Part 2: Assessment, Treatment and Monitoring

Comprehensive Assessment

Following a positive screen for depression a complete biopsychosocial (holistic) assessment should be conducted including:

- A review of diagnostic criteria in the DSM-5-TR.
- An estimate of severity, including presence of psychotic or catatonic symptoms.
- Rule out bipolar mood disorder as antidepressants can precipitate mania.
- Risk of suicide, by directly asking patients about suicidal ideation, intent, and plan.
- Personal or family history of mood disorder.
- Medication use, including over-the-counter, and substance use.
- Review of current stressors, recent losses and life situation.
- Level of functioning/disability including pain.
- Family situation, social integration/support, caregiving burden.
- Impact of social determinants of health (e.g. poverty, ageism, racism).
- Mental status exam, plus assessment of cognitive function.
- Physical exam and lab tests to determine if medical issues contribute or mimic depressive symptoms.

Treatment can be divided into 3 main phases:

1. Acute treatment phase: to achieve remission of symptoms.
2. Continuation phase: to prevent recurrence or relapse of same episode of illness.
3. Maintenance or prophylaxis phase: to prevent future episodes or recurrence.

Guidelines for Treatment

Psychosocial interventions:

- Exercise (encourage activity at individual pace and capacity).
- Mindfulness and other mind-body practices (including tai chi and yoga).
- Increased social activity and support.
- Self-help (books, videos, websites, apps).

Psychotherapies:

- For mild to moderate depression psychotherapy or antidepressant medication are both first-line treatments. They can be used in combination.
  - Indications influenced by coping style, history including trauma, level of cognitive function.
  - Psychotherapy provided by trained mental health professionals either individually or in groups.
- Psychotherapies with the most evidence for effectiveness in older adults include cognitive behavioural therapy (CBT) – individual and group, and problem-solving therapy (PST).
- Evidence also supports behaviour therapy, behavioural activation, reminiscence, and other psychotherapies including psychodynamic psychotherapy and interpersonal therapy.

Pharmacological treatment:

- Outcomes are optimal when medications are used in combination with psychosocial or psychotherapy treatments.
  - see table for commonly used antidepressants.
  - see full guidelines for details of prescribing and monitoring.
- It is recommended that clinicians consider duloxetine or sertraline 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 serum sodium level should be done within 2–4 weeks of initiating SSRI or SNRI antidepressants. Prescribers may consider checking the sodium level after 2 weeks for those patients on diuretics or who have a history of hyponatremia.
- Patients need to be closely monitored for medication compliance, substance use, suicidal ideation, and development of drug toxicity.

What to Do if First-Line Treatment is Not Working

- Consider switching to a different antidepressant or augmenting with another antidepressant from a different class or lithium or an antipsychotic (e.g. aripiprazole) or a specific form of psychotherapy.
- **rTMS** (left-sided only or sequential bilateral or deep rTMS) should be considered in the treatment of older adults 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.
- **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.
  - Failed to respond to 1 or more adequate antidepressant trials plus psychotherapy, especially if their health is deteriorating rapidly due to depression.
  - As a first-line treatment in older, severely depressed patients who are at high risk of poor outcomes—those with suicidal ideation or intent, severe physical illness, or with psychotic features.

Recommended Antidepressant Medications

Medication	Starting Dose	Average Therapeutic dose	Maximum dose	Considerations
Selective Serotonin Reuptake Inhibitors (SSRI)				
Sertraline	25-50mg daily	50-200mg daily	200mg daily	Possible QTc prolongation.
Escitalopram	2.5-5mg daily	10-20mg daily	10mg* daily	
Citalopram	5-10mg daily	20-30mg daily	20mg* daily	
Serotonin and norepinephrine reuptake inhibitors (SNRIs)				
Duloxetine	30mg daily	60-120mg daily	120mg daily	May increase blood pressure.
Venlafaxine	37.5mg daily	150-300mg daily	300mg daily	May increase blood pressure.
Other antidepressants				
Mirtazipine	7.5-15mg qhs	30-45mg qhs	45mg qhs	Sedating, weight gain.
Bupropion SR	100mg qam	100-150mg BID	200mg BID	Activating. Risk of seizure with high dosage.
Bupropion XL	150mg daily	150mg BID	450mg daily	Activating. Risk of seizure with high dosage.
Nortriptyline (tricyclic)	10-25mg qhs	40-100mg qhs	150 mg qhs	Not first-line. Anti-cholinergic properties, cardiovascular side effects. Monitor blood levels.
Vortioxetine	10mg daily	10-20mg daily	20mg daily	

*Recommended maximum dosage for older adults.
qhs = each evening, qam = each morning, bid = twice per day

Monitoring and Long-Term Treatment

Health care providers should monitor the older adult for recurrence of depression for the first 2 years after treatment.

- Ongoing monitoring should focus on depressive symptoms present during initial episode.
- Older adults in remission of their first episode should be treated for a minimum of one year and up to 2 years from time of improvement.
- Older adults with recurrent episodes should receive indefinite maintenance therapy.
- In LTC homes, response to therapy should be evaluated monthly after initial improvement and then every three months, as well as annual assessment after remission of symptoms.

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Pocket card on

Depression

Assessment and Treatment of Older Adults

Based on:
Canadian Guidelines on Prevention, Assessment and Treatment of Depression Among Older Adults (2021)

For more information visit www.ccsmh.ca

This clinical resource is intended for information purposes only and is not intended to be interpreted or used as a standard of medical practice.

CCSMH Canadian Coalition for Seniors' Mental Health

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Part 1: Prevention, Risk, Screening

Preventing Depression

- Interventions to reduce social isolation and loneliness.
- Social prescribing 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" (Friedli and Watson 2004).
- Increased physical activity.
- Promoting hope and positive thinking through clinical interactions.
- Stepped-care approach (e.g., watchful waiting, cognitive-behavioural therapy [CBT-based] bibliotherapy, problem-solving therapy, and referral to primary care for antidepressant medication).

Is My Patient at Risk for Depression?

Predisposing factors:

- Female
- Widowed or divorced
- Previous depression history
- Brain changes due to vascular problems
- Physical illness including pain, chronic disabling illness and frailty
- Medications or polypharmacy
- Excessive alcohol use
- Social determinants of health and low social support, loneliness and isolation
- Care partner for person with a major disease (e.g., dementia)
- Personality factors (e.g., relationship or dependence problems)

Precipitating factors:

- Recent bereavement
- Move from home to other places (e.g., long term care)
- Adverse life events (e.g., losses, separation, financial crisis)
- Chronic stress with declining health, family, or marital problems
- Social isolation
- Persistent sleep difficulties

Recommended Screening Options

In all settings:

- The Geriatric Depression Scale (e.g. 15 item version)
- Patient Health Questionnaire-9 (PHQ-9)

For depression in the presence of dementia or significant cognitive difficulties:

- The Cornell Scale for Depression in Dementia

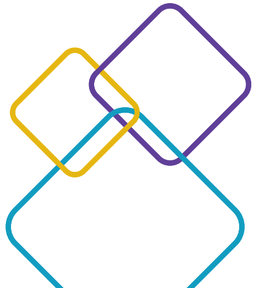
Diagnostic Criteria for Depression – DSM-5-TR (APA, 2022)

At least 5 of 9 symptoms (1 of which must be depressed mood or loss of interest or pleasure), present on most days, most of the time, for at least 2 weeks:

- Depressed mood
- Loss of interest or pleasure in normal, previously enjoyed activities
- Decreased energy and increased fatigue
- Sleep disturbance
- Inappropriate feelings of guilt
- Diminished ability to think or concentrate
- Appetite change (i.e., usually loss of appetite in the elderly)
- Psychomotor agitation or retardation
- Suicidal ideation or recurrent thoughts of death

Make a clear DSM-5 diagnosis & document. Different types of depressive disorders include:

- Major depressive episodes (i.e., part of unipolar, bipolar mood disorder or secondary to a medical condition, a medication, or a substance)
- Persistent depressive disorder (formerly dysthymic disorder)
- A major depressive episode can occur at any time during bereavement
- Adjustment disorder with depressed mood
- For a major depressive episode add specifiers if relevant such as: with anxious distress, with mixed features, with melancholic features, with atypical features, with psychotic features, with seasonal pattern



Suicide Risk

Non-modifiable risk factors:

- Old age
- Male gender
- Being widowed or divorced
- Previous attempt at self-harm
- Losses (e.g., health status, role, independence, significant relations)

Potentially modifiable risk factors:

- Social isolation
- Presence of chronic pain
- Abuse/misuse of alcohol or other medications
- Presence & severity of depression
- Presence of hopelessness and suicidal ideation
- Access to means, especially firearms

Behaviors to alert clinicians to potential suicide:

- Agitation
- Giving personal possessions away
- Reviewing one's will
- Increase in alcohol use
- Non-compliance with medical treatment
- Taking unnecessary risk
- Preoccupation with death

Notes