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

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NOTHING TO DISCLOSE
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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

**FROM Illness orientation**
- prevention not a priority
- a solo provider approach
- provider, disease-centered
- reactive and episodic care
- limited role for individuals in management

**TO Wellness orientation**
- prevention a priority
- an interdisciplinary team approach
- patient-centered
- proactive, continuing care
- 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

- 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

- PHQ-9 scale
  - making a provisional diagnosis
  - Sensitive to change

- PHQ-9 linked Treatment Recommendations

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<table>
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<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
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<tbody>
<tr>
<td>5-9</td>
<td>Minimal Symptoms *</td>
<td>Support, educate to call if worse; return in 1 month</td>
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<tr>
<td>10-14</td>
<td>Minor depression++</td>
<td>Support, watchful waiting</td>
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<td></td>
<td>Dysthymia*</td>
<td>Antidepressant or psychotherapy</td>
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<td></td>
<td>Major depression, mild</td>
<td>Antidepressant or psychotherapy</td>
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<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
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<tr>
<td>≥ 20</td>
<td>Major depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
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* 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.
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Implementing A Standard Measure 2008-2010

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

Making of Rise UP

• 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

• 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

• 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

- 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

**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

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?