MIND OVER MOOD IN PRIMARY CARE

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Why the Book?

• Widely available and affordable
• Written for consumers
• Clinicians guide includes outline for delivery in an 8 or 12 week group format
• Includes questionnaires to track progress
• Covers anxiety as well as depression
• Use of a single model provides consistency and decreases confusion.

Why Depression

• Most common reason for referral to Mental Health Program – accounts for 37.8% of referrals (3155/8349 in 2007)
• Anxiety Disorders second at 14%
• Combined total for both is 51.8%
• Depression also co morbid with many chronic medical illnesses e.g. diabetes, COPD, coronary artery disease
Started Talking
September 2005

- Pilot group started April 5 2006
- The number story:
  - 19 referred
  - 12 screened (SCID 1 for current MDE) and accepted
  - 9 attended session 1
  - 8 completed

How Things Have Changed

- Total # referred to group = 208
- Total # attended group = 79
- Referral Process changed to orientation session, now back to brief screenings
- Current group: second for 2009
  - 38 referred
  - 18 at orientation

HFHT Mental Health Groups

This document provides an estimate of the hours of Mental Health Counsellor time required to facilitate existing groups.

The total identified is number of hours for EACH counsellor. Almost all of the groups have two facilitators at each session.

<table>
<thead>
<tr>
<th>Name of Group</th>
<th>Number of Sessions</th>
<th>Prep Time</th>
<th>Evaluation / Paperwork</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women's Stress Management Level 1</td>
<td>8 x 2.5 hrs each</td>
<td>8</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Women's Stress Management Level 2</td>
<td>6 x 2.5 hrs each</td>
<td>6</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder Group</td>
<td>7 x 2.5 hrs each</td>
<td>10</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Cognitive Behaviour Therapy for Depression</td>
<td>14 x 2.5 hrs each</td>
<td>15</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>Cognitive Behaviour Therapy for Insomnia</td>
<td>8 x 2.5 hrs each</td>
<td>8</td>
<td>4</td>
<td>32</td>
</tr>
</tbody>
</table>

These numbers are estimates only and may need adjustment as facilitators log their actual hours in groups.
Pros of a Manualized Group Format

- Faster route to delivery of group
- Comes with evidence of some success
- Less use of clinician time for group development
- Increased sense of security and confidence for group facilitators

Cons of a Manualized Group Format

- Staying pure is difficult!
- Group facilitator may be more familiar / comfortable with other techniques or formats and have to stifle the impulse to utilize them
- May need to work at “keeping it real” when repeating the same information many times. Want to avoid sounding like a “script”

Future Plans

- Linked to the Depression Initiative
- Stanford self management groups
- Perhaps modules based on level of depression and/or topics e.g. activation, reframing, returning to the workplace etc.
- Increasing accessibility by offering evening or Saturday groups at a variety of locations
- Peer co-leaders?
- I.T. - how it can be utilized to enhance the delivery of group
### WORKSHEET 8.2: Action Plan

<table>
<thead>
<tr>
<th>Action plan</th>
<th>Time to begin</th>
<th>Possible problems</th>
<th>Strategies to overcome problems</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decide on group format, meet with peers, hi support</td>
<td>Later</td>
<td>Difficulty getting time to meet with clients and complete tasks in the required time</td>
<td>Set aside time in advance in schedule to do literature review and to meet with peers</td>
<td>Meetings were held; format was chosen</td>
</tr>
<tr>
<td>Talk to supervisor/manager on groups, service advantages, funding needed</td>
<td></td>
<td></td>
<td></td>
<td>Presentations were made to supervisor/manager; group was accepted as effective means of service; budget was proposed and approved</td>
</tr>
<tr>
<td>Talk to doctor(s)/mental health counsellors, nurse practitioners, allied health professionals in practices: to educate re: group program, appropriate referrals, screening process</td>
<td></td>
<td></td>
<td></td>
<td>Ongoing need to remind other professionals: Mental Health Counsellors are main source of referrals and often the most reliable re: preliminary screening criteria</td>
</tr>
</tbody>
</table>

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Sample content information from Hamilton FHT.
**WORKSHEET 8.2: Action Plan Cont’d**

**GOAL:**

<table>
<thead>
<tr>
<th>Action plan</th>
<th>Time to begin</th>
<th>Possible problems</th>
<th>Strategies to overcome/plan for</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact potential attendees. Do screenings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some referred folks may not show for screenings.
Follow up with folks and referral sources re: first week attendance; consider allowing someone to start in week two – not after that.
Phoned referrals if no show for screenings and or first group meeting; phoned referral source re: no show for screening or if inappropriate referral; send feedback form to referral source if referred person drops out of group.

Groups were run and continue to be run twice per year; training of other mental health counselors to run the group format used is allowing for more groups to be available in a variety of time/day.

Feedback forms completed and sent to referral sources re: each attendee for each group – so referral sources have feedback re: person attended and progress towards meeting goals.

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Thanks for your attendance and interest!

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