disorders 205 (2016) 1–12

Meta-Analyses

- Negative Studies
  - efficacy was not found in patients over the age of 65
  - lower rates of response in the older adults who were male, of older age, and who had a longer mean length of episode of depression

Tedeschini, J Clin Psychiatry 2011;72(12):1660–1668
Catali et al., Journal of Affective Disorders 147 (2013) 1–8

Prevention of Relapse Studies

- Escitalopram 10-20 (24 weeks)
  - risk of relapse was 4.4 times higher for the placebo group
- Citalopram X 48 weeks -positive
- A systematic reviews/meta-analysis
  - ongoing treatment with antidepressants is efficacious in preventing relapse as compared to placebo
  - maintenance treatment with SSRIs was better than placebo in preventing relapse with NNT = 5

Gorwood et al., Am J Geriatr Psychiatry 2007; 15:581–593
Klysner et al., JOURNAL OF PSYCHIATRY (2002), 181, 29-35
Kok et al., Am J Geriatr Psychiatry 19:3, March 2011
Tham et al., Journal of Affective Disorders 205 (2016) 1–12

MODIFIED: SELECTING AN ANTIDEPRESSANT/MONITORING FOR SIDE EFFECTS AND DRUG INTERACTIONS

It is recommended that clinicians consider sertraline or duloxetine as first-line medications for an acute episode of major depression in older adults. Alternatives include escitalopram and citalopram based on the low possibility of drug interactions but concern about QTc interval may limit dosage to sub-therapeutic levels. **[A]**

In addition, we suggest clinicians should choose an antidepressant with lowest risk of anticholinergic side effects and drug-drug interactions, as well as being relatively safe in the case of cardiovascular comorbidity. Patients need to be closely monitored for medication compliance, substance use, suicidal ideation, and development of drug toxicity. **[D]**

MODIFIED:	TITRATION AND DURATION OF THERAPY (FREQUENCY OF FOLLOW-UP)

When starting antidepressants, patients should initially be seen every 1–2 weeks (in-person or virtually) to assess response, side effects, and to titrate the dose. Visits should include, at a minimum, supportive psychosocial interventions and monitoring for worsening of depression, agitation, and suicide risk. [D]

MODIFIED:	MONITORING FOR SIDE EFFECTS AND DRUG INTERACTIONS (SODIUM)

When prescribing SSRI or SNRI antidepressants to older adults, the prescriber should screen for a history of hyponatremia before prescribing, as part of the consent process and then consider getting a sodium level prior to starting the antidepressant if there is a history of hyponatremia. [C]

A serum sodium level should be done within 2–4 weeks of initiating SSRI or SNRI antidepressants. Prescribers may consider checking the level after 2 weeks for those patients on diuretics or who have a history of hyponatremia. There is a lower of risk of hyponatremia with TCAs, bupropion, and mirtazapine. [C]

How Long to Stay on Antidepressant?

- Minimum of 1 year, even in the case of a single episode (Diniz 2014).
- A Cochrane review in 2016
  - quality of evidence was low with only 3 RCTs
  - NNT = 5
  - The authors suggest that “Continuing antidepressant medication for 12 months appears to be helpful with no increased harms..”

Unchanged

- Older patients who have had more than 2 depressive episodes, had particularly severe or difficult-to-treat depressions or required ECT should continue to take antidepressant maintenance treatment indefinitely, unless there is a specific contraindication to its use. [D]

Treatment Resistance

- Only 50% of elderly patients respond to first-line treatment and less than 40% reach remission

Bennabi et al., J Affect Disord 171:137–141

Approach

- Assess medication adherence
- ? alcohol, substances, and medications
- The diagnosis should be reviewed
- Drug-drug interactions
- Medical conditions should be reviewed, hyponatremia.

MODIFIED: TITRATION AND DURATION OF THERAPY (INADEQUATE RESPONSE)

When significant improvement has occurred but recovery is not complete after an adequate trial, the clinician should consider:

- a further 4 weeks of monotherapy or consider augmentation with another antidepressant or lithium or an antipsychotic (e.g., aripiprazole) or specific psychotherapy (e.g., IPT, CBT, PST).
- a switch to another antidepressant (same or another class) after discussing with the patient the potential risk of losing any significant improvements made with the first treatment. **[C]**
- augmentation with lithium remains a viable option but needs to be used carefully due to the risk of lithium toxicity; the clinician must be aware of how to monitor the patient on lithium over time through investigations.

NOTE: 2006 recommendation did not include augmentation with an antipsychotic.

Recommendations regarding subtypes of depression

- Persistent depressive disorder
- MDE – severe without psychosis
- MDE – severe with psychosis

Recommendations: Treatment: Dysthymic Disorder – Persistent Depressive Disorder

2006 RECOMMENDATIONS	2021 NEW OR UPDATED RECOMMENDATIONS
Patients with dysthymic disorder should be treated with pharmacological therapy, with or without psychotherapy, with periodic reassessment to measure response. **[B]**	Clinicians may consider non-pharmacological approaches as first-line in persistent depressive disorder, with pharmacotherapy recommended for those who have persistent or worsening symptoms despite psychosocial interventions. **[C]**

MODIFIED:	TREATMENT: MAJOR DEPRESSIVE DISORDER, SINGLE OR RECURRENT EPISODE – SEVERE BUT WITHOUT PSYCHOSIS

UNCHANGED – Patients with severe unipolar depression should be offered a combination of antidepressants and concurrent psychotherapy when appropriate services are available and there is no contraindication to either treatment. [**D**]

MODIFIED – Electroconvulsive therapy (ECT) should be considered in the treatment of older patients with severe unipolar depression who have previously had a good response to a course of ECT and/or failed to respond to 1 or more adequate antidepressant trials plus psychotherapy, especially if their health is deteriorating rapidly due to depression. ECT is a first-line treatment in older, depressed patients who are at high risk of poor outcomes—those with suicidal ideation or intent, severe physical illness, or with psychotic features. [**A**]

ECT can also be useful for continuation/maintenance therapy of older patients who are partially responsive, treatment resistant, or treatment intolerant with pharmacotherapy during the acute phase of treatment. [**B**]

MODIFIED:	TREATMENT: MAJOR DEPRESSIVE DISORDER, SINGLE OR RECURRENT EPISODES – SEVERE WITH PSYCHOTIC FEATURES

Recently, more placebo-controlled clinical trials reported safe and effective use of combined antidepressant and antipsychotic drugs in MDD with psychotic features, so we recommend that clinicians use their judgement based on severity and patient's physical conditions to try combination pharmacotherapy first. ECT should be considered after 4–8 weeks if combination therapy fails, is poorly tolerated, or if patient develops severe health consequences. [**B**]

Mood Stabilizers: emphasize need for close monitoring

All mood stabilizers require monitoring over time for possible short-term and longer-term adverse events. Using lithium requires the patient, family, and healthcare team to understand the factors that may increase lithium levels leading to potential toxicity. Lithium can cause hypothyroidism, hypercalcemia through hyperparathyroidism, and renal dysfunction. The clinician must regularly monitor the patient on lithium, including laboratory investigations. **[B]**

NEW: REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (rTMS)

We recommend repetitive transcranial magnetic stimulation (rTMS; left-sided only or sequential bilateral or deep rTMS) for older adults (> 60 years) with unipolar depression who have failed to respond to at least 1 adequate trial of antidepressant. rTMS is not recommended in patients who have failed a course of ECT or who have a seizure disorder. [**B**]

NEW: PHARMACOGENETIC TESTING

At present we do not recommend the broad use of pharmacogenetic testing in older adults with late-life depression. Patients with recurrent severe side effects to several anti-depressant drugs may benefit from pursuing a pharmacogenetic test to see if CYP450 metabolism is contributing. [C]

Recommendations:
Special Populations-

Depression associated with Dementia, Parkinson's Disease & Stroke

What are the Challenges in Diagnosing Depression in Dementia?

- Unable to recall
- Unable to articulate/describe
- Loss if interest vs inability
- Sleep and appetite
- Psychomotor changes

Depression of Dementia (dAD) NIMH

DSM

- At least 5 symptoms
- Almost every day

dAD

- At least 3 symptoms
- Not every day
- Added irritability
- Added social isolation or withdrawal

Olin et al., Am J of Ger Psych 2002, 10: 125-128, 129-141

MODIFIED: SPECIAL POPULATIONS: DEMENTIA

UNCHANGED: Patients who have mild depressive symptoms or symptoms of short duration should be treated with psychosocial supportive interventions first. [D]

MODIFIED: There is limited evidence to recommend antidepressant therapy for mild or moderate depression associated with dementia at this time. Behavioural interventions may be utilized as a first-line intervention and antidepressant medication could be offered if symptoms are severe and persistent, understanding that efficacy is not well established and that side effects could occur. [D]

NEW: SPECIAL POPULATIONS: PARKINSON'S DISEASE

We recommend SSRIs as first line for the treatment of depression in patients with Parkinson's disease with SNRIs as an alternative. CBT can also be considered. [**B**]

MODIFIED:	SPECIAL POPULATIONS: VASCULAR DEPRESSION/ POST-STROKE DEPRESSION

Consider SSRIs as first-line treatment for post-stroke depression (PSD) regardless of whether or not the stroke is ischemic or hemorrhagic. Second-line treatments can include SNRIs and mirtazapine. Methylphenidate may also be considered, especially if apathy is significant. [**B**]

NOTE: The 2006 recommendations suggested that venlafaxine be avoided. Methylphenidate was not mentioned.

Recommendations: Models of Care

MODELS OF CARE

Recommendations: Models of Care

2006 RECOMMENDATIONS	2021 NEW OR UPDATED RECOMMENDATIONS
Health care professionals and organizations should implement a model of care that addresses the physical/functional as well as the psychosocial needs of older depressed adults. Given the complex care needs of older adults, these are most likely to require interdisciplinary involvement in care, whether in primary care or specialized mental health settings. **[B]**	Unchanged
Health care professionals and organizations should implement a model of care that promotes continuity of care as older adults appear to respond better to consistent primary care providers. **[B]**	Unchanged
	New: Core elements of evidence-based models for treating late-life depression in primary care include: improved patient education, incorporating interprofessional staff as depression care managers who routinely assess and follow patients clinically, utilizing a stepped-care approach. Treatment prescriptions are provided by a primary care physician or nurse practitioner, with as needed psychiatric consultation. An individualized plan of care should be developed using a collaborative approach. **[A]**
	New: To optimize access to clinical services, "senior-friendly" virtual care options (e.g., videoconferencing) should be available. Older adult patients should have appropriate equipment and support, to ensure effective and efficient communication to optimize virtual care encounters. **[C]**

Conclusions

- The updated guidelines have expanded to include prevention strategies
- Greater emphasis on a variety of psychosocial interventions including physical activity
- Some important modifications to pharmacological treatments
- Inclusion of rTMS as a potential treatment
- Updates on evidence-based models of care including virtual care

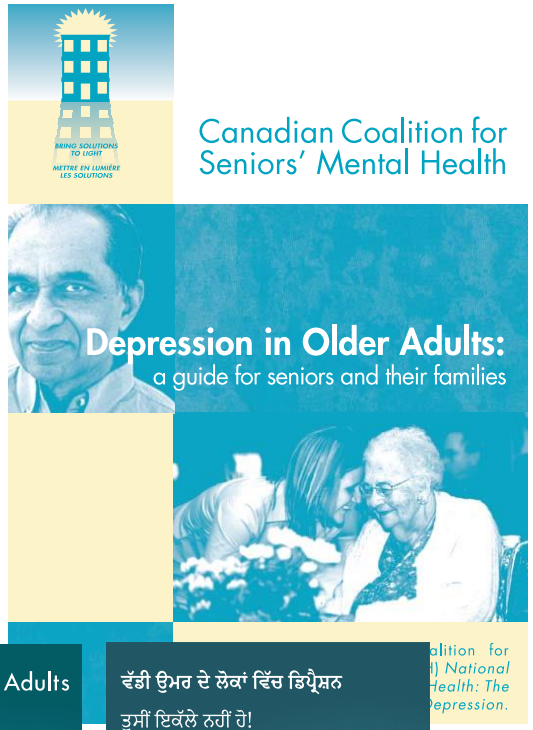
Resources

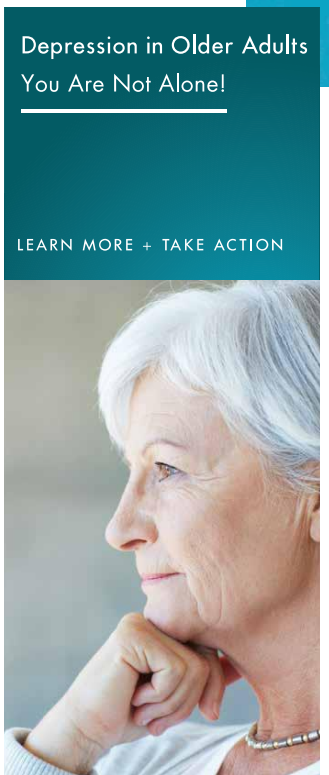
ORDER OF EXCELLENCE

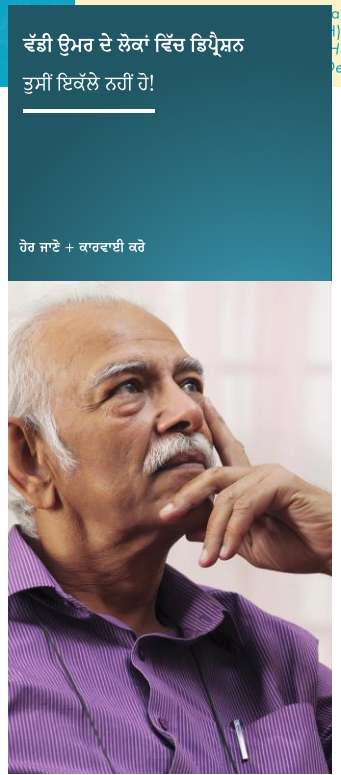
Mental Health Commission of Canada / Commission de la santé mentale du Canada

Summary: Guidelines for Comprehensive Mental Health Services for Older Adults in Canada

mentalhealthcommission.ca







If you're interested in joining CCSMH please contact: www.ccsmh.ca

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Canadian Coalition for Seniors' Mental Health
To promote seniors' mental health by connecting people, ideas and resources.

Coalition Canadienne pour la Santé Mentale des Personnes Âgées
Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.

Thank You! Any Questions?