BRITISH COLUMBIA'S PROVINCIAL

Depression Strategy

PHASE 1 REPORT OCTOBER 2002

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Ministry of Health Services

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British Columbia's Provincial Depression Strategy is being accomplished under the direction of the Ministry of Health Services, Mental Health and Addictions Division. The initiative is being facilitated by the University of British Columbia's Mental Health Evaluation & Community Consultation Unit (Mheccu). The final draft of this report was approved in October 2002.

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CONTENTS

Executive Summary

In the Fall of 2001, British Columbia's Provincial Depression Strategy was initiated by the Honourable Gulzar Cheema, Minister of State for Mental Health, in order to identify and pursue strategic opportunities to improve the quality and effectiveness of British Columbia's approach to the prevention and treatment of depression.

Each year, 1 in 25 British Columbians will have depressive illness and, because they are so often disabling, these illnesses create a profound health burden. Depression and stress disorders at work account for more than 30% of all disability recorded at major Canadian corporations and represent the fastest growing category of disability claims.

In this first phase of a multi-year strategy, opportunities to reduce the morbidity and disability associated with depressive illnesses were examined. Several major approaches were identified as likely to produce significant improvements in health care for depression. The **early-intervention** approach seeks to identify specific groups of people who are particularly vulnerable for depression and assists this group with early assessment and treatment to prevent depression onset and minimize disability. The **collaborative care** (also known as **shared care**) approach changes the structure of health-care delivery so that primary care providers and mental health specialists work together more closely in the treatment of people with depression and their families. The **stepped care** approach is a staged approach to treatment that fits the intensity of treatment to need, reserving intensive treatments and high cost resources for instances when they are most needed. Finally, the **chronic disease management** approach is based on evidence that chronic diseases such as diabetes, asthma and depression require a unique model of treatment delivery.

The following themes were identified as holding potential value:

1) Improved awareness regarding depressive illnesses, including information relevant to their prevention and treatment, amongst people affected by depression, their family members, co-workers and the community-at-large;

2) Improved utilization of information, services and supports that may reduce the individual and societal impact of depression;

3) Improved appropriateness of services and supports such that interventions are based on evidence and best practices; and,

4) Improved outcomes of services and supports, i.e. symptom reduction, improvements in function and productivity and prevention of relapse and chronicity.

Executive Summary, continued

In addition, on the recommendation of the Provincial Depression Strategy Advisory Committee, the first phase of the initiative assembled experts to address six specific topics: 1) Depression in the workplace; 2) Depression in children & adolescents; 3) Depression in the elderly; 4) Concurrent substance use disorder and depression; 5) Cultural expressions of depression; and, 6) Postpartum depression.

The information gathered in the initial phase of the British Columbia Depression Strategy has been synthesized to produce a series of recommendations that advance the following aims:

- **Provide educational support to people with depression and families about depressive disorders,** to ensure they have access to accurate, standard and timely information about depression, including causes and treatment of depression, self-management and depression resources;
- **Support primary care practitioners** in their effort to improve depression education and treatment;
- **Provide educational support to health professionals in a variety of service sectors,** about the recognition and management of depression, including treatment manuals, screening instruments, and instructional videos;
- **Support integration and cohesion of services,** to maximize their quality, efficiency and effectiveness;
- **Provide educational support to segments of the general public,** to improve community awareness and understanding of depression, and,
- **Apply chronic disease management models to depression treatment** that have been effective in improving other chronic conditions such as diabetes, asthma and cardiovascular disease.

In order to gauge the success of the strategy, a set of evaluative activities will be implemented.

In conclusion, this first phase of the Provincial Depression Strategy has prepared a path forward for subsequent action in improving the quality and effectiveness of British Columbia's approach to the prevention and treatment of depression.

Section 1

INTRODUCTION

Purpose

The purpose of the Provincial Depression Strategy is to identify opportunities to improve the quality and effectiveness of British Columbia's approach to the prevention and treatment of depression. In order to identify opportunities most likely to be effective, the strategy is to be guided by available evidence and by relevant experience gained in British Columbia and in other jurisdictions.

Section 2

Background

The Honourable Gulzar Cheema, Minister of State for Mental Health, founded the Provincial Depression Strategy project as a province-wide initiative to improve the quality and effectiveness of British Columbia's approach to the prevention and treatment of depression. At Minister Cheema's request, the Provincial Depression Strategy is being accomplished under the direction of the Ministry of Health Services, Mental Health and Addictions Division. The initiative is being facilitated by the University of British Columbia's Mental Health Evaluation & Community Consultation Unit (Mheccu).

continued . . .

Background, continued

To assist the activities of the Provincial Depression Strategy, advice is provided by a Provincial Depression Strategy Advisory Committee with broad representation including consumers, family members, healthcare providers, healthcare administrators, members of the business community and other stakeholders (membership is listed in **Appendix A.1**). The initiative includes extensive partnership with a wide variety of stakeholders. During its initial phase, undertaken from September 2001 through March 2002, the initiative reviewed and analyzed extensive information to develop an overarching framework and produce strategic recommendations for the purpose of advancing British Columbia's approach to the prevention and treatment of depression. Expert Search Symposia were held to assist in the development of recommendations to address six specific topics: Depression in the Workplace; Depression in Children & Adolescents; Depression in the Elderly; Concurrent Substance Use Disorder and Depression; Cultural Expressions of Depression; and Postpartum Depression. In addition, a depression management tool to support stepped care interventions in primary care settings was prepared for dissemination and grant proposals were developed to support the initiation of a substantive pilot study. Subsequent phases of the Provincial Depression Strategy initiative will aim to implement priority recommendations.

Section 3

Rationale for the Proposed Strategy

Depressive disorders are characterized by disabling symptoms **(Table 1)** and are responsible for a substantial amount of disability and suffering.[1]

Table 1. Symptoms of Depression

- depressed mood
- feelings of worthlessness
- sleep disturbance
- fatigue or loss of energy
- excessive or inappropriate guilt
- social withdrawal
- lack of interest or pleasure
- decrease or increase in appetite
- significant weight loss or gain
- feelings of inertia or agitation
- irritability
- difficulty thinking or concentrating
- suicidal ideation or suicidal behaviour

Rationale for the Proposed Strategy, continued

Diagnostic classification systems have developed criteria to identify distinct depressive syndromes with characteristic features. **Major Depression** is diagnosed when an individual has manifested a sufficient number of symptoms to meet specified criteria and the symptoms have persisted for two weeks or more.[2] Although the severity of symptoms associated with Major Depression can extend across a wide range, the syndrome is often severe and is sometimes accompanied by intense suicidal ideation and psychotic symptoms.[3]

Dysthymia is diagnosed when an individual experiences a chronically depressed mood, i.e. at least two years in duration (in children and adolescents, persistence for a minimum of one year is required for diagnosis and mood can be irritable) with fewer symptoms than seen in Major Depression.[4] **Postpartum Depression** is a form of depressive disorder that occurs in women in the period following the delivery of a baby. It can range in severity from mild to very severe and psychotic symptoms may be present. **Seasonal Affective Disorder** is associated with recurrent seasonal episodes of depression during winter months.[6] Populations living in regions with dark winters, e.g. extreme northern latitudes, are more commonly affected and recent studies suggest that genetic factors also play a significant role.[8] **Atypical Depression** is a syndrome that is characterized by mood reactivity, excessive sleepiness, leaden paralysis, over-eating, and rejection sensitivity.[9] It is not known whether atypical depression is a stable subtype of depression or if it is just one of several forms of depression that an individual may express during a lifetime of recurrent depressions.

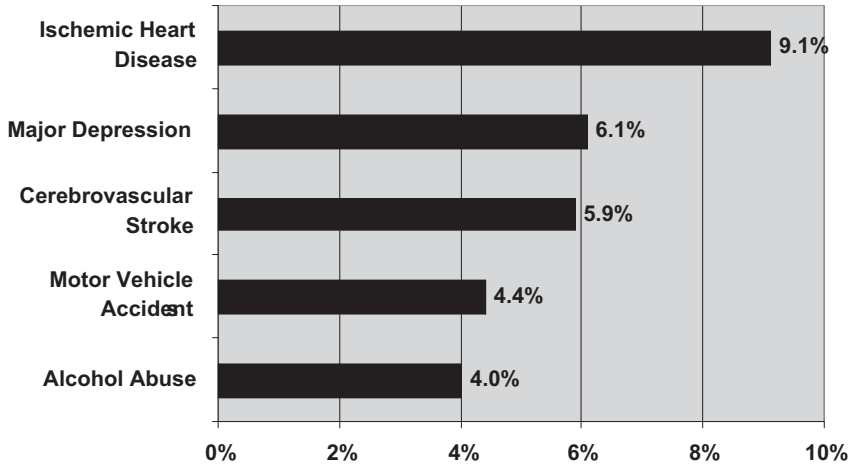
The following sections discuss the burden of disease and cost to society that result from depressive illness, identify the impact of depression on British Columbians and describe treatment gaps that require attention.

Rationale for the Proposed Strategy, continued

A. High Burden of Disease and Cost to Society

Depression has been identified to be responsible for an enormous burden of disease worldwide.[10,11] A study by the World Health Organization and World Bank has estimated that depression is second only to ischemic heart disease in terms of the overall health burden on society [10] **(Figure 1)**.

Figure 1. Estimated burden of disease as determined by the World Health Organization and World Bank Study



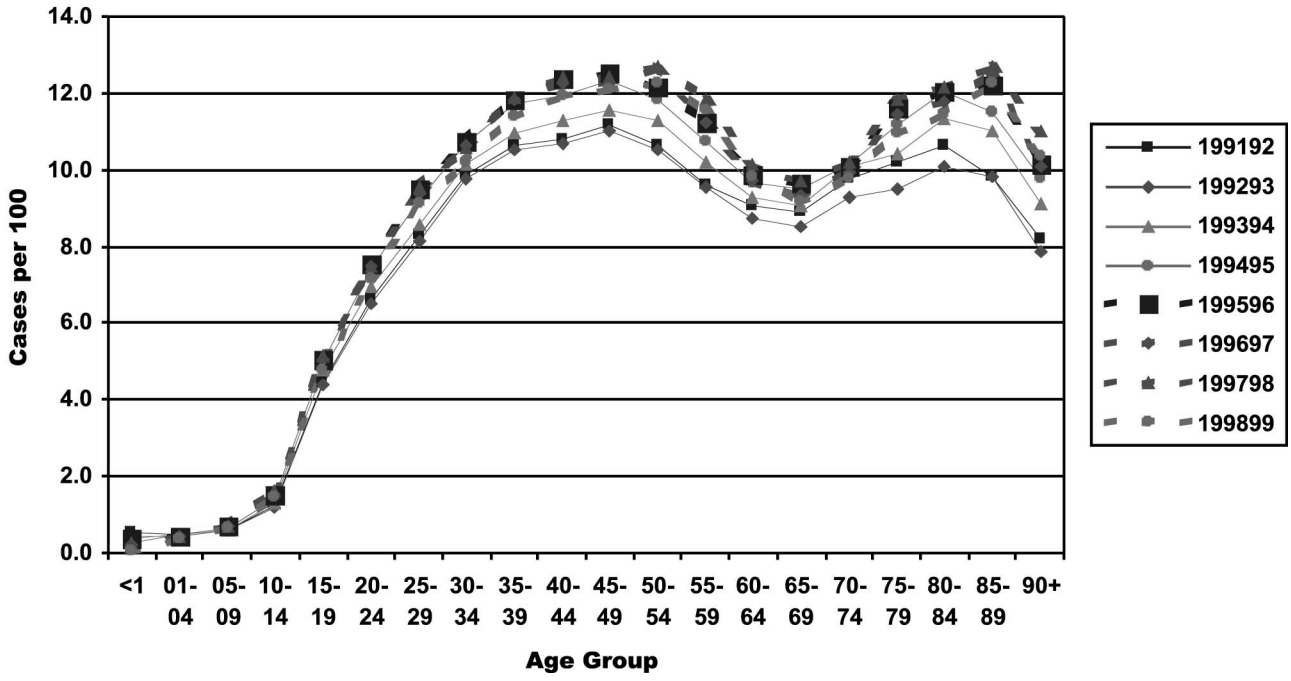
In 2001, the Canadian Economic Roundtable on Depression conference identified depression as a major cause of worker disability and corresponding lost productivity.[12] Depression and stress disorders at work account for more than 30% of all disability recorded at major Canadian corporations. In addition, depression is the fastest growing category of disability claims and only musculoskeletal pain or injury (e.g. back pain, soft-tissue injury, and fractures) result in more disability.[13] It has been found that business costs have substantially increased over recent years through accelerated disability and absenteeism resulting from depression.[14] Depression is closely associated with other major health problems and chronic medical illnesses and there is emerging evidence that the treatment of depression may also decrease the prevalence of these associated problems.[15]

Rationale for the Proposed Strategy, continued

B. Impact of Depression on British Columbians

Depression has found to be common in every society that has been studied. The average lifetime prevalence of major depression is estimated to be 6% and in any given year, approximately 4% of the adult population will meet criteria for a depressive illness.[16] Over recent years, more than 300,000 British Columbians (approximately 8.5% of the province's population) have seen a physician for problems related to depression or anxiety each year.[17] More than 200,000 of those seen were women or girls and more than 100,000 were male. Depression affects people across the lifespan as indicated by **Figure 2**, which shows the percentage of people at various ages who have been seen by a physician for depression in British Columbia over an eight-year period. During the teenage years, there is a rapid rise in the number of people seen for depression, but the highest rates are during midlife and late life.

Figure 2. Percentage of BC population in various age groups seen by a physician for depression



Rationale for the Proposed Strategy, continued

B. Impact of Depression on British Columbians continued

A substantial proportion of people with depressive illness commit suicide. More British Columbians die by suicide each year than by deaths resulting from traffic fatalities, AIDS, or illicit drug deaths. In young people aged 15 – 24, suicide is the second leading cause of death.

In view of the substantial disability and mortality associated with depressive disorders, it is important to identify the most effective strategies for prevention and treatment.[19] Because such a large proportion of the population is affected, there is a need to make the most efficient use of healthcare resources in applying such strategies.

C. Current Obstacles and Treatment Gaps

Studies have identified a number of factors that diminish treatment outcomes in depression and have described significant gaps in treatment that require attention. Depression may not be recognized by those suffering from its symptoms,[20] or by family members or colleagues of those affected. Physicians and other healthcare providers may not recognize the presence of depression or may fail to accurately diagnose the specific problem.[21] Even when recognized, the stigma associated with depression and various treatments for mental disorders (e.g. psychiatric care, hospitalization, electroconvulsive therapy) prevents many people from receiving help.[22]

Depressed individuals may be prescribed medications that are ineffective, and antidepressants that would be effective at a higher dosage are often prescribed at doses too low to be effective.[23] Antidepressant medications may not be prescribed for a long enough time period to produce improvement and, commonly, people fail to take the medication properly or discontinue its use prematurely.[24]

Rationale for the Proposed Strategy, continued

C. Current Obstacles and Treatment Gaps continued

When patients do not respond adequately to treatment by a primary care physician, appropriate referral to specialist mental health treatment may not be undertaken. Often, mental health specialist support is unavailable or of negligible value as a result of lengthy wait lists for consultation.[25]

When given a choice of treatments for depression, most people prefer counselling to treatment with antidepressant medication.[26] It has been established that evidence-based psychotherapies for depression, e.g. cognitive-behaviour therapy or interpersonal therapy, produce improvements equivalent to antidepressants that persist over a longer time period.[27] However, primary care physicians in British Columbia frequently refer patients to mental health specialists who provide non-evidence-based psychotherapy or counselling and such treatment is likely to be ineffective.

Currently, only a small proportion of mental health specialists practicing in British Columbia provide evidence-based psychotherapies for depression. Despite the success of the **Changeways** program in training many healthcare professionals to provide group cognitive-behavioural treatment for depression, patients are most likely to receive treatment with medication, non-evidence-based counselling or a combination of both. Factors that are considered to have influenced current practice patterns include: effective marketing efforts by pharmaceutical manufacturers;[28,29] medical service payment schedules that inhibit counselling;[30] and lengthy lag times from establishment of research evidence to uptake by educators and clinical practitioners.[31]

Additional barriers to effective treatment exist as a result of social, ethno-cultural and gender-related factors. Language may constitute one such barrier, or treatment services may be delivered in a manner that is not concordant with an individual's cultural or spiritual ideology. Women may experience difficulties in accessing treatment services while caring for children and other family members, and those living in poverty have been found to be particularly compromised.[32,33]

Section 4

Environmental Scan

Preliminary research evidence indicates that prevention and early intervention strategies may be of value.

continued . . .

Environmental Scan, continued

A. Prevention and Early Intervention Strategies

Preliminary research evidence indicates that prevention and early intervention strategies may be of value. Cognitive-behavioural workshops given to 10- to 13- year old children who were identified to be at-risk for depression developed depressive symptoms significantly less often than did similar children who did not receive preventive treatment and this trend persisted over time.[31] Research at the University of Calgary is currently exploring the use of the world-wide web and interactive voice telephone technology to test interventions aimed at preventing depression, such as cognitive and behavioural techniques, maximizing sleep quality, and reducing alcohol and drug use.

B. Collaborative Care Models

Collaborative care (also known as **shared care**) approaches have been developed for various illnesses and health problems. In general, they aim to enhance the effectiveness of primary care interventions through treatment protocols that delineate clear tasks, roles and responsibilities for specific members of a team of multidisciplinary treatment providers working in collaboration.[35, 36]

Collaborative care approaches to the treatment of depression also provide primary care physicians with enhanced tools and decision supports[37, 38] and facilitate the availability of specialist services when these are needed. In a number of studies evaluating collaborative care, when delivered in other (non-Canadian) healthcare environments, outcomes have been produced that are superior to those produced by usual approaches to the treatment of depression[39, 40, 41, 42]

This approach may also be a promising one for Canadian healthcare systems and, consequently, collaborative care models of care for depression have been established in various jurisdictions across Canada.[43, 44, 45, 46]

A wide variety of models of collaborative care for depression have been applied. Some models bring mental health specialist care on-site to the offices and clinics of primary care physicians[43, 45] and other approaches designate specific time slots when psychiatrists or other mental health specialists are available for consultation. Models that have supplemented follow-up care for depressed patients, provided via the telephone or in-person by nurses or other healthcare workers,

continued . . .

Environmental Scan, continued

B. Collaborative Care Models continued

have found significant benefits despite minimal expenditures of time.[47, 48, 49] However, not all approaches to collaborative care have been effective[50] and models that provide only education and guidelines to primary care physicians have not been found to improve outcomes.[51]

Collaborative mental health care models have attracted the attention of Canadian decision-makers because they may achieve improved outcomes and benefits through a reconfiguration of existing mental health specialty resources and may result in minimal cost-increments or be cost-neutral.[52, 53]

C. Stepped-Care Approaches

Stepped-care is an approach applied to address various illnesses and conditions in which a staged approach to treatment is guided by evidence to optimize outcomes while making the best use of available resources. Stepped-care models aim to fit the intensity of treatment to need, reserving intensive treatments and high-cost resources for instances when they are most needed. Whenever appropriate, initial treatment efforts apply low intensity services, moving forward to increase treatment intensity as required.

Stepped-care treatment for depression requires protocols to guide appropriate intervention. Some stepped-care approaches assign case managers to ensure that appropriate supports or services are being applied and received.[54] In order to optimize the benefit obtained at a number of the steps that can be undertaken in the management of depression, a variety of tools have been developed for use by patients, family members and healthcare providers.

Environmental Scan, continued

D. Chronic Disease Management Models

As depressive disorders frequently recur or become chronic illnesses,[55] models that have been effectively utilized to improve outcomes in other chronic conditions, such as asthma, diabetes or hypertension, have been applied to the management of depression. Chronic disease management models apply procedures to increase adherence to treatment protocols, including reminder systems and dedicated follow-up services.[56] They also seek to empower consumers in assuming a significant role in the management of illness and encourage the development of effective support networks. Cost-efficient implementation of chronic disease management models to the treatment of depression requires a re-structuring of the traditional roles of healthcare professionals.[57]

E. System-Wide Initiatives

The United Kingdom's **Defeat Depression Campaign** was a five-year national campaign launched in 1991 to achieve broad aims:

- To educate health professionals, particularly general practitioners, about recognition and management of depression.
- To educate the general public about depression and the availability of treatment, in order to encourage people to seek help earlier.
- To reduce the stigma associated with depression.

Clinical guidelines and continuing education programs were developed by professional associations to improve general practitioners' skills in recognizing treating depression and a concerted effort was made to encourage uptake by physicians throughout the United Kingdom. A mail survey estimated that two thirds of general practitioners were aware of the campaign, 40% identified having definitely or possibly made changes in practice as a result its activities.[58] The physicians rated a consensus statement on the recognition and management of depression in general practice and clinical guidelines as having made the most significant impact. The campaign was determined to have had the greatest impact upon younger physicians and female physicians.

Environmental Scan, continued

E. System-Wide Initiatives continued

The campaign also utilized newspaper and magazine articles, radio and television programs and other media to disseminate information to the public. Surveys of public attitudes found significant, albeit modest improvements in public attitudes to depression and its treatment with changes in the order of 5-10%.[59] Public attitudes to depression and to treatment by counselling were determined to be favourable, whereas antidepressants were commonly regarded as addictive and less effective. It is unclear whether the national campaign produced significant improvements in the burden of depression. Suicide rates dropped during the course of the campaign, however it is unknown whether the decreasing rates had any relationship to the campaign's activities.[60]

In 2001, the Australian government established a national initiative, **beyondblue**,[61] and identified the following priorities:

- Improved community awareness and understanding of depression
- Increased support for people with depressive illness and their caregivers.
- Establishment and evaluation of prevention and early intervention programs
- Promotion of depression-related research addressing education, prevention and treatment.
- Support for primary care practitioners in their efforts to improve depression education and treatment.

The Australian initiative is in its early stages of operation and has planned a number of substantial programs including:

- The implementation and evaluation of a national school- based program for the prevention of depression in young people
- A national program designed to increase the detection of postpartum depression and evaluate the effectiveness of early intervention
- The formation of a national coalition engaging consumers and caregivers in dialogue through community forums, focus groups, e-mail informational networks and self-help support groups.

In the U.S.A., the Robert Wood Johnson Foundation has recently funded a five-year, $12 million (U.S. funds) national program to increase the use of effective models for the treatment of depression in primary care settings.[62] The program will provide demonstration project grants, value research grants and leadership grants to research efforts that address the following issues:

- The application of chronic disease management models to depression treatment
- Uptake and maintenance of longitudinal models of care by health systems and practitioners
- Economic systems strategies that effectively engage patients/consumers, providers, practices, plans, and purchasers

Environmental Scan, continued

F. Innovations in Treatment

Preliminary evidence exists for a number of new treatment approaches for depressive disorders. Further research is warranted in order to better evaluate the effectiveness of these treatments and to identify specific indications for their use.

Exercise has been found to be associated with reductions in depressive symptoms and the use of regular exercise programs may be a beneficial approach to the treatment of depression in selected circumstances.[63] **St. John's Wort** (hypericum perforatum), an herb that has been used for centuries as a folk-remedy for various ailments, has been found to improve symptoms of depression. Current research indicates that St. John's Wort is less effective than tricyclic antidepressant medications[64] and its value in the treatment of severe depression has not been established. Some side effects and drug interactions have been reported with its use and the availability of unregulated preparations increases the likelihood of untoward effects.

Treatments using light, *e.g.* bright light therapy[65] and dawn simulation,[66] have been found to have an antidepressant effect and their utility in the treatment of people with Seasonal Affective Disorder (SAD) has been well established.[65] Recent studies have found that light treatments also reduce the symptoms of other forms of depressive illness, including non-seasonal major depression[67] and pre-menstrual depression.[68]

Repetitive transcranial magnetic stimulation (rTMS) is a new treatment that applies a strong magnetic current to specific areas of the skull inducing electrical stimulation to localized regions of the brain. Unlike electroconvulsive therapy, the electrical stimulation does not generalize and, consequently, rTMS treatment for depression does not induce a seizure and does not require anesthesia. Studies indicate that rTMS is effective in reducing depressive symptoms, although initial reports suggest that it may not be effective for depression accompanied by psychotic features.[69, 70] **Vagal nerve stimulation,** a procedure used in the treatment of epilepsy, has also been found to improve depressive symptoms and has been approved for use in treatment-resistant depression.[71] Treatment involves the delivery of electrical pulses to the vagal nerve by a pulse generator usually implanted in the chest wall.

Environmental Scan, continued

G. Expert Search Symposia Findings

A series of Expert Search Symposia was convened to obtain input from expert stakeholders in regard to a number of specific topics and populations. On the recommendation of the Advisory Committee, six areas were addressed during the first phase of the initiative. Advisory Committee members recommended participants for each topic and an effort was made to involve consumers, family members, healthcare providers and administrators with expertise in the issue that was being addressed. Each group addressed the same set of questions **(see Appendix B)** in order to identify significant opportunities to advance relevant prevention and treatment efforts in British Columbia. Many other topics and populations were identified that might benefit from specific attention and the Advisory Committee intended that additional Expert Search Symposia would be convened in subsequent phases.

The following sections summarize information obtained in each of the six Expert Search Symposia and highlight potential areas for advancing prevention and treatment efforts. Information included in these sections reflects general themes that emerged from the symposia. Additional and more detailed findings will be provided in a subsequent report. Information included in these sections reflects general themes that emerged from the symposia. Additional and more detailed findings will be provided in a subsequent report. Information provided by each of the groups is not intended to be comprehensive or representative of all stakeholders in the province. Furthermore, in view of the diverse geography and demography of British Columbia and the significant regional variations that exist, some of the information that has been obtained may not apply to all areas or populations.

Currently, there are comprehensive provincial planning initiatives underway that address areas related to the Expert Search Symposia topics (for example, Best Practices in Mental Health Services for the Elderly Population in British Columbia,[72] and the British Columbia Mental Health Plan for Children and Youth).[73] Efforts were made to include some individuals in the Expert SearchSymposia who are actively involved in the respective comprehensive initiatives in order to increase the coherence and consistency of the information received. The results of the comprehensive initiatives, soon to be available, will provide valuable information and recommendations to add to the following synopses of the Expert Search Symposia discussions.

Environmental Scan, continued

G. Expert Search Symposia Findings continued

1. Depression in the Workplace

The workplace presents an important and under-utilized opportunity to reach many adults in British Columbia who suffer from depression or are at risk of developing the disorder and apply strategic actions to protect against its development. Heightened efforts to identify and manage depression in the workplace are likely to increase the productivity of workers. With increased awareness of the potential benefits, business leaders and employers may be prepared to increase the availability of effective services and supports to employees with depression or at-risk of illness. To facilitate such developments, active involvement of the business community, including members of the Board of Trade, Chambers of Commerce and other agencies is vital.

The present initiative by the Canadian Mental Health Association – BC Division establishing the BC Business and Economic Round Table on Mental Health, will encourage and support efforts by industry to establish clear, comprehensive protocols for identifying and addressing the occurrence of depression and other mental illness in the workplace.

Improvements in the quality of care for depression provided by Employee Assistance Programs (EAPs) could produce substantial benefit as many workers in British Columbia receive employee benefits that include access to EAP treatment when needed. The availability of standards for effective treatment of depression, which could be distributed to EAPs and employers, would increase the likelihood that effective treatment is offered to employees. In order to maximize work potential and long-term outcome in depression, physicians require evidence-based guidelines and educational support to assist them in making determinations regarding medical leave-of-absence, short-term and long term disability.

Environmental Scan, continued

G. Expert Search Symposia Findings continued

2. Postpartum Depression

Prenatal programs and classes were identified as excellent opportunities to improve prevention and early intervention efforts addressing women at-risk for postpartum depression. Family physician offices, well-baby clinics and public health nurse home-visit programs were also identified as important targets for initiatives to increase recognition and improve treatment.

Province-wide dissemination of information, standards and guidelines regarding specific aspects of treatment, e.g. the efficacy and safety of antidepressant and antipsychotic medications during breast-feeding, would be beneficial. Specific efforts to increase awareness and understanding of post-partum depression should be directed toward new Canadians and their family members through various channels. Given the profound risks associated with unrecognized or untreated postpartum depression, standards for receipt of treatment should be established, monitored and evaluated.

New models of service delivery could better meet the needs of women with postpartum depression and their families. Treatment programs must provide services that accommodate the needs of parents who are caring for children while facing the problems produced by depressive illness.

In addressing post-partum depression, it is recognized that optimal service developments must address a larger framework that attend to gender-related issues in healthcare. It is recommended that subsequent phases of the Provincial Depression Strategy expand their focus on gender-related issues in the prevention and treatment of depression.

3. Depression in Children & Adolescents

There is a broad and diverse spectrum of resources and service providers contributing to the care of children and youth with depression in British Columbia. A “roadmap” pamphlet outlining optimum pathways of care would be a useful tool to improve collaborative and coordinated service delivery and could be made available to families, schools, health care professionals and child and family services.

An opportunity exists to improve the treatment of depression in children and adolescents through targeted educational initiatives for key healthcare providers. Because the information used to guide treatment in this area is continually expanding, health professionals will need to update their knowledge and skill frequently so that new developments in treatment can be utilized to achieve the best outcomes possible. Recent research studies have found that depressive illness

Environmental Scan, continued

G. Expert Search Symposia Findings continued

3. Depression in Children & Adolescents *continued*

appearing in individuals before the age of 18, termed **early onset depression,** is particularly prone to become recurrent or chronic.[74] Consequently, children and adolescents who develop depression are considered important candidates for early intervention with chronic disease management strategies.

It will be important to help parents and teachers to become more adept at identifying children and adolescents at risk for depression or manifesting initial symptoms. This can be achieved through province-wide initiatives to raise awareness and disseminate high quality informational resources. Particularly important topics to address are those related to coping skills and strategies for parents and others who are caring for children and adolescents with depression.

4. Depression in the Elderly

In the elderly, depression may present characteristic symptoms that differ from those seen in younger individuals, such as withdrawn behaviour, anxious preoccupation with physical problems or difficulties with memory. Symptoms are sometimes misperceived as a normal part of aging or a feature of some other concurrent physical or mental problem, e.g. following a stroke or accompanying dementia. There is a need to help the general public in British Columbia become aware that depression is not a normal part of aging and recognize that effective treatment can achieve profound improvements in quality of life.

In addressing stigma, an important issue affecting elderly people is widespread public misperception and fear of electroconvulsive therapy (ECT) as a treatment for depression.[75, 76] Currently, ECT is the most effective and safe treatment available for many elderly patients with severe and disabling depression.[77, 78] Because ECT is so commonly feared and misunderstood, many elderly patients are deprived of its potential benefits when well-intentioned family members, health professionals or others delay or avert treatment with ECT on the basis of inaccurate information about its risks. A British Columbia initiative to develop guidelines for best practices in ECT has been undertaken. Its final report "Electroconvulsive Therapy – Guidelines for Health Authorities in British Columbia" [79] is available on the Mental Health and Addictions, Ministry of Health Services, Government of British Columbia website under the Mental Health Publications at **http://www.healthservices.gov.bc.ca/mhd/publications.html**.

Environmental Scan, continued

G. Expert Search Symposia Findings continued

4. Depression in the Elderly *continued*

A network of Psychogeriatric Outreach Teams, established in many British Columbia communities, provides high quality mental health services and supports to the elderly. This network successfully coordinates a multidisciplinary approach that includes active involvement of primary care physicians and provides a foundation to sustain quality, cost-effective care. Future service developments will benefit from advance planning to fit new programs within the existing network of services. Through the British Columbia Psychogeriatric Association's continuing education activities, healthcare providers are provided support in their efforts to develop and maintain high level skills and incorporate evidence-based advancements into their clinical practices. These activities are strengthened by a philosophical commitment to interdisciplinary educational programs and collaborative clinical service.

In most British Columbia communities, homecare services address only physical illnesses, but they could be utilized as a cost-effective means to provide important aspects of mental health care to elderly people, particularly to those with depressive illnesses. With educational support and development, homecare services could help reduce the need for acute care and long term hospitalization through early intervention and by the application of effective protocols for the prevention of relapse in recurrent depression. "Guidelines for Elderly Mental Health Care Planning For Best Practices for Health Authorities" was released to serve as a guide for health authorities in designing, developing, implementing and evaluating services that maximize quality of life for elderly people who have complex and challenging mental health problems. It is anticipated these activities will be reflected in the health authorities planning. The report is available on the Mental Health and Addictions, Ministry of Health Services, Government of British Columbia website under the Mental Health Publications at **http://www.healthservices.gov.bc.ca/mhd/publications.html**

5. Concurrent Substance Use Disorder & Depression

Treatment services for people with concurrent depression and substance use disorder in British Columbia can be improved by integrating two systems of care that have largely functioned in relative isolation; **Mental Health Services** and **Alcohol and Drug Services**. An integrated system would eliminate many of the current problems that are encountered by clients due to conflicting treatment philosophies and contradictory policies that currently exist across the two systems. A genuine structural unification at all levels of these systems, but particularly at the front-line provider level, would facilitate the delivery of effective treatment and promote continuity of care.

Environmental Scan, continued

G. Expert Search Symposia Findings continued

5. Concurrent Substance Use Disorder & Depression *continued*

A substantial provincial educational effort is considered a high priority. Many healthcare providers who have been working in alcohol and drug services in British Columbia will need to develop skills in providing mental health services and supports. Similarly, mental health service providers will require skills in the treatment of addiction. Both groups will need to identify strategies that successfully combine interventions and optimize treatment outcomes.

Concurrent substance use disorders and depressive illnesses, i.e. **dual diagnosis** problems, exist in many different forms and affect a wide range of people. Alcohol use problems often co-exist with chronic or recurrent depressive disorders and may be concealed from work colleagues or family members for lengthy periods. Misuse of benzodiazepines or other prescribed medications is a common occurrence amongst elderly depressed patients. Profound episodes of depression are frequently experienced by people with chronic heroin, cocaine or methamphetamine addiction. A recent study found that 90% of individuals with concurrent mental and substance use disorders developed their mental disorder first, at median age 11. The majority of these mental disorders are anxiety or mood disorders. By intervening early with children and youth there is an opportunity for preventing concurrent disorders and the resulting complexity of their treatment.[80]

In view of the divergent types of concurrent disorders that occur in British Columbia, no single treatment approach will be adequate. Certain treatment programs and healthcare workers will insist on exclusive adherence to abstinence models while others will be strongly opposed and will adamantly promote the use of harm reduction approaches. However, to respond appropriately to the diverse problems and circumstances, a range of treatment models and approaches is required, each backed by sufficient evidence to demonstrate effectiveness.

Because of their unique role in British Columbia's healthcare system, family physicians encounter the vast majority of people who experience concurrent depression and substance use disorder. Informational resources, decision tools and collaborative care services can enhance the effectiveness of treatment delivered by family physicians to patients with concurrent disorders.

Environmental Scan, continued

G. Expert Search Symposia Findings continued

6. Cultural Expressions of Depression

British Columbia is a multicultural province, with many language groups and cultures represented. Healthcare providers at all levels of the system will benefit from ongoing education and support to enhance awareness of cultural differences and understand how such differences affect the presentation of depression and willingness to seek out care. Education efforts designed to overcome stigma should be directed toward various linguistic and cultural communities; these hold the promise of improving willingness to seek appropriate help.

In order to increase access to treatment services for depression in the various non-English languages spoken in British Columbia, central listings should be maintained to identify healthcare providers and languages spoken. The ability to provide services in the languages spoken in a community should be a major consideration in recruitment and hiring.

Increased communication and awareness about existing multicultural resources and development of written informational resources and website information in several languages would be of value. Depression has been identified to be a significant problem in many First Nations communities, and the development of culturally congruent services to serve such communities would be beneficial.

Section 5

A Strategy for British Columbia

SECTION 5

A Strategy for British Columbia

A. Principles Underlying the Strategy

The following principles are suggested to help guide the activities of the provincial depression strategy:

- An inclusive approach that seeks active engagement of interested individuals, stakeholder groups, members of the business community and government representatives to help achieve its goals
- Adherence to an approach that is well-informed by evidence and substantiated by expertise and experience gained in British Columbia and in other jurisdictions
- A focused set of activities likely to result in beneficial outcomes for a significant proportion of British Columbians affected by depression
- Adherence to project goals that are clearly defined, measurable and achievable during the course of the initiative
- Pursuit of strategic opportunities to achieve improvements in the effectiveness, efficiency and distribution of existing services and supports
- Particular attention to the support of primary care providers in view of their important role in providing healthcare for depression in British Columbia
- An emphasis upon improved dissemination of high quality information and resources to support patients, families and communities
- Inclusion of activities to increase public awareness and diminish stigmatization of depression and its treatment

A Strategy for British Columbia, continued

B. Goals of the Strategy

1. Improved awareness regarding depressive illnesses, including information relevant to their prevention and treatment, amongst people affected by depression, their family members, co-workers and the community-at-large. This includes dispelling myths and eradicating stigma associated with depression and its treatment.

2. Improved utilization of information, services and supports that may reduce the individual and societal impact of depression.

3. Improved appropriateness of services and supports such that interventions are based on current evidence and best practices.

4. Improved outcomes of services and supports, i.e. symptom reduction, improvements in function and productivity and prevention of relapse and chronicity.

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives

This section provides a description of the key initiatives recommended for implementation during the subsequent phases of British Columbia's Provincial Depression Strategy. To achieve the desired objectives, it is recommended that each initiative be implemented according to a framework comprised of five key components: Standards, Tools, Awareness, Training and Evaluation **(Figure 3)**.

The implementation of each initiative first requires the formulation of **Standards**, which may stipulate performance targets, specify clinical protocols and care maps, or set out expected goals. Standards guide quality improvement and they should be practical, feasible and clearly written.

Framework for System Improvement

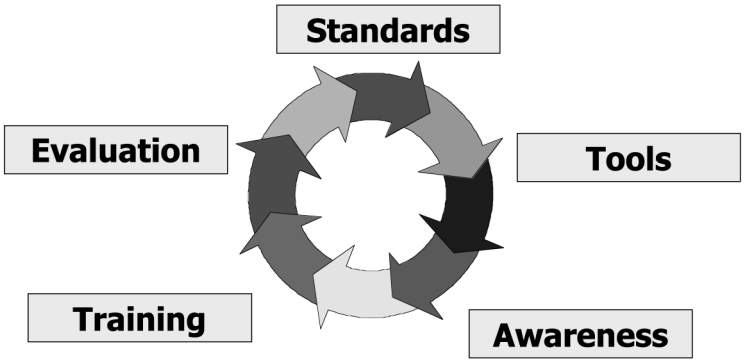


Figure 3. "STATE" model recommended for the implementation of each initiative

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

Tools are used to help meet the standards and they might include: treatment manuals, screening instruments, clinical decision algorithms, reminder sheets, software programs for data entry, patient education pamphlets and instructional videos.

Once tools have been developed and are ready for use, there is a need to promote **Awareness** of the particular initiative being addressed. In some situations, awareness raising efforts will focus upon a particular group, e.g. individuals at high risk for developing depressive illness, family physicians, mental health program managers and administrators. When communities have been well-informed and adequately prepared for new initiatives and, when key groups of people actively participate, the initiatives are more likely to be successful.[81] A study that examined a failed initiative concluded that it may have been unsuccessful because a number of the key people involved had not developed an awareness of the initiative's potential benefits and consequently had little enthusiasm for its activities.[50] Therefore, attention to the Awareness component of the STATE framework may increase the likelihood of an initiative's success.

The **Training** component refers to the full spectrum of activities and approaches that can be undertaken to increase knowledge and skills. In British Columbia, opportunities for distance education have advanced through the development of telehealth programs and advances in information and communications systems.

Finally, the overall impact of each initiative will need to receive **Evaluation** in order to assess effectiveness and determine whether the initiative should be maintained or altered. The Evaluation component of each initiative will utilize the Standards that will have been developed. Note that the Evaluation component will be discussed in a later section of this document, i.e. Gauging Success.

As depicted in **Figure 3**, the steps in the STATE model can be considered to be a cycle of actions that are repeated and refined over time.

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

The following list of recommended initiatives has been developed through a synthesis of all sources of information. Further information on the methods used to develop these recommendations is outlined in **Appendix D**. The highest priorities for recommended action in the Provincial Depression Strategy should be those in which:

i. many people are likely to benefit, and

ii. strategic opportunities exist to achieve significant impact with a relatively small investment of resources

Furthermore, actions should be carefully timed to maximize their success, given that certain activities would best be undertaken early in the course of the overall initiative whereas other activities would benefit from longer preparation or should be built on a foundation of preceding events.

The recommendations have been grouped within four categories.

1. Strategies Addressing Individuals At-Risk

1(a) Community-oriented speakers' program to raise awareness and diminish stigmatization of depression

A program of public forums and presentations by media celebrities, community leaders and government representatives is recommended to raise awareness and reduce stigma. A speakers' tour could reach communities throughout British Columbia and, through an organized planning process, specific community groups and sectors could be selected to maximize the impact of the initiative. Presentations by speakers describing their personal experiences of depression effectively reduce stigma and often prompt dramatic shifts in attitudes and behaviour. Through partnership with community-based agencies and the medical community, presentations can address specific cultural groups, chambers of commerce, workplace environments, schools, seniors' centres and other selected settings, thereby strengthening existing social networks.

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

1. Strategies Addressing Individuals At-Risk *continued*

1(b) Dissemination of public informational resources

The production and dissemination of high quality public information resources to assist people in British Columbia in the prevention and treatment of depression is recommended. A coordinated initiative by agencies and organizations with relevant expertise is required in order to ensure that cohesive and clear information is made available to the public. Informational content must be based on the best available evidence and should be produced with a uniform format to facilitate recognition and utilization of resources. Materials should provide useful information that will meet identified needs and help people to implement the best available knowledge in prevention and treatment of depressive illness. The development and dissemination of specific materials for depression should be undertaken in coordination with the production and distribution of informational resources for related health problems and conditions.

1(c) Dissemination of specialized and multilingual informational resources

It is recommended that information regarding depressive illnesses and their prevention and treatment be disseminated to specific groups in British Columbia who could derive benefit, but who currently have limited access to the information. For example, new Canadians would benefit from improved access to multilingual information regarding the recognition of depression, its various expressions and effective treatments. In addition, specific information regarding early identification and treatment of postpartum depression would be beneficial to women receiving prenatal care and individuals enrolled in prenatal classes (such information should also be produced in various languages).

1(d) Depression Screening Day activities

On an annual basis, British Columbia has regularly held **Depression Screening and Education Day** initiatives to increase public awareness and disseminate information to people affected by depression, individuals at-risk, family members and community groups. The initiative is led by the Canadian Mental Health Association – BC Division, and supported by various individuals and communities including members of the Mood Disorders Association of British Columbia and teaching faculty in the Mood Disorders Division of the University of British Columbia's Department of Psychiatry. It is recommended that Depression Screening and Education Day activities be continued and, in partnership with members of the research community, an expanded evaluation of outcomes be achieved. Moreover, the success of Depression Screening and Education Day program leaders in effectively engaging the participation of new communities in its initiatives each year has extended the reach of public awareness activities, and such efforts should be promoted.

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

1. Strategies Addressing Individuals At-Risk *continued*

1(e) Provincial Depression Strategy website

Initial content prepared for the Provincial Depression Strategy Web-site includes a description of the provincial initiative, relevant background information, an account of projects, events and activities, Advisory Committee membership and minutes of meetings **(Appendix B)**. An area of the web-site designed for consumers and family members provides extensive information about depression and its management, selected reading materials and references and links to high quality sites and resources. In addition, an area of the site is devoted to the support of British Columbia's healthcare providers with access to treatment tools and resources to enhance prevention and treatment. The website will require ongoing development and refinement. It is recommended that current content for consumers and family members be adapted and translated to other written languages commonly used in British Columbia. In addition, specific content for children, adolescents and seniors and additional informational resources and supports for British Columbia's healthcare providers should be developed. Web-site development should be integrated with other initiatives that produce and disseminate information to the general public such as those in recommendation 1(b).

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

1. Strategies Addressing Individuals At-Risk *continued*

1(f) Prevention & early intervention initiative for individuals at high risk

It is recommended that a new initiative be developed to implement specific prevention and early intervention activities directed toward specific groups of people who are at high risk. Individuals at high risk to develop depressive illness include: children or adolescents with multiple risk factors including extensive family histories of depression; socially isolated seniors recently widowed; and women who previously have had postpartum depression and are about to give birth. In many such circumstances, there are opportunities to prevent illness or intervene early, thereby minimizing disability and avoiding chronicity.

As an example, one high-risk group suggested for consideration consists of women who previously had an episode of postpartum depression. Recurrence rates of postpartum depression have been found to be unacceptably high[32] and the consequences of the illness are often profoundly damaging, including potential long-term sequelae affecting the child.[33] The recommended initiative would seek to reduce recurrences of postpartum depression and, when recurrences occur, to diminish negative consequences and sequelae. Physicians, nurses and other healthcare providers at well-baby clinics and public health nurses undertaking post-natal home visits would play key roles in the prevention and early intervention initiative. The initiative would set standards for adherence to evidence-based guidelines and protocols, developed as a component of this new initiative, raise awareness, provide training and undertake evaluation.

Similar opportunities can be utilized to enhance prevention and early intervention efforts to address other important problems related to depression and can be implemented in schools, workplace environments, nursing homes and other settings.

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

2. Enhancing Self-Management, Family & Community Support

2(a) Dissemination of self-care depression tools

A recent British Columbia initiative developed tools to help consumers in their efforts to recover from depression and prevent relapse. These comprise a series of self-care manuals and companion materials to guide physicians and other healthcare providers in efforts to support the self-management activities. The handout for primary care providers is included in **Appendix C**. The tools utilize evidence-based approaches and have been field-tested to ascertain their acceptability and utility. They can be utilized as a component of a stepped-care approach to depression and combined with other services and supports. It is recommended that these tools be widely disseminated and made freely available in British Columbia through the Provincial Depression Strategy website and other sources. Adaptation and translation of these materials to other languages in common usage in British Columbia is also recommended.

2(b) Family psychoeducation initiative

A Vancouver Island initiative aims to improve treatment outcomes for depression by facilitating collaborative care and providing adjunctive family psychoeducation services. It is recommended that opportunities be identified to evaluate the outcomes of this initiative with particular attention to the potential benefits associated with family psychoeducation for depression. Potentially, adjunctive family psychoeducation may improve outcomes and be shown to be a valuable component of treatment services for depression. Therefore, information regarding the outcomes of the recent initiative in Vancouver Island may be useful in the design and planning of other treatment programs in British Columbia.

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

3. Strategies to Enhance Primary Care Services

3(a) Primary care protocol and guideline development

As a component of the Joint Utilization Committee of the Medical Services Commission and the British Columbia Medical Association, guidelines and protocols are developed and disseminated to primary care physicians throughout the province. It is recommended that guidelines and protocols be developed to assist primary care physicians in the treatment of depressive disorders with particular attention to stepped-care and chronic disease management models.

3(b) Collaborative care initiatives

A number of initiatives are planned or underway to enhance collaboration amongst primary care physicians and other healthcare providers in the delivery of treatment for depression. In general, an integral component of these initiatives is to provide decision tools and informational supports to the primary care physicians. It is recommended that opportunities be identified to evaluate these initiatives in regard to: their impact on patient outcomes; their cost-effectiveness, their feasibility, and, the responses and attitudes of health professionals toward these models.

A Strategy for British Columbia, continued

C. Key Provincial Depression Strategy Initiatives continued

4. Optimizing the Use of Specialist Mental Health Services

4(a) Dissemination of standards, tools, and training for evidence-based treatment and promotion of adherence

It is recommended that provincial standards be developed for the provision of evidence-based treatment for depressive disorders. The standards should be developed through a collaborative effort that involves expert clinicians from each of the province's health authorities and should be oriented toward community mental health clinics, hospital-based treatments, and psychiatrist and psychologist treatment. It is important that these standards and tools be disseminated to private sector providers, such as Employee Assistance Programs.

4(b) Delivery of education in evidence-based treatment of depression

It is recommended that professional associations, university programs, health authorities and other providers of education to mental health specialists review current professional training and continuing education programs to ensure that appropriate skills are being imparted in the provision of evidence-based treatment to people with depression.

Changeways is a program developed by psychologists at Vancouver Hospital and Health Sciences Centre at UBC Hospital to enhance the dissemination of evidence-based treatments.[84]

Healthcare professionals working in the community mental health clinics of more than 50 communities throughout the province have been trained by the **Changeways** program to deliver cognitive-behavioural group treatment for depression. The program has been well-received by healthcare providers and constitutes a cost-effective and feasible method for the wide dissemination of evidence-based care unique in Canada. As a result of the training that has been provided by the **Changeways** program, group cognitive-behavioural treatment is available in many communities. It is recommended that group treatment services for depression provided by healthcare providers following receipt of **Changeways** program training be evaluated for fidelity to effective group cognitive-behavioural treatment. If fidelity is demonstrated, further development and expansion of the **Changeways** program is recommended.

Section 6

Gauging Success

Each of the initiatives undertaken as a component of the Provincial Depression Strategy should undergo a carefully planned evaluation that is designed at the very outset of the activity. Evaluation should include process measurement to assess whether intended standards, tools, and training activities are successfully implemented throughout the province. This would constitute a quality improvement initiative and would evaluate the extent to which standards and tools have been disseminated to relevant providers, the quantity and quality of training that has been provided to staff, the fidelity to standards that has been achieved and the extent to which treatment tools have been appropriately applied.

Gauging Success, continued

Actual improvements in health status attained through implementation of these components should also be evaluated. It is not feasible to conduct evaluation for all cases or even all agencies delivering service. Instead, a demonstration project should be undertaken in which the necessary methodological controls and evaluative resources are utilized. Efforts to initiate such a study are currently underway.

It is recommended that a planned program of fidelity assessments should be undertaken within each of the health authorities to ensure that mental health programs are adhering to standards and protocols.

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Appendix A.1

Membership of the Depression Strategy Advisory Committee (DSAC)

Dr. Donald Milliken, *Past President, British Columbia Psychiatric Association* (Chairperson)

Ms. Marilyn Carey, *Mental Health Clinician, Powell River Youth and Family Services*

Ms. Ahlay Chin, *Coordinator, Richmond Chinese Mental Health Support Group*

Ms. Bev Gutray, *Executive Director, Canadian Mental Health Association – British Columbia Division*

Ms. Sarah Hamid, *Communications & Depression Screening Coordinator, Canadian Mental Health Association – British Columbia Division*

Ms. Susan Kaiser, *Board Member, Kaiser Foundation*

Ms. Michelle Kayne, *Student, Simon Fraser University*

Dr. Stephen Kline, *Medical Director, Mental Health, Vancouver Island Health Authority*

Dr. Raymond Lam, *Head, Division of Clinical Neurosciences, Department of Psychiatry, Faculty of Medicine, University of British Columbia*

Mr. Pritam Singh Mander, *Community Representative*

Dr. Erin Michalak, *Post-Doctoral Fellow, Division of Clinical Neurosciences, Department of Psychiatry, Faculty of Medicine, University of British Columbia*

Mr. Bill Mussell, *Manager and Principal Educator, Sal'i'shan Institute Society and President, Native Association of Canada*

Dr. Heidi Oetter, *Past President, British Columbia Medical Association*

Mr.Wally Philips, *Past Director, British Columbia Chamber of Commerce*

Ms. Kathie Stenton, *Director of Regional Operations, Employment and Benefits Division, Ministry of Human Resources*

Ms. Valerie Tregillis, *Director of Strategic Initiatives, Medical and Pharmaceutical Services, Ministry of Health Services*

Mr. Gerrit van der Leer, *Manager, Mental Health and Addictions, Ministry of Health Services*

Mr. Mervyn Van Steinburg, *Director, Labour Participation Department, Canadian Labour Congress & United Way, Lower Mainland*

Mr. Robert Winram, *past Chief Executive Officer, Mood Disorders Association of British Columbia*

Ms. Cinder Woods, *Senior Mental Health Consultant, British Columbia Ministry of Children and Family Development*

Appendix A.2

Membership of the Expert Search Symposia

Child and Youth Depression

Faciliator: Dr. Paul Waraich, Mheccu

Dr. Claire Wood, Child Psychiatrist, Victoria

Ms. Lorraine Hathaway, Social Worker, Department of Psychiatry,
British Columbia Children's Hospital

Ms. Denise Zachary, Community Mental Health Clinician

Dr. Ellen Anderson, Family Physician, Victoria

Dr. Iain Forbes, Family Physician

Ms. Nicole Lindstrom, Consumer Representative

Ms. Cinder Woods, Senior Mental Health Consultant, Ministry of Children and Family Development

Depression in the Elderly

Facilitator: Dr. Elliot Goldner, Mheccu

Dr. Martha Donnelly, Geriatric Psychiatrist, Departments of Family Practice and Psychiatry,
University of British Columbia

Ms. Barbara Lindsay, Manager of Advocacy/Public Policy, Alzheimer's Society of B.C.

Ms. Amanda Brown, Social Worker, West Vancouver Geriatric Assessement Unit

Ms. Linda Myers, Manager, Psychogeriatic Services, Integrated Mental Health Centre

Ms. Kay Smithman, Family Member Representative

Ms. Lorraine Lyons, Nurse Clinician, Providence Health Care

Dr. Kathy Bell-Irving, Family Physician, Vancouver

Appendix A.2 continued

Membership of the Expert Search Symposia, continued

Postpartum Depression

Facilitator: Dr. Dan Bilsker, Mheccu

Ms. Doris Bodnar, Provincial Outreach Coordinator, Reproductive Mental Health Program, British Columbia Women's Hospital

Ms. Dr. Diana Carter, Reproductive Mental Health Program, British Columbia Women's Hospital

Ms. Kerry McLean-Small, Thompson Postpartum Support Program

Ms. Carmen Schultz, Consumer Representative, Chilliwack Healthier Living

Ms. Judith Fearing, Life After Delivery Support Program

Ms. Pat Gibson, Mental Health Worker & Facilitator, Nanaimo Postpartum Support Group

Dr. Katherine Jacques-Trevison, Practioner of Holistic Medicine

Dr. Mick Whittle, Family Physician, Princeton

Ms. Joy Hill, Postpartum Support Society

Ms. Althea Gibb, Social Worker, Maternity Ward, Burnaby Hospital

Ms. Sheila Robinson, Ministry of Children and Family Development

Substance Use and Depression

Facilitator: Dr. Elliot Goldner, Mheccu

Ms. Irene Ralph, Registered Psychiatric Nurse, Grand Forks

Ms. Michelle Kayne, Family Member Representative

Dr. Jeff Dian, Family Physician

Dr. Patricia Conrod, Department of Psychology, University of British Columbia

Mr. David Ramsey, Counsellor, Vancouver Native Healing Center

Ms. Sarah Davis, Counsellor, Residential School Healing Center

Ms. Kay Armstrong, Clinical Counsellor, Concurrent Disorders Clinic

Appendix A.2 continued

Workplace Depression

Facilitator: Dr. Dan Bilsker, Mheccu

Dr. Chris Stewart-Patterson, Family Physician, Occupational Health, St. Paul's Hospital

Ms. Sarah Hamid, Communications Coordinator, Canadian Mental Health Association – BC Division, Consumer Representative

Dr. Dan Stone, Psychologist, Employee Assistance Program

Mr. Joe Bergmann, Consumer Representative

Dr. Tim Lepard, Physician, Occupational Health

Dr. Merv Gilbert, Psychologist, University of British Columbia

Mr. Wally Philips, Past Director, British Columbia Chamber of Commerce

Cultural Expression of Depression

Facilitator: Dr. Randy Paterson, Mheccu

Dr. Hiram Mok, Psychiatrist, Vancouver General Hospital

Dr. Charles Brasfield, Psychologist & Psychiatrist, Vancouver, Bella Bella

Dr. Kala Singh, Mental Health Cultural Liason Worker

Ms. Sophia Woo, Mental Health Cultural Liason Worker

Mr. Perry Omeasoo, Mental Health Cultural Liason Worker

Mr. Cho Van Le, Mental Health Cultural Liason Worker

Mr. Michael Koo, Mental Health Cultural Liason Worker

Ms. Ahlay Chin, Coordinator, Richmond Chinese Mental Health Support Group

Appendix B

Summary of Depression Strategy Website Development

The Depression Strategy website is located at **http://www.mheccu.ubc.ca/depression** and directly linked to the Mental Health and Addictions, Ministry of Health Services, Government of British Columbia website under Adult Mental Health Policy at *http://www.healthservices.gov.bc.ca/mhd*. The website will act as an information resource for consumers and families. Secondly, it will inform the public about the progress of the BC Depression Strategy. Thirdly, it will act as an information resource for physicians and other healthcare workers. Initial emphasis has been placed on the first two of these priorities, leaving professional resources for later development.To these ends, the following components have been developed.

1. Depression Strategy Section

This section will include pages devoted to the following:

- The Depression Strategy Advisory Committee(DSAC) membership
- British Columbia's Provincial Depression Strategy – Phase 1 Report
- Progress of the Depression Strategy

2. Resources for Consumers and their Families

This section will include information devoted to the following:

- Information on causes and types of depression
- How depression is treated
- Lifestyle management of depression
- The Self-Care Depression Program
- Depression in specific populations, e.g. depression in children and adolescence, in older adults, and across cultures
- Helpful books on Depression and related topics

Appendix B, continued

BC Depression Strategy

Contents

- About the BC Depression Strategy
- Resources for Healthcare Providers
- Resources for Consumers and Families
- BC Depression Resources
- Depression Links

Send us your Feedback!

Depression and other difficulties can be serious problems requiring professional help. Information and materials on this site are not intended as substitutes for care by a qualified healthcare professional.

If you suspect that you are or may be depressed, please see your physician. more...

Welcome

Ask the average British Columbian – even the average healthcare professional – to list the most significant health problems in the province: the most common, the most expensive, the most disabling, the ones responsible for the greatest cost to the person, the family, and to workplace productivity. You will receive a variety of answers. Cancer, heart disease, diabetes, Alzheimer's disease. All of these answers are correct. But chances are, one answer will be missing.

Few people will think to include depression on the list.

In fact, depression is one of the leading causes of disability province-wide:

- Depression and stress disorders account for more than 30% of all disability recorded at major Canadian corporations.
- In any given year, approximately 4 percent of the adult population will meet criteria for a depressive illness.
- The World Health Organization has identified depression as one of the top 5 health problems world-wide in terms of years lost to disease-related disability.
- Depression is believed to cost the Canadian economy approximately 8.8 billion dollars per year, mostly in lost productivity.

Fortunately, depression is a treatable problem. Millions of dollars worth of research has been conducted into the nature and treatment of depression, and genuine gains have been made. Treatments range from self-care strategies (including exercise and dietary management) to psychotherapy (particularly specific evidence-based therapies) to medical interventions (such as medication).

The British Columbia government has committed itself to improving the availability of information and effective treatment for depression in a program called the BC Depression Strategy. This website includes material detailing:

- The nature and progress of the BC Depression Strategy.
- Information on depression and its care for consumers and their families.
- Information on depression for healthcare providers.
- Links to various healthcare resources, including facilities within BC and information sites on the internet.

We hope that you find this site useful.

Last Revised: 23 October 2002

BRITISH COLUMBIA
Ministry of Health Services

Mheccu Mental Health Evaluation & Community Consultation Unit

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For website enquiries contact webmaster@mheccu.ubc.ca

Appendix C

Self-Care Depression Program: Handout for Primary Care Providers

The following is the text of a brief handout designed for use by primary care practitioners with individuals recently diagnosed with depression. A Patient Guide has also been developed and is available on the Mheccu website in English and Chinese and will soon by available in Punjabi and Spanish. A Physician Guide has been developed in conjunction with the Patient Guide.

WHAT YOU CAN DO ABOUT DEPRESSION: THE SELF CARE DEPRESSION PROGRAM

The Self Care Depression Program has been designed by researchers at the University of British Columbia to provide depressed individuals with information and tools they can use in overcoming depression. It is meant to work alongside the treatments provided by your family physician and other mental health care providers. It helps you to become an active part of your depression treatment, working with your health providers. This brochure gives you a brief overview of the Self-Care Depression Program and tells you how you can obtain the Self-Care patient guide.

What is depression?

Depression is a disorder that can include: very low mood that lasts much longer than is normal for you; a sense of emotional numbness or emptiness; disrupted sleep; significant change of appetite; anxiety; loss of interest in previously enjoyable activities; and other symptoms that your physician can describe. More than 15% of adults will be depressed at some time in their lives. The diagnosis of depression is usually made by a family physician.

How is depression treated?

From medical research, we know that there are two effective forms of treatment for depression:

1. Antidepressant medication is effective for most people with serious depression and is the most widely-used depression treatment. Your family physician will advise you on whether medication is appropriate and how to use it. Some people have difficulty with side effects.

2. Cognitive behavioral therapy (CBT) is also effective for most people with depression. Unfortunately, it can be hard to find therapists who are trained in this method. In B.C., there is a free program called Changeways that offers CBT in a small group. It is provided by some mental health centers and hospitals. If it is available in your area, you can be referred to this group treatment by your family physician.

Appendix C. continued

What causes depression?

Although the nature and cause of depression are not fully known, research studies have identified five factors as contributing to the onset and continuation of depression. These are:

Situation: Depression is often triggered by loss, conflict, isolation, and stress. If attempts to cope with the situation are not successful, you may begin to feel overwhelmed and hopeless.

Thoughts: Depressed people usually have a biased way of interpreting situations. They are unrealistically negative about their current situation, are unfairly critical of themselves, and are overly pessimistic about the future. These habits of thinking increase the negative impact of difficult life situations.

Emotions: Depression often begins with discouragement and sadness. As the depression continues, these feelings give way to more severe and painful kinds of emotional experience: despair, anxiety, and numbness.

Physical State: Depression often includes a variety of physical symptoms: altered sleep, low energy, changes in brain chemistry, and so on. The physical changes of depression make it harder to cope with the life problems.

Actions: Depressed people often withdraw from other people, reduce their activity level, and take less care of themselves. They refuse social invitations, stop eating well, or exercising, give up hobbies, and so on. Those changes make the depression worse.

Appendix C. continued

Three ways to get control of depression

1. Reactivating Your Life

During depression, most people don't do the things that normally keep their mood positive. But if you stop taking care of yourself or doing the things you normally like, your life becomes more dull and depressing. Although it can feel as though you're comforting yourself by being less active, in fact you may be helping the depression get worse.

■ **What activities could be increased?**

Involvement with family & friends:

Self-Care (like exercise, eating well):

Personally Rewarding Activities (like hobbies):

■ **Choose 2 activities to begin increasing**

1._____

2._____

Appendix C. continued

Three ways to get control of depression, continued

- **Set realistic goals**

Make your goals specific [exactly what you intend to do this week], realistic [things you can accomplish even if you feel very depressed this week] and scheduled [write down in a schedule exactly when you're going to do it].

ACTIVITY	HOW OFTEN?	WHEN?
1.		
2.		

Think of your activity goals as appointments with yourself. Treat these goals as respectfully as you would an appointment with your physician. If you must cancel one of these appointments with yourself, reschedule immediately and don't miss it.

- **Carry out your goals, then review how it went.**

Praise yourself for what you did. Depression is likely to make you focus on the things you haven't done, and ignore or downplay your accomplishments. This keeps the depression going, because you will constantly feel like a failure. Deliberately remind yourself of achievements, no matter how small they may seem.

- **Set your goals again for the next week and add one more (no more than 3 goals at a time). Continue.**

Appendix C. continued

Three ways to get control of depression, continued

2. Challenging Old Thinking Habits

When you are depressed, you are likely to think about your problems to the exclusion of anything else. In addition to dwelling on the serious problems you face, you may also magnify small problems. Negative thinking is often:

Unfair. Negative events are given much more significance than positive ones.

Unrealistic. Issues become distorted or magnified.

The aim is to evaluate our lives and ourselves in a realistic manner. Our goal is balanced, fair, and realistic thinking.

■ **Learn to identify negatively biased thoughts.** Here are some common examples:
Filtering – only looking at the bad things in your life and ignoring the good.
Perfectionism – if you don't do it perfectly you feel like a complete failure.
Catastrophizing – a small disappointment is a disaster, negative events are magnified.
Labeling – you talk to yourself harshly and call yourself names like "idiot" that you would never say to someone else.

■ **Notice how your own negative thinking triggers depressed mood.** Most thinking is so quick and so automatic that we don't even realize we are doing it. We must learn to become aware of negative thinking as it occurs. Every time your mood sinks just a little bit deeper, ask yourself this important question: "What was going through my mind just then?" Write down your unfair and unrealistic negative thoughts.

■ **Learn to challenge these negative thoughts and replace them with fair and realistic ones.** Challenging negative thoughts involves deliberately rethinking the situation that got you upset. To do this you can use a strategy called the Three-Column Technique

Appendix C. continued

Three ways to get control of depression, continued

2. Challenging Old Thinking Habits, continued

Situation	Negative Thought	Fair and Realistic Thought

Here's a way to come up with fair & realistic thoughts.
For each of the negative thoughts, ask questions like:

- "Would most people say that the evidence supports my negative idea? If not, what idea is supported by the evidence?" Can I get more information to use as evidence?
- "What would I say to a friend in the same situation who had the same thoughts?"
- "What's a less extreme way of looking at the situation?"
- "What are the results of thinking in this way? Is there another way to think about it that gives better results?"

- Practice thinking about situations in fair and realistic ways. When you find yourself in these situations, deliberately rehearse your fair and realistic thinking. Don't assume that it will happen on its own. Talk back to the negative thinking. You will probably find that for the first while the realistic thinking sounds false to you. Only with time and repetition does the realistic thinking – the truth – begin to feel true to you. Eventually you will come to believe it fully.

Appendix C. continued

Three ways to get control of depression, continued

3. Solving Problems Effectively

Depression is often the result of life problems that have become overwhelming. Also, as people get depressed their ability to solve problems may decline.

- **Make a list of all the problems you can think of. Pick one.**
  Choose one that you really want to solve and it seems to be reasonably solvable. Start by picking one that is less difficult. Ask yourself whether there are people who might help you in solving this problem and whether you solve similar problems before [how did you do it?]. Think of all the actions you could take that might at least help the problem: write them down.

- **Choose the best action from your list.**
  Think of the advantages or disadvantages of each action, then just pick one that takes you at least part way towards a solution.

- **Make an action plan** that is specific, realistic, and scheduled like we described for activity planning.

- **Carry out your plan,** then review how it went. Praise yourself for what you did.

- **Set a plan for the next week. Continue.**

Appendix C. continued

What is the Self-Care Depression Program Patient Guide?

The Patient Guide is a 47-page booklet that gives a lot more information and help with learning these new skills for gaining control of depression. In addition, it includes valuable information about lifestyle changes that are also helpful in overcoming depression.

Where can I get the Self-Care Depression Program Patient Guide?

Your health care provider might have copies of this guide to hand out. If not, you can download it at no cost from: **www.mheccu.ubc.ca/publications**

Dan Bilsker, PhD

Randy Paterson, PhD

Mheccu, UBC

Note:This handout is intended to deliver up-to-date information on the topic of depression. It does not provide clinical assessment or treatment of depression. If expert assistance or treatment is needed, the services of a competent professional should be sought.

Appendix D

Various Information Resources Utilized in Developing Recommendations

Collection of data/consultation

This initial stage of the depression strategy involved a broad variety of information collection techniques to collect data on the success and failures of depression initiatives in other jurisdictions.

1. Literature review:

Extensive review of health databases such as MEDLINE, the Cochrane database of systematic reviews and worldwide depression initiative websites for relevant documents related to completed and ongoing depression initiatives in other jurisdictions.

2. Consultation with international experts:

Consultation by internationally recognized experts from the UK (Dr. John Geddes), the U.S. (Dr. Wayne Katon) and Canada (Dr. Raymond Lam) concerning strategies likely to be effective in our particular system. In September 2001 an e-Policy teleconference was held with the above experts to solicit their answers to the following questions:

1. Given the British Columbia context, and given an opportunity to focus province-wide effort on a three-year strategic initiative, what changes to the system of services would be most likely to produce significant reductions in the burden of illness associated with depression?

2. Would the use of a screening instrument in general practitioners' offices improve recognition and lead to better outcomes?

3. As depressive illness is often recurrent or chronic in its course, how would British Columbia's system of services best utilize its existing human resources to optimize treatment outcomes?

4. In order to make optimal use of the province's finite resources, how would you configure a stepped-care approach to the treatment of depressive disorders?

Appendix D, continued

Various Information Resources Utilized in Developing Recommendations, continued

Collection of data/consultation, continued

3. Expert Search symposia on depression in special populations:

On March 4th and 8th, 2002 focus groups were convened using a broad variety of expert stakeholders to obtain input on how to improve the management of depression in a variety of special populations including:

1. Postpartum Depression
2. Workplace Depression
3. Depression in the Elderly
4. Child and Youth Depression
5. Cultural Expressions of Depression
6. Substance Use and Depression

The following questions were asked (example from postpartum group):

1. Given currently available resources in the health system, what are 3 actions that could be taken to improve mental health services for postpartum depression? List the things that you think could be done without major additional expenditures.

2. If new funding were made available to improve services for postpartum depression, what would the top 3 priorities be?

3. What are the most important teachings about postpartum depression that should be conveyed to the families of depressed individuals? How might this information best be conveyed?

4. What are the most important teachings about postpartum depression that should be conveyed to primary care providers? How might this information best be conveyed?

5. The Depression Strategy is likely to have a substantial public education component. What are the most important teachings about postpartum depression that should be conveyed to the public? Do you have ideas about the best methods of conveying this information?

6. What are 2 actions that could be taken by the provincial mental health system to reduce stigma associated with postpartum depression?

Appendix D, continued

7. One aspect of the Depression Strategy is the improvement of information and resources for health-care providers in the mental health system (outpatient mental health facilities, inpatient psychiatric units, psychiatrists). What are the most important teachings about postpartum depression that should be conveyed to mental healthcare providers? How could this be accomplished?

8. It will be important to evaluate the impact of any changes that are made as part of the depression strategy. What are 2 outcome indicators that would reflect the quality of service for postpartum depression?

4. Depression advisory committee

A provincial advisory committee was convened by the Hon. Minister Cheema involving a variety of stakeholders including consumers groups such as the CMHA and the Mood disorders associations, representation form the B.C chamber of commerce, labor groups, various provincial ministries, clinicians and professional associations. On an ongoing basis advisory group members would raise issues relevant to the depression strategy. These issues would be discussed and compiled as recommendations in the minutes of the meetings.

Analysis of data collected:

The table inserted at the end of this appendix summarizes the analysis of data collected through the course of the first phase of the depression strategy. The most commonly suggested interventions to improve depression care were listed in table rows. The sources of these suggestions and the potential cost-effectiveness of these outcomes were listed in table columns. The most broadly recommended interventions were extracted from this table and presented in two groups, interventions that require minimal additional investment, and those which would require at least some degree of added resources.

It must be noted that several limitations exist for the procedure used for consensus. Different sources of information have different emphases and often focused on different issues. Consequently, a lack of consensus across the evidence streams should not necessarily be argued against its importance.

Analysis of the B.C linked health database:

In addition to gathering information on interventions to improve depression care, we also examined the current status of health care delivery for depression in British Columbia. This was examined using linked data on hospital discharges, outpatient physician visits and registration at community mental health centers.

Appendix D, continued

Intervention (In order of frequency of recommendations)	**Evidence in Literature**	**International expert consultation**	**Expert group consultation**	**Depression advisory committee recommendation**
Improved coordination of existing services e.g. roadmap of services, stepped care	+++	3/3 experts	6/6 (elderly, substance, child, cultural, postpartum, workplace)	Yes
Prevention and early intervention and ongoing care through targeting depression in community settings e.g. family doctors office, home visits for new mothers, Prenatal programs, school-based programs, homecare	+++	3/3 experts	5/6 (child, substance, postpartum, elderly, cultural)	Yes
Increased emphasis on provision of evidence based treatments e.g in EAP	+++	3/3 experts	4/6 (work, postpartum, substance, child)	Yes
Case management	+++	2/3 experts	1/6 (child)	Yes
Shared care with psychiatrist	+++	2/3 experts	3/6 (elderly, child, cultural, workplace)	-
Group psychotherapy	+++	2/3 experts	2/6 (child, workplace)	-
Self care for patients and families	++	2/3 experts	3/6 (child, postpartum, workplace)	Yes
Targeted General public education /stigma reduction appropriate to audience	+	3/3 experts	3/6 (elderly, cultural, child)	Yes

Appendix D, continued

Intervention (In order of frequency of recommendations)	**Evidence in Literature**	**International expert consultation**	**Expert group consultation**	**Depression advisory committee recommendation**
Enhanced Professional education	+	2/3 experts	5/6 (child, work, elderly, substance, cultural)	Yes
Province-wide dissemination of information, standards and guidelines regarding specific aspects of treatment	+	-	4/6 (work, postpartum, substance, child)	Yes
Improvements in the quality of care for depression provided by Employee Assistance Programs	+	1/3	1/6 (work)	-
Screening in primary care	++	1/3 experts	1/6 (child)	-
Standards for receipt of treatment monitored and evaluated.	+	1/3	1/6 (postpartum)	Yes
Understanding of depression should be directed toward new Canadians and their family members through various channels	?	-	2/6 (postpartum, cultural)	-
Range of treatment services that use different approaches congruent with different populations	-	-	2/6 (substance, cultural	Yes
Multilingual services/information	-	-	1/6 cultural	Yes

Feedback: Depression Strategy – Phase I Report

FEEDBACK

The *Depression Strategy – Phase 1 Report* is the first phase of a multi-year strategy to assist Health Authorities, Ministry of Health Services, and Ministry of Health Planning to assist in planning of services for people with clinical depression. In preparation for the next phase, please answer any or all of the following questions and send it to the address shown at the bottom:

1. Is this a useful document? Will it assist you in planning and delivering of services for people with clinical depression in your region? Briefly explain your response.

2. Please identify errors and identify any additional areas you would suggest for the next phase.

Feedback: Depression Strategy – Phase I Report

3. Does the document as a whole provide clear and appropriate recommendations for planning and delivering of services for people with clinical depression in your region.

4. Additional comments *(Please attach another page if you need more space)*

Name _____

Position _____

Health Authority _____

Address _____

Phone _____

Fax _____

E-Mail _____

Please return to: Mental Health and Addictions, Ministry of Health Services, 1515 Blanshard Street, Victoria, BC V8W 3C8

Mheccu

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