

Problems Solving Therapy for Depression in Older Adults: Research and Clinical Issues

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June 16, 2015

Key Objectives

1. Review the evidence for problem solving therapy (PST) for depression in older adults
2. Discuss the implementation and evaluation of problem solving therapy at Providence Care
3. Explore further opportunities for research studies in PST

My Problem

- I work in a geriatric psychiatry program with the equivalent of 1 psychiatrist and 7 full-time nurses. Many of the patients that we see would benefit from psychotherapy although I don't have time to do it and our nurses have not had extensive training. Only patients that can afford private psychotherapy have access to this so a lot of people miss out. I feel like I'm throwing pills at problems that would be better dealt with psychotherapy. Also need a psychotherapy service that will fit with our patient population and service needs.

My Goal

- To be able to offer time-limited, evidence-based psychotherapy as a part of our outreach program which our nurses could receive training in a brief period of time and could be implemented by nurses in routine care.

Possible Solutions

Solutions	Pros	Cons
Go with status quo	<ul style="list-style-type: none"> + Easy + Acceptable to nurses and me + Little time commitment 	<ul style="list-style-type: none"> - Not really going to be a great long-term solution - Patients are probably not going to get the best care - Our psychiatric service should be able to provide psychotherapy
CBT/IPT training for nurses	<ul style="list-style-type: none"> + I have some training in these + Lots of experienced clinicians around + Good evidence in the elderly 	<ul style="list-style-type: none"> - Typical sessions are bit longer than we would like - Training for nurses to become proficient may not be feasible - ? evidence in cognitive impairment - Not sure if this is the best fit for our program
? Problem-solving therapy	<ul style="list-style-type: none"> + Emerging research for older adults + Used in shared-care models which I'm interested in + Face validity as a therapy + Adapted for case management + Evidence in older adults and those with cognitive impairment 	<ul style="list-style-type: none"> - Not familiar with PST - Not sure how hard it is to learn or get training - Not aware of any local resources

Selection of Solution

- Examine whether PST might be an option to integrate into our geriatric psychiatry outreach program at Providence Care

Action Plan

- Internet search about Problem Solving Therapy
- Read some research about Problem Solving Therapy
- Apply for a few small grants to support some pilot studies if it seems like a good option

Verification of Action Plan

- Online resources and information about PST
 - AIMS Centre at University of Washington – online materials and worksheets on PST, link to PST Training Centre at University of California at San Francisco
 - PST used as part of their depression care management programs (IMPACT)
 - PST Training provided through UCSF PST Centre
- Contacted PST Training Centre at UCSF (Dr. Arean)
 - They offer training and PST Certification
 - They have a Canadian psychologist on staff who would like to train some Canadians – Dr. Rebecca Crabb PhD
 - Provided a reasonable quote for training and supervision
 - I can become a trainer and train my nurses and other clinicians
- Received small grant from Queen's University to support implementation and evaluation

PHQ-9 Depression Questionnaire

- Before PHQ-9 = 6

- After PHQ-9 = 1

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: Doreen Seitz DATE: Oct 2, 2017

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns: 0 + 1 + 0 + 0 = 6

(Healthcare professional. For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL: 6

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somehow difficult	Very difficult	Extremely difficult
		<input checked="" type="checkbox"/>		

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: Doreen Seitz DATE: Feb 19, 2017

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns: 0 + 1 + 0 + 0 = 1

(Healthcare professional. For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL: 1

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somehow difficult	Very difficult	Extremely difficult
	<input checked="" type="checkbox"/>			

Framework for PST in Depression

- Everyone has problems
- Interplay between problems and depression
 - Problems contribute to making depression worse
 - Depression makes it hard to solve problems
 - Downward spiral



7 Steps to PST

1. Problem Definition
2. Identification of Goal
3. Brainstorming Solutions
4. Weighing Pros and Cons of Solutions
5. Select a Solution
6. Implement Action Plan to Carry Out Solution
7. Verification of the Outcomes

Problem Solving Therapy

- Typically 4 – 8 sessions scheduled weekly to biweekly
- Initial session is 45 – 60 minutes, follow-up sessions 30 minutes maximum
- Introductory, middle, and termination sessions

Problem Solving Therapy

- Introductory Sessions
 - Discuss the structure of PST, weekly meetings
 - Review the relationship between depression and problems
 - Explain why PST is helpful and its evidence base
 - Introduce PHQ-9
 - Introduce 7 steps of PST
 - Generate initial Problem List
 - Solve a Problem
 - May also include Pleasant Activity/Behavioral Activation (IMPACT)

PHQ-9

- Patient Health Questionnaire-9
- Self-reported depression measure
- Completed every week prior to PST and reviewed to track progress

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
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8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

Problem List

- “What kind of problems are you having now that led you to seek out help?”
- Just a quick listing, not detailed at this point
- Use Problem List worksheet to help generate problems
- Good to have a variety of problems to work on

Problems with relationships	Problems with having a daily pleasant activity
Problems with work or volunteer activities	Problems with sexual activity or intimacy
Problems with money/finances	Problems with religious or moral values
Problems with living arrangements	Problems with self-image
Problems with transportation	Problems with aging
Problems with health	Problems with loneliness

Problem Solving Worksheet

PROBLEM-SOLVING WORKSHEET

Name: _____ Date: _____ Visit #: _____

Review of progress during previous week:

Rate how Satisfied you feel with your effort (0 - 10) (0 = Not at all; 10 = Super): ____ Mood (0-10): ____

1. Problem:

2. Goal:

3. Options/Solutions: 4. Pros versus Cons (Effort, Time, Money, Emotional Impact, Involving Others)

a)	a) Pros (+) What makes this a good choice?	a) Cons
b)	b) Pros (+) What makes this a good choice?	b) Cons
c)	c) Pros (+) What makes this a good choice?	c) Cons
d)	d) Pros (+) What makes this a good choice?	d) Cons

Problem Solving Worksheet

5. Choice of solution:	
6. Action Plan (Steps to achieve solution):	<u>Write down the tasks you completed.</u>
a)	
b)	
c)	
d)	
Pleasant Daily Activities.	<u>Rate how Satisfied it made you feel (0 – 10)</u> (0 = Not at all; 10 = Super)
Date Activity	
Next appointment: _____	

Follow-Up Sessions

- 30 minutes in length
- Always begin with an agenda:
 - Review PHQ-9 scores and compare to previous week
 - Review action plan from previous week
 - Solve a new problem
 - Anything else patient wants to address
- Address any crises first prior to any other work

Termination

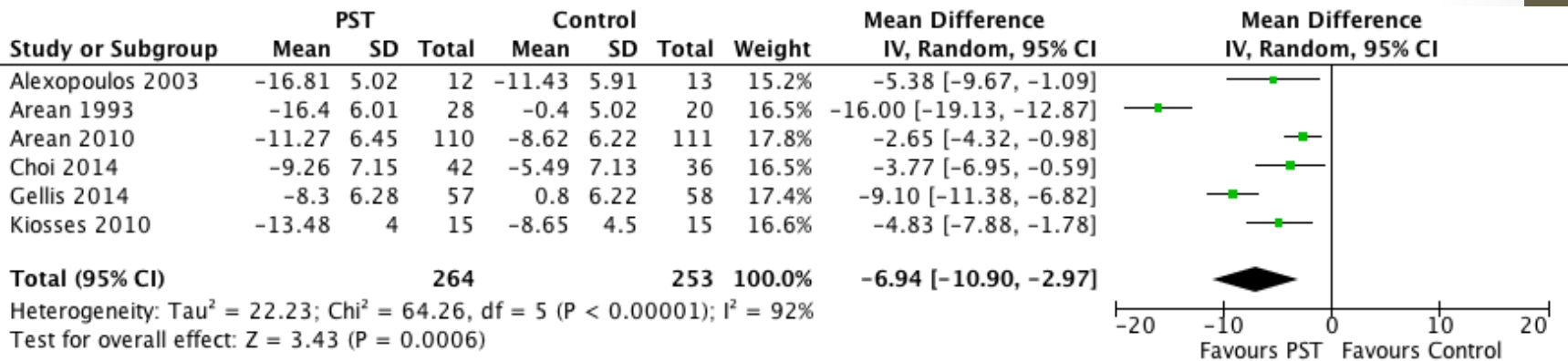
- Similar to follow-up sessions
- Helpful to review PHQ-9 at the beginning of therapy and at last session to review improvement
- Review problems that patient was having at the start of therapy and strategies that patient used to overcome them
- Discuss risk of relapse and strategies to reduce relapse
 - Encourage ongoing use of PST for new problems that occur
 - Maintenance medication if appropriate

Evidence for PST in Older Adults

- Systematic review and meta-analysis of PST for treatment of MDD in older adults¹
- Nine RCTs comparing PST to control condition (wait-list, psychoeducation, supportive therapy)
- Total N=569 participants.
- Majority of studies 6 – 12 weeks in duration, delivered 1-to-1 with therapists

Study (Author, year)	Number	Patient Characteristics			Therapy Characteristics		Outcome Measures				
		Mean age (SD)	Depression diagnosis	Cognitive impairment	Setting and delivery	Duration and frequency	Instrument	PST baseline Mean (SD)	PST endpoint Mean (SD)	Control baseline Mean (SD)	Control endpoint Mean (SD)
Alexopoulos, 2011	PST=110	73.0 (7.8)	SCID-R/DSM-IV; HRSD>20	Yes (executive): (MMSE>24; DRS-IP <34, Stroop<26	In person	Weekly x 12	WHODAS II	26.8 (5)	22.0 (4)	25.6 (5)	24.4 (5)
	Control (ST)=111										
Alexopoulos, 2003	PST=12	74.12 (7.27)	HRSD>18; DSM IV TR	Yes (executive): MMSE>24, DRS-IP <34, Stroop<26	In person	Weekly x 12	HRSD	23.9 (3.38)	7.09 (6.25)	25.35 (5.51)	13.92 (6.29)
	Control (ST)=13										
Arean, 2010	PST=110	72.8 (7.6)	SCID-R/DSM-IV; HRSD>20	Yes (executive): (MMSE>24; DRS-IP <34, Stroop<26	In person	Weekly x 12	HRSD	24.1 (3.9)	12.83 (8.25)	24.5 (4.6)	15.88 (7.5)
	Control (ST)=111	73.2 (7.9)									
Arean, 1993	PST=28	67	BDI >19, GDS>9, HRSD>17, RDC	Dementia excluded	In person (group)	Weekly x 12	HRSD	25.2 (5.7)	8.8 (6.3)	22.4 (5.5)	22.0 (4.5)
	Control=20	65.5					BDI	23.7 (5.2)	15.7 (6.9)	23.0 (4.3)	21.2 (6.0)
Choi, 2014	PST=42	65.21 (9.22)	HRSD ≥15,	Dementia excluded	In person and video calls	Weekly x 6	HRSD	27.75 (0.83)	14.44 (1.19)	24.64 (1.07)	19.16 (1.26)
	Control=36						WHODAS II	34.21 (1.23)	30.13 (1.19)	38.03 (1.28)	34.97 (1.48)
Gellis, 2014	PST=57	80.1 (7.8)	PHQ-2 > 3	Dementia excluded	Telephone	Weekly x 8	HRSD	18.1 (6.9)	9.8 (5.6)	18.1 (6.9)	9.8 (5.6)
	Control=58	78.3 (6.9)									
Gellis, 2007	PST=20	79.73	CES-D>22	Dementia excluded	In person	Weekly x 6	BDI	29.43 (6.5)	10.20 (7.8)	30.3 (6.2)	27.4 (7.6)
	Control=20	80.12									
Hussian, 1981	PST=6	73.61	BDI, top scorers, mean score 35.6	Not indicated	In person	5 sessions/2 weeks	BDI	NR	NR	NR	NR
	Control=6										
Kiosses 2010	PST=15	80.46 (8.45)	SCID; HDRS>17	Yes MMSE >18; DRS-IP <31, Stroop<19	In person	Weekly x 12	HRSD	22.40 (3.92)	8.92 (4.07)	21.40 (2.80)	12.75 (5.72)
	Control (ST)=15										

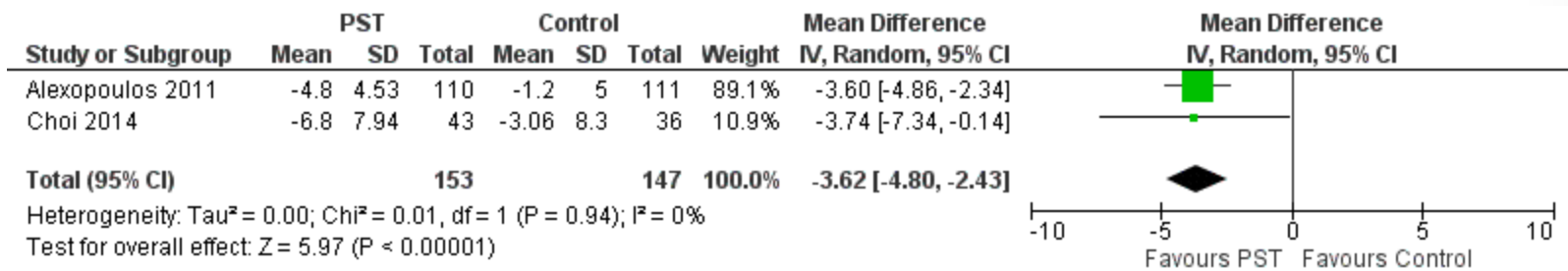
PST for MDD in Older Adults: Change in HAMD



Mean Difference: -6.94 (-10.9 to - 2.97, $P = 0.0006$)

Effect size: Cohen's $d = 1.15$, 95% CI 1.76 to 0.55

PST for MDD in Older Adults: Change in Disability



Quality of Studies

	Random sequence	Allocation concealment	Blinding of participants	Blinding of outcome	Incomplete outcome data	Selective reporting	Other bias
Alexopoulos 2003	+	?	?	?	+	+	+
Alexopoulos 2011	+	?	?	-	+	+	+
Arean 1993	+	?	?	?	+	+	+
Arean 2010	+	?	?	-	+	+	+
Choi 2014	+	?	?	?	?	-	+
Gellis 2007	+	?	-	?	+	+	+
Gellis 2014	+	?	-	+	+	?	+
Kiosses 2010	+	?	?	+	+	+	+

Subgroup and Sensitivity Analysis

- PST equally effective in study populations with and without cognitive impairment
- PST effective when compared to supportive therapy or with wait-list controls
- Sensitivity analyses demonstrate that overall results are robust to effects of individual studies

Meta-Analysis of Problem Solving Therapy for the Treatment of Major Depressive Disorder in Older Adults

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Background

Major depressive disorder (MDD) affects approximately 10% of older adults and is associated with poor outcomes.
 Guidelines indicate that treatment of MDD in older adults should be individualized, taking into account comorbidities, social support, and functional status.
 Problem Solving Therapy (PST) is a structured, manualized, and evidence-based approach to treating MDD in older adults.
 We conducted a meta-analysis to evaluate the effectiveness of PST for the treatment of MDD in older adults.

Methods

Search Strategy: We performed a comprehensive search of major Medline databases including MEDLINE, PsycINFO, CINAHL, and the Cochrane Library.
Study Selection: All randomized controlled trials comparing PST to control conditions including wait list or usual care, placebo, medication, other psychological treatments.
Participants: We included older adults (average study population of $n = 60$ were diagnosed with MDD).
Studies that included other depressive disorders such as dysthymia, minor or subthreshold depression were included.
Data Extraction: Two authors independently extracted data from included studies.
Primary Outcomes: Change in depression symptoms as the rating scale employed for individuals who received PST compared to control conditions.
Quality Assessment: Cochrane Collaboration's risk assessment tool was used to evaluate quality of included studies and authors' reports of bias.
Sensitivity & Meta-Analysis: Studies that used the same depression rating measure were included in the meta-analysis. We explored heterogeneity and differences in the depression rating scale employed for the PST group compared to the control group were entered into the review manager software program RevMan version 5.2.
**Assess Mean Differences in the Change Depression scores and risk confidence intervals were calculated in RevMan using random-effects models with inverse variance weighting.
Subgroups & Sensitivity Analysis: Those including participants with comorbid cognitive impairment, Subthreshold depression group, and longer duration of PST were analyzed separately relative to others.
 The impact of individual studies on the pooled estimate was assessed in the meta-analysis with assessment by sequentially removing individual studies and repeating the meta-analysis.**

Results

Study Selection
 A total of 1,776 citations were reviewed and nine publications from eight unique studies met criteria for inclusion in the review (Figure 1).

Characteristics of Included Studies
 There was a total of 568 participants (270 PST, 278 control) (Table 1). Median study sample size was 46. Mean age of the study samples varied from 65.2 to 83.3 years. There was a female preponderance in all studies that reported the gender distribution. The average duration of follow-up was 12 weeks from baseline.

Study	n	Mean Age	Depression Measure	Follow-up (Weeks)	Quality Assessment
Choi et al. (2011)	40	71.0	BDI-II	12	High
Choi et al. (2012)	40	71.0	BDI-II	12	High
Choi et al. (2013)	40	71.0	BDI-II	12	High
Choi et al. (2014)	40	71.0	BDI-II	12	High
Choi et al. (2015)	40	71.0	BDI-II	12	High
Choi et al. (2016)	40	71.0	BDI-II	12	High
Choi et al. (2017)	40	71.0	BDI-II	12	High
Choi et al. (2018)	40	71.0	BDI-II	12	High
Choi et al. (2019)	40	71.0	BDI-II	12	High
Choi et al. (2020)	40	71.0	BDI-II	12	High

Quality Assessment

Overall, the quality of included studies was good and is summarized in Figure 2. The most consistent issues with regard to potential sources of bias in the included publications was concealment of random allocation and blinding.



Efficacy of PST on Depressive Symptoms

A total of 6 studies evaluated the effect of PST on depression using the change in Hamilton Depression Rating Scale (HDRS) score (Figure 3). In meta-analysis, there was a significant reduction in HDRS score for PST compared to control conditions. The effect size was large (Cohen's $d = 1.12$, 95% CI 0.76 to 0.55). Two studies reported the change in Beck Depression Inventory (BDI) score between PST and control groups (Figure 4).



Efficacy of PST on Disability

Two studies examined the effect of PST on disability using the 12-item World Health Organization Disability Assessment Schedule II (WHODAS-II) (Figure 5). Meta-analysis showed an effect size of 0.68 (Cohen's $d = 0.68$, 95% CI 0.43 to 0.28).

The Drop-Out or Withdrawal
 Most studies had few or no dropouts. The difference between groups in the PST group (1.7%) and control groups (11.4%) was not significant ($OR = 1.20$, 95% CI 0.72 to 2.05, $P = 0.48$).

Subgroup and Sensitivity Analyses

PST was more effective in studies that used Supportive Therapy as a control condition measured by the HDRS ($MD = -4.32$, 95% CI -6.41 to -2.23, $Z = 4.05$, $P < 0.0001$).
 PST was effective in populations with and without executive dysfunction with no difference noted between these subgroups.
 PST was effective in studies that used 8 or fewer sessions and in studies using more than 8 sessions with no difference in the effectiveness of PST noted in these subgroups ($\chi^2 = 0.03$, $df = 1$, $P = 0.86$).

The most difference in change in depression scores for PST when compared to controls was not statistically different after sequentially removing individual studies and repeating the meta-analysis.

Conclusions

- Our review and meta-analysis adds support to the growing body of preliminary evidence indicating that PST is an effective treatment for older adults with major depression.
- PST can be provided by healthcare practitioners from different backgrounds and is easily adapted to a variety of clinical settings.
- PST is one of the few treatment options demonstrated to be effective in patients with cognitive impairment or disability.
- More research is needed on predictors and moderators of treatment response in older adults, as well as on the comparative and long term efficacy of PST.

References

1. Bauer DC. (2002) Depression in late life: review and commentary. *J Geriatr Psychiatry Neurol* 15: 249-265.
2. 2006 Second Guidelines for Seniors Mental Health: The Assessment and Treatment of Depression. Canadian Coalition for Seniors Mental Health.
3. Klein WL, Nestle CE, Nease AM, Schenck H, Christopher J & Joseph TA. (1992) Comparative effectiveness of social problem-solving therapy and relaxation therapy in treatment for depression in older adults. *J Geriatr Psychiatry Neurol* 5: 1003-1010.

Acknowledgements

Funding for this project was provided through a Queen's University Department of Psychiatry Research Award.



PST Certification and Training

- In-person workshop or online study:
 - Review free online training modules provided through IMPACT centre
 - Review “Problem Solving Therapy” book
 - PST sessions videorecorded by UCSF and available online
- 8 weekly 1 hour role plays with PST supervisor
 - Initial session, several middle sessions, termination session
 - Each session highlights 1 component of PST (e.g. problem definition)
- Review of PST Cases with supervisor
 - Minimum of 3 sessions recorded with 1 – 2 clients
 - Rated for adherence by PST supervisor
- Train the trainer
 - Provide a workshop, co-lead role plays, and co-supervise PST trainees with supervisor

PST Implementation

- Dr. Dallas Seitz
 - Certification in PST through UCSF
- Training of outreach case manager RN in geriatric psychiatry in Seniors Mental Health Program at Providence Care:
 - Hastings Prince Edward: Spring 2014 (8 case managers)
 - Co-facilitated by Dr. Rebecca Crabb, UCSF
 - Lennox & Addington: Winter 2014 (3 psychiatrists, 4 case managers)
 - Led by Dr. Dallas Seitz

PST Certification and Adherence

- HPE: 6 case managers completed PST certification, 2 in process
- L & A: 1 case manager in progress

PST Adherence: Introductory Session

Domain (N=8)	Average Score (SD)
Time Management	4.2 (0.9)
Psychoeducation	4.0 (0.6)
Problem List	3.9 (0.7)
Problem Solving (Overall)	3.9 (0.4)
Problem Definition	3 (0.6)
Goal	3.4 (0.5)
Generating Solutions	3.9 (0.4)
Decision Making	4 (0)
Action Plan	4 (0.8)
Processes	3.7 (0.8)
Communication	4.2 (0.4)
Adherence/Competence	4 (0.6)
Global Rating	3.9 (0.4)

0 = very poor, 5 = very good

PST Implementation

Participants (N=17)	
Mean age (SD)	79.4 (7.3)
Female Gender N (%)	11 (64.7)
Living Situation	
Alone	6 (35%)
With family	11 (64.7)
Receiving Antidepressant, N (%)	15 (88.2%)
Mean MoCA Score, Mean (SD)	20.8 (5.4)
Number of Sessions	5.3 (3.1)

Change in Depression Scores

	Baseline PHQ-9	Endpoint PHQ-9	Difference
Overall (N=11)	14.9 (8.3)	10.2 (7.7)	-4.7
High vs Low Baseline Depression			
PHQ-9 <20 (N=7)	13.3 (4.11)	11.4 (8.3)	-1.9
PHQ-9 >20 (N=4)	21.3 (1.25)	13.8 (8.1)	-7.5
MoCA			
MoCA > 20	14.3(6.2)	8.33 (9.3)	-6
MoCA < 20	16.3 (3.8)	12.25(5.0)	-4.1

Client Satisfaction Questionnaire

Item (N=4)	Mean (SD)
Overall quality of service	3.5 (0.6)
Service that you wanted	3 (0)
Program met my needs	2.8 (1.0)
Recommend program to others	3.8 (0.5)
Satisfaction with amount of help	3.8 (0.5)
Helped me deal with problems	3.5 (0.6)
General satisfaction	4 (0)
Return to program in future	4 (0)

Preliminary Experience with PST

- Acceptable to patients – “Makes sense”
- Easy to link problems brought up in consultation to PST model
- PST methods can be used for specific problems even if not part of PST therapy
- Can demonstrate PST within about 15 minutes to see if they think it would be helpful

Future Directions

- Ongoing evaluation of program and implementation in remaining outreach teams
- Collaboration with Western University
 - Training of 8 case managers, 6 completed certification
- Preliminary work with other programs
 - Stroke prevention clinics
- Funding application for future research studies
 - RCT: post-stroke depression or depression in nursing homes

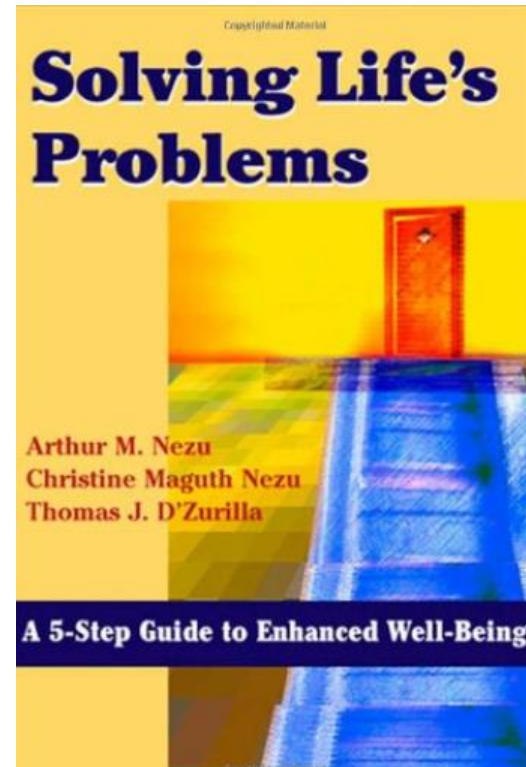
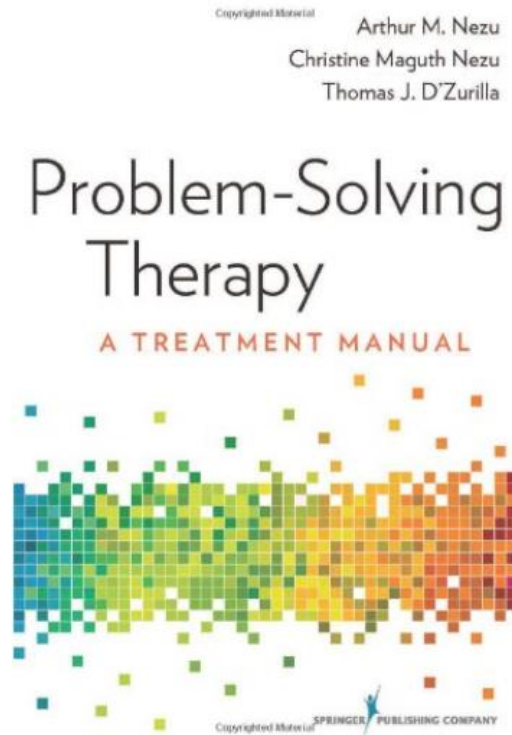
Conclusions

- Problem solving therapy is a time-limited, evidence-based treatment shown to be effective in a range of mental disorders
- PST has a strong evidence base for treatment of depression in older adults and can be delivered by a variety of practitioners in different clinical settings
- PST could have a number of potential applications in our current mental health system

Resources

- National Network of PST Clinicians, Trainers & Researchers
 - <http://pstnetwork.ucsf.edu/>
- IMPACT Depression Online Training Modules
 - <http://depts.washington.edu/impacttr/IMPACT.html>

Resources



Acknowledgments

- Geriatric Psychiatry Outreach Program
 - Diane Muldoon RN
 - Debbie Penney RN
 - Jennifer Stratford RN
 - Andrea Rhyno RN
 - Nancy Halladay-Rombough RN
 - Erin Baldwin RN
 - David Potts RN
 - Bonnie Booth-Pyne RN
 - Shauna Sweeney RN
 - Tricia Dominik RN
 - Angela Callahan RN
 - Marg Catlin RN
 - Susan Ilkov-Moor MD
 - Maria Hussain MD
 - Julia Kirkham MD
- UCSF PST Training Centre
 - Dr. Rebecca Crabb PhD
 - Dr. Patricia Areal PhD
- Research Funding
 - Department of Psychiatry
 - CTAQ Grant “Volunteer Friendly Visits for Home-Bound Depressed Older Adults”
- Trainees and Students
 - Calvin Chan Meds 2016
 - Julia Kirkham MD FRCPC

Questions

- Contact Information:
 - email: seitzd@providencecare.ca