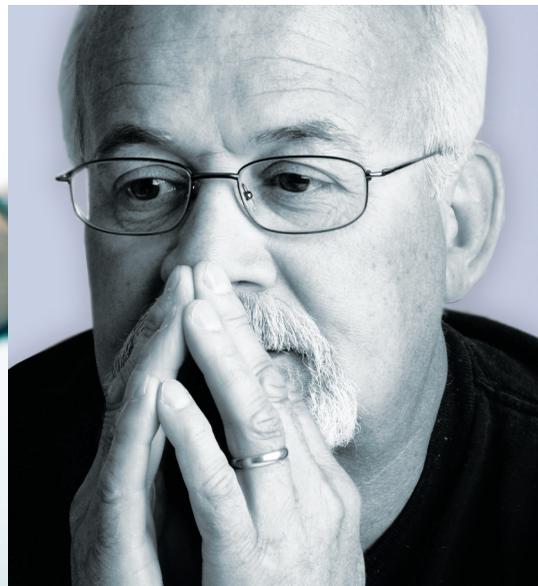


Stepping out of the Shadows

Collaborating to Improve Services for Patients with Depression



A Policy Paper by BC's Physicians | August 2009



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Collaborating to Improve Services
for Patients with Depression

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August 2009

The BCMA Council on Health Economics and Policy (CHEP) reviews and formulates policy through the use of project-oriented groups of practising physicians and professional staff.

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Executive Summary

Depression is a serious medical illness that goes beyond temporary feelings of sadness. As many as 870,000 British Columbians may experience a major depressive episode in their lifetime. Unfortunately, those who seek treatment for depression face a fragmented health care system hampered by a history of chronic under-funding for mental health services. The result is that too few patients are recognized and diagnosed, and among those who are correctly diagnosed, too few are able to access medically necessary follow-up care.

The cost of the status quo to individual health is enormous. In high-income countries like Canada, depression is the leading contributor to the burden of disease and the leading cause of disability (World Health Organization, 2008). In other words, the health burden of depression is greater than the burden caused by common diseases such as heart attack, stroke, and diabetes. The economic impact is equally concerning. The annual direct and indirect costs of depression in Canada exceed \$14 billion. For an average British Columbia company with 500 employees, yearly costs of untreated depression are nearly \$1.4 million in lost work days and reduced productivity (BC Business and Economic Roundtable on Mental Health, 2007).

Fortunately, recent initiatives in the delivery of mental health services for patients with depression – including collaborative efforts between the BCMA and the BC Ministry of Health Services – suggest that there is no lack of knowledge about how to improve care. The 2002 release of BC's Provincial Depression Strategy, the implementation of the Changeways program in the Vancouver Coastal Health Authority, the introduction of new GP mental health planning and related fees, and the launch of the mental health practice support program all point to the willingness and potential for government, physicians, and other health care stakeholders to work together to improve access to, and the quality of, care for patients with depression.

In this policy paper, the physicians of BC offer 14 recommendations to improve the status quo. These include:

- A call for the provincial government to adopt wait time benchmarks for the treatment of depression.
- The introduction of tax incentives for employers that implement a workplace mental health strategy.
- The creation of a Provincial Mental Health Commission to provide leadership at a provincial level and improve the delivery of primary care services for patients with depression.

Creating and implementing such policies requires, first and foremost, collaboration. Indeed, the experiences with current BCMA-Ministry of Health Services chronic disease collaborative efforts bode well for such an approach. If there is a theme among the recommendations posed in this paper, it is that greater collaboration among stakeholders – namely the business community, government, and providers – is the most promising route to tangible improvements. We hope that together we can work to step out of the shadows of depression and improve the lives of patients.

Recommendations

1. The federal government must match transfer payments for mental health funding equally with other medically necessary services as mandated under the Canada Health Act.
2. The provincial government must establish a straightforward and understandable system of tracking funds, system capacity, and human resources (particularly to and within health authorities) for the care of persons with mental health problems, including depression. The establishment of such a system may be facilitated by a comprehensive review undertaken by the Auditor General of British Columbia.
3. The provincial government should introduce tax incentives or other measures for employers that implement a workplace mental health strategy that is based on a provincial standard.
4. Efforts to increase the use of depression screening and case-finding tools should not be promoted in isolation, but rather as part of broader organizational enhancements, such as those found in collaborative care programs.
5. The Ministry of Health Services, the BCMA, WorkSafeBC, and the business community should examine ways to improve understanding and implementation of programs and strategies that address depression in the workplace.
6. Recognizing the serious nature of depression, patients with major depression must be treated within established wait time benchmarks as specified by the Canadian Psychiatric Association.
 - a. After referral by a general practitioner, access to a psychiatrist for a patient with major depression should be no more than 24 hours for emergent conditions, 2 weeks for urgent conditions, and 4 weeks for scheduled services.
 - b. In the event that treatment cannot be provided within these times at the usual public facility, the provincial government must offer a care guarantee whereby treatment will be offered within the benchmark wait time at another public facility, in or out of the province, or in a private facility, at no added cost to the patient.
7. The Ministry of Health should continue to fund the development of, and expand if necessary, the structured chronic disease management approach for patients with mental health disorders, including depression.
8. To further the understanding of and ability to treat mental illness, the provincial government should enhance BC physicians' ability to conduct advanced research for basic and applied mental health, including depression.
9. The provincial government should provide enhanced resources for the education and training of physicians to treat depression in adults and youth.
10. The Ministry of Health Services should support efforts to improve the flow of information regarding available resources to care for patients with depression among GPs, specialists, and other mental health providers through pilot studies and, if successful, provide ongoing program funding.
11. The joint BCMA-Ministry of Health Services Shared Care Committee and/or another appropriate joint body should fund pilot projects and, if they are successful, ongoing programs to foster the GP-specialist interface with respect to treating patients with depression.

12. A joint BCMA-Ministry of Health Services Provincial Mental Health Commission should be established in order to facilitate improvements in mental health care. Both parties should select additional members including, among others, the business community, the health authorities, appropriate and responsible non-governmental and patient organizations, and non-physician mental health practitioners.
13. The provincial government, through its letters of expectation, must coordinate measures and objectives across health authorities with respect to mental health and depression.
14. The provincial government, in consultation with recognized and relevant professional bodies, should regulate and certify providers of cognitive behavioural therapy and other scientifically valid therapies to ensure the safety and quality of care for people referred for such therapy.

Introduction

Patients with depression confront a health care system that is under-resourced. Too few patients with depression are recognized and diagnosed, and many are unable to access medically necessary follow-up care. The social, personal, and economic costs of the status quo are too great to be ignored.

In May 2006, the Standing Senate Committee on Social Affairs, Science and Technology released its final report on mental health, entitled *Out of the Shadows at Last*. The report compiled more than 2,000 submissions from individuals and organizations with an interest in improving Canada's mental health system. The hundreds of individuals with depression and other mental illnesses who testified before the Committee recounted touching and often tragic personal stories of the stigma and discrimination they have faced in nearly every venue of society.

Fortunately, the release of BC's Provincial Depression Strategy in 2002, the creation of the Standing Senate Committee itself, recent changes to Medical Services Plan funding to improve treatment for mental health patients, and a growing awareness of the biosychosocial nature of mental illness—in other words, the roles that biology and the psychological and social environments play—all point to society's progress in reducing the stigma and shame associated with mental illness, thereby doing much to bring these patients and their conditions "out of the shadows."

Yet despite this progress, our health care system has yet to address adequately three major problems facing patients with depression:

1. *Compared to those suffering from non-mental health conditions, patients with depression confront a health care system that is significantly under-resourced.* The exclusion of psychiatric hospitals and facilities from federal funding and cost sharing under the Canada Health Act (and its predecessor, the Hospital Insurance and Diagnostic Services Act) created a legacy of under-funding for mental health services.
2. *Too few patients with depression are recognized and diagnosed.* A 2007 study found that less than half of patients with depression are recognized by their primary care physicians (Cepoiu et al., 2008). The persistent stigma around mental illness, the challenge of diagnosing mental illness when patients present with physical rather than emotional complaints, and system-level disincentives and barriers to providing treatment conspire against early and accurate recognition of depression by primary care providers.
3. *Once diagnosed, too few patients suffering from depression are able to access medically necessary follow-up care to maintain and improve their mental health.* In a five-country survey of treatment for mental health disorders, Canada had the lowest level of treatment rates for patients with mental illness (Bijl et al., 2003).

The unnecessary social, personal, and economic costs that stem from the status quo signal a problem of such wide-ranging impact it can no longer be tolerated. Depression is the leading cause of disability. Not surprising, the economic implications are staggering: for an average British Columbia company with 500

employees, untreated depression costs nearly \$1.4 million in lost work days and reduced productivity (BC Business and Economic Roundtable on Mental Health, 2007).

In order to address these three major problems regarding depression, the BCMA makes 14 recommendations. Foremost among these is a call for the provincial government to adopt wait time benchmarks for the treatment of depression to improve patients' access to care. Also included are recommendations calling for tax incentives or other measures for employers that implement a workplace mental health strategy, as well as a call for the creation of a Provincial Mental Health Commission to provide leadership at a provincial level and improve the delivery of primary care services for patients with depression.

This paper is organized in five sections. Section 1, "Understanding Depression," defines depression and explores the breadth of the problem with data on its incidence and prevalence. Section 2 examines the economic, social, and health costs of depression for various stakeholders, including individuals, government, and business. The paper continues in Section 3 with a presentation of the organization, delivery, and financing of care for patients with depression in British Columbia, identifying both success stories and gaps in care. Section 4, "Challenges and Opportunities," offers recommendations in four areas: policies to increase resources for mental health services, the recognition and diagnosis of patients with depression, improving access to treatment and follow-up care, and improved accountability and oversight. The paper concludes in Section 5 with additional summary remarks.

I. Understanding Depression

Depression is a serious medical illness that goes beyond temporary feelings of sadness. It is the leading contributor to the burden of disease and the leading cause of disability – more than heart disease, stroke, diabetes, and other common diseases. As many as 870,000 British Columbians – many with other serious chronic conditions – may experience a major depressive episode in their lifetime.

The everyday use of the word “depression” often differs from a clinical definition, which can lead to confusion about what is really being discussed. At one extreme, “depression” can refer to the “blues” or sadness that is a normal part of life, and at the other extreme, it may mean a more serious condition of a lowered mood state with persistent symptoms associated with dysfunction (Patten, 2008a). People with depression may experience a variety of symptoms, including feelings of long-lasting sadness, anxiety, feelings of emptiness, pessimism, guilt, hopelessness, helplessness, feelings of worthlessness, irritability, an inability to feel pleasure, loss of interest in sex, lack of energy and enthusiasm, disturbed sleep, changes in appetite, or thoughts of suicide (M. Kirby, 2008).

For purposes of this paper, we refer to depression as the clinically diagnosable disorder of major depression.¹ Major depression goes beyond temporary feelings of sadness and is a serious medical illness. The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) and the WHO’s International Classification of Diseases (ICD-10) provide the most widely-used criteria for diagnosing depression (American Psychiatric Association, 2000; World Health Organization, 2007). The DSM-IV criteria for “major depressive disorder” (roughly analogous to the ICD-10 classification of “recurrent depressive disorder”), subtypes of major depressive disorder, and several screening tools for depression are described in Exhibit 1.

1. However, the depressive syndrome exists across a spectrum of severity that ranges from sub-clinical to severe and functionally disabling.

A review of the entire continuum of care for patients with depression and the related clinical, social, organizational, and economic issues is beyond the scope of this paper. Instead, we focus more specifically on first line and intensive services and supports that affect the majority of patients suffering from depression (i.e., the prevention, assessment, and treatment provided by frontline providers; services provided in the community or hospital settings for people with serious mental illness). Our analysis therefore excludes issues around patients with complex, treatment-resistant depression – these patients require services and supports provided (usually) through highly specialized programs. This exclusion is not intended to diminish the importance or urgency of such cases, but rather to recognize that such a comprehensive examination is beyond the scope of this paper.

Often, the public policy issues and solutions for depression are inseparable or overlap with those for the broader category of mental health. Where appropriate, this paper will refer to both mental health in general and depression in particular.

Exhibit 1: Diagnosis, subtypes and screening for major depressive disorder

Criteria for Clinical Diagnosis	Subtypes of Major Depressive Disorder
<p>Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:</p> <ol style="list-style-type: none"> 1) Depressed mood 2) Loss of interest or pleasure 3) Weight loss 4) Changes in sleep 5) Movement changes 6) Fatigue or loss of energy 7) Low self-esteem 8) Impaired concentration and decision making 9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide 	<ul style="list-style-type: none"> ▪ Melancholic depression ▪ Atypical depression ▪ Catatonic depression ▪ Postpartum depression ▪ Seasonal affective disorder <p>Major depressive disorder subsumes bipolar disorder.</p> <p style="text-align: center;">Screening for Depression</p> <p>Multiple tools for screening for depression are available to practitioners. Some common tools include:</p> <ul style="list-style-type: none"> ▪ PHQ-9. Patient Health Questionnaire 9. Nine questions rated on a 0 to 3 scale. ▪ Beck Depression Inventory. Twenty-one question survey completed by patient, answers scored on 0 to 3 scale. ▪ Zung Depression Rating Scale. Twenty question survey completed by patient; Likert scale format; asks half of questions positively and half negatively; answers scored on 1 to 4 scale.

Sources: Adapted from American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. "Depression Screening Tools" (2008), downloaded from www.fpnotebook.com, accessed March 4, 2009. Major depressive disorder is distinctive from bipolar disorder, which is diagnosed and managed differently.

Estimates of the prevalence of depression vary depending on the population in question and the time period under consideration, although rates tend to be higher in women than men. Patten estimates the 12-month prevalence rates for Canadians age 12-24 at 9.6% (women) and 5.2% (men). For Canadians age 25-44, the rates are lower: 8.6% (women) and 3.5% (men). Although some studies suggest that there is an increasing prevalence of depression (Grof, 1997; Spaner, Bland, & Newman, 1994), research on adults from a population in Atlantic Canada found a steady rate of 5% for major depressive episodes combined with dysthymia over a 40-year period (Murphy, Laird, Monson, Sobol, & Leighton, 2000). In a recent Canadian Medical Association survey, 15% of Canadians reported that they have been diagnosed by a doctor as being clinically depressed and many experience numerous issues associated with mental illness, such as stress (36%) and feelings of helplessness or worthlessness (23%) (Canadian Medical Association, 2008). A recent paper suggests that lifetime prevalence exceeds 20% and may be as high as 50% (Patten, 2008b). As many as 870,000 British Columbians may experience a major depressive episode in their lifetime, taking

into account the current provincial population (O’Neil, 2009) and lifetime prevalence rate of 19.7% (Patten, 2009). A 2002 analysis of provincial data revealed that annually more than 300,000 British Columbians had seen a physician for problems related to depression or anxiety, with the highest rates during midlife and late life (Goldner, 2002). Depression is first among diseases of global disease burden and is the number one cause of years of life lived with disability for both males and females (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). The result is an enormous public health burden that exceeds other common sources of morbidity and mortality—more than heart disease, stroke, diabetes, and other common diseases (Kessler, Greenberg, Mickelson, Meneades, & Wang, 2001; Ustun, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004; Wells et al., 1989; World Health Organization, 2008).

The burden of the disease extends beyond those suffering from depression alone. Problems can extend to the patient’s caregivers and other family members (van Wijngaarden, Schene, & Koeter, 2004). Postpartum depression, for example, can have significant adverse effects on fathers, other caregivers, and children (Roberts, Bushnell, Collings, & Purdie, 2006; Stein, Malmberg, Sylva, Barnes, & Leach, 2008).

Likewise, the burden of disease also extends to those suffering from chronic conditions. Approximately a quarter of people living with chronic diseases or co-morbidities also live with depression (W. J. Katon et al., 2004). Eleven to 15% of patients with diabetes have major depression, which contributes predictably to poorer health outcomes (W. J. Katon et al., 2004). Using survey data on chronic disease patterns, Currie and Wang found that rates of major depression were more than three times greater among those with chronic back pain than those without (Currie & Wang, 2004), with depression a significant predictor of first-onset back pain (Currie & Wang, 2005). Individuals with asthma, arthritis, high blood pressure, chronic bronchitis, diabetes, heart disease, and cancer are all at increased risk for depression compared to the general population (Patten, 1999, 2001). Research evidence likewise shows that the reverse is true: those with depression are at a heightened risk of mental illness (Exhibit 2).

Exhibit 2: Heightened risk of medical illness for people with depression

Medical condition	Risk level
Stroke	2.6 times the rate for the general population
Epilepsy	4 to 6 times the rate for the general population
Alzheimer	1.71 to 2.67 times the rate for the general population
Diabetes (type 2)	Depression is an independent risk factor
Cancer	1.35 to 1.88 times the rate for the general population
Obesity	Childhood or adolescent depression is a predictor of obesity

Source: *Mental Illness & Addiction in Canada*, Mood Disorders Society of Canada, 2007. Second edition.

II. The Costs of Depression

In high-income countries like Canada, the burden of depression is greater than the burden caused by common diseases such as heart attack, stroke, and diabetes. For an average British Columbia company with 500 employees, yearly costs of untreated depression are nearly \$1.4 million in lost work days and reduced productivity.

The burden of depression is best understood in comparison to other common sources of morbidity and mortality. The World Health Organization uses disability adjusted life years (DALYs) to perform such a comparison. One DALY represents the loss of the equivalent of one year of full health (World Health Organization, 2008). This allows an apples-to-apples comparison of diseases that cause early death but little disability (e.g., motor vehicle accidents) with those that do not cause death but are disabling (e.g., Alzheimer disease).

For high-income countries like Canada, major depressive disorders were the leading cause of burden of disease, responsible for the loss of over 10 million DALYs (Exhibit 3). In other words, the burden of major depressive disorders was greater than the burden caused by common diseases such as ischaemic heart disease, cerebrovascular disease, and diabetes mellitus.

Exhibit 3: Leading causes of burden of disease (DALYs*), all ages, high-income countries, 2004

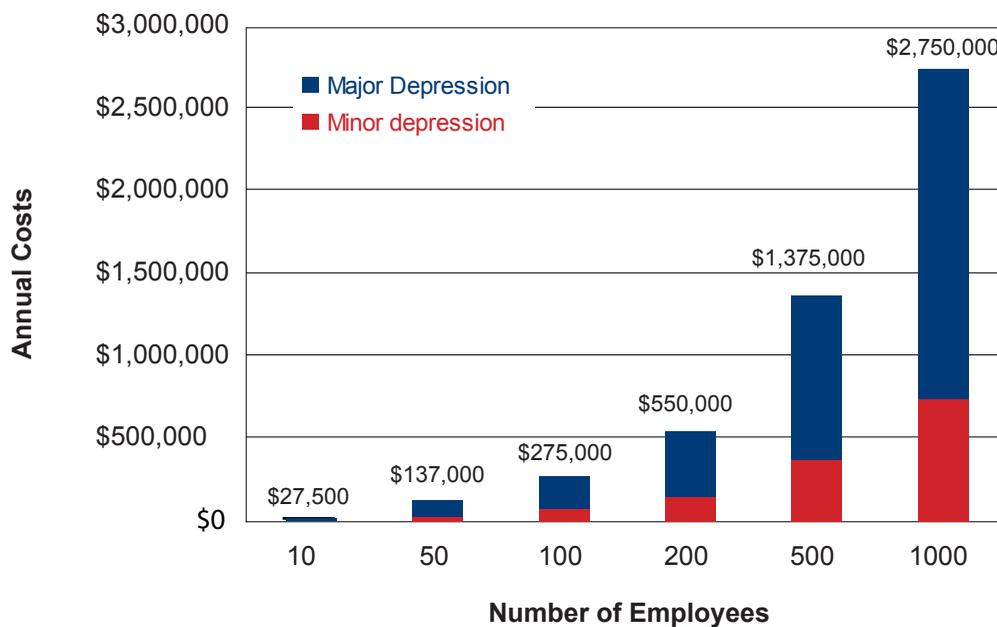
Rank	Disease or Injury	DALYs (millions)
1	Major depressive disorders	10.0
2	Ischaemic heart disease	7.7
3	Cerebrovascular disease	4.8
4	Alzheimer and other dementias	4.4
5	Alcohol use disorders	4.2
6	Hearing loss, adult onset	4.2
7	COPD	3.7
8	Diabetes mellitus	3.6
9	Trachea, bronchus, lung cancers	3.6
10	Road traffic accidents	3.1

Source: Adapted from World Health Organization (2008). Global Burden of Disease 2004 Update. Geneva, WHO Press. * DALY = disability adjusted life years

The resulting economic burden of depression is likewise significant. A 2001 Health Canada study found that the annual direct and indirect costs of depression (visits to non-medical mental health professionals) exceeded \$14 billion (Stephens & Joubert, 2001). Although this estimate included costs for distressed patients (e.g., patients with anxiety disorders), the authors note that their results “may also be an underestimate of the true value” given methodological limitations, notably the very conservative definition of depression used. A recent economic analysis for all mental illness in Canada found that including the costs associated with those suffering from undiagnosed mental illness, as well as the associated costs for all non-mental health services associated with mental illness, produced substantially higher estimates of economic burden (K. L. Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008). Similarly, including these costs in estimates of the burden of depression would likely reveal that such figures are also underestimates.

The economic impact of depression is further amplified because so many of those suffering from depression are of working age, and the impact of depression on job performance is strongly associated with absenteeism and decreased productivity (Gilmour & Patten, 2007). Such costs have been estimated at \$2.6 billion per year for Canada (Stephens & Joubert, 2001). For an average British Columbia company with 500 employees, yearly costs of untreated depression are nearly \$1.4 million in lost work days and reduced productivity (BC Business and Economic Roundtable on Mental Health 2007) (Exhibit 4).

Exhibit 4: Estimated costs of untreated depression for businesses in British Columbia by number of employees



Source: BC Business and Economic Roundtable on Mental Health. Depression Cost Calculator. <http://www.bcmentalhealthworks.ca>. Accessed February 11, 2009. Assumes average annual salary of \$50,000. The cost of major depression (long term disability) is full time equivalent employees, times 4% (the average number of people in the workforce that is experiencing major depression) times \$50,000 (lost salary + medication costs). The cost of minor depression (shorter term disabilities) is measured in terms of presenteeism (employee remains at work but is less productive) and estimated to cost a minimum of 25% in lost productivity. Dollar figures in boxes equal total costs of major and minor depression.

III. Organization, Delivery, and Financing of Care for Patients with Depression

Patients with depression face barriers to accessing care at every stage of their condition, from initial diagnosis to follow-up care. A history of chronic under-funding of mental health services and a lack of information on how and where money is being spent in the system inhibits necessary, system-wide reforms.

Given the significant health and economic costs associated with depression, the primary challenge facing health care policymakers in British Columbia is to improve patient access to services and the quality of services provided. Physicians and other care providers, the business community, the provincial government, and health authorities all have important roles to play. This section examines the current organization, delivery, and financing of care for patients with depression.

Organization and Delivery of Care

Exhibits 5 and 6 outline the depressed patient's journey through the health care system:

Step I: Decision to seek help from the health care system. Patients suffering from depression, and those around them, may be unaware of the presence of the illness, and therefore may fail to seek help. Even when aware of the problem, the stigma and shame surrounding mental illness may convince patients not to seek help. Only half of Canadians would tell friends or co-workers that they have a family member suffering from a mental illness (50%), compared to 72% who would discuss cancer or 68% who would discuss diabetes (Canadian Medical Association, 2008). It is therefore not surprising that across Canada, less than half of depressed women consult a health professional (Stewart, Gucciardi, & Grace, 2004). In British Columbia, only 48% of those who have experienced depression or anxiety visited a doctor for that problem (Canadian Mental Health Association, 2002).

Step II: Entry into the health care system. Patients with depression may access the health care system through a variety of entry points, including the hospital emergency room or outpatient/community-based services (particularly if the patient does not have a regular GP), where patients may face lengthy waits for services. However, the most common access point in BC's health care system remains the general practitioner. Eighty-three percent of Canadians who seek help for a diagnosable mental health disorder see their family physician (Gilbody, Sheldon, & House, 2008). Research suggests, however, that depression is both under-diagnosed and under-treated at this step in the patient's journey. Less than half of patients with depression are recognized by their primary care physicians (Cepoiu et al., 2008). In a study of Ontario patients with major depression, over half received no treatment (Parikh, Lesage, Kennedy, & Goering, 1999).

Step III: Continuing care for depression. Those patients who are treated for their depression feel that the treatment they receive is effective. Citing data from the Canadian Community Health Survey, Patten observes that over half of respondents reported that their treatment helped them "a lot," and this perception was "equally positive whether treatment was received from primary caregivers, such as general practitioners and family doctors, or mental health specialists" (Patten, 2008c).

Exhibit 5: Patient access to health services for the treatment of depression

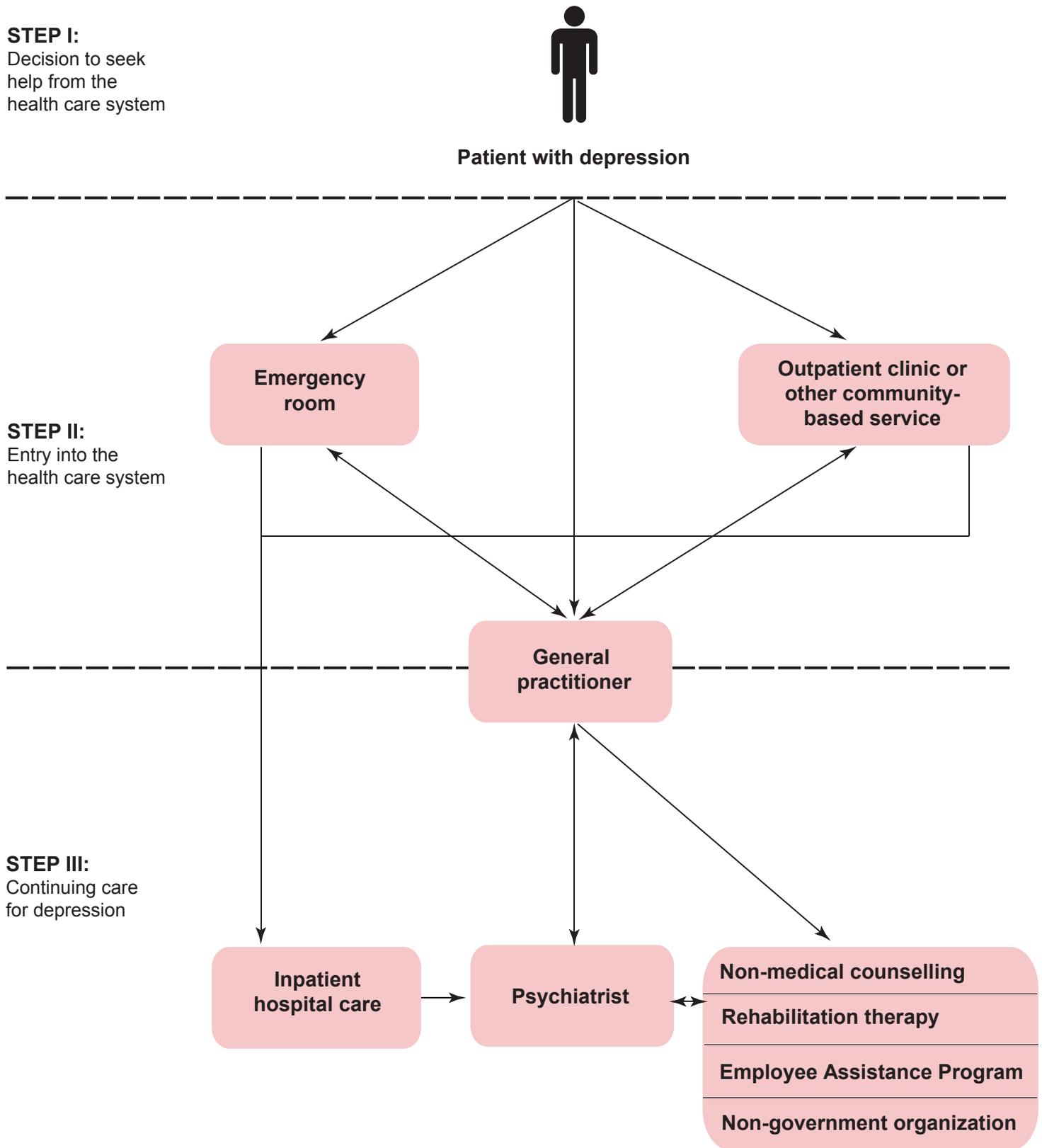


Exhibit 6: Problems, barriers, and consequences to restricted access to care for patients with depression

- STEP I:**
Decision to seek help from the health care system
1. Patient or those around them (e.g., family, co-workers) fail to recognize the signs of depression
 2. Patient may choose not to seek help
 3. Patient seeks help for reason other than depression
-

- STEP II:**
Entry into the health care system
1. Delays in recognition and diagnosis due to a lack of diagnostic expertise, delayed access
 2. Poor rapid access to primary care physician
 3. Delays in initiating or modifying treatment
 4. Sub-optimal therapy (choice of treatment modality or agent, dose, duration)
 5. Delay in accessing specialists
 6. Revolving door between providers (e.g., GP, emergency room, psychiatrist, counsellor)
 7. Progressive decline in patient's condition and social status
-

- STEP III:**
Continuing care for depression
1. Lack of support and training of primary care physicians to provide mental health care
 2. Limited access to specialists
 3. Limited access to non-medicinal therapeutic services
 4. Sub-optimal outcomes due to variable quality of medical and non-medical counselling services, rehabilitation therapy
 5. Lack of self-management support or education
 6. Patient non-compliance with therapy

A substantial body of research confirms that even when correctly diagnosed, depression is under-treated. Access to an inpatient psychiatric bed may be delayed because of inadequate supply of beds. When GPs decide that a consultation with a psychiatrist is necessary, they are likely confronted with excessive wait times well beyond the maximum of 24 hours (emergent), 1 week (urgent), or 4 weeks (scheduled) recommended by the Canadian Psychiatric Association (Canadian Psychiatric Association, 2006). A recent survey of physicians suggests that the wait time from GP referral to psychiatrist treatment in British Columbia exceeds 4 months (Esmail, Hazel, & Walker, 2008), and waits in rural areas may be even longer (Canadian Psychiatric Association, 2006).

Should the patient remain with the GP, the quality of the ongoing care may not be consistent with recommended guidelines. American researchers have found that inappropriate discontinuation of antidepressant therapy is widespread in the community treatment of depression, with fewer than 30% of patients continuing therapy for more than 90 days, fewer than 50% receiving guideline-level pharmacotherapy, and fewer than 10% of patients receiving guideline-level psychotherapy (Olfson, Marcus, Tedeschi, & Wan, 2006). Such sub-optimal therapy not only leads to unnecessary pain and suffering, but also increases the risk of relapse or recurrence (Melfi et al., 1998). The quality of care provided by non-medical mental health professionals, which can vary considerably, may also be an issue. Research suggests that clinicians' ability to demonstrate cognitive behavioural (CBT) techniques, and hence the quality of care provided, may depend on the type of training received (Sholomskas et al., 2005).

The reasons for the reduced access and sub-optimal care are varied. On one hand, there are challenges facing individual physicians and patients. It can be exceptionally difficult for physicians to identify untreated depressed patients, given that they are less likely than their treated counterparts to feel they have a mental health problem, to seek treatment for such a problem, or to feel comfortable consulting a professional about their mood disorder (Lin & Parikh, 1999). The continuing stigma of mental illness certainly plays a role here. With respect to referrals, psychiatrists may be reluctant to add patients to an already overburdened practice out of concern that the severity of the condition does not warrant a specialist consult and would be more appropriately managed in a GP's practice. GPs, perhaps frustrated by past attempts to get a specialist consult, may presume that pursuing one is futile. Often, both GPs and specialists assume a psychiatric referral is a form of long-term care, even if the patient may require much less contact with the specialist. Indeed, while few would expect a neurologist to refer a patient to a non-neurologist for rehabilitative and follow-up care, many assume the opposite in the case of a psychiatrist. Finally, despite the existence of depression treatment guidelines for BC physicians, many practitioners and their patients are exposed to multiple, confusing, and often conflicting messages on the appropriate treatment standards (Barbui, Furukawa, & Cipriani, 2008; Deshauer et al., 2008; Katz et al., 2008).

On the other hand, there are also system-level issues that must be resolved before progress is possible. Resolving the concerns over waits that exceed medically acceptable standards (Canadian Psychiatric Association, 2006; Esmail et al., 2008), the training and quality of care for non-medical mental health providers (Sholomskas et al., 2005), the stigma associated with mental illness in the workplace and in the general public (Canadian Medical Association, 2008), the GP-specialist interface in the referral and management of patients, and the inadequate infrastructure, are beyond the reach of any one person or health care stakeholder and require coordinated efforts at the level of the provincial government or health authority.

Financing of Care

According to the Ministry of Health Services, British Columbia spends \$1.2 billion per year on mental health and addiction services (Ministry of Health Services, 2009a). This is more than the annual budget for all of PharmaCare (\$900 million in 2006) (Pharmaceutical Services Division, 2007), more than quadruple the annual amount spent on all health research in BC (\$278 million in 2007) (Province of British Columbia, 2007), and more than half the total of all federal health transfers to British Columbia (\$2.47 billion in 2005) (Health Council of Canada, 2006).

Three important questions arise from the Ministry's figures: first, how can we know if the correct figure is \$1.2 billion; second, where is the money being spent; and third, are we getting value for money?

Historical evidence suggests that, at least with respect to services for psychiatric patients, we may be spending less than we think. Canada has a long history of minimizing or ignoring the needs of the mentally ill. The Hospital Insurance and Diagnostic Services Act (1957), the precursor to the Canada Health Act, stated that for the purposes of federal funding and cost sharing:

“Hospital” includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include...a hospital or institution primarily for the mentally disordered... (Freeman, 1994)

This exclusion effectively eliminated the majority of psychiatric patients from sharing in the increased federal-provincial transfer payments that supported and led the development of Canada's health system through the 1960s and 70s. In contrast to every other branch of medicine, care for patients with psychiatric illnesses was left entirely in the hands of provincial governments, with none of the federal support for the upgrading of facilities or services that existed in other areas.

Not surprisingly, this made it much more attractive for provinces to invest dollars in the other, non-psychiatric areas of hospital and health care, where such investments would be matched by the federal government. Unfortunately, the clinical effects of this good financial stewardship were disastrous for the mentally ill.

A simple example lies in the increase in nurse staffing per 100 patients from 1961 to 1975. Mental hospitals started out with significantly fewer nurses than general hospitals. Over the next 15 years, while the numbers of nurses increased in both types of institutions, the increase in nurses per patient in general hospitals was three times that for patients in mental hospitals. Over the next decades, the same problems of reduced resourcing persisted.

In 1964, less than a decade after the Hospital Insurance Act was introduced, the Hall Commission stated:

Of all the problems presented before the Commission, that which reflects the greatest public concern, apart from financing of health services generally, is mental illness – case finding, diagnosis, treatment, and rehabilitation... Treatment of the mentally ill has been for too long characterized by callousness and neglect.

Despite such sentiments, the 1984 Canada Health Act continued the same exclusionary clauses, continuing to isolate patients with serious psychiatric illnesses from the mainstream of federal health care funding.

Faced with this reality, and like many other provinces, British Columbia has never provided a consistent, coherent, and effective policy to ensure that mentally ill patients receive services at a level equal to those offered to physically ill patients with an equivalent level of disability. The results have been predictable. As the recent Senate of Canada report *Out of the Shadows at Last* comments:

Mental illness, in general, is not often treated with the same degree of seriousness as physical illness...Achieving equity would mark an important step in combating the stigma...and the discrimination against people living with [mental illness].

Quite simply, mental health services and additional treatment are underfunded in relation to their prevalence and the economic burden of illness they impose. (M. J. Kirby & Keon, 2006)

Determining the appropriate level of public funding for mental health services, including services for patients with depression, is a matter of debate. In British Columbia, 8% of all public health expenditures and 6.4% of total (public and private) health expenditures are devoted to mental health. These figures are above the national averages (6.1% and 4.8%, respectively), but still well below the proportions spent by other developed countries. Australia, Ireland, the United States, Denmark, the Netherlands, Germany, and the United Kingdom spend between 6.7% and 12.1% of their total health expenditures on mental health (Kim Lian Lim, Jacobs, & Dewa, 2008).

Of course, comparing percentages of total spending across countries has some drawbacks, namely that countries vary in their total health care spending levels and measure mental health spending differently. Nonetheless, if one accepts that mental health patients, including those with depression, should be offered an equivalent level of services as non-mental health patients, Canada and British Columbia must dramatically increase funding for such services. One estimate suggests increases as high as \$6.3 billion nationally (Kim Lian Lim et al., 2008).

IV. Challenges and Opportunities

Recent initiatives in the delivery of mental health services for patients with depression suggest that there is no lack of knowledge about how to improve care. We offer recommendations in four areas: policies to increase resources for mental health services, the recognition and diagnosis of patients with depression, improving access to treatment and follow-up care, and improved accountability and oversight.

The preceding sections outline the major barriers to access and quality of care that patients with depression face in BC's health care system. These observations are not new, and many have initiated programs and policies to improve the status quo (Appendix). Indeed, the great potential of these programs suggests that there is no lack of knowledge of what needs to be done to improve care for patients with depression.

Nonetheless, major challenges remain, particularly with respect to the three needs raised at the beginning of this paper: the need for additional resources, the need to improve recognition and diagnosis for people with depression, and the need to improve access to treatment and follow-up care. This section provides recommendations in each of these three areas. We also include a fourth area, improving oversight and accountability, as a means of facilitating the first three. Finally, although the focus of this paper is depression, the recommendations tend to cover the broader area of mental health. This stems from the fact that, in a practical sense, it is largely impossible to separate those policy recommendations that affect patients with depression from those that would impact patients with other mental disorders.

Increasing Resources for Mental Health Services

The exclusion of mental health care from sharing in the increased federal-provincial transfer payments that supported and led the development of Canada's health system through the 1960s and 70s has led to a chronic under-funding for care of patients with depression and other mental disorders. A necessary first step for any system-wide efforts to bring parity for mental health is for the federal government to match transfer payments for mental health funding equally with other medically necessary services as mandated under the Canada Health Act.

Recommendation 1: The federal government must match transfer payments for mental health funding equally with other medically necessary services as mandated under the Canada Health Act.

Because hospitals no longer officially allocate beds to particular services or particular functions, there is no externally identified capacity for any services. In theory, this promotes flexibility at the local level. However, this change also means that independent organizations like the Canadian Institute for Health Information (CIHI) can no longer track changes in available acute care bed base for psychiatric patients—data are limited to hospital separations for mental illness (Canadian Institute for Health Information, 2009). Further sources of confusion are the ways in which federal funding for psychiatric services is provided to provinces outside the Canada Health Act through block funding for social programs. This makes it impossible to easily identify

how much of the total health care budget is being spent for the care of patients with psychiatric illnesses, whether and to what extent the impact of the downsizing of Riverview (the greatest reduction in in-patient resources for any group of medically ill patients in BC) has been offset by additional spending elsewhere in the system; and whether there has been an increase in funding in community services to care for patients who would otherwise have been cared for as inpatients.

According to the Ministry of Health Services, British Columbia spends \$1.2 billion per year on mental health and addiction services (Ministry of Health Services, 2009a). However, this figure raises more questions than it answers. Information on the total amount spent, the allocation of these funds, and the most important question of whether we are getting value for money, is nearly impossible to obtain, and without it, meaningful system-level reform is impossible. Because it is impossible to plan adequately for the allocation of resources until we know how current funds are being spent, the provincial government must establish a straightforward and understandable system of tracking funds, system capacity, and human resources (particularly to and within health authorities) for the care of persons with mental health problems, including depression. The establishment of such a system may be facilitated by a comprehensive review undertaken by the Auditor General of British Columbia.

Recommendation 2: The provincial government must establish a straightforward and understandable system of tracking funds, system capacity, and human resources (particularly to and within health authorities) for the care of persons with mental health problems, including depression. The establishment of such a system may be facilitated by a comprehensive review undertaken by the Auditor General of British Columbia.

The direct and indirect costs of depression to employers are significant. Depression is responsible for over half of all mental health diagnoses and claims and leads to more days of disability than common chronic conditions such as heart disease, diabetes, high blood pressure, and low back pain (Conti & Burton, 1994). Claims data in British Columbia currently show that in the health care industry, for example, mental disorders, including depression, account for 24% of all active long-term disability (LTD) claims. Indeed, depression is the primary diagnosis in more than 66% of all mental illness claims and overall represents over 16% of all active LTD claims. Recent surveys in health care organizations also show a high level of depressive symptoms and associated work impairment and confirm the low rates of diagnosis and effective treatment described elsewhere in the paper. So that businesses, including small- and medium-sized businesses, have available the necessary resources to engage in such activities, the BCMA calls upon the provincial government to introduce tax incentives or other measures for employers that implement a workplace mental health strategy that is based on a provincial standard.

Recommendation 3: The provincial government should introduce tax incentives or other measures for employers that implement a workplace mental health strategy that is based on a provincial standard.

Improving the Recognition and Diagnosis for People with Depression

An obvious and necessary step to improving access to care for patients with depression is finding those patients in the first place. Screening and case-finding tools, such as standardized patient questionnaires to determine if someone is suffering from depression or another mental illness, have been proposed as quick and cheap methods to find patients in need of care. Many have recommended the expanded use of such tools in a variety of settings (e.g., physician's office, other community-based settings). The use of screening tools for depression in schools, for example, has been acknowledged as an important way to identify under-treated adolescent and child populations (Cuijpers, van Straten, Smits, & Smit, 2006). Similarly, the Canadian Task Force on Preventive Health Care and similar bodies in the US and UK recommend the use of screening and case-finding tools (MacMillan et al., 2005).

However, a recent review of studies on the effectiveness of screening and case finding revealed an important caveat to the use of these tools: when used alone, without any other changes in the organization of care, such tools appear to have little or no impact on the detection and management of depression by clinicians (Gilbody et al., 2008). In other words, simply having physicians administer a standardized questionnaire to patients does little to help identify those patients and treat their depression. Instead, the authors of the review suggest that screening tools should be accompanied by "organizational enhancements." Such enhancements include, for example, the use of coordinated follow-up, case managers with a mental health background, and regular supervision of case managers—in other words, the kinds of systems and structures found in collaborative care programs.

Because the authors of the study caution that the results of their study "should be considered hypothesis generating" with "further randomized trials needed to test the robustness of these findings," the prudent strategy would be to promote an expanded use of screening tools only when also accompanied by organizational enhancements, such as those found in collaborative care programs.

Recommendation 4: Efforts to increase the use of depression screening and case-finding tools should not be promoted in isolation, but rather as part of broader organizational enhancements, such as those found in collaborative care programs.

The prevalence of depression as well as the problems of under-diagnosis and under-treatment of depressed patients in the general population are mirrored in the working population (Bilsker, Gilbert, Myette, & Stewart-Patterson, 2004). In a study of the US population, just over half of depressed workers with 12-month major depressive disorder (MDD) (56.7%) received treatment, and of those, fewer than half (41.7%) received care consistent with published treatment guidelines. In other words, among all patients with 12-month MDD, only 24% were diagnosed and received adequate care (Kessler, Merikangas, & Wang, 2008).

Employers can take steps to identify depression and lessen its impact. Many employer-related stakeholders, including employee assistance programs (EAPs), human resource departments, occupation health physicians, and others interact directly with employees who may suffer from depression. An obvious,

if perhaps neglected, first step is greater education for these stakeholders and employees of the signs and symptoms of depression. Such knowledge may help reduce the stigma and discrimination around depression, itself a major barrier to effectively addressing the problem of mental illness in the workplace. Selective interventions that focus on high-risk groups, such as offering help through an EAP, allowing workers to have some control over their workload, establishing clear workplace roles, establishing a supportive workplace environment, implementing job sharing and job security policies, may reduce or eliminate those modifiable risk factors or stressors that increase the risk of depression (Couser, 2008). Although the evidence for the effectiveness of preventive organizational interventions is weak, some research suggests that reducing the symptoms of depression does help prevent later onset of depression (Wells et al., 2000). Others argue that since the evidence *does* show that depression at any level of severity has a negative impact on work function, efforts should be made to reduce symptoms (Bilsker et al., 2004).

Although developing an employee mental health strategy and related programs can be an effective way to address the challenge of depression in the workplace, implementing one will be difficult for many employers, particularly small- and medium-sized businesses with limited resources. Ironically, small businesses are both the hardest hit when an employee suffers from depression (since they have fewer human resources to compensate for the loss) and the least likely to have at their disposal the means to develop and implement a mental health strategy. For this reason, the BCMA recommends that the Provincial Mental Health Commission or another collaborative body including representatives from the Ministry of Health Services, the BCMA, WorkSafeBC, and the business community examine ways to improve understanding and implementation of programs to address depression in the workplace.

Recommendation 5: The Ministry of Health Services, the BCMA, WorkSafeBC and the business community should examine ways to improve understanding and implementation of programs and strategies that address depression in the workplace.

Improving Access to Treatment and Follow-up Care for Patients

The issue of timely access to services must be addressed. All British Columbians with psychiatric illness, regardless of area of residence (e.g., rural or urban), should have timely access to necessary care. Recognizing the significant problem of poor access to specialist services for patients with psychiatric illness, in March 2006 the Canadian Psychiatric Association released wait time benchmarks for various conditions (Canadian Psychiatric Association, 2006). That same year, Premier Gordon Campbell announced multiple provincial initiatives to manage wait times; however, these initiatives were aimed at surgical services, and no initiative was directed toward wait times for psychiatric services (Ministry of Health Services, 2009c). The formal adoption of wait time benchmarks for depression by the provincial government would serve two important objectives. First, it would signal a genuine recognition of the need to treat mental illness with parity to non-mental illness. Second, benchmark wait times would serve as milestones in mental health policy, the achievement of which demonstrate, in part, the overall health of the health care system. The provincial government's ability to guarantee treatment for patients with depression within benchmark wait times would indicate the presence of sufficient health human resources, integration among service

providers, and the capacity to monitor and respond to the demand for health services. The BCMA therefore calls upon the provincial government to adopt wait times for patients with depression.

Recommendation 6: Recognizing the serious nature of depression, patients with major depression must be treated within established wait time benchmarks as specified by the Canadian Psychiatric Association.

- a) After referral by a general practitioner, access to a psychiatrist for a patient with major depression should be no more than 24 hours for emergent conditions, 2 weeks for urgent conditions, and 4 weeks for scheduled services.
- b) In the event that treatment cannot be provided within these times at the usual public facility, the provincial government must offer a care guarantee whereby treatment will be offered within the benchmark wait time at another public facility, in or out of the province, or in a private facility, at no added cost to the patient.

The fragmentation of care for patients with depression results in more than a simple inconvenience for them and their providers – the quality of care itself suffers. An extensive and robust literature has demonstrated that, compared to usual care, patients with depression who receive care from an integrated team of providers are more likely to report better adherence to medication, increased satisfaction with care, and improved health outcomes (W. Katon et al., 1996; W. Katon et al., 1999; W. Katon et al., 1995; Unutzer et al., 2002). Such research is consistent with other findings on the value of adopting key components of evidence-based models for chronic illness care (Von Korff, Glasgow, & Sharpe, 2002; Wagner, 2000).

The BC Ministry of Health Services and the BCMA, through the joint General Practice Services Committee (GPSC), have taken important steps in this area by incorporating lessons from the research on collaborative care and the management of chronic diseases. In the case of patients with Axis I diagnoses confirmed by DSM-IV criteria, the BCMA fee guide now allows general practitioners to bill a \$100 mental health planning fee in addition to four counselling fees (ranging from \$51-\$76, depending on age) per patient. Once the four counselling fees have been billed, the physician may then bill an additional four mental health management fees (also ranging from \$51-\$76, depending on age). To facilitate two-way communication with eligible patients via telephone or email, GPs may also bill a \$15 mental health telephone/email management fee (British Columbia Medical Association & British Columbia Ministry of Health Services, 2008). These fee guide changes are also accompanied by the launch of the mental health Practice Support Program (PSP). This program, funded by \$2.5 million from the GPSC, involves three half-day learning sessions with two intervening action periods to test new skills and knowledge. The goal of the program is to offer general practitioners, who treat the vast majority of people with mental health issues such as depression, with specific support and training related to the screening, diagnosis, and treatment of such patients (Dines, 2009). The BCMA supports the ongoing funding and, if necessary, expansion of this program.

Recommendation 7: The Ministry of Health should continue to fund the development of, and expand if necessary, the structured chronic disease management approach for patients with mental health disorders, including depression.

Recognizing that, as with any area of scientific inquiry, our understanding of depression is evolving, the provincial government is in a position to take a proactive role in facilitating the development and dissemination of knowledge in basic and applied mental health, including depression. To that end, the BCMA supports efforts by the provincial government to enhance our province's ability to conduct advanced research for basic and applied mental health. Furthermore, to ensure that such knowledge is transmitted to physicians and incorporated into the care of patients, the provincial government should also provide enhanced resources for the education and training of physicians to treat depression in adults and youth.

Recommendation 8: To further the understanding of and ability to treat mental illness, the provincial government should enhance BC physicians' ability to conduct advanced research for basic and applied mental health, including depression.

Recommendation 9: The provincial government should provide enhanced resources for the education and training of physicians to treat depression in adults and youth.

A lack of information on the availability, skills, locations, and training of non-physician providers such as social workers, psychologists, or specialized programs to treat those suffering from depression inhibits the proper flow and referral of patients across the health care system. Without such information, care can remain fragmented, and all mental health providers are limited in their ability to help patients navigate the mental health care system. Recognizing the importance of better information flows, particularly to improve providers' awareness of care offered by other mental health providers, the GPSC has agreed to fund a pilot, publicly-available directory of mental health resources on Vancouver Island. The Community Health and Resource Directory is expected to be functional in late 2009. The provincial government should continue to support this and other similar efforts, through pilot studies and ongoing program funding, where appropriate.

Recommendation 10: The Ministry of Health Services should support efforts to improve the flow of information regarding available resources to care for patients with depression among GPs, specialists, and other mental health providers through pilot studies and, if successful, provide ongoing program funding.

GPs are often frustrated with both the inability to refer depressed patients to psychiatrists and the fear that, once referred, patients may remain indefinitely with the specialist and not return to the GP's practice. Psychiatrists, for their part, worry that the GP referral they receive may be for a patient whose condition does not really require specialist services, potentially wasting valuable time that would better serve the more seriously ill. Neither group of physicians is well served by an organizational structure that hinders the flow of information between patients and providers, making effective referrals difficult. Too often, a sense of mistrust and frustration on both sides takes the place of a professional relationship that should be characterized by mutual respect.

Improving the GP-specialist interface is primarily an organizational challenge. Determining the best ways to reorganize the system to remove the barriers to quality care is best done at a macro level, where decisions about funding, incentives, and the distribution of resources can be made. This does not, however, imply that such reorganization is inherently costly. Indeed, several changes may require only one-time funding for change management, communications, or other training. Potential reforms may include adopting a psychiatrist's version of "advanced access" programs, currently used by GPs in British Columbia; adopting measures to encourage GP-specialist interactions early in the course of treatment of depressed patients; and funding specialist mental health clinics staffed by part-time community physicians. Indeed, in many respects, the quality of care for patients with depression could be improved by implementing for specialist physicians many of the innovations already in place for GPs. GPs, for example, can bill when they talk over the phone to a psychiatrist for advice about their patients, but the psychiatrist cannot.

Therefore, the BCMA recommends that the joint BCMA-Ministry of Health Services Shared Care Committee and/or the proposed Provincial Mental Health Commission examine ways to foster the GP-specialist interface with respect to treating patients with depression.

Recommendation 11: The joint BCMA-Ministry of Health Services Shared Care Committee and/or another appropriate joint body should fund pilot projects and, if they are successful, ongoing programs to foster the GP-specialist interface with respect to treating patients with depression.

Improving Oversight and Accountability

Without follow-through and implementation of its objectives, the promise of the provincial depression strategy is unfulfilled, and the vacuum of leadership in mental health at the provincial level remains. Moreover, the ability to improve the coordination of the organization, delivery, and finance of existing health services for depressed patients is seriously diminished without input from the provincial government and health authorities. The BCMA therefore recommends the creation of a Provincial Mental Health Commission (PMHC). Because of the wide-reaching effects of depression (e.g., depression in the workplace, see below), membership of the Commission should be broad, including representatives of the Mental Health and Addictions Branch of the Ministry of Health Services, the health authorities, the business community, practising physicians appointed by the BCMA, and appropriate and responsible non-governmental and patient organizations and non-physician mental health practitioners. The PMHC should adopt, as one of its

first initiatives, a review of the Provincial Depression Strategy and investigate gaps in its implementation to date. To ensure accountability, the PMHC should report annually to the Legislature on the state of mental health services in British Columbia. Ultimately, we envision the PMHC as responsible for reviewing the research on depression, coordinating the efforts of stakeholders, and ensuring effective implementation of its recommendations.

Recommendation 12: A joint BCMA-Ministry of Health Services Provincial Mental Health Commission should be established in order to facilitate improvements in mental health care. Both parties should select additional members including, among others, the business community, the health authorities, appropriate and responsible non-governmental and patient organizations, and non-physician mental health practitioners.

In 2002, the provincial government released a report on the provincial depression strategy (Goldner, 2002). The report was authored by the Depression Strategy Advisory Committee and followed the initiation of the strategy in 2001 by the Minister of State for Mental Health. In the report, the authors outlined a multi-year strategy to reduce the morbidity and disability associated with depressive illnesses. This strategy – organized around addressing at-risk individuals through self-management; family and community support; enhancing primary care services; and optimizing the use of specialist mental health services – reflected much of the scientific literature and the concerns of the public and health care providers. However, failure to follow through on the plan in several areas has left British Columbia without a coordinated strategy for addressing depression and other mental illnesses. Although a Mental Health and Addictions Branch exists within the Ministry of Health, there are no published goals or objectives to plan for services in a systematic way. Rather, the government website comments that the actual services are delivered through various local health authorities (Ministry of Health Services, 2009b). A review of the health authority performance agreements (now called *government letters of expectation*) published on the websites of the respective health authorities provides little evidence of a coordinated strategy. For this reason, the BCMA calls on the provincial government to work with the health authorities to coordinate measures and objectives for health authorities' government letters of expectation with respect to mental health and depression.

Recommendation 13: The provincial government, through its letters of expectation, must coordinate measures and objectives across health authorities with respect to mental health and depression.

Because many patients receive ongoing care from non-physicians via contracted-out services (e.g., counsellors, professional therapists in employee assistance programs), any comprehensive effort to improve care for depressed patients must examine the accessibility and quality of such services. For example, evidence suggests that the quality of care provided by individuals offering one type of evidence-based psychotherapy, cognitive behavioural therapy (CBT), varies by the type of training received (Sholomskas et al., 2005), and that quality improvement programs can – depending on how implemented – affect the

quality of mental health programs for patients with depression (Wells et al., 2000). However, without standardized training of CBT providers or, at a minimum, objective information that physicians can use to assess the quality and training of non-physician CBT providers, physicians may be reluctant to refer patients to such providers. Patients, and those who pay for their care, may similarly be reluctant to contract with providers in the absence of standardized training and quality measures. The BCMA therefore recommends that the provincial government, in consultation with recognized and relevant professional bodies, should regulate and certify providers of cognitive behavioural therapy and other scientifically valid therapies to ensure the safety and quality of care for people referred for such therapy.

Recommendation 14: The provincial government, in consultation with recognized and relevant professional bodies, should regulate and certify providers of cognitive behavioural therapy and other scientifically valid therapies to ensure the safety and quality of care for people referred for such therapy.

V. Conclusion

This paper began with three disappointing assertions: that care for depressed patients and others with mental illness in British Columbia is under-resourced relative to non-mental health services; that too few depressed patients are properly diagnosed; and that once diagnosed, too few of these patients are adequately treated. The resulting burden of depression – in social, medical, and economic terms – is enormous and unnecessary. An enlightened public policy would reduce that burden by combining what we know from the latest scientific research with our own provincial experiences in providing care.

Creating and implementing such a policy requires, first and foremost, collaboration. If there is a theme among the 14 recommendations posed in this paper, it is that greater collaboration among stakeholders, namely the business community, government, and providers, is the most promising route to reducing the burden of depression. The proposed Provincial Mental Health Commission (PMHC) would bring together these stakeholders in a meaningful and productive way. Working with, and perhaps if modelled after, the successful collaborative committees of the BCMA and Ministry of Health Services (e.g., GP Services Committee and Specialist Services Committee), the PMHC could be a results-driven body that would lead to tangible improvements in depressed patients' access to quality care. We hope that together we can work to step out of the shadows of depression and improve the lives of patients.

Appendix

Programs and Initiatives in BC Addressing Depression Management

Program	Description
Clinical practice guidelines for physicians*	In addition to the Diagnosis and Management of Major Depressive Disorders guidelines developed in 2004 by the Guidelines and Protocols Advisory Committee (GPAC, a joint BCMA-Ministry of Health committee), GPAC is presently developing clinical practice guidelines for children and youth with depression and anxiety, with a strong focus on non-pharmacological interventions.
Guide for Physicians, Families and Individuals*	The Ministry, in partnership with the BCMA, also produced the <i>Family Physician Guide for Depression, Anxiety Disorders, Early Psychosis and Substance Use Disorders</i> , released in 2007. The purpose of this document is to provide a practical, office-based tool for physicians dealing with depression and other major mental disorders, and supplemented with information for individuals and family members (Self Care Depression Patient Guide) translated into the five most common languages in BC: Cantonese, Mandarin, Vietnamese, Punjabi and Korean. The Guide has been widely distributed and is available on the Ministry Mental Health & Addictions website: http://www.healthservices.gov.bc.ca/mhd/physicians_guide.html
Depression and Anxiety Disorders Self Management Toolkits	The Depression and Anxiety Self-Management Toolkits developed by the BC Partners for Mental Health and Addictions Information are complementary tools available for physicians and their patients through the BC Partners website: http://www.heretohelp.bc.ca . The BC Partners also support annual depression screening days during mental illness awareness week in October to support client self assessment of depression and access to self management information.
Bounce Back: Reclaim Your Health	Funded by a Ministry \$6 million grant in March 2007, this guided self-management support program is delivered in close collaboration with primary care practices and Integrated Health Networks. Five Interior-region branches of the Canadian Mental Health Association – 100 Mile House, Kamloops, Kelowna, Salmon Arm and Vernon – are the first to launch a new 2-year program to help people with chronic physical conditions (such as arthritis, diabetes or heart disease) better cope with depression and anxiety.
Community-Based GP Mental Health Initiative*	A community-based mental health care initiative implemented on January 1, 2008, resulting from a partnership between the provincial government and the BCMA, to improve access and the quality of care, with special attention paid to the coordination of the patients' care, including an assessment, a mental health care plan specific to the patient, as well as ongoing review for patients who live in their home or in assisted living.
Mental Health Assessment Training Module for Physicians*	To support family physicians in the accurate assessment and diagnosis of patients with clinical depression, a Mental Health Assessment training module was developed for implementation as part of the Practice Support Program (with linkage to Bounce Back). This module was developed in partnership by a GP Services Committee working group that included psychiatrists, psychologists, family physicians, and the Canadian Mental Health Association.
Integrated Health Networks	Integrated Health Networks in the Interior Health Authority, Northern Health Authority, and Vancouver Coastal Health Authority are providing comprehensive and coordinated services to meet the needs of patients living with mental illness and addictions, including those with depression.

Workplace Mental Health Initiatives	In 2005 the PHSA developed an integrated and comprehensive Workplace Mental Health and Addiction strategy in order to raise awareness of the impact of depression and other mental illnesses. This strategy includes coordinated workplace health activities designed to improve staff and organizational health. Also, the PHSA is supporting the BC Economic Roundtable on workplace mental health and the annual workplace mental health conference.
Community Health and Resource Directory*	General Practice Services Committee (GPSC) has launched a \$1.17 million, 3-month pilot project linking central Vancouver Island physicians with mental health and addiction resources for patients through a new, secure, web-based database.

* Developed in cooperation with the BCMA.

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