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Enhancing Depression Care: How Implementing the PHQ-9 Has Shaped Our Service Response

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NOTHING TO DISCLOSE

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serving over 250,000 people

- FPs: 131
- Nursing: 116
- NP/RPN 22/10
- MHCs: 71
- Psychiatrists: 18
- RDs: 19
- Pharmacists: 9
- Respiratory Ed: 2

Depression Care: The Way We Were

- Depression: historically, the most common reason for mental health referral
- Original MHCs were experienced clinicians from hospital outpatient mental health clinics
  - Used various tools/ scales to measure depression or **none** at all

- Depression Education – 2 hour sessions offered in the community every month
- First 12-session CBT for Depression Group was offered in 2005

Mental Health Care at HFHT in 2008

- Included:
  - Mental Health Counsellors
  - Consulting Psychiatrists
  - Peer Support Worker program
  - Mental Health Groups
    - 12-wk CBT group for Depression
- September 2008: new Depression Care Coordinator

A Shift in (Depression) Management

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FROM Illness orientation	TO Wellness orientation
• prevention not a priority	• prevention a priority
• a solo provider approach	• an interdisciplinary team approach
• provider, disease-centered	• patient-centered
• reactive and episodic care	• proactive, continuing care
• limited role for individuals in management	• individuals empowered for self-management and part of the care team

Adapted from M Jain, MOHLTC, Feb 8, 2007: Ontario Chronic Disease & Prevention Management Framework

Recommendations
CDM for Depression in Primary Care

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- Standard measure of Depression symptoms & screening, e.g., 2 Question Screen & PHQ-9
- Evidence-based Treatment Algorithm & Guidelines
- Supported Patient Self-Management
  - Patient's personal goals
- Regular Patient follow-up
  - Care manager
  - Psychiatry consults as required
  - Greater use of telephone
- Depression Registries
- Plan to prevent Depression relapse

(Kates & Mach 2007)

PHQ-9: A Keystone

- The PHQ-9 has become a keystone in facilitating systematic detection and management of depression in primary care, including
  - making a diagnosis
  - selecting treatment
  - monitoring treatment response
  - suggesting when to alter treatment

(Kroenke et al 2001; DeJesus et al 2007)

Depression Care Guidelines:
MacArthur Toolkit

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- PHQ-9 scale
  - making a provisional diagnosis
  - Sensitive to change
- PHQ-9 linked Treatment Recommendations

http://www.depression-primarycare.org/

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
5-9	Minimal Symptoms*	Support, educate to call if worse; return in 1 month
10-14	Minor depression++	Support, watchful waiting
	Dysthymia*	Antidepressant or psychotherapy
	Major depression, *mild*	Antidepressant or psychotherapy
15-19	Major depression, *moderately severe*	Antidepressant or psychotherapy
≥ 20	Major depression, *severe*	Antidepressant and psychotherapy (especially if not improved on monotherapy)

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask, *"In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?"*).

++ If symptoms present ≥ one month or severe functional impairment, consider active treatment.

Implementing A Standard Measure 2008-2010

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2-Question Screen & PHQ-9

- 1st step: Program Managers
  - In-Service meetings with RNs, MHCs, RDs, Pharmacists
- Allieds practitioners asked to introduce PHQ-9 to FPs
- Psychiatrists ask/use PHQ-9 at consults
- HFHT-wide Depression education events

- Practice survey Fall 2010: >85% of FPs using PHQ-9 in initial visit for Depression

Re-thinking our Treatment Response

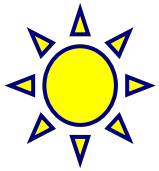
- Our treatment resources are geared to moderate-severe depression. Patients with **mild-moderate** depression may not desire or require
  - individual talk therapy
  - 12-week group therapy
  - antidepressant medication

- A window of opportunity for Supported Self Management

- Increasing literature on utility of short, structured groups in primary care setting

McNaughton JL 2009 Can Fam Physician; Cuijpers P et al 2008 Am J Psychiatry

Making of Rise UP



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- A treatment option for patients with depression
  - Showing early symptoms
  - **Activation focus**, emphasis on self care
  - 4 week format, structured
  - Group or (at home) Self-Care options
  - Can increase access to treatment for patients
    - CBT groups wait list

Launching Rise UP

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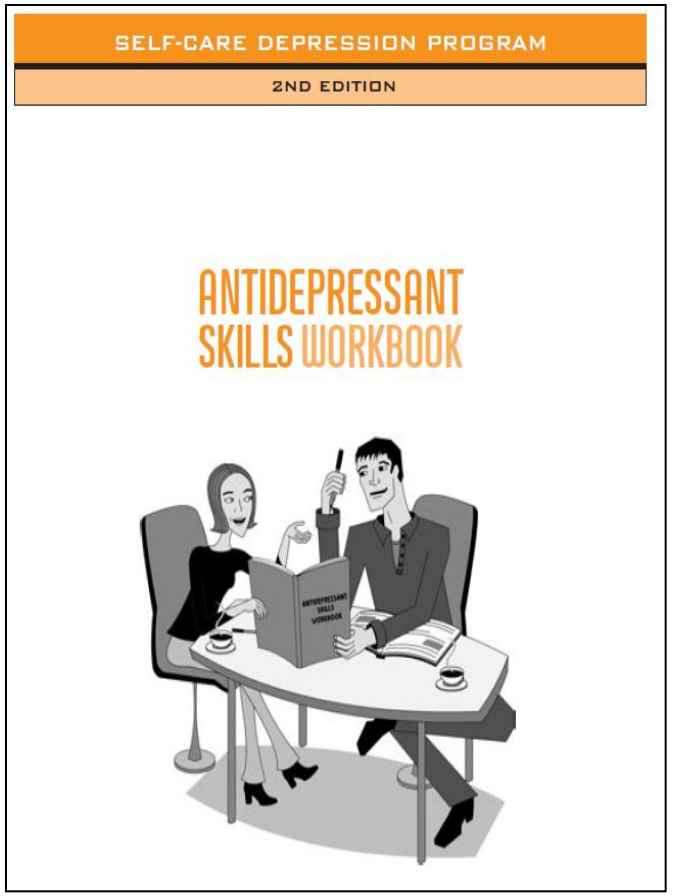
- Core content for Group & Self Care options
- Antidepressant Skills Workbook: a cost-effective way to deliver well-validated techniques/strategies for improving self-care in depression
- Activation focus
- Original intent: patients with PHQ-9 scores in 5-14 (mild to moderate) range



Our Evolving Insights

- Stratifying Depression Groups (Rise UP, CBT) based on PHQ-9 score is/was missing the boat
  - PHQ-9 scores for both groups shows same range & include persons with all levels of depression
  - Cannot assume a lower PHQ-9 score = early symptoms of depression

- Rise UP is a good first experience of groups
  - Gateway for longer, more intensive CBT group

Moving Towards A *Matched Care* Model

- Originally, concept of ***Stepped Care***
  - Starting with least & moving up to most care as needed (implies stratification of care options)

- Providing care that is a better **match** of intervention to clinical need
  - PHQ-9 score is part
  - Patient preference is part
  - Fluctuating course of depression plays a role
  - Patient & clinician access to our resources is crucial

CDM for Depression in Primary Care after 3 years: we're making dents

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(Kates & Mach 2007)

Ongoing:
Process of Depression Care

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- 2 sites have been meeting to discuss:
  - Referral process
    - When/who does PHQ-9?
    - Maximise HFHT resources
    - Reduce volume of referrals to MHC
  - Use a CDM registry?
    - Tracking PHQ-9 results
  - Use an electronic reminder system?
    - follow-ups with PHQ-9

Some of our Questions/Issues:

- PHQ-9: What is frequency of use for Monitoring response to treatment, Maintenance visits?
- In future: could patients do a PHQ-9 on-line & self-refer to group?
- Case management for depression/registries – how feasible?
- (Continuous) updating guidelines for depression care, e.g., CANMAT 2010
  - Moving away a strict toolkit (original: MacArthur) to incorporate new clinical information, e.g., evaluating clinical response after initiation of antidepressant, i.e., doing a follow-up PHQ-9 sooner than 4 weeks

PHQ-9 &
HFHT Groups for Depression

Fall 2010

- Started position as group coordinator in the Mental Health Program
- Groups is being promoted as ways to address;
  - Population Health
  - Experience of care
  - Cost of care
  - Long wait lists to see Mental Health Counsellor
  - Promote self management

First Impressions

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- Depression care has been a focus in recent years
- PHQ-9 is being widely used and accepted
  - PHQ-9 is now included with group referral
  - pre/post PHQ-9 scores in group
- Rise Up group newly developed is going very well, lots of excitement and energy
  - A group has just finished (Sept 2010) and there are so many referrals that we created 3 more groups
- We have discovered something important here! What is it?

Discoveries

- There is a need for depression groups
- Participants have appreciated the short group, find the material attractive and easy to read.
- Develop concrete tools to use immediately
- PHQ-9 scores have decreased, functioning increases
- Good group experience, open to more
- Facilitators enjoy running the group, easy to commit to shorter group

History

- Have historically run a CBT Depression group
  - 1-2x/year, 12 sessions, using *Mind Over Mood*
- Long group, hard to get facilitators, participants drop off after 7-8 sessions
- Material requires lots of reading, literacy at grade 14.2
- How do we take what we have discovered in Rise Up group into next steps?

Further Development

- Issues to address
  - Literacy
  - Amount of reading
  - Visual presentation
  - Concrete tools
  - Decrease PHQ-9 score
  - Increase Functioning
  - Evaluating benefit of group participation

New CBT Depression Group

- No workbook, create own workbook from visually attractive and simple worksheets.
  - Inexpensive
  - Use worksheets to teach skills that will be started in group and practiced at home
- Shortened group to 7 sessions
- Develop questionnaires in addition to PHQ-9 to look at how participants have changed thinking and behaviour

What are Participants saying?

- Some have been through both programs
- In a small focus group we asked about their experiences
- Some did Rise Up first, they felt that was a good way to do it and that the two programs went together well
- Some did CBT Depression first, they also felt that was a good way and the programs went together well

Depression Groups

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❑Rise UP

- 4 sessions, 90 minutes each
- Antidepressant Skills Workbook, by Dan Bilsker and Randy Paterson
- Focus on Education, Activation and Relapse

- Session 1-Reactivating your life, (Nutrition)
- Session 2-Realistic Thinking, (Sleep)
- Session 3-Problem Solving, (Drugs, Alcohol and Caffeine)
- Session 4-Reduce risk of Relapse

Depression Groups

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❑CBT for Depression

- 7 sessions, 2 hours each
- Create workbook based on weekly handouts
- Focus on Education, Thought Records, Thought Testing, Action Plans and Relapse

- Session 1- Understanding Depression and CBT (Making connections)
- Session 2- Unhelpful Thinking Habits and Automatic Thoughts
- Session 3- Collecting Evidence
- Session 4- Writing Balanced or Alternative Thoughts
- Session 5- Testing the New Balanced Thought (Action)
- Session 6- Making an Action Plan
- Session 7- Relapse Prevention

CBT Depression: So Far

- Have run 6 groups since January 2011
- First 5 groups: 33 evaluations received
  - PHQ-9 average scores have decreased
  - 90% report good to excellent opportunity to participate
  - 85% checked Group Discussion as one of the most useful parts
  - 75% report the information easy to understand & very helpful
  - Most common comment on evaluation: *"I am not alone"*
  - Most identified changes they would make as result of group

What Else?

- Monthly CBT Support Group: started April 2011
- Is there need for a CBT Depression Part 2?
  - Look at Core Beliefs
- Is there a role for Peer Support?
- Follow Up
  - Who and how?