Prevention, Assessment and Treatment of Depression among Older Adults: a Canadian Perspective

Dr. David Conn
Baycrest & University of Toronto

JoyAge International Symposium
Hong Kong October 2022

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Baycrest

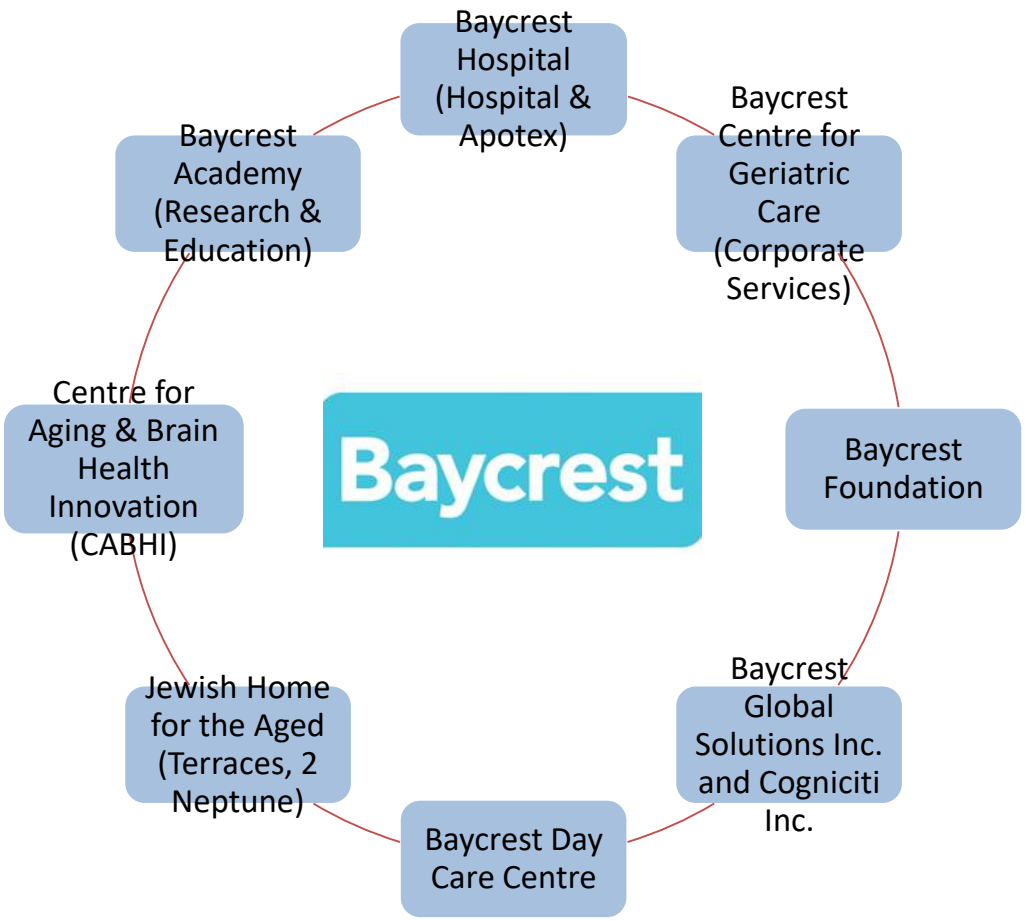
CCSMH CANADIAN COALITION FOR SENIORS' MENTAL HEALTH

CCSMPA LA COALITION CANADIENNE POUR LA SANTÉ MENTALES DES PERSONNES ÂGÉES

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

Outline

- Canadian Coalition for Seniors Mental Health: origins and development
- Guidelines for Depression among Older Adults
- Promising Practices



All Legal Entities

- 1900+ employees
- ***2000*** *volunteers**
- Post-Acute Care Hospital
- Outpatient Clinics
- Largest LTC Home in Ontario
- Full Corporate Services
- Fundraising Foundation
- Independent Living
- Global Entrepreneurial Ventures
- Innovation Centre
- World Class UofT affiliated Neuroscience Research
- Centre for Education
- Fully affiliated University of Toronto teaching hospital

Canadian Coalition for Seniors Mental Health (CCSMH)

- CAGP created the Millennium Project - 1999

  "To improve the mental health of the elderly in LTC through education, advocacy and collaboration"

- National Symposium 2002: Gaps in Mental Health Services for Seniors in LTC Facilities

  "To engage all relevant stakeholders in order to identify and implement action plans to improve mental health for seniors living in LTC facilities"

  ACTION: Formation of a National Coalition – Birth of CCSMH

Canadian Coalition for Seniors' Mental Health (CCSMH)

www.ccsmh.ca

The mission of the CCSMH is:

To promote the mental health of older adults by connecting people, ideas, and resources.

Founded 2002 - Linked to CAGP

Inaugural Steering Committee 2002

Steering Committee

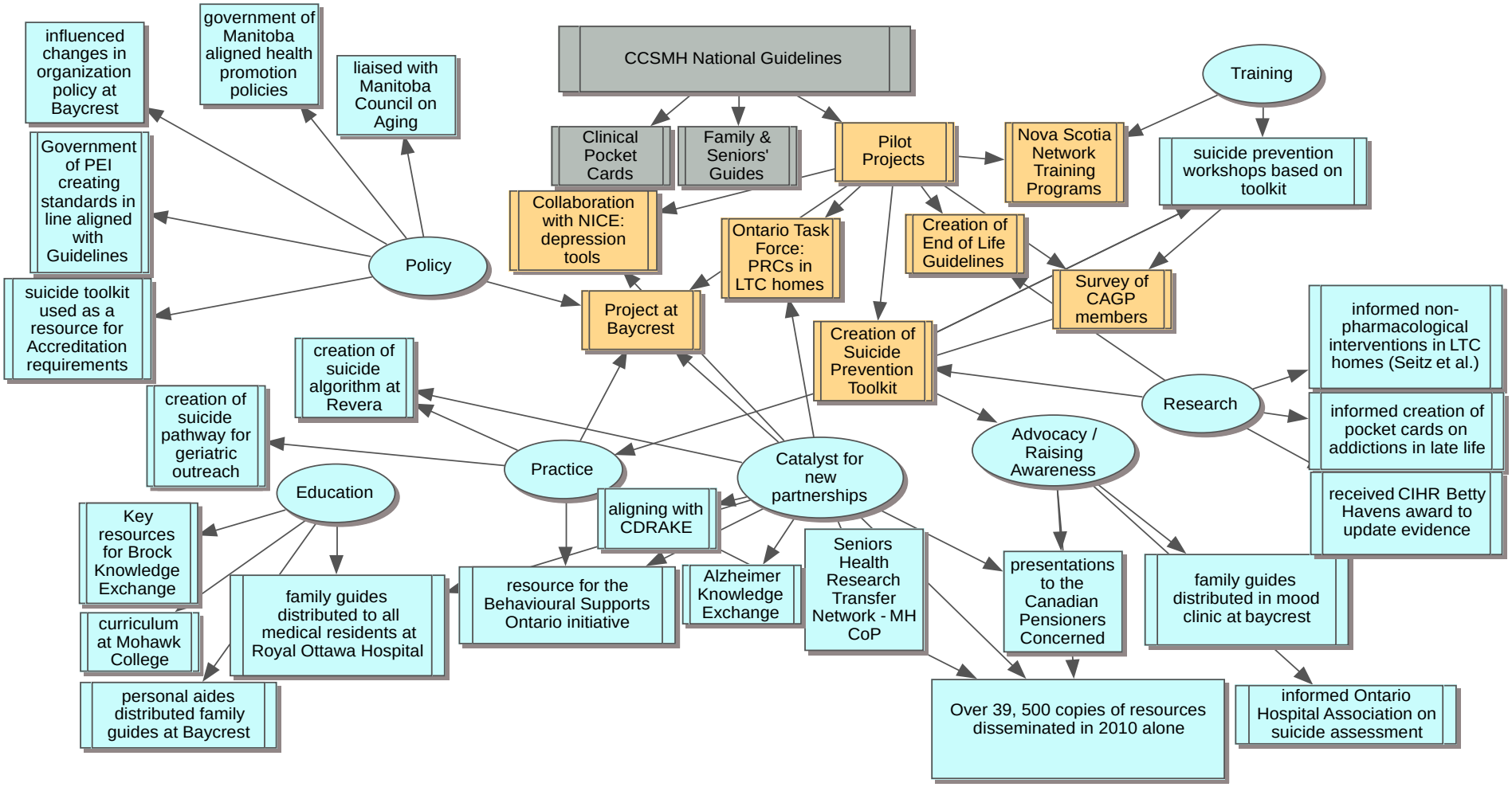
Canadian Academy of Geriatric Psychiatry	Dr. David Conn
Canadian Academy of Geriatric Psychiatry	Dr. Ken LeClair
Canadian Society of Consulting Pharmacists	Margot Priddle
College of Family Physicians of Canada	Dr. Chris Frank
Health Canada	Dr. Louise Plouffe
Canadian Psychological Association	Dr. Maggie Gibson
Canadian Geriatrics Society	Dr. David Hogan
Alzheimer's Society of Canada	Ilona Horgen
Canadian Mental Health Association	Bonnie Pape
Canadian Nurses Association	Dr. Sharon Moore
CARP, Canada's Association for the Fifty Plus	Judy Cutler
Canadian Association for Community Care	Dr. Taylor Alexander
Canadian Association of Social Workers	Jean Burtt
Canadian Caregiver Coalition	Esther Roberts

National Guidelines for Seniors' Mental Health

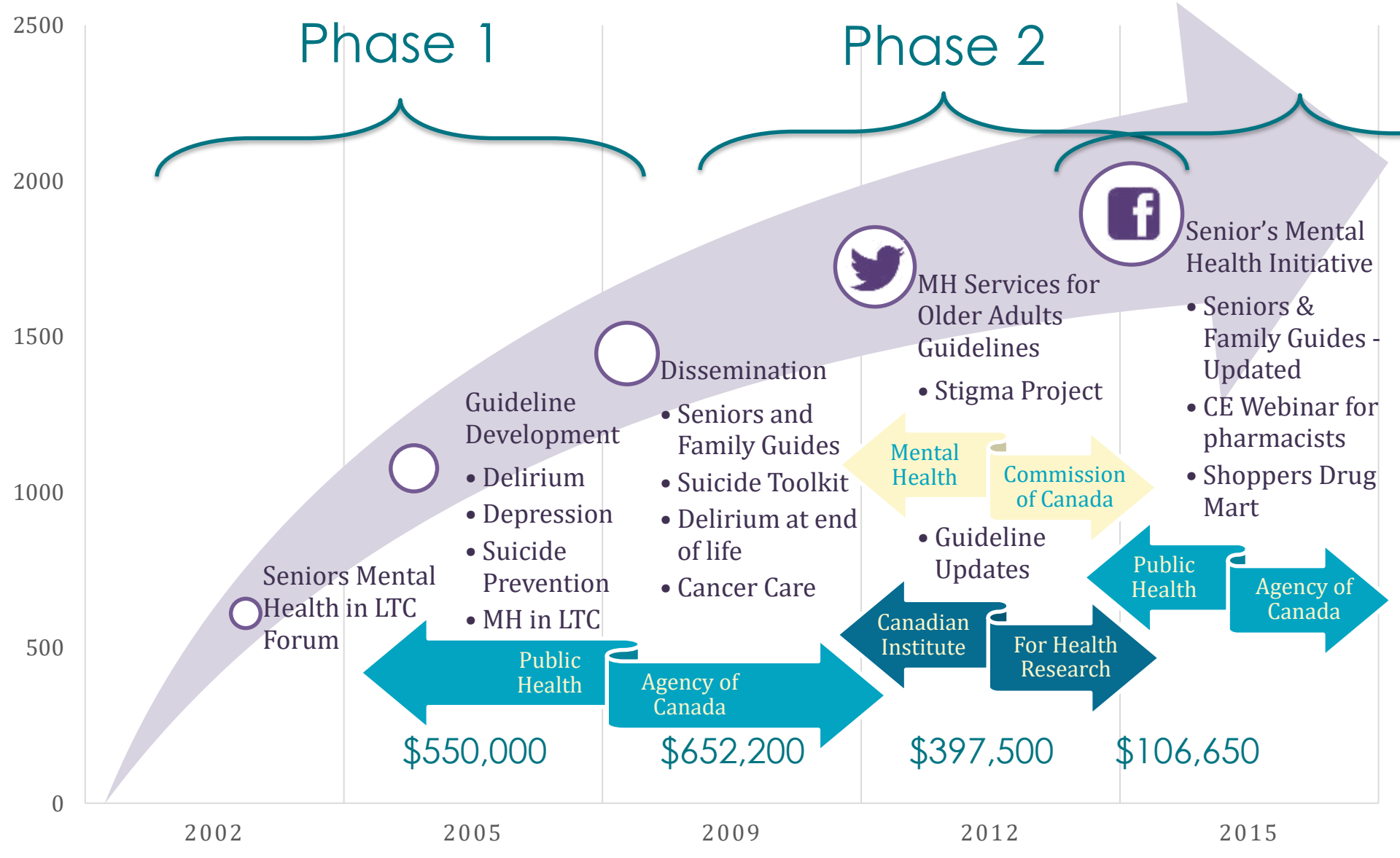
- In 2005 the CCSMH was awarded funding from the Public Health Agency of Canada (Population Health Fund)
- **Project goal:** To lead and facilitate the development of evidence-based recommendations for best practice guidelines in areas of seniors' mental health

Guidelines – Impact

(from evaluation report)



Building & Sustaining the Coalition



Phase 3 - Growth ! (2017-22)

- Transforming Healthcare for Dementia Prevention: Health Behaviour Change as First Line Medicine. Centre for Aging and Brain Health Innovation (CABHI) (2018-2019).
- Development of 4 National Guidelines for Older Adults: Prevention, Assessment and Treatment of Alcohol, Opioid, Benzodiazepine and Cannabis Use Disorders. Funded by Health Canada, Substance Use and Addictions Program (SUAP). (2017-20)
- Cannabis Use and Older Adults: Developing E-Learning Modules and Knowledge Translation Tools for Clinicians and Students. Funded by Health Canada, Substance Use and Addictions Program (SUAP). (2020-2022).

- Other recent projects funded by MHCC (scoping review on MH services), PHAC (gaps in research on suicide), RBC Foundation (National ECHO), CSA (mental health in residential settings).

Phase 4 (current)

- Guidelines for identifying and addressing seniors' isolation & loneliness. Funding to the Canadian Coalition for Seniors' Mental Health (CCSMH) from an anonymous Private Foundation (2022-24).
- Moving evidence to action for seniors' mental health promotion during the COVID-19 pandemic and beyond. Public Health Agency of Canada (2022-2024).

  - Clinical Guidelines for BPSD
  - Clinical Guidelines for Anxiety / Anxiety Disorders
  - KT tools for SUD Guidelines
  - KT tools for updated Depression Guidelines

Coalition: Assumptions

- The goal cannot be reached by any one individual or group working alone
- Participants should include a diversity of individuals and groups who represent the concern and/or geographic area or population
- Shared interests make consensus among the partners possible

Roussos & Fawcett, 2000

Guide to successful Coalitions: 9 Dimensions

- Readiness
- Intentionality (clear goals, action plans)
- Structure and organizational capacity
- Taking Action
- Membership
- Leadership
- Dollars & Resources
- Relationships
- Technical assistance

T. Wolff (2001)

Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic

COVID-19 Mental Disorders Collaborators*

www.thelancet.com Published online October 8, 2021 https://doi.org/10.1016/S0140-6736(21)02143-7

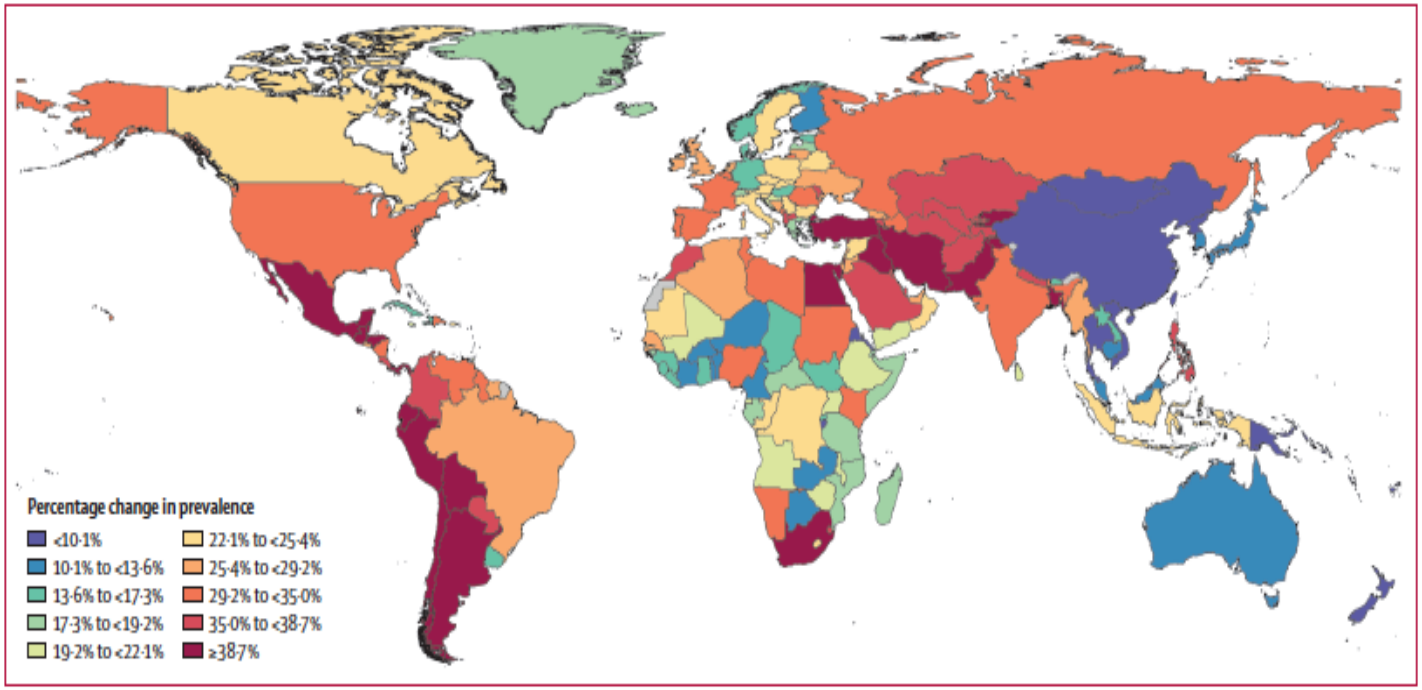


Figure 2: Change in the prevalence of major depressive disorder after adjustment for (ie, during) the COVID-19 pandemic, 2020

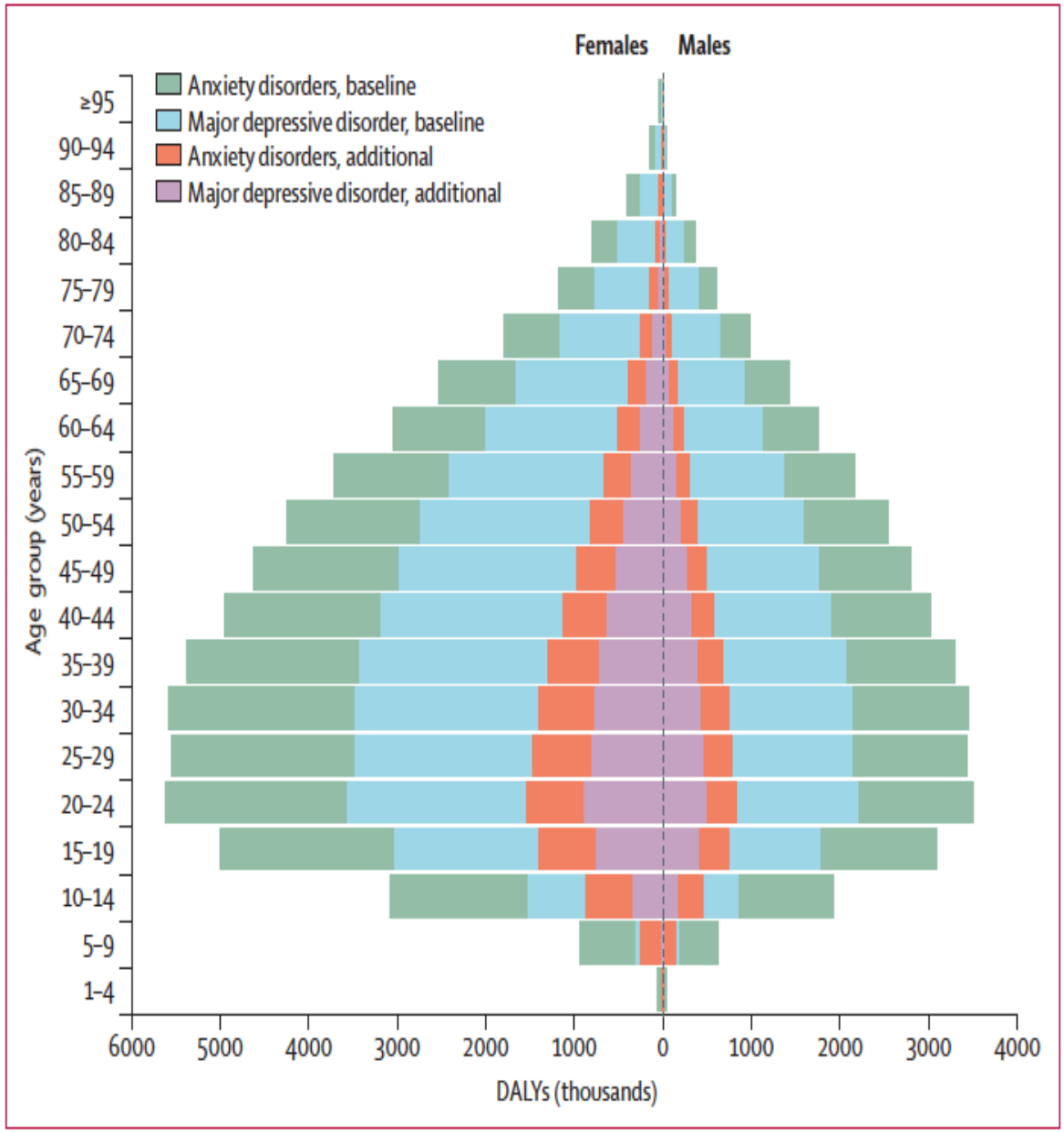
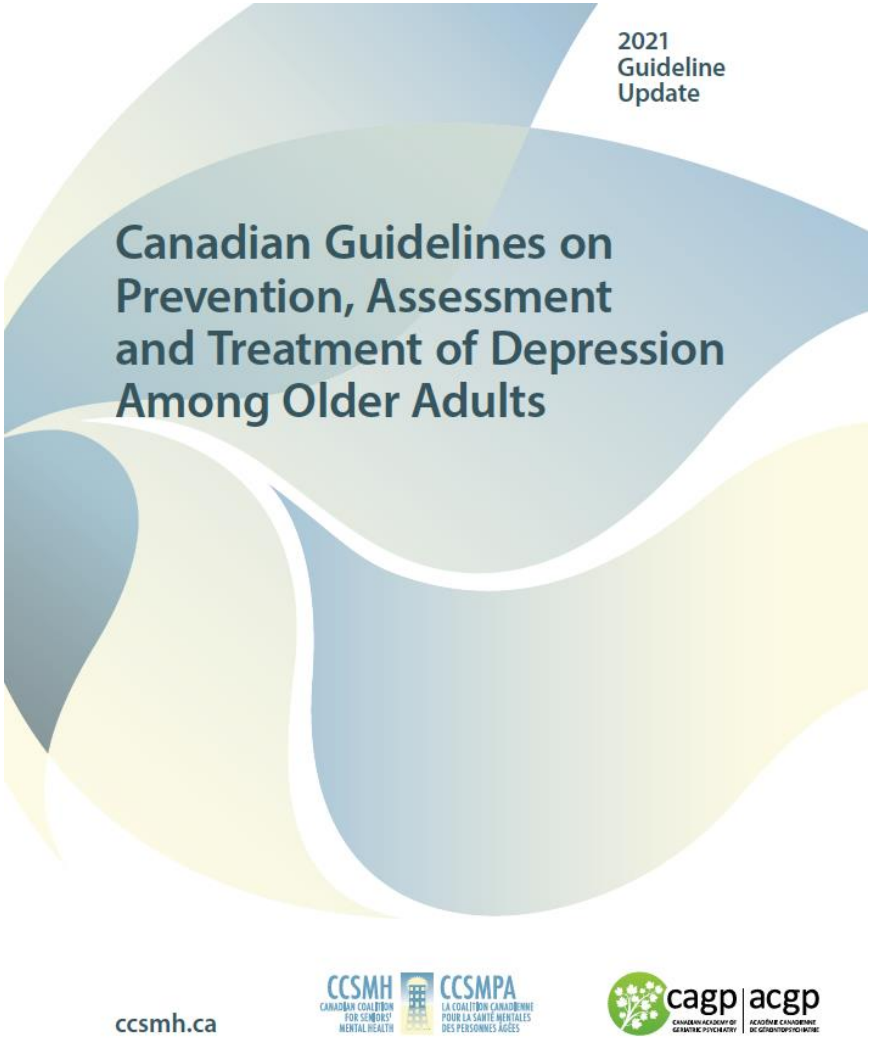
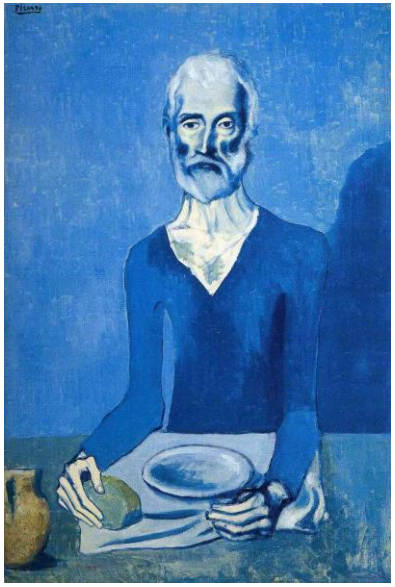


***Figure 4*: Global burden of major depressive disorder and anxiety disorders by age and sex, 2020**

Baseline refers to pre-pandemic DALYs and additional refers to additional burden due to the COVID–19 pandemic. DALYs=disability-adjusted life-years.





2 main sections:

- New or modified recommendations
- Side-by-side comparison of 2006 and 2021 recommendations (50 / 71 essentially unchanged)
- 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

2021 Guideline Update Group

Dr. David Conn, M.B., B.Ch., B.A.O., FRCPC
Group Chair
VP, Education and Director of Centre for Education, Baycrest Health Sciences
Professor, Department of Psychiatry, University of Toronto
Co-Chair, Canadian Coalition for Seniors' Mental Health

Lori Amdam, B.Sc.N, M.S.N.
Group Member
Education Consultant, Gerontology
CCSMH Steering Committee Member
Vancouver Island, British Columbia, Canada

Dr. Daniel M. Blumberger, MD, MSc, FRCPC
Group Member
Director & Chair, Temerty Centre for Therapeutic Brain Intervention
Clinician Scientist, Campbell Family Research Institute
Centre for Addiction and Mental Health
Professor, Department of Psychiatry, University of Toronto

Dr. Chris Frank, MD, FCFP
Group Member
Care of the Elderly Family Physician,
Professor, Department of Medicine,
Queen's University, Kingston, Ontario

Dr. Cindy Grief, MSc., MD, FRCPC
Group Member
Medical Director, Mental Health Services, Baycrest Health Sciences
Assistant Professor,
University of Toronto

Dr. Robert Madan, MD, FRCPC
Group Member
Psychiatrist-in-Chief & Executive Medical Director, Baycrest Health Sciences
Associate Professor,
University of Toronto

Dr. Kiran Rabheru, MD, CCFP, FRCP
Group Member
Geriatric Psychiatrist, TOH
Professor of Psychiatry,
University of Ottawa
Co-Chair, Canadian Coalition for Seniors' Mental Health

Anar Dilara MBBS, MPH, MPhil
Former Research Assistant,
Canadian Coalition for Seniors' Mental Health

Daniella Minchopoulos, BASc
Former Project Assistant,
Canadian Coalition for Seniors' Mental Health

Original 2006 Guideline Development Group (with 2006 titles)

Dr. Marie-France Tourigny-Rivard, M.D., FRCPC
Co-Lead
Professor and Chief of the Geriatric Psychiatry Division, Department of Psychiatry, University of Ottawa
Clinical Director, Geriatric Psychiatry Program, Royal Ottawa Hospital, Ottawa, Ontario

Dr. Diane Buchanan, RN, DNSc, GNC (C)
Co-Lead
Assistant Professor, School of Nursing, Queen's University, Kingston, Ontario

Dr. Philippe Cappeliez, Ph.D.
Group Member
Professor, School of Psychology, University of Ottawa, Ottawa, Ontario

Dr. Chris Frank, MD, FCFP
Group Member
Care of the Elderly, Professor, Department of Medicine, Queen's University, Kingston, Ontario

Pronica Janikowski, R.Ph., B.Sc. Phm., CGP
Group Member
Certified Geriatric Pharmacist, Long-Term Care Facility Consultant, Picton Clinic Pharmacy, Picton, Ontario

Faith Malach, MHSc, MSW, RSW
Project Director
Executive Director, Canadian Coalition for Seniors' Mental Health, Adjunct Practice Professor, Faculty of Social Work, University of Toronto, Toronto, Ontario

Jennifer Mokry, MSW, RSW
Project Coordinator
Project Manager, Canadian Coalition for Seniors' Mental Health, Toronto, Ontario

Lily Spanjevic, RN, BScN, MN, CPMHN(C), GNC (C)
Group Member
Advanced Practice Leader-Geriatric Rehabilitation Program, Toronto Rehabilitation Institute, Toronto, Ontario

Dr. Alastair Flint, MB, FRCPC, FRANZCP
Consultant
Professor of Psychiatry, University of Toronto
Head, Geriatric Psychiatry Program, University Health Network, Toronto, Ontario

Dr. Nathan Herrmann, MD, FRCPC
Consultant
Head, Division of Geriatric Psychiatry, Sunnybrook and Women's College Health Sciences Centre, Professor of Psychiatry, University of Toronto, Toronto, Ontario

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)

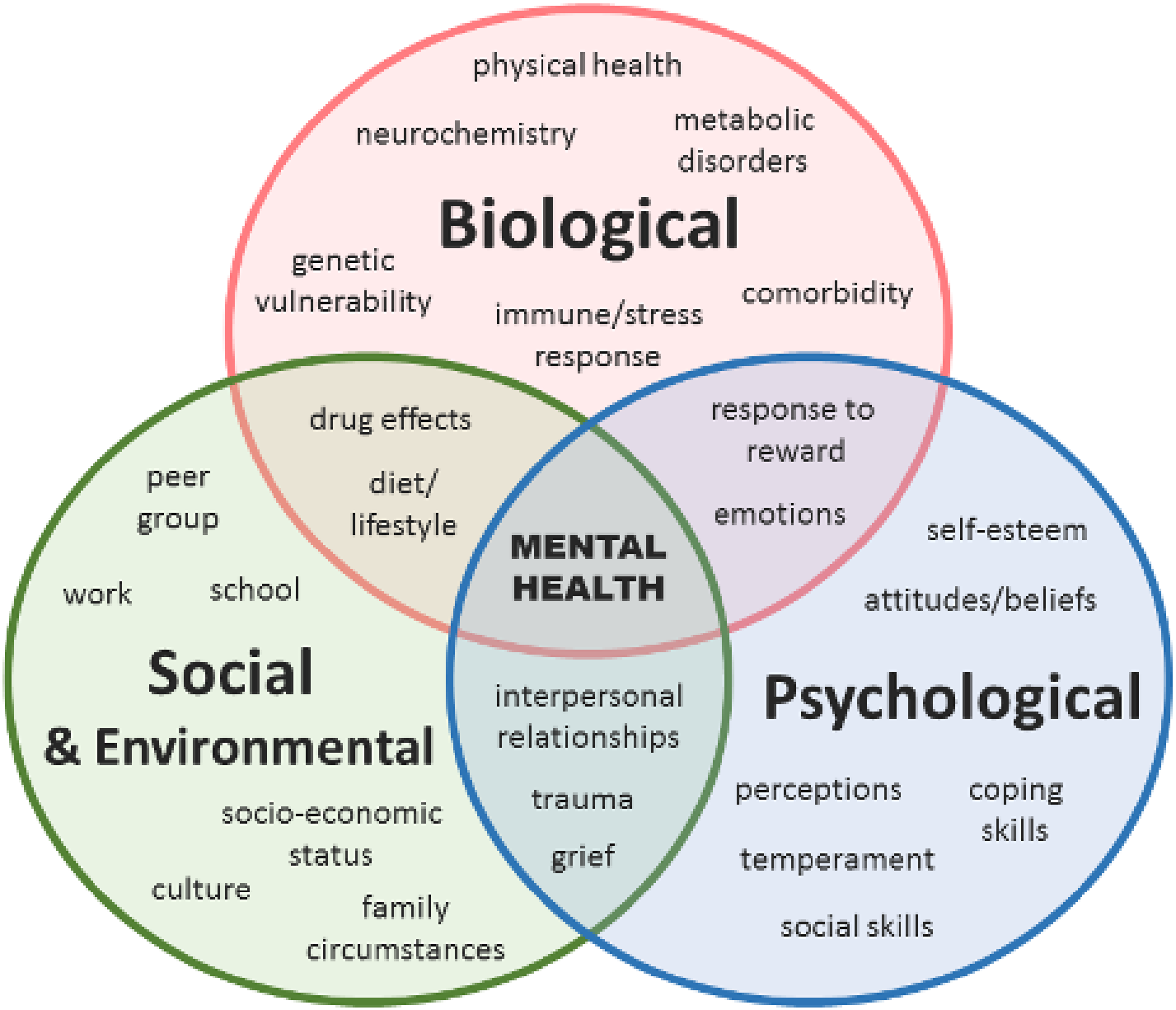
Differential Diagnosis “I feel down…”

- 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

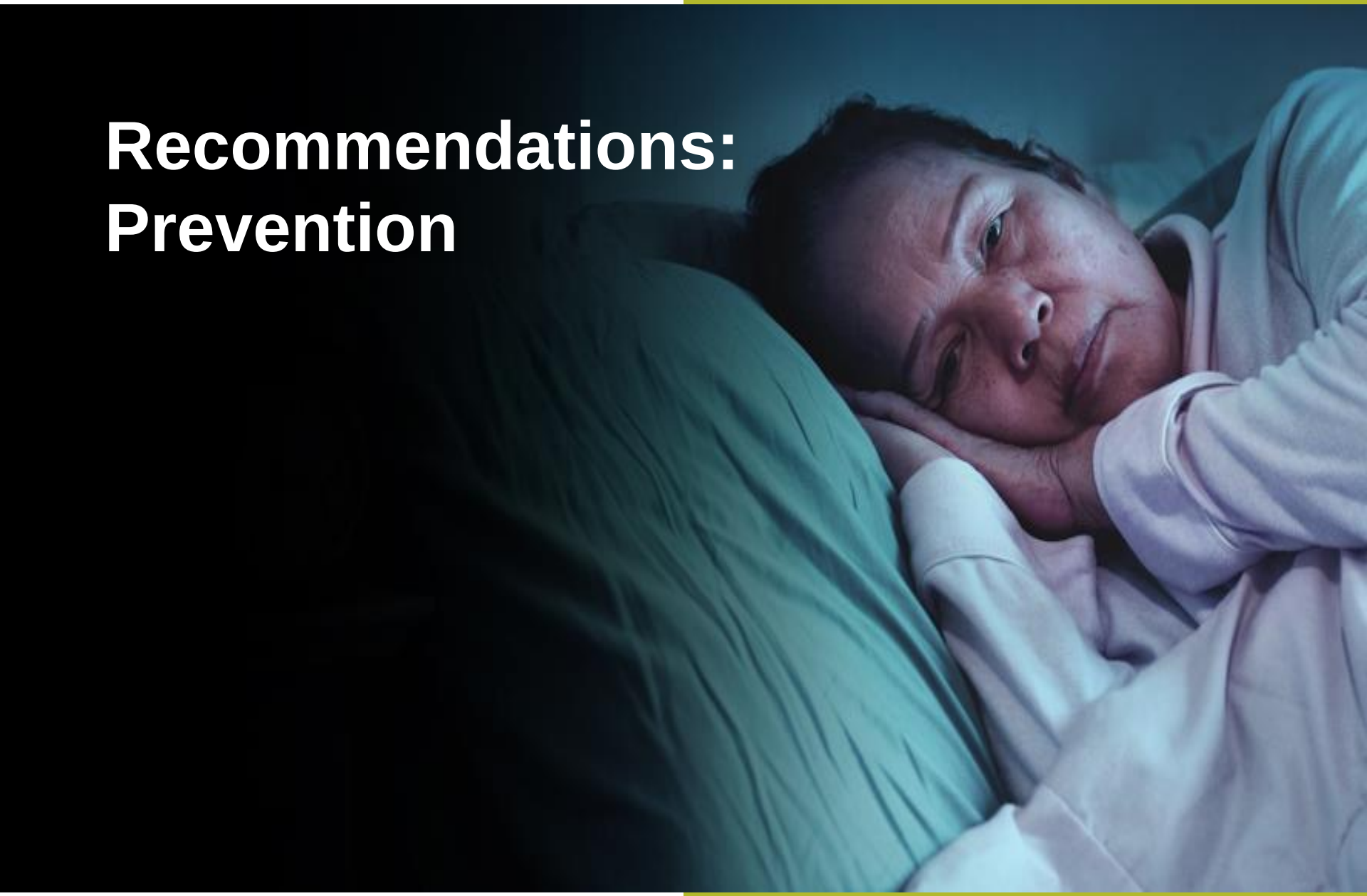
MDE Symptoms (DSM-5)

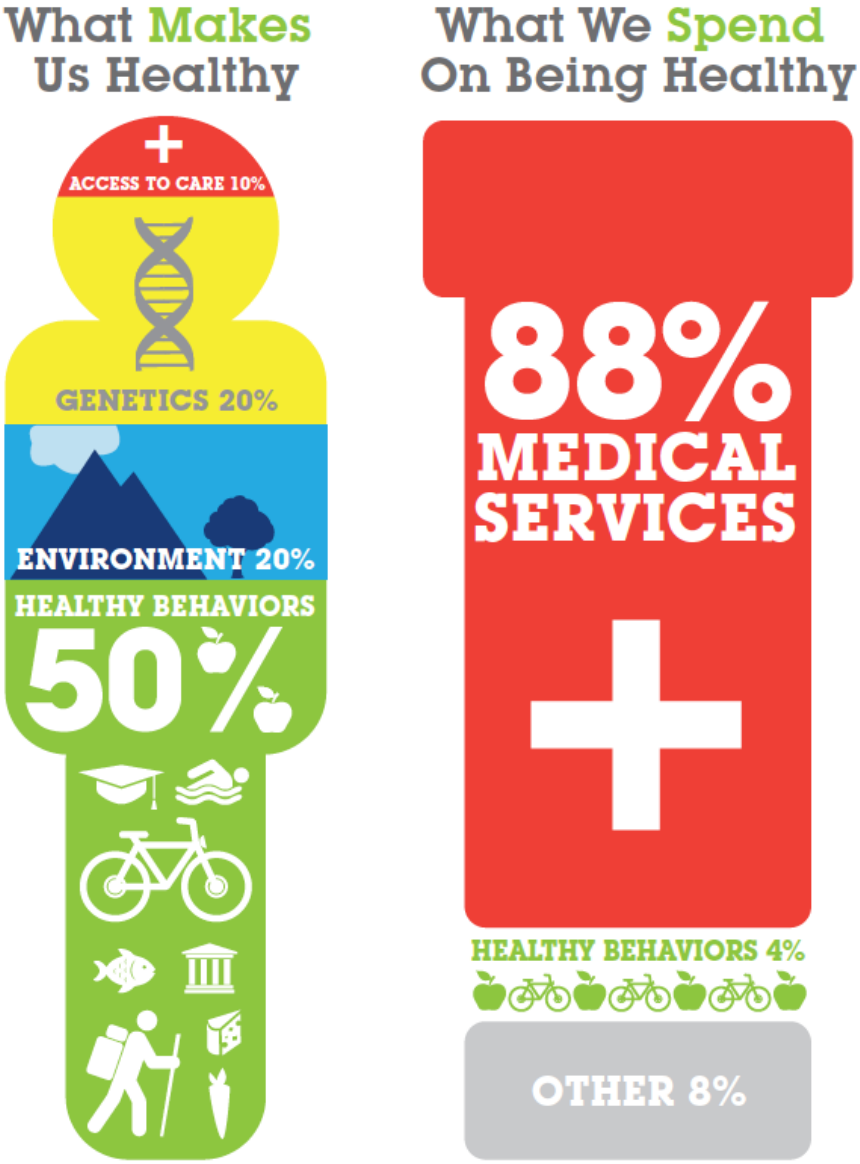
- *Depressed/empty
- *Anhedonia
- Sleep (less or more)
- Appetite (less or more)
- Reduced energy
- Poor concentration
- Guilt or worthlessness
- Psychomotor slowing or restlessness
- Thoughts of death or suicide
- Distress or impairment in functioning X 2 weeks
- 5/9 symptoms

The Bio-Psycho-Social Model



Recommendations: Prevention





Data courtesy of the Boston Foundation and the New England Healthcare Institute

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.

CCSMH Guidelines - Recommendations

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]

Systematic reviews: Quan et al., (2019), *Aging Mental Health,*
Franck et al., (2016), *Qual Life Res.*

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

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**]

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]

Recommendations regarding subtypes of depression

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

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.

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

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.

MODELS OF CARE

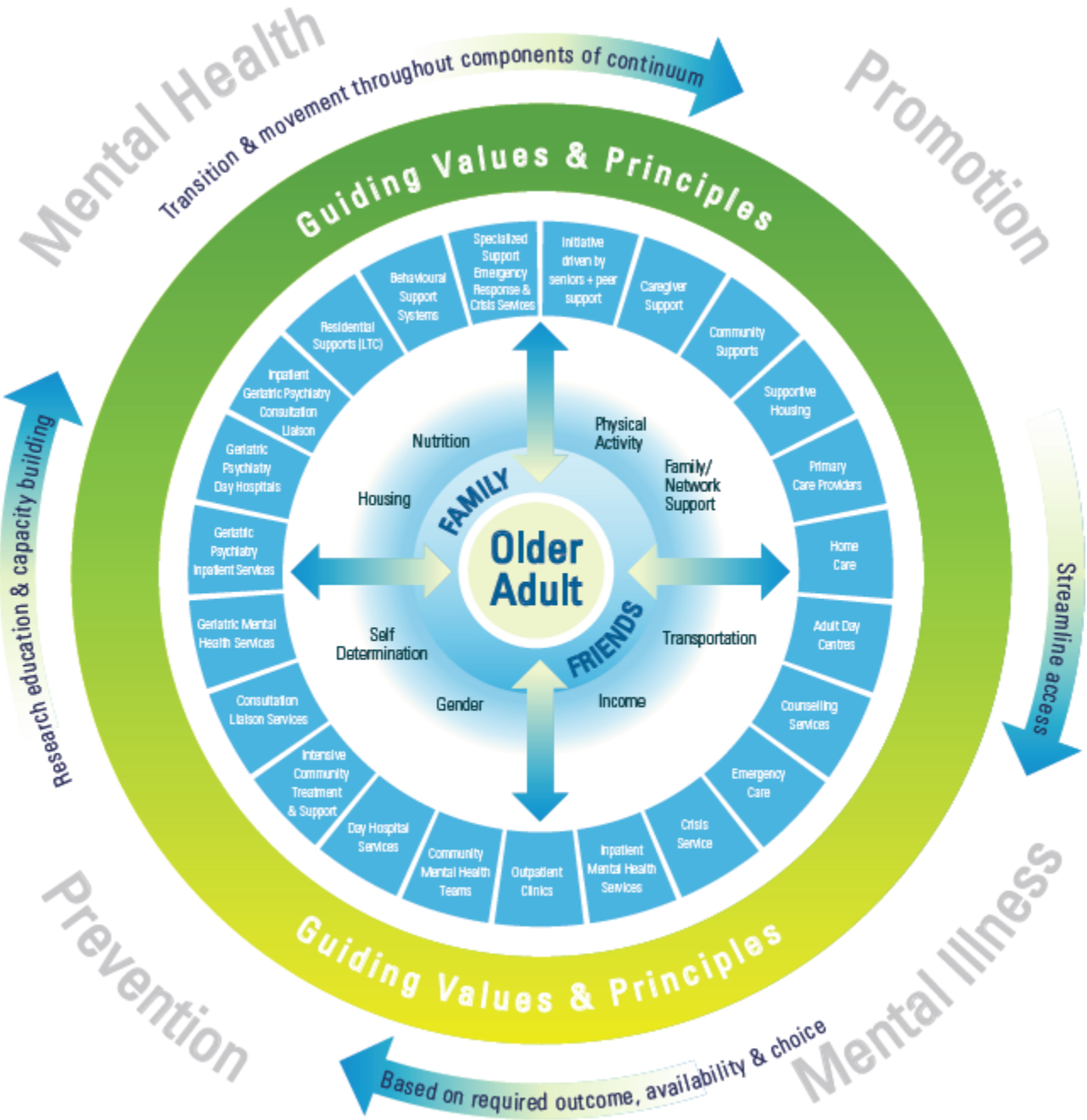
Recommendations: Models of Care

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]**

Mental Health Commission of Canada

Commission de la santé mentale du Canada

Guidelines for Comprehensive Mental Health Services for Older Adults in Canada


Mental Health Promotion
Transition & movement throughout components of continuum
Guiding Values & Principles
Specialized Support Emergency Response & Crisis Services
Initiative driven by seniors + peer support
Caregiver Support
Community Supports
Supportive Housing
Primary Care Providers
Home Care
Adult Day Centres
Counselling Services
Emergency Care
Crisis Service
Inpatient Mental Health Services
Outpatient Clinics
Community Mental Health Teams
Day Hospital Services
Intensive Community Treatment & Support
Consultation Liaison Services
Geriatric Mental Health Services
Geriatric Psychiatry Inpatient Services
Geriatric Psychiatry Day Hospitals
Inpatient Geriatric Psychiatry Consultation Liaison
Residential Supports (LTC)
Behavioural Support Systems
Physical Activity
Family/ Network Support
Transportation
Income
Gender
Self Determination
Housing
Nutrition
FAMILY
FRIENDS
Older Adult
Streamline access
Based on required outcome, availability & choice
Prevention Mental Illness
Research education & capacity building

ORDER OF EXCELLENCE

CANADA AWARDS FOR EXCELLENCE / PRIX CANADA POUR L'EXCELLENCE 2017

MENTAL HEALTH AT WORK® RECIPIENT

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

Compendium of Good Practices for Improving Seniors Mental Health in Canada

A resource to support the implementation of *Guidelines for Comprehensive Mental Health Services for Older Adults*

Compiled by Marie-France Tourigny-Rivard, MD, FRCPC

Mental Health Commission of Canada

mentalhealthcommission.ca

Model Services & Programs

- Promotion & prevention
  - Fountain of Health
  - Mental Health First Aid Seniors
  - Peer Support Service
  - Community Outreach to reduce isolation
- Collaborative Mental Health Services
  - Shared care model

The Fountain of Health Initiative
www.fountainofhealth.ca

Bringing Seniors' Mental Health Promotion into Clinical Practice

fountain of health

Why are we not there?

"While evidence clearly shows **lifestyle interventions and behavior change** to be the **most effective first-line of therapy for reducing chronic disease**, **the majority of physicians are not following these guidelines**, citing lack of knowledge, skill, or confidence in counseling patients about lifestyle interventions"

American College of Preventive Medicine http://www.acpm.org/

What is the Fountain of Health?

- Canadian initiative
- Translates science of brain neuroplasticity & resilience to:
  - Public
  - Healthcare providers

- Promote brain health by modifying key health behaviours
  - **Tools clinical practice to promote health**
  - **Move beyond illness treatment**
  - **Based in Cognitive Behaviour Therapy (CBT)**

- Build a movement for optimal aging:
  - Support Age Friendly Communities

FoH 5 Key Areas of Focus

fountain of health

- Social Activity
- Positive Thinking
- Physical Activity
- Mental Health
- Lifelong Learning

FOH Clinical Tools

Clinician Tools Are:

- Quick and simple to use (about 10 minutes).
- CBT-based (with SMART goal setting).
- Evidence- based (with outcome measures).

How To:

STEP #1: Get a baseline

STEP #2: Set a SMART goal, keep a record

STEP #3: Follow up (over 2 visits) & evaluate impact

International Psychogeriatrics (2019), 31:2, 173–180 © International Psychogeriatric Association 2018
doi:10.1017/S1041610218000480

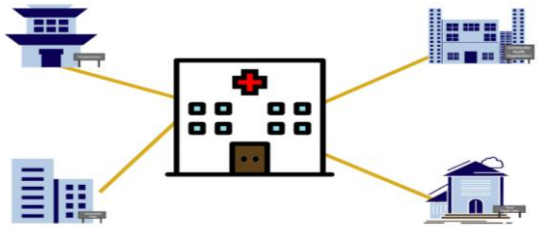
The Fountain of Health: effective health promotion knowledge transfer in individual primary care and group community-based formats

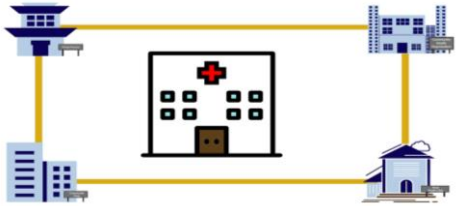
Amy Gough,[1] Beverley Cassidy,[1] Kiran Rabheru,[2] David Conn,[3] Donaldo D. Canales[4] and Keri-Leigh Cassidy[1]

[1] *Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia, Canada*
[2] *Department of Psychiatry, University of Ottawa, Ottawa, Ontario, Canada; The Ottawa Hospital, Ottawa, Ontario, Canada*
[3] *Department of Psychiatry, Baycrest Centre, University of Toronto, Toronto, Ontario, Canada; Baycrest Health Sciences, Toronto, Ontario, Canada*
[4] *Research Services, Saint John Regional Hospital, Saint John, New Brunswick, Canada*

What is Project ECHO®?

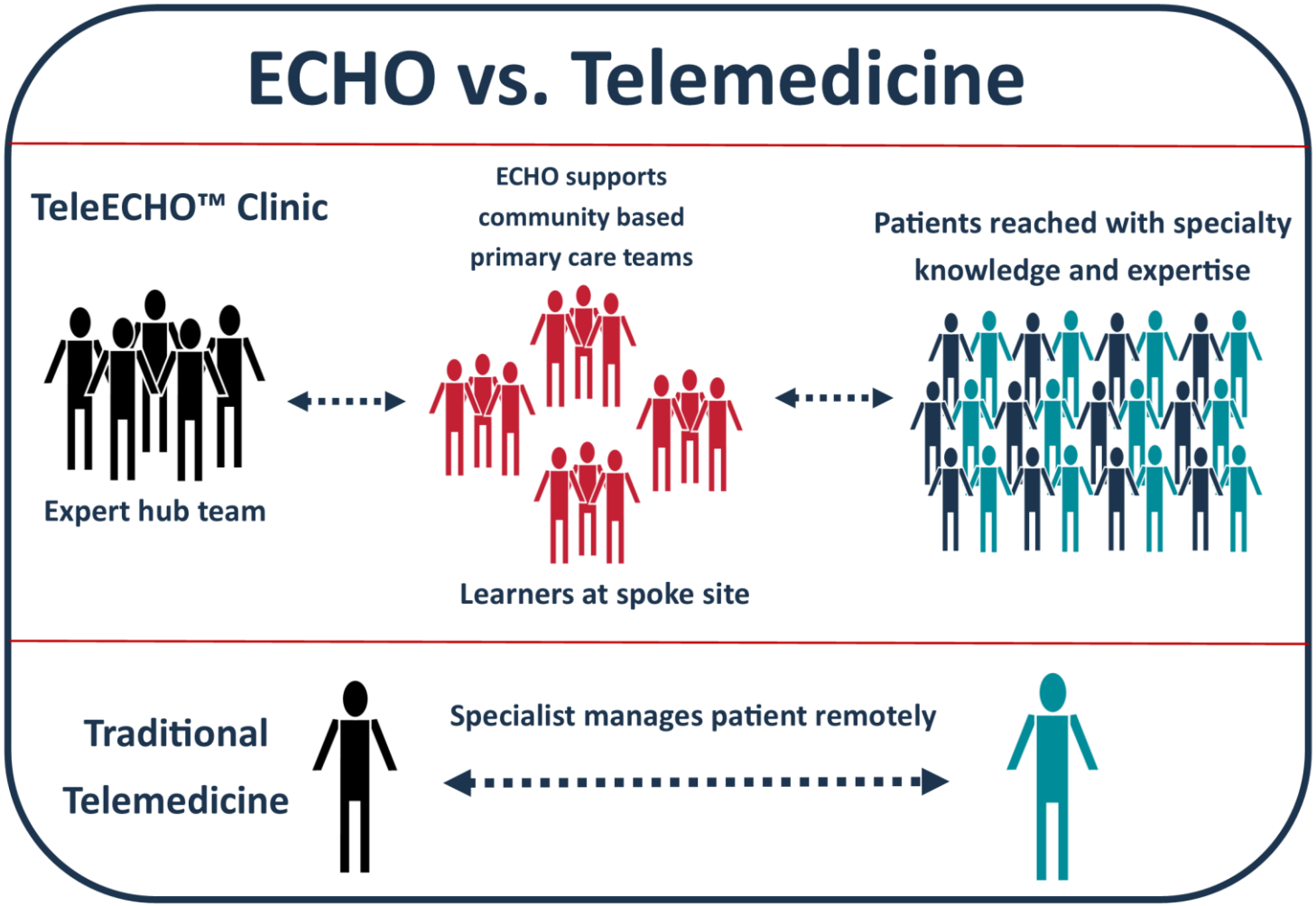
- **Project E**xtension of **C**ommunity **H**ealth **O**utcomes
- Education program created by Dr. Sanjeev Arora in 2003 at University of New Mexico
- Establishes hub-and-spoke knowledge-sharing networks between with academic health science centres and community care partners
- Multidirectional Learning
- Uses videoconferencing to build capacity usually focused on primary care providers





The model has now spread to > 50 countries around the globe. In Canada – Ontario has invested in ECHO programs. Baycrest in partnership with the NE Specialized Geriatric Centre has been running ECHOs since 2018 focused on care of older adults.

ECHO vs. Telemedicine



Anatomy of a Typical ECHO Session

one and a half hours per session

Learning Partners sign up to attend a weekly program

Short Didactic
20 – 30 mins

Case presented by one of the learners

Facilitated Discussion

Recommendations

ECHO Hubs

Hubs 463

Countries 52

Click to view

Hubs | Programs

Search for Hubs

Search

Filter by Content Focus

All

Filter by Hub Country

All

Filter by Hub State/Region

All

Hub	Focus	Website	Email	Hub City	Hub St./Pr./Reg.	Hub Country
Banner Health DBA Banner Alzheimer's Institute	Healthcare, Behavioral and Mental Health			Phoenix	Arizona	United States
Baycrest Centre for Geriatric Care	Healthcare, Infectious Diseases, Covid-19, Complex Care, Geriatrics, Neurology			Toronto	Ontario	Canada
Baylor College of Medicine	Healthcare, Infectious Diseases, Covid-19, HIV, Tuberculosis			Houston	Texas	United States
Baylor St. Luke's Medical Center	Healthcare, Cardiology, Infectious Diseases, Hepatitis B, Hepatitis C, Gastroenterology			Houston	Texas	United States
Baystate Medical Center Inc.	Healthcare, Geriatrics			Springfield	Massachusetts	United States
BC Centre for Palliative Care	Healthcare, Palliative Care, Behavioral and Mental Health			New Westminister	BC	Canada
Beacon Health Options	Healthcare, Behavioral and Mental Health, Substance Use Disorders			Hialeah	Florida	United States

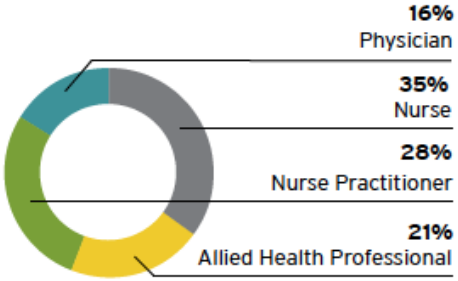
Please email any questions to:

Last Updated: 10/19/2021

ECHO Care of the Elderly: Community

Spring and Fall 2020

Primary Profession (n=108)



Years in Practice (n=108)

Quotes from Learning Partners

> Thank you very much for this ECHO course. It has been a great experience learning from other professionals from a variety of health disciplines. I very much appreciate the opportunities fostered by this program and hope to participate in more sessions in the future.

Knowledge

↑ 6% from pre-to-post ECHO

Self-Efficacy

↑ 20% from pre-to-post ECHO

100% would recommend to other providers.

Satisfaction Rating: 4.5

CURRICULUM

- Behavioural and Psychological Symptoms of Dementia
- Delirium
- Dementia
- Driving and Dementia
- Falls and Bone Health
- Frailty
- Goals of Care
- Incontinence
- Medical Cannabis
- Mood Disorders
- Movement Disorders
- Nutrition and Appetite
- Pain
- Polypharmacy
- Sleep Disorders

JAMDA 22 (2021) 238–244

JAMDA

journal homepage: www.jamda.com

Original Study

Building Long-Term Care Staff Capacity During COVID-19 Through Just-in-Time Learning: Evaluation of a Modified ECHO Model

Navena R. Lingum MSc [a], Lisa Guttman Sokoloff MS [a], Raquel M. Meyer PhD [b], Shaen Gingrich BHSc(Hon), MPT [c], Devin J. Sodums MSc [d], Anna Theresa Santiago MPH, MSc [d], Sid Feldman MD [e,f], Stacey Guy PhD [b], Andrea Moser MD [f], Salma Shaikh MD [a], Cindy J. Grief MSc, MD [g], David K. Conn MB [a,g,*]

[a] *Centre for Education and Knowledge Exchange in Aging, Baycrest, Toronto, ON, Canada*
[b] *Ontario Centres for Learning, Research and Innovation in Long-Term Care, Baycrest, Toronto, ON, Canada*
[c] *North East Specialized Geriatric Services—a program of Health Sciences North, Sudbury, ON, Canada*
[d] *Kunin-Lunenfeld Centre for Applied Research and Evaluation, Baycrest, Toronto, Ontario Canada*
[e] *Apotex Centre, Jewish Home for the Aged, Baycrest, Toronto, ON, Canada*
[f] *Department of Family and Community Medicine, Baycrest, Toronto, ON, Canada*
[g] *Department of Psychiatry, Baycrest, Toronto, ON, Canada*

Establishing a Canadian National ECHO Educational Program focused on Mental Health of Older Adults

David Conn, Lisa Sokoloff, Claire Checkland, Jasmeen Guraya, Vivian Ewa, Sid Feldman, Cindy Grief, Andrea Hunter, Navena Lingum, Ian MacKay, Kiran Rabheru, Anna Santiago, Dallas Seitz, Devin Sodums, Laurel Steed

IPA Virtual Congress 2021

Funded by RBC Foundation

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CANADIAN ACADEMY OF GERIATRIC PSYCHIATRY | ACADÉMIE CANADIENNE DE GÉRONTOPSYCHIATRIE

Baycrest

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.

Project ECHO®

Curriculum

6-WEEK

- Anxiety Disorders
- Engaging Caregivers & Care Partners
- Delirium
- Screening, Assessment & Diagnosis of Dementia
- BPSD & Management of Dementia
- Mood Disorders

10-WEEK

- Substance Use Disorders
- Suicide Risk & Assessment
- Consent & Capacity
- Promoting Wellness & Mental Health
- Cultural Sensitivity
- Late Life Psychosis/Schizophrenia
- End of Life & Palliative Care
- De-prescribing & Polypharmacy
- Sleep Disorders
- Loss, Grief & Bereavement

**curriculum was developed through a review of feedback from previous cycles and a needs assessment of physicians, interprofessional team members and older adults from across the country*

International Psychogeriatrics: page 1 of 6 © International Psychogeriatric Association 2013
doi:10.1017/S104161021300118X

Program evaluation of a telepsychiatry service for older adults connecting a university-affiliated geriatric center to a rural psychogeriatric outreach service in Northwest Ontario, Canada

David K. Conn,[1,2] Robert Madan,[1,2] Jenny Lam,[1] Tim Patterson[3] and Sandy Skirten[4,5]

[1] *Department of Psychiatry, Baycrest Centre, Toronto, Ontario, Canada*
[2] *Division of Geriatric Psychiatry, University of Toronto, Toronto, Ontario, Canada*
[3] *Telehealth Services, Baycrest Centre, Toronto, Ontario, Canada*
[4] *District Mental Health Service for Older Adults Program, Northwest Ontario, Ontario, Canada*
[5] *Canadian Mental Health Association, Fort Frances, Ontario, Canada*

Conclusions

- CCSMH is celebrating 20 years of national leadership in the field of seniors' mental health.
- The updated depression guidelines have expanded to include prevention strategies
- Greater emphasis on a variety of psychosocial interventions including physical activity
- Updates on evidence-based models of care including virtual care
- Some useful model programs were highlighted including the Fountain of Health and ECHO.

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

David Conn (dconn@baycrest.org)
Co-Chair, CCSMH

Claire Checkland
Executive Director, CCSMH

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To promote seniors' mental health by connecting people, ideas and resources.
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