CANMAT 2023 UPDATE:

CLINICAL GUIDELINES FOR THE MANAGEMENT OF MDD IN ADULTS

QUESTION 2:

What Are the Principles for Depression Management?

What are the phases and objectives of treatment?

Treatment goals should be individualized using a patient-centered approach that promotes shared decision-making to determine relevant outcomes

General objectives of MDD treatment

Achieve symptomatic remission

Recover full functioning

Restore quality of life

Prevent recurrence

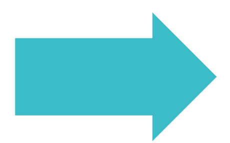
Ensure safety and treatment acceptability

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

Main objectives by treatment phase

2-phase treatment model

Acute phase
Address patient safety
Select evidence-based treatments
Improve symptom severity and functioning



Maintenance phase
Consolidate symptom remission
Restore functioning and QoL
Promote resilience
Prevent symptom recurrence

Psychoeducation and self-management are integral to MDD management

- **Psychoeducation**: knowledge and information about symptoms, coping strategies, and treatment options
- **Self-management:** techniques to empower patients to actively manage their illness and live well

LoE, Level of Evidence Level 1 Level 2 Level 3 Level 4

MDD, major depressive disorder; QoL; quality of life.
Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

Acute phase of treatment

Goals: Address patient safety and select evidence-based treatments to improve symptom severity and functioning

- Approximately **8-16 weeks**, until symptom remission

Address patient safety

- Assess suicide and safety risks
- Define treatment setting
- Develop a safety plan

Treat to symptom remission and functional improvement

- Establish rapport & therapeutic alliance
- Psychoeducation and self-management
- Implement evidence-based treatment(s)
- Monitor tolerability, adherence, response, and side effects

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Maintenance phase of treatment

Goals: Consolidate symptom remission, restore functioning and QoL, promote resilience, and prevent symptom recurrence

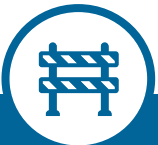
- Approximately **6-24 months** following acute phase (longer if clinically indicated)

Maintain symptomatic remission

- Evidence-based adjustments to treatment(s)
- Address residual symptoms

Restore functioning and QoL to premorbid levels

- Psychoeducation and self-management
- Treat comorbidities
- Additional psychosocial interventions



Prevent recurrence

- Psychoeducation to identify early symptoms for early intervention
- Monitor long-term side effects and adherence issues
- Address barriers to care
- Promote resilience

Consolidate gains during treatment discontinuation

- Discontinue treatments when clinically indicated
- Evidence-based approaches when stopping treatment
- Continue treatment when discontinuation is not indicated

QoL, quality of life.

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

Why is symptom remission important?

Symptom remission remains a crucial clinical target for acute treatment

- **Reduces risk of relapse**
- Failure to achieve remission is associated with continued **symptom burden and poor functional outcomes**
- However, patients often prioritize **functioning and QoL** more than the absence of symptoms

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QoL, quality of life.

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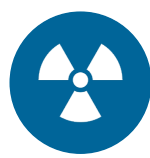
Persistent depressive symptoms



A common and **major risk factor for disease recurrence**

Isolated, mild, and intermittent symptoms can be treated using a **symptom-targeted approach** with a focus on **patient comfort and functionality**

Some patients **may not achieve symptom remission** despite treatment with several evidence-based approaches

Therapeutic focus for patients with DTD should shift from symptom remission to prioritizing the best possible **improvement in functioning and QoL**

DTD, difficult-to-treat depression; QoL, quality of life.
Lam RW, Kennedy SH, Adams C, et al. Can J Psychiatry. 2024 Sep;69(9):641-87.

How are suicide and safety risks managed?

MDD risk management should prioritize suicide risk assessment and safety planning

- Risk of suicide attempts in **individuals with MDD is 5-fold higher** than the general population
- In Canada, there are **~15 deaths by suicide per 100,000 males** and **~5 deaths per 100,000 females**, representing **more than 4,000 suicide deaths** per year
- Among those who die by suicide, **about half suffer from MDD**

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Suicide risk assessment

- Should be a **routine part of psychiatric interviews** (especially in ER settings)
- Should aim to make patients feel genuinely listened to and validated
- Focus should be to understand:
  - Basis for **suicidal ideation/behaviour**
  - Personal **strengths and protective factors** to leverage for **safety planning**
  - **Foreseeable changes**
  - Modifiable **risk factors**

Potentially modifiable risk factors for suicide in MDD

Symptoms and life events

- Suicidal ideation with a well-developed plan and/or intent to act
- Hopelessness
- Anxiety
- Impulsivity
- Psychotic symptoms
- Stressful life events

Comorbid conditions

- Substance use disorders (especially alcohol)
- Personality disorders (especially cluster B)
- PTSD
- Sleep disorders
- Chronic painful medical conditions

ER, emergency room; MDD, major depressive disorder; PTSD, posttraumatic stress disorder.

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Suicide risk management

- Should prioritize individualized care, therapeutic risk management, and evidence-based safety planning

Goals of care for high-risk patients

Timely pharmacological & nonpharmacological treatments

Modify patient environment & circumstances

Monitor severity of suicidal ideation

Ensure regular follow-up

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

Suicide safety plan*

Identify **warning signs**
- E.g., thoughts, feelings, and circumstances

Enlist **personalized coping strategies**
- E.g., self-management

Enable **distraction and connect** with people
- E.g., go for a walk with a friend, use support groups or online forums

Engage with **social and community** supports
- E.g., involve personal contacts in contingency plans

Identify **professional contacts**
- E.g., crisis lines, mental health providers, urgent care clinics, ERs

Make the **environment safe**
- E.g., remove excess medications, firearms, sharp objects, or ropes

*Adapted from Hawton et al. Lancet Psychiatry 2022;9:922-928.
ER, emergency room.
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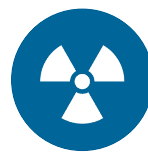
Tools for suicide and safety risk management

Validated suicide risk scales have **low sensitivity and predictive power** for suicide behaviours and should ***only* be used with clinician judgment**



Inpatient treatment settings may be warranted for **patients at high risk (e.g., suicidal ideation with intent to act and/or psychotic symptoms)**

Risk of suicide increases in the **month after initiating or stopping an antidepressant,** requiring enhanced surveillance and safety planning

In Canada and the United States calling or texting **9-8-8 allows rapid access to help** for individuals, family members, or clinicians

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What is the role of patient preference?

Patient preference plays a key role in depression management

- **Shared decision-making** helps **establish a strong therapeutic alliance**, facilitating:
  - **Mutual contributions** to the decision-making process
  - **Psychoeducation** about critical aspects of treatment
- **Shared decision-making is recommended to improve the care experience** for people with MDD
- **Patient preference** should especially be considered with other clinical factors when **selecting treatment options** including psychological and pharmacological interventions

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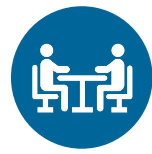
Considerations for shared decision-making

Explain the range of MDD treatments: lifestyle changes, self-management, psychotherapy, pharmacotherapy, neuromodulation, and CAM

Educate on how treatments work: dispel myths and stigma and provide psychoeducational aid (e.g., CHOICE-D patient and family guide)*



Discuss local realities of the healthcare ecosystem: e.g., limitations to accessing evidence-based psychological and neuromodulation treatments

Provide preferred treatments: agree on treatment plan, explain recommendations, and provide alternatives so patients can select and adhere to a plan that aligns with their values and needs

*CHOICE-D is a free downloadable psychoeducational patient and family guide to depression treatment developed by CANMAT; available at www.CANMAT.org.
CAM, complementary and alternative medicine; CANMAT, Canadian Network for Mood and Anxiety Treatments; MDD, major depressive disorder.
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How does treatment cost and access influence management?

Public healthcare

May offer limited or no access to some evidence-based treatments, especially psychological, neuromodulation, or infusions

Private healthcare

May provide more options but cost may be a significant barrier to access for many patients

- Newer agents are generally more expensive than older agents available in generic formulations
- **Be familiar with the cost of treatment** and a patient's **insurance coverage and ability to pay**

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What lifestyle interventions are effective?

Different lifestyle factors have been implicated in the risk of developing MDD and worsening symptom severity

Lifestyle modifications that are beneficial in MDEs

Exercise/increase physical activity

Healthier diet

Smoking cessation

Sleep hygiene

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Substantial evidence for the efficacy of exercise for MDD

- **Supervised exercise* recommendations:**
  - **1st-line monotherapy for mild MDD**
  - **2nd-line adjunctive treatment for moderate severity MDD**
- Exercise can reduce **suicidal ideation** and provide benefit when **combined with antidepressants**
- **Meta-analyses show benefits in reducing depressive symptoms:**
  - **Moderate-high** intensity supervised aerobic activity in adolescents & young adults
  - **Low-moderate** intensity in midlife & older women
  - **High-intensity** interval training in adults

*Low to moderate intensity for 30 to 40 minutes, 3 to 4 times weekly for minimum of 9 weeks

LoE, Level of Evidence Level 1 Level 2 Level 3 Level 4

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Maintaining healthy sleep and circadian rhythms

- **Sleep hygiene recommendations:**
  - **Adjunctive sleep hygiene with CBT-I as 2nd-line treatment**
  - **Adjunctive sleep deprivation as a 3rd-line treatment**
  - **Instructing patients on sleep hygiene**
- **Sleep disturbances** are common **symptoms of MDEs**
- **Disturbed sleep** increases risk of **developing MDD**
- **Restoring restful sleep** is an **important objective** of MDD treatment and prevention
- **Sleep deprivation/wake therapy*** may have a rapid but transient antidepressant effect

***Caution:** sleep deprivation may **precipitate hypomanic episodes** in individuals not previously diagnosed with bipolar disorder

LoE, Level of Evidence Level 1 Level 2 Level 3 Level 4

CBT-I, cognitive behavioural therapy for insomnia; MDD, major depressive disorder; MDE, major depressive episode.

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Light therapy

- **Light therapy* recommendations:**
  - **1st-line monotherapy for seasonal (winter) MDE**
  - **2nd-line for mild severity nonseasonal MDE**
  - **Adjunctive for moderate severity nonseasonal MDE**
- **Natural light exposure** is important for maintaining **circadian rhythmicity**
- **Light therapy** is a chronobiological intervention in which a device delivers timed exposure to supplemental bright light

*10,000 lux white light for 30 minutes daily

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MDE, major depressive episode.
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Diet and dietary interventions

- **Diet recommendations:**
  - **Adjunctive healthy diet* is a 3rd-line treatment**
  - **Adjunctive Mediterranean diet**
- **Unhealthy diet**** has been associated with **increased prevalence and severity of depressive symptoms**
- There are **few interventional studies** exploring **diet manipulation** in MDD
- Evidence regarding **newer interventions** such as **probiotics is equivocal**

*Varied diet with high content of fruit, vegetables, and fibre, and low in saturated fat and carbohydrates

LoE, Level of Evidence Level 1 Level 2 Level 3 Level 4

**High in saturated fats and carbohydrates and low fruit and vegetable content.
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Summary of recommendations for lifestyle interventions

Line of treatment	Lifestyle intervention	Level of evidence
1st Line	• Supervised exercise (low-moderate intensity, 30-40 min, 3-4 times/week for a minimum of 9 weeks) for MDE of mild severity	Level 1
	• Light therapy (10,000 lux white light for 30 min/day) for MDEs with seasonal (winter) pattern	Level 1
2nd Line	• Light therapy for mild severity nonseasonal MDE	Level 2
	• Adjunctive exercise for moderate severity MDE	Level 2
	• Adjunctive light therapy for moderate severity nonseasonal MDE	Level 2
	• Adjunctive sleep hygiene and CBT-I	Level 3
3rd Line	• Adjunctive healthy diet (varied diet with high fruit, vegetable, and fibre content, and low saturated fat and carbohydrates)	Level 3
	• Adjunctive Mediterranean diet	Level 3
	• Adjunctive sleep deprivation (wake therapy)	Level 3
Insufficient evidence	• Probiotics	n/a

LoE, Level of Evidence — Level 1 — Level 2 — Level 3 — Level 4

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Who delivers and monitors care?

Service delivery models that emphasize evidence-based treatments may be beneficial for the management of MDD

Stepped care

- Sequential treatments of increasing intensity as needed
- Patients usually enter at the least intensive step effective for their illness
- Patients move up or down depending on symptom progression or response
- Efficacious and cost-effective in managing depression

Stratified care

- Initial treatments customized to both the severity and complexity of patient needs
- Efficacious and cost-effective in managing depression

Collaborative care

- Primary care frameworks that emphasize multidisciplinary involvement
- Effective in reducing depressive symptoms and suicidal ideation
- Especially effective in patients with comorbid medical conditions and from equity-deserving groups

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