Post Stroke Depression Session Summary – Southeastern Ontario Primary Care/ Stroke Prevention Clinic Event February 2020

Depression is common after a stroke. Post stroke depression is associated with poorer functional outcomes, increased mortality and greatly impacts recovery. Routine post stroke depression screening is recommended. Screening helps identify those needing support for optimal recovery. At times, there is uncertainty about the management of post stroke depression (e.g., how to refer patients for timely access to psychiatry and mental health services).

Health care professionals surveyed during the preparation for this event, as well as from a previous similar event and discussion with Stroke Prevention Clinics (SPC) and the Vascular Protection Clinic (VPC), indicated a need to learn more about screening and management for post stroke depression. The following is a brief summary of the discussion and recommendations from the Post-Stroke Depression Session during the Southeastern Ontario Primary Care/SPC/VPC event held February 5th, 2020. For a more detailed summary of the Event, see Appendix A.

Barriers/Challenges for Screening/Managing Post Stroke Depression	Opportunities
A. Uncertainty about **screening** for depression after stroke	• Screen at all transitions along the care continuum and whenever indicated • Can use Patient Health Questionnaire (PHQ) 2 or PHQ9 ○ If PHQ2 is positive evaluate further using the PHQ 9 • If communication disorder, consider using the Stroke Aphasia Depression Questionnaire (SADQ) • Obtain collateral history from family/caregiver, nursing & allied health

B. Uncertainty about **how to refer patients** for services once patients screen positive for depression	• Establish formal referral processes
	• If patient screens positive for mild depression:
	  ○ Flag primary care provider for follow up
	  ○ May refer to mental health services
	  ○ Provide information about mood & local support groups (e.g., stroke support groups)
	• If patient screens positive for moderate to severe depression:
	  ○ Check medications/pharmacology
	  ○ Consider starting on antidepressant medication
	  ○ Refer to psychiatry early & connect to mental health services
	• Provide information about calling mental health Help Line
	• If patient has suicidal ideation, send to ED
	• Consider referral to Geriatric Psychiatry Outreach program, where available

C. **Limited access** to psychiatry and mental health services for stroke/TIA patients. Long wait times for psychiatry.	• Refer back to primary care • Some primary care teams have social work who can help with therapy and referral on to psychiatry • Consider using OTN or other telemedicine technology to make connections with psychiatry; Some physicians make use of e-Consult for psychiatry support

Barriers/Challenges for Screening/Managing Post Stroke Depression	Opportunities

D. Comfort level in **prescribing antidepressants** for patients post stroke	• Consult with pharmacist
	• Assess polypharmacy
	• Consider comorbidities
	• There can be drug/disease (e.g., liver disease) and drug/drug interactions (e.g., Warfarin with Fluvoxamine or Fluoxetine)
	• Selective Serotonin Inhibitors (SSRIs) are generally recommended -
	  o If cardiac history get an ECG. If prolonged QT interval, consider Paroxetine (Paxil)
	  o If no cardiac history get an ECG once
	  o Dosing-aim to increase after 2 weeks if no clinical improvement
	  o SSRIs can have cumulative bleeding risk so monitor with anticoagulation or antiplatelet therapy

E. Use of **non-pharmacological approaches**	• Cognitive Behavioural Therapy (CBT)
	  o Best for mild-moderate depression, or more severe when in combination with medications
	  o Offered in many primary care teams
	• Problem Solving Therapy
	  o Works best for mild to moderate depression
	  o Involves having smart goals
	  o Helps with functional day-to-day issues
	• Social Prescribing
	  o Most effective among patients with milder depression
	  o Community support groups, healthy lifestyle programs, etc.
	• Link with Mental health counsellors
	• Connect to therapeutic exercise programs
	• Consider virtual supports
	• On-line resources (e.g., Bounce Back Ontario)

F. Post stroke depression **with cognitive impairment, aphasia, or physical limitations**	• Use team approach o Include other disciplines in management (e.g., speech language therapy or occupational therapy)

<u>Summary:</u> Depression is common after stroke and can negatively impact recovery. Screen regularly for depression after stroke. For moderate-severe depression, refer early to psychiatry/mental health services +/- Geriatric Psychiatry Outreach where available (KFLA & Quinte). If moderate-severe depression, consider pharmacotherapy. Ask patients regularly about adherence. Connect patients to non-pharmacological interventions which may be most successful in combination with anti-depressants, as well as being more effective in patients with mild-moderate depression. Primary care teams have formal mental health processes. Primary care teams often have a social worker and/or occupational therapist that can assist with therapy and referral to psychiatry. Consider using telemedicine to make connections with psychiatry and other mental health services, if needed.

Resources

Screening Tools:

- To learn more about the PHQ9, click here
    - For a copy of the PHQ9, click here & the PHQ2, click here
- With significant aphasia may use Stroke Aphasia Depression Questionnaire (SADQ). Click here for more information about the SADQ

Seniors Mental Health Community and Behavioural Supports through Providence Care which includes Geriatric Psychiatry Outreach services in the Belleville, Napanee, Smiths Falls and Brockville areas.

Psychiatry:

- Psychiatry services in Southeastern Ontario (click top geographical area tabs to help narrow your search)
    - e-Consults for timely advice from psychiatry:
        - Ontario eConsult program

Cognitive Behavioural Therapy (CBT)

- To learn more about CBT, click here

On-line resources: Bounce Back Ontario for mild-moderate depression

Stroke Support Groups including Aphasia Supportive Conversation Groups & **Community Stroke Exercise** Programs: click here

CAMH for mental health information, click here

Canadian Stroke Best Practices: Mood and Cognition, click here

This resource list is not all-inclusive. Will be adding to this list-stay tuned!

Appendix A

Highlights from Post-Stroke Depression Session- Southeastern Ontario Primary Care/Stroke Prevention Clinic Event February 2020

1) What is your routine practice related to screening for Post Stoke Depression? Management of the patient who screens positive?

Stroke Prevention Clinics (SPC)/ Vascular Protection Clinic (VPC):

- SPC physicians and nurses often screen for depression. SPCs also screen for cognitive impairment using the Montreal Cognitive Assessment (MoCA)
- Some SPCs are uncertain about how to refer patients for services once patients screen positive for depression
- If the patient screens positive for mild depression:
    - flag to primary care for follow up
    - may refer to psychiatry or mental health services, if available
    - provide information about mood & local stroke support groups
        - Self-referral can be made to stroke support groups
- If the patient screens positive for major depression:
    - check medications/pharmacology
    - may start on medications
    - refer to psychiatry/mental health services
- Self-harm is explored. Information is given about calling the mental health help line

Primary Care:

- Screening is done using Patient Health Questionnaire (PHQ) 2 (first 2 questions of the PHQ9: low interaction in doing things, low mood), or PHQ 9(valid screen for post stroke depression). To learn more about the PHQ9, click here
    - For a copy of the PHQ9, click here & the PHQ2, click here
- If patient has suicidal ideation, they send patient to ED
- Have formal referral processes to psychiatry and mental health services
- If patient screens moderate to severe on PHQ9, they refer to psychiatry early; may start on pharmacotherapy
- Some primary care physicians are comfortable with prescribing pharmacotherapy, others less so
- Some primary care teams have social work embedded into practice. If patient screens mild, physician will refer to or discuss with a social worker, who can then refer on to psychiatry, as needed
- If social work is not embedded in the practice setting, then they refer to psychiatry
- At times, videoconference via OTN is used to make connections with psychiatry
- Community Health Centres may also have additional resources:
    - Cognitive Behavioural Therapy with social worker
- Make use of on-line mental health resources (e.g., on line Cognitive Behavioural Therapy)

Geriatric Psychiatrist:

- *The DSM-5 refers to "post stroke mood disorders as stroke with depressive features, major depressive-like episode, or mixed mood features" (DSM-5, pp 221-231)*
- Screen for depression post stroke and can use the PHQ9; there are other validated screens as well
- Screen also for cognitive impairment which often coincides with depression. Use the MoCA for screening for cognitive impairment
- Obtain collateral history from family and caregivers including nursing and allied health
- With significant aphasia may use Stroke Aphasia Depression Questionnaire (SADQ). Click here for more information about the SADQ
- Can be "watchful" waiting if symptoms are not severe

Other:

- Palliative care nurse will do a depression screen, refers back to primary care provider with a request for support

2) What challenges/ barriers to screening or managing depression do you identify in your practice?

- Some patients have no primary care physician or nurse practitioner
- Some areas have limited access to psychiatry for stroke/TIA patients (e.g., Lanark area)
- There is tremendous variability in access to resources both within and across the south east region
- Screeners outside of primary care who refer back to primary care feel a loss of control over what happens with the information they share; continue to feel concern for their patients with symptoms of depression
- Long wait times for psychiatry
- Some non-pharmacological approaches (e.g., Cognitive Behavioural Therapy and Problem Solving Therapy) may be less effective or not feasible with patients having cognitive decline or communication challenges
- Limited access to mental health group therapy for patients with stroke
- Some physicians are less comfortable in prescribing medications for depression in the setting of stroke
- Post stroke depression with cognitive impairment or aphasia or physical limitations
    - How could this be managed?
        - Include other disciplines such as speech language therapy, occupational therapy
        - Refer to Geriatric psychiatry outreach program, where available

3) What tools and resources are available to support you in your practice related to post-stroke depression?

Geriatric Psychiatry Outpatient programs

- Where available

Psychiatry

- Psychiatry e-consults; Some physicians are making use of e-consults with psychiatry

Cognitive Behavioural Therapy (CBT)

- Most effective if cognition is somewhat intact and with younger patients (<60)

- CBT + medications together – most effective
- Best for mild to moderate depression, or more severe when in combination with medications

Problem Solving Therapy

- Involves having smart goals
- Helps with functional day to day issues
- Works best for mild to moderate depression

Social Prescribing

- Get involved in community support groups, healthy lifestyle programs, etc.
- Most effective among patients with milder depression

Medications

- May need medications for non-pharmacological interventions to work
- Most primary care physicians are comfortable treating depression
- Use medications regularly if in moderate-severe range on PHQ9 scale or if depression symptoms are impeding rehabilitation progression in stroke recovery

Other

- Mental health counsellors
- Pharmacists
- Therapeutic exercise programs
- On-line resources (e.g., Bounce Back Ontario for mild-moderate depression)

4) Recommendations discussed

- Depression screening should be done at all points of transition – acute to rehabilitation to home and whenever indicated. The highest risk for post stroke depression is in the first 3 months but may develop at any point in the first year or beyond
- Be aware that a higher level of disability (including cognitive impairment) increases the risk for depression
- Non-pharmacological interventions may be most successful in combination with prescription anti-depressant medication, as well as being more effective in patients with mild-moderate depression

<u>Pharmacotherapy for post stroke depression</u>

- Depression is not managed differently because of the stroke itself. Consider other co-morbidities. There can be drug/disease interactions (e.g., liver disease) as well as drug/drug interactions (e.g., Warfarin with Fluvoxamine (Luvox) or Fluoxetine (Prozac)
- Older adults can be medically complex; co-morbidities increase with age; polypharmacy must be assessed
- Medication risk is unchanged for different stroke subtypes such as hemorrhagic vs. ischemic
- Selective Serotonin Inhibitors (SSRIs) are generally recommended for post stroke depression
    - SSRI's can have mild antiplatelet – hematological effect
    - Cumulative risk might increase so caution in patients on anticoagulant/ antiplatelet therapy

Psychiatrist – **"go to" SSRI medications for post stroke depression:**

1. a) Citalopram; b) Escitalopram (start with 5 to 10 mg)
    - Low drug-drug interactions and drug -disease interactions
2. Sertraline

- If cardiac history:
    - Get an ECG first and a cardiac profile
    - If prolonged QT interval – consider Paroxetine (Paxil)
- If no cardiac history: still check with ECG once
- High GI side effects and sexual dysfunction with Sertraline and Paroxetine
- Dosing –If no clinical improvement, aim to increase after 2 weeks