

CANMAT 2023 UPDATE:
CLINICAL GUIDELINES FOR
THE MANAGEMENT OF MDD IN ADULTS



QUESTION 1:

What Are Important
Issues for Assessment
and Diagnosis?

What are important issues for assessment and diagnosis?



According to the **WHO (2020)** estimates, **>300 million individuals worldwide are living with MDD**



~12% of Canadians (≥ 12 years old) reported a **lifetime episode of MDD** and **4.7%** experienced an **MDE** within the last year



MDD may lead to **social and occupational impairment, diminished quality of life, and elevated risk of suicide**

Worldwide, depression is the second leading medical cause of disability

What are the risk factors for MDD?



Static, nonmodifiable risk factors

- Female sex
- Family history of mood disorders
- History of adverse childhood events/ maltreatment
- Death of spouse



Dynamic, potentially modifiable risk factors

- Chronic nonpsychiatric medical illnesses
- Psychiatric comorbidities, especially anxiety
- Alcohol and substance use disorders
- Insomnia, night shift work
- Periods of hormonal changes*
- Recent stressful life events
- Job strain/income inequality
- Bereavement
- Peer victimization/bullying/cyberbullying
- Gender dysphoria
- Sedentary lifestyle/screen time

*E.g., puberty, pregnancy, postpartum, and perimenopause. MDD, major depressive disorder. Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

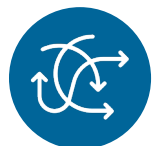
How and who should be screened for depression?



Up to **60%** of individuals with MDD are **unrecognized or misidentified** in **primary care** settings



Routine screening involves **all patients or at-risk groups** **regularly completing screening** procedures at prespecified intervals



Routine depression screening **may improve outcomes** in settings where **additional interventions are available** for those screening positive 



Potential risks of routine screening include **stigmatization, impact on occupational or insurance status, and false-positives***

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*Prevalence and impact of these risks have not been rigorously evaluated.

MDD, major depressive disorder.

Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

How and who should be screened for depression?

CANMAT guidelines recommend depression screening 



Using a validated scale



In primary and secondary care settings



For patients who have risk factors



When resources are available for subsequent diagnostic assessment and treatment

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What screening tools can be used?

PHQ-2 Screening



Brief 2-item patient health questionnaire comprised of two items from the PHQ-9



Useful in primary care settings



Multiple languages and digital formats



Questions pertain to feelings of depression/hopelessness and anhedonia/lack of interest over preceding 2 weeks (scale of 0-3)



A PHQ-2 score of ≥ 2 is considered positive, and warrants follow up

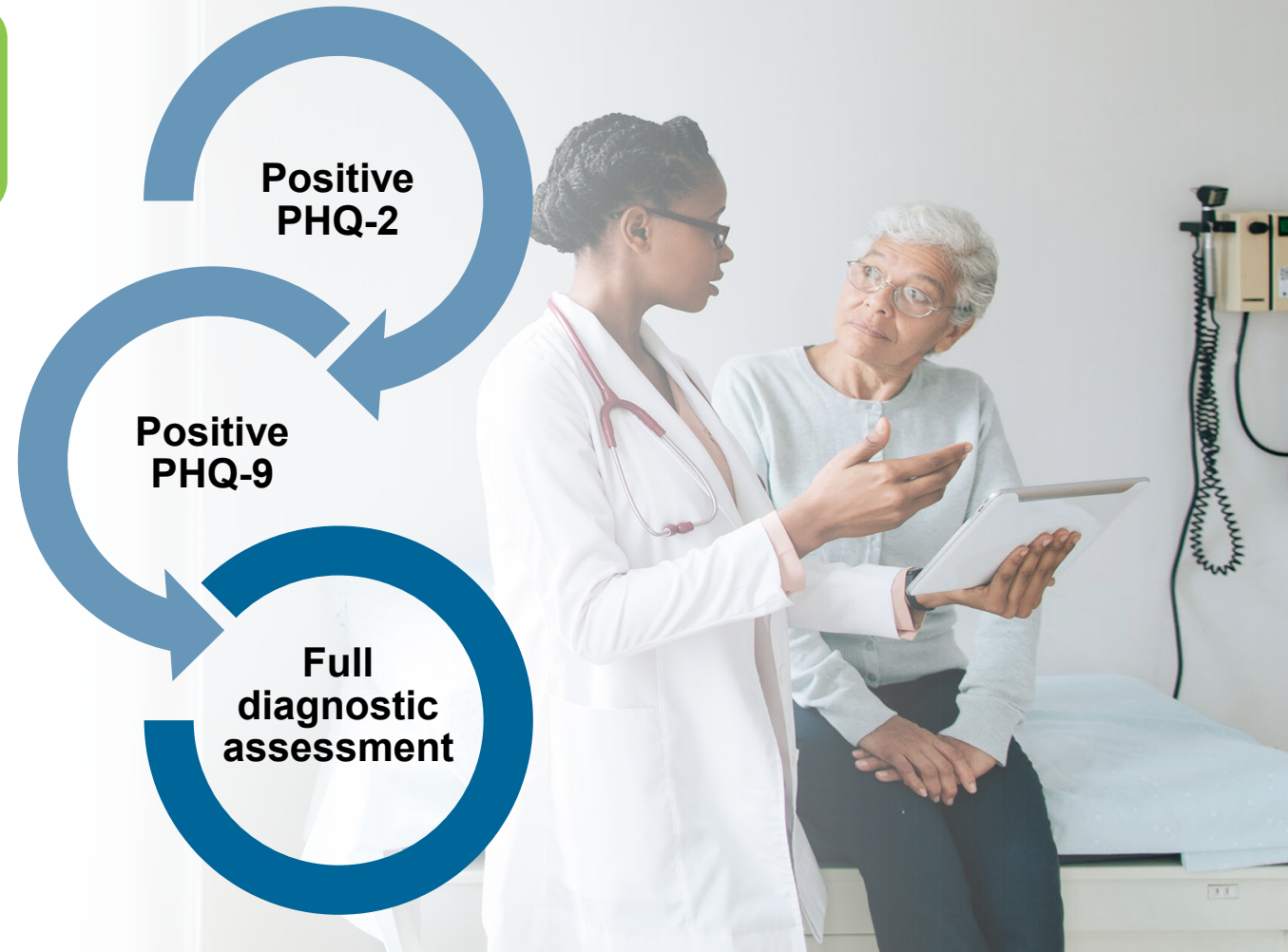
What screening tools can be used?

A positive PHQ-2 score should be followed by PHQ-9 screening



- A **positive PHQ-2** followed by a **positive PHQ-9** has a similar sensitivity but **better specificity** than PHQ-9 alone
- Positive screens should be followed by a **full diagnostic assessment**

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What factors are important in assessment and diagnosis?

Comprehensive diagnostic assessment is the first step in the clinical management of MD



Incorporate **diagnostic framework** (i.e., DSM-5-TR or ICD-11) and explore:

- Emotional, cognitive, and somatic symptoms
- Lifespan vulnerability and resiliency factors
- History of childhood maltreatment and/or stressful/traumatic experiences
- Collateral information
- Ethnocultural diversity

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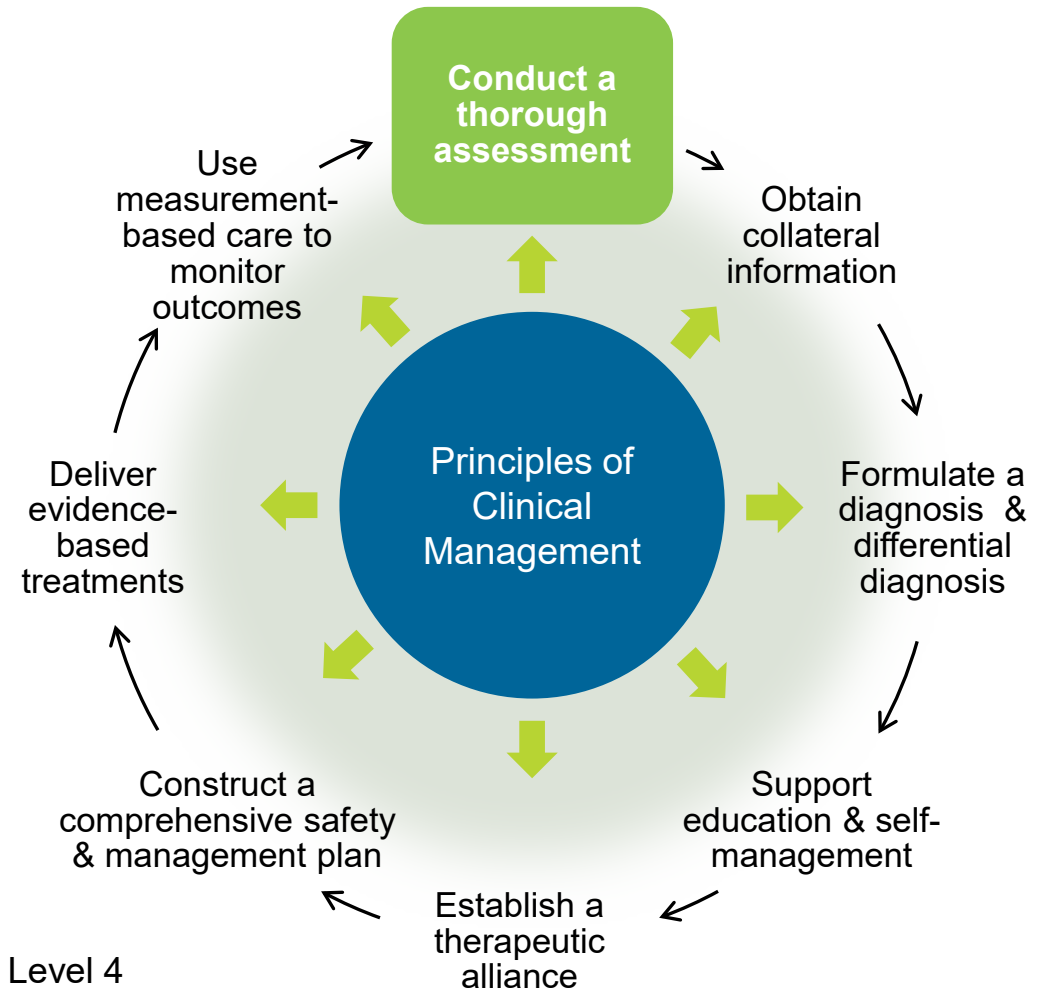
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What factors are important in assessment and diagnosis?

Formulate a diagnosis & differential diagnosis



Medical workup: detailed history and targeted physical exam to rule out nonpsychiatric medical conditions



Bloodwork: CBC and TSH are low-cost tests that may help rule out anaemia and thyroid dysfunction 



Additional lab tests only if: history/exam suggests other conditions, medical comorbidities, substance use disorders, older adults, self-neglect, impaired judgement or communication 



ECG, EEG, or neuroimaging diagnostic tests only if clinically indicated 

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What are diagnostic specifiers and symptom dimensions?

DSM-5-TR specifiers describe symptom & course patterns of an MDE



Episode specifiers (cross-sectional symptoms & features)

- Melancholic
- Atypical
- Psychotic
- Catatonic
- Anxious distress
- Mixed features



Course specifiers (longitudinal patterns)

- Seasonal
- Peripartum onset

Specifiers have some utility for prognosis but limited value for treatment selection*

Additional clinical dimensions (not identified in DSM-5-TR) may better guide treatment selection



Cognitive dysfunction



Sleep disturbance



Somatic symptoms



Anhedonia

*Except for psychotic features and seasonal patterns.

DSM-5, Diagnostic and Statistical Manual, 5th edition, Text Revision; MDE, major depressive episode.
Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

What are diagnostic specifiers and symptom dimensions?

20-30% of individuals with MDEs have a chronic course exceeding 2 years

Persistent Depressive Disorder
≥2 depressive symptoms present for more than 2 years



PDD specifiers: chronic MDE (full criteria), MDE in partial remission, or dysthymia (chronic course of subthreshold depressive symptoms that do not meet criteria for MDE)*



Patients with PDD: lower response rates to standard treatment and less likely to achieve remission than patients with episodic MDEs



PDD management: employ DTD framework and focus treatment on improving quality of life and functioning instead of symptom remission



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*Specifier conflation makes it difficult to differentiate specific treatments for PDD.

DTD, difficult-to-treat depression; MDE, major depressive episode; PDD, persistent depressive disorder.

Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

How can access for equity deserving groups be improved?

Lack of access and underutilization of mental health services in equity-deserving groups



Prevalence of MDD is higher in **racialized, Indigenous, gender minority, and certain religious populations**



Barriers to care: cost, cultural beliefs, stigma, language, fear of judgment, geographic disparities, fragmented health services



Overcoming barriers: screening programs, culturally competent and collaborative care, digital health interventions



How can access for equity deserving groups be improved?



Screening

Routinely screen for depression in equity-deserving groups using validated scales (i.e. PHQ)



Cultural competency

Sociocultural and language needs are explicitly addressed



Trauma informed approaches

E.g., influence of transgenerational and other traumas for Indigenous patients



Collaborative care

Including case managers, primary care providers, and mental health specialists



Telehealth & DHIs

Telehealth in preferred language can improve access and outcomes



DHIs can enhance service delivery but limited by digital literacy and cost



Training mental health professionals in cultural competency, trauma-informed care, healthcare disparities, and personal bias improves care and access for equity-deserving groups

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Recommendations for MDD screening and assessment

Summary Recommendations

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Carry a high index of suspicion for MDD in individuals with exposure to static nonmodifiable risk factors and dynamic, potentially modifiable risk factors



Screen for depression using a validated scale (e.g., PHQ-2 followed by the PHQ-9) in individuals with risk factors for depression, when there are supports and resources in place to follow up with full diagnostic assessment and treatment



Conduct a comprehensive diagnostic assessment that addresses biological, psychological, and social factors while recognizing ethnocultural diversity, within a longitudinal life-course framework



For equity-deserving groups in particular, use screening, culturally competent care, collaborative care, and DHIs to improve access to and quality of mental health care



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