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Self-management training in cognitive-behavioral therapy skills: A project to address unmet mental health needs in Victoria, BC

Group medical visits facilitated by primary care physicians were found to be a cost-effective and equitable way to deliver early intervention services and support patients with mild-to-moderate depression and anxiety.

ABSTRACT

Background: The total cost of mental health disorders to Canada’s economy is estimated to be more than \$50 billion annually. Although evidence supports the use of cognitive-behavioral therapy for depression and anxiety disorders, access to therapy is limited. This is especially the case in the Vancouver Island community of Victoria, where depression and anxiety are prevalent but treatment is difficult to obtain. In 2015 the Cognitive Behavioural Therapy (CBT) Skills Group program was initiated to provide early, destigmatizing, equitable, and timely intervention on a large scale and to enhance collaborative care between psychiatrists and family physicians. Funding was provided by the Shared Care Committee with contributions

from the Victoria Division of Family Practice and Island Health. Family physicians were trained by psychiatrists to facilitate the CBT-based training to be delivered in 90-minute group medical visits over 8 consecutive weeks. A referral centre was established and participants were asked to sign up online to join a skills group of 15 members.

Methods: Four psychometric scales were used to measure participant depression symptoms, anxiety symptoms, and functional disability: the Patient Health Questionnaire-8 (PHQ-8), the Generalized Anxiety Disorder-7 (GAD-7) scale, the Work and Social Adjustment Scale (WSAS), and the Sheehan Disability Scale (SDS). Participants used these scales to provide preintervention and postintervention self-reports. As well, participants rated the impact of the program and provided qualitative feedback. All participant responses were converted into non-nominal data and analyzed by an external agency (Reichert and

et al). Results: The program was well-received and participants reported a reduction in symptoms of depression and anxiety. Average patient satisfaction was 4.66 on a 5-point scale.

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Self-Management Training in Cognitive-Behavioral Therapy Skills

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FOUR PSYCHOMETRIC SCALES WERE USED TO MEASURE PARTICIPANT DEPRESSION SYMPTOMS, ANXIETY SYMPTOMS, AND FUNCTIONAL DISABILITY:

- Patient Health Questionnaire-8 (PHQ-8)
- Generalized Anxiety Disorder-7 (GAD-7) Scale
- Work and Social Adjustment Scale (WSAS)
- Sheehan Disability Scale (SDS)

Participants used these scales to provide preintervention and postintervention self-reports.

Self-reported data suggest participants experienced a reduction in symptoms of depression and anxiety. Average patient satisfaction was 4.66 on a 5-point scale.

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Associates). A wait-time analysis was also conducted partway through the project period.

Results: From September 2015 to April 2018, a total of 2352 participants registered in 149 CBT skills groups. The majority of participants were female (1820) and their average age was 46 years. More than half of participants attended most sessions. Self-reports were collected from 874 of 1403 participants attending six or more of the eight sessions for a response rate of 62%. Mean symptom scores on psychometric scales for anxiety, depression, and functional disability indicated improvement, with many participants demonstrating a shift from moderate to mild levels of symptom severity (n = 802). The average participant satisfaction rating for the program on a 5-point Likert scale was 4.66. The wait-time analysis showed that approximately three-quarters of participants referred had entered a group within 3 months of referral (628 of 832), and approximately one-quarter entered a group within 1 month of referral (204 of 832).

Conclusions: The self-report data analyzed during the project suggest participants in the CBT Skills Group program experienced a reduction in symptoms of depression and anxiety. However, these results must be interpreted cautiously because data were not collected for research purposes but for program quality improvement. A particular challenge encountered during the project was the lack of resources to individually screen and prepare each patient. Consequently, patients who were not a good fit for group CBT delivery (e.g., patients with personality disorder or active trauma symptoms) were occasionally referred. While it may seem costly to use family physicians to facilitate CBT skills groups, the cost of usual care wherein family physicians provide four 20-minute individual appointments (\$209.80) was comparable to the per-person cost of the intervention (\$197.52), where patients receive 12 hours of physician-led group time, making the skills groups a cost-effective and equitable way to deliver early intervention services. Current limitations in mental health care also make physicians the only viable service providers. Furthermore, having family physicians deliver mental health services may reduce stigma by showing that mental health affects general health and is valued as a vital part of primary care.

Background

Mental health conditions are the leading cause of chronic illness in Canada. In 2016 one in five people were affected by a mental illness, nearly twice the number affected by heart disease and type 2 diabetes.¹ The costs of untreated mental health disorders are immense: individuals suffer poor quality of life, disability, lost productivity,¹ physical health problems, increased mortality,² impaired social functioning, and negative impacts on the development and mental health of offspring.³ The total economic burden of mental health problems in Canada is estimated to be over \$50 billion annually.¹

Surveys report a high rate of mental health conditions on Vancouver Island.⁴ Equally alarming is the steady rise in depression and anxiety each year in this region, as seen by comparing the 2013 prevalence rate of 24.3% with the considerably lower 1992 rate of 3.7%.⁴ A recent Canadian study showed that the rise in mental health conditions is growing most rapidly in children and youth, suggesting this trend will continue.² Unfortunately, mental health services have not kept up with the demand, and access to treatment is a major obstacle to managing this crisis.

Treatment

A biopsychosocial model is used most commonly to treat depression and anxiety, with treatment guidelines addressing both the biological component (e.g., antidepressant therapy) and psychosocial component (e.g., psychotherapy and self-management skills such as cognitive-behavioral therapy (CBT), mindfulness-based interventions, and interpersonal interventions).³

Meta-analyses show that CBT is equivalent to antidepressants in treating depression⁵ and most anxiety disorders.⁶ Consequently, psychosocial treatments are often recommended as monotherapy for mild-to-moderate anxiety and depression, or in combination with medication for more severe symptoms.^{3,7} However, access

to psychosocial treatments is extremely limited in the Vancouver Island community of Victoria. While psychiatrists and public mental health teams provide publicly funded psychosocial treatments, the criteria for entry is a very high

level of symptom severity, meaning those with mild-to-moderate symptoms are frequently deemed “not sick enough.” Treatment from a nonphysician mental health professional such as a clinical counselor or psychologist typically falls under the private system for people with mild-to-moderate symptoms,

making cost a major barrier to treatment. This is especially the case for those most in need, as mental health conditions are associated with lower earning potential and socioeconomic status, both as risk factors and as a consequence of such illnesses.⁸

With 1.6 million Canadians reporting unmet mental health care needs each year, a recent Canadian Mental Health Association survey reported that 85% of Canadians felt that mental health services are among the most underfunded services in the health care system.⁹

Since treatment by a physician is covered by the BC Medical Services Plan (MSP), family physicians remain the only viable service providers for many of those with mild-to-moderate anxiety and depression. Indeed, up to 80% of Canadians rely on the primary care system for mental health care.⁹ However, family physicians experience many limitations in providing adequate psychosocial treatments for their patients. First, the major family physician shortage in most of BC, including Vancouver Island,¹⁰ leaves family physicians with limited time and resources to adequately address mental health needs. Second, family physicians are restricted to eight 20-minute individual counseling sessions and one mental health planning session per patient (equivalent to 3.2 hours total), as outlined in the General Practice section of the Medical Services Commission payment schedule.¹¹ Finally, many family physicians have too little experience to provide evidence-based

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psychosocial care to their patients, as these skills are not consistently included in family practice training.

Further complicating service delivery is the added burden of stigma concerning mental health conditions. Many people with mental health conditions describe this stigma as more debilitating than the illnesses themselves.¹² Stigma leads to discrimination and disempowerment and can ultimately prevent those who most need services from seeking them.¹³ Mental health interventions need to address stigma both when promoting an intervention to patients and physicians and as a treatment target.

While accessing evidence-based treatment is difficult for people struggling with mild-to-moderate depression and anxiety, the Mental Health Commission of Canada has stated that “Investments in evidence-based programs that focus on early and timely intervention can go a long way to prevent or mitigate the impact of illnesses over the life course.”⁷¹ The challenge is translating knowledge about treating depression and anxiety into action—specifically, delivering early interventions for mild-to-moderate depression and anxiety conditions.^{1,14} Based on suggestions from the Organisation for Economic Co-operation and Development, the World Bank, and the World Health Organization, the Mental Health Strategy for Canada states we must focus on delivering “upstream efforts, timely intervention, improved access to evidence-based treatment, and addressing inequities and the social determinants in transforming mental health care.”⁷¹

CBT Skills Group program

The Cognitive Behavioural Therapy (CBT) Skills Group program was developed to deliver evidence-based primary care treatments for mild-to-moderate depression and anxiety. Our primary aim was to implement a cost-effective and highly accessible service able to provide early, destigmatizing, equitable, and

timely intervention on a large scale. Our secondary aims were to enhance collaboration and mentorship between psychiatrists and family physicians, and to expand family physicians’ knowledge and confidence in promoting the use of evidence-based psychosocial skills.

Our primary aim was to implement a cost-effective and highly accessible service able to provide early, destigmatizing, equitable, and timely intervention on a large scale.

A team of family physicians and psychiatrists secured funding from the Shared Cared Committee and the Victoria Division of Family Practice to develop curriculum and assist with start-up costs for the program. The team developed 90-minute sessions to be delivered through group medical visits over 8 consecutive weeks:

- Session 1. Introduction to CBT; distress tolerance skills (dialectical behavioral therapy—DBT).
- Session 2. Introduction to mindfulness (mindfulness-based cognitive therapy—MBCT; mindful self-compassion—MSC).
- Session 3. Mindfulness approach to difficult thoughts (MBCT).
- Session 4. Cognitive therapy (CBT).
- Session 5. Introduction to emotions and opposite action (DBT/CBT).
- Session 6. Troubleshooting and motivation enhancement (CBT/motivational interviewing).
- Session 7. Exploring values and value-based specific, measurable, achievable, relevant, time-based (SMART) goals (acceptance and commitment therapy—ACT).
- Session 8. Relapse prevention and moving forward.

The integration of skills seen in the program mirrors recent protocols designed by leaders in CBT approaches such as Barlow and colleagues,¹⁵ and emphasizes psychoeducation and skills acquisition for a primary care population.

A collaborative process was used to train four family physicians to facilitate CBT skills groups. A family physician first observed a psychiatrist facilitating a full set of eight sessions, then took on a minor co-facilitator role for another set of sessions, and finally acted as a

major co-facilitator for a third set of sessions. After the training period, family physicians facilitated groups on their own, with ongoing consultation with psychiatrists as needed. Physician facilitators were compensated through MSP with a GMV (group medical visit) code fee. Sessional support was available to the family physician and the mentoring psychiatrist for 30 to 60 minutes of debriefing time per session during the training.

A centralized referral centre was established, embedded within the Victoria Division of Family Practice, and a medical office assistant was hired to manage referrals, communicate with referring physicians, book rooms for groups, and schedule groups and facilitators.

Methods

Prospective participants were screened by referring family physicians, who received information about the CBT Skills Group program through a launch event and written media (e-newsletter, website, brochure).

Exclusion criteria for participants included severe depression, active risk of harm to self or others, cognitive impairment, significant level of substance use, personality disorder that may interfere with group process, and active psychosis, mania, or trauma/dissociative symptoms.

Psychometric scales

Group facilitators provided participants with self-report measures to complete before and after treatment: the Patient Health Questionnaire-8 (PHQ-8), the Generalized Anxiety Disorder-7 (GAD-7) scale, and the Work and Social Adjustment Scale (WSAS).

The PHQ-8 and PHQ-9 are self-report symptom checklists that score each DSM depression criterion from 0 to 3, with the PHQ-8 omitting the final question in the PHQ-9 about suicidal ideation.¹⁶ The original validation studies for the PHQ consisted of 6000 patients and showed identical thresholds for the scoring of depression severity in both the PHQ-8 and PHQ-9.¹⁶

The GAD-7 is a self-report symptom checklist that scores seven generalized anxiety symptoms from 0 to 3, and has been found to have high internal reliability and validity.¹⁷

The WSAS is a self-report scale measuring

perceived functional disability on a scale from 0 to 8 (i.e., impairment regarding certain tasks related to work, home, leisure, and social relationships). The WSAS has high internal reliability and sensitivity. It is comparable to the PHQ and GAD-7 in measuring treatment effects, and also measures a distinct functioning factor not captured in the PHQ and GAD-7.¹⁸

Midway through the evaluation process, feedback led to a change in the measure of functional status from the WSAS to the Sheehan Disability Scale (SDS), as this scale is more commonly used in clinical practice in primary care. The SDS is a three-item self-report. It is a discretized analog measure of functional disability in work, social, and family life that has high internal reliability and construct validity in primary care¹⁹ and is sensitive to treatment effects.²⁰

Participants were also asked to rate their experience in the program and the impact of the program on them by responding to statements such as “I felt welcome in the group” and “I am more confident managing emotions.” They were asked to do this using a Likert scale ranging from 1 for strongly disagree to 5 for strongly agree. All program completers were also invited to submit written qualitative feedback, and volunteers were interviewed in focus groups by independent evaluators. Demographic and wait-time data were collected. Ethics approval was not sought because the project was conducted for quality improvement purposes under the auspices of the Shared Care Committee and the Victoria Division of Family Practice, not under the auspices of an academic institution.

Data analysis

All participant responses were converted into non-nominal data and analyzed by an external agency (Reichert and Associates). Results from the four psychometric scales (PHQ-8, GAD-7, WSAS, and later SDS) completed by participants before and after the program were compared. Symptom response rates were also obtained, with “full response” defined as a 50% or greater reduction in symptoms, and “partial response” defined as a 25% to 49% reduction in symptoms. The PHQ-8 scores were further analyzed to determine rates of remission from depression before and after intervention.

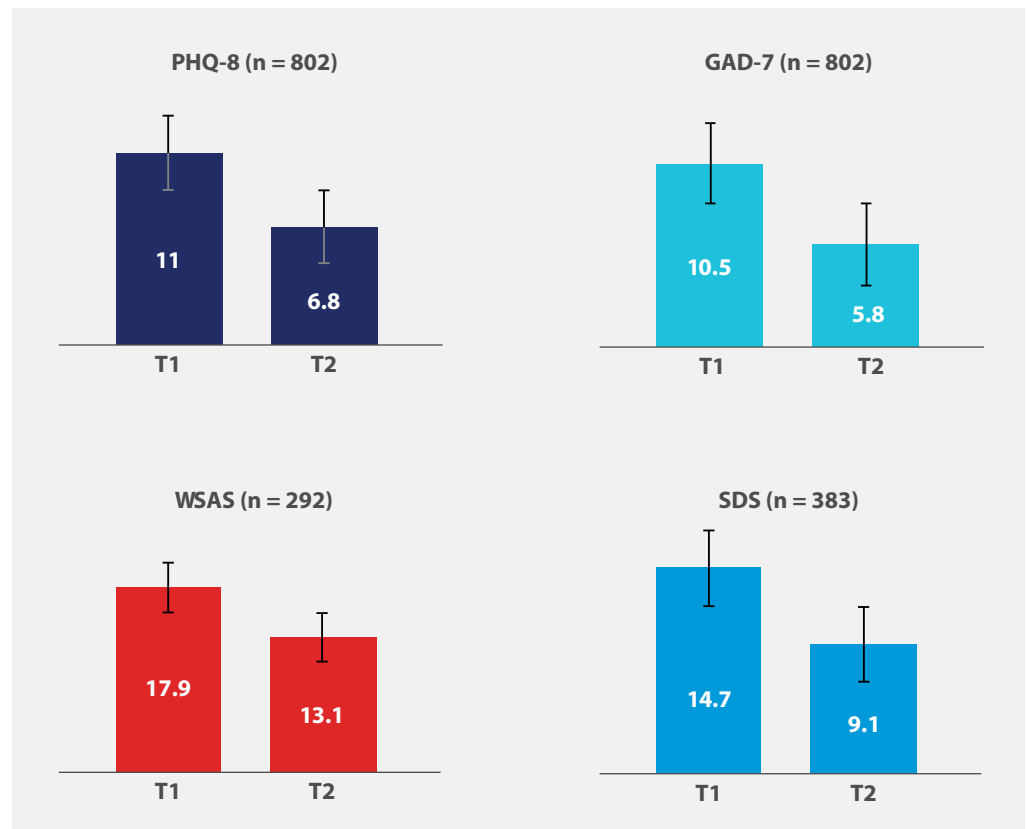


FIGURE 1. Changes in symptoms measured by four psychometric scales* used by participants before (T1) and after (T2) the 8-week CBT training program.

*PHQ-8—Patient Health Questionnaire; GAD-7—Generalized Anxiety Disorder; WSAS—Work and Social Adjustment Scale; SDS—Sheehan Disability Scale

A wait-time analysis was conducted partway through the project to determine how many days participants waited for treatment. Referrals from September 2016 to July 2017 were considered.

Results

The program received 4150 referrals from 376 referring physicians between September 2015 and April 2018. Of those patients referred, 2352 registered themselves in 149 groups. The majority of participants (77%) were female (n = 1820). The average age of participants was 46 years (range 17 to 89 years).

Sixty percent of participants attended six to eight sessions (n = 1403), while 29% attended one to five sessions (n = 687), and 8% did not attend any sessions (n = 193).

Self-reports were collected from 874 of the 1403 program completers (those who attended six or more of the eight sessions) for a response

rate of 62%. The remaining 38% did not complete self-reports because they did not attend the last session or left without responding. No attempts were made to follow up with non-responders due to a lack of additional resources for this.

Results from *t* test analyses [Figure 1] indicate improvements in mean symptom scores of program completers for depression (PHQ-8: -4.2, $P < .0001$, Cohen's *d* effect size = 0.86, n = 802), anxiety (GAD-7: -4.6, $P < .0001$, Cohen's *d* effect size = 0.99, n = 802), and work and social function (SDS pre-post: -5.3, Cohen's *d* effect size = 0.77, n = 383; WSAS: -4.8, Cohen's *d* effect size = 0.62, n = 292). A small minority of participants with a change in work status during the course of the program (N = 13) did not fill out the work score of the SDS at T1 or T2, and were thus removed from analysis as their scores were artificially low because they did not complete a third of the questionnaire.

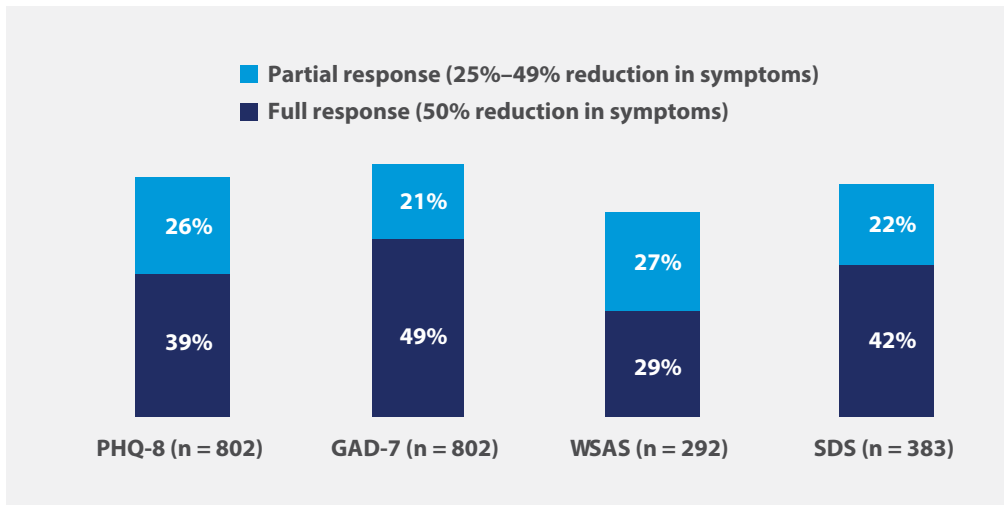


FIGURE 2. Symptom response rates measured by four psychometric scales* used by participants after the 8-week CBT skills training program.

*PHQ-8—Patient Health Questionnaire; GAD-7—Generalized Anxiety Disorder; WSAS—Work and Social Adjustment Scale; SDS—Sheehan Disability Scale

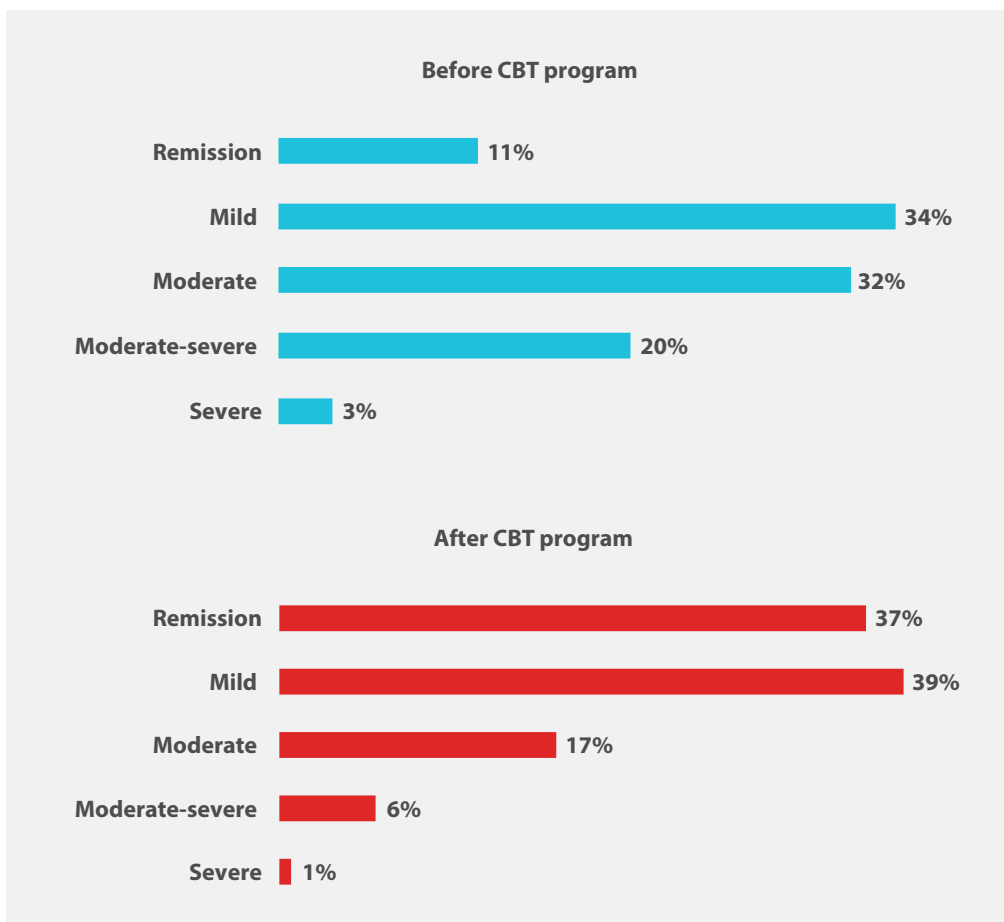


FIGURE 3. Depression severity measured by PHQ-8* scores of participants before and after the 8-week CBT skills training program.

*Patient Health Questionnaire ratings: Remission = 0–4; Mild = 5–9; Moderate = 10–14; Moderate-severe = 15–19; Severe = 20–24

Improvements in symptoms can also be seen in the remission and response rates for all four psychometric scales [Figure 2] and the reductions in depression severity measured by the PHQ-8 [Figure 3].

Analyses of the findings revealed that all improvements were statistically significant, and clinical significance was demonstrated by mean score changes that represented a shift from moderate to mild symptomatology.

Participant responses to questions about their experience indicate that most would recommend the program to friends and family [Figure 4]. Participant responses to questions about program outcomes indicate most felt more able to manage their mental health symptoms [Figure 5]. The average participant satisfaction rating was 4.66 out of 5.00.

Qualitative feedback suggests that participants valued learning new skills to manage mental health problems, receiving support and a sense of normalization in the group setting, and learning they were not alone in their suffering. Many participants recommended offering longer or more sessions.

A wait-time analysis on referrals from September 2016 to July 2017 showed that three-quarters of participants (628 of 832) entered a group within 3 months of referral, with one-quarter (204 of 832) beginning within 1 month of referral [Figure 6].

Conclusions

Project findings suggest the Cognitive Behavioural Therapy (CBT) Skills Group program provides accessible and timely intervention for those with mild-to-moderate anxiety and depression.

Self-reports completed before and after participants took part in a skills group showed symptom improvements comparable to those found in the literature for both group and individual CBT.^{21,22} However, outcome measures reported here must be interpreted cautiously, as the purpose of data collection was quality improvement, not research. There was no randomization, and there were no control groups. As well, final surveys were collected only from participants who attended the last skills group session.

Reviews of the effectiveness of CBT for anxiety show that both group and individual delivery are effective and comparable.⁷ In studies comparing group and individual CBT for depression, only small differences were found favoring individual CBT delivery, especially in terms of dropout rates, but it is questionable whether the differences were clinically significant.^{23,24} The Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for depression recognize the slight superiority of individual CBT, but also support group interventions when considering cost, accessibility, and patient preference.³

Challenges

Dropout rates for the program, which included failure to register for a group after referral, nonattendance after registering, and partial attendance, were a significant obstacle since funding was dependent on MSP billings (and thus attendance at group sessions). A large meta-analysis of 115 studies (N = 20995) examining dropout rates found group CBT to have higher pretreatment dropout rates of 14.5% compared with 9.7% for individual CBT, and a dropout rate of 24.6% during group CBT that was comparable to the rate for individual CBT.²⁵ High dropout rates occur in both individual and group interventions for depression and anxiety because of the symptoms of the conditions themselves (i.e., those with anxiety disorders often practise avoidance and those with depression often suffer from poor motivation and fatigue). The group setting can be especially anxiety-provoking for individuals with mental health symptoms. As well, group interventions are less flexible than individual interventions and require a more structured protocol to serve all participants. Consequently, the group format may not meet the specific needs of each participant. While the CBT Skills Group program emphasizes self-management rather than psychotherapy proper, the outcomes found are reflective of those reported for group CBT.

A particular challenge encountered in this project was the lack of resources to individually screen and prepare each patient. The program relied on referring physicians to screen and orient prospective participants. Consequently, patients who were not a good fit for a group

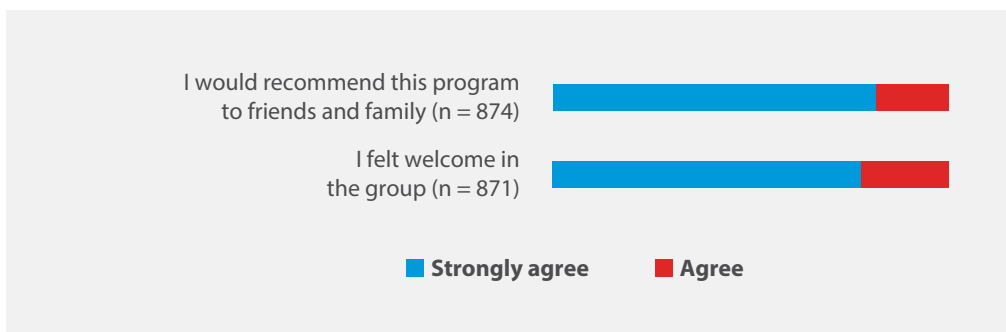


FIGURE 4. Participant experience rating.

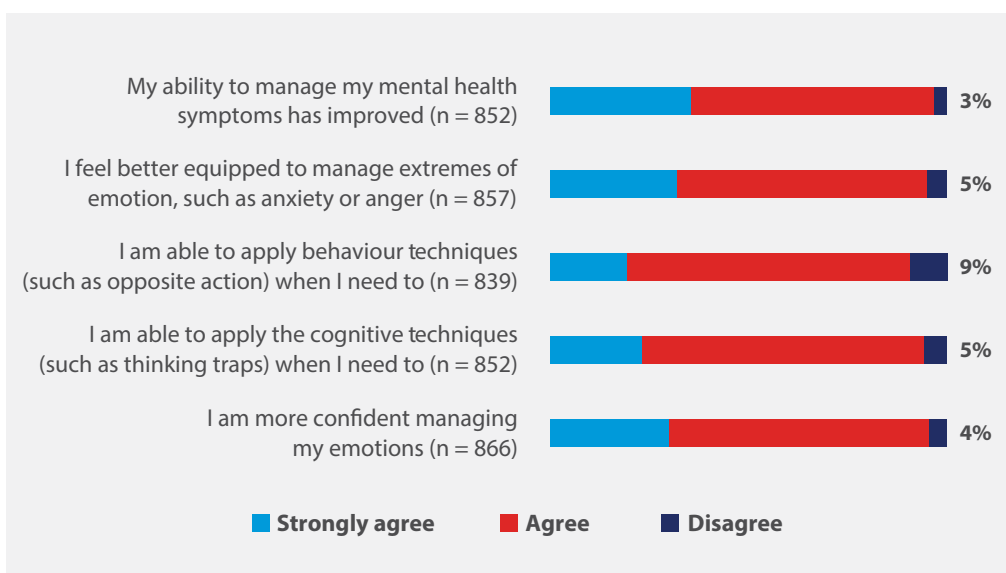


FIGURE 5. Participant outcomes rating.

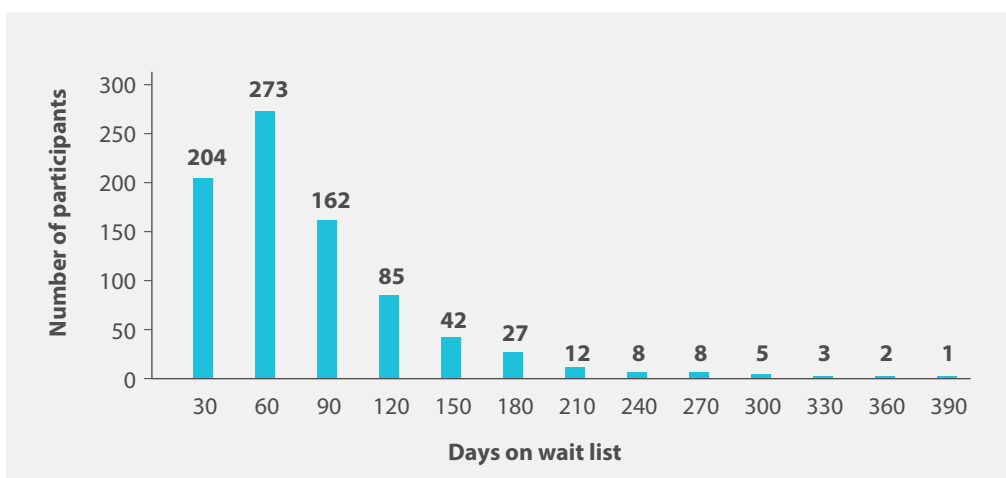


FIGURE 6. Wait times for 832 patients referred to the CBT Skills Group program, September 2016 to July 2017.

setting (e.g., patients with personality disorder symptoms, active trauma symptoms, or poor motivation) were occasionally referred and their participation adversely affected the group. To address this, quality improvement efforts targeted referring physician selection skills via presentations at grand rounds, dine-and-learns, and annual general meetings. As well, direct feedback was provided by the group facilitator to the referrer on each patient's appropriateness for the group setting, and inclusion and exclusion criteria were featured repeatedly in the Victoria Division of Family Practice e-newsletter. A patient no-show fee is currently being trialed to address patient nonattendance and dropouts.

Benefits

As observed in the qualitative feedback, group CBT skills delivery may offer benefits over individual delivery, especially for reducing stigma. Contact with group members reminds participants they are not alone and provides opportunities to build social support, which is known to improve outcomes in mental health.²⁶ Participants in the project commonly exchanged contact information when the group sessions ended, and several groups continued to meet as peers.

The skills groups proved to be a cost-effective and equitable way to deliver early intervention services with service providers who already provide care for patients with mild-to-moderate mental health concerns. Traditionally, family physicians provide mental health care to their patients through individual visits instead of groups. Based on the payment schedule that was current when the project began, the cost to the health care system for a patient to receive 12 hours of group time led by a family physician was \$197.52 (based on 15 patients per session). This cost was comparable to the cost of four 20-minute individual appointments

(\$209.80) with a family physician.²⁷ Currently, if a family physician were to use all MSP and General Practice Services Committee incentive fee codes for in-person care per patient per year, the cost would be twice as much to see a patient individually compared to a patient attending a group medical visit. The group visits would also provide 3.75 times more in-person interaction.¹¹ Furthermore, having family physicians deliver mental health services can reduce stigma by showing that mental health affects general health and is valued as a vital part of primary care.

The use of family physicians as group facilitators also enhances collaboration and mentorship between psychiatrists and family physicians. Having family physicians and psychiatrists work together expands family physicians' knowledge and confidence regarding psychosocial skills in primary care, opens pathways for communication, and enables family physicians to coach patients with mental health conditions in their individual practices.

Further quality improvements

In response to feedback from participants, more advanced program offerings (e.g., booster groups, mindfulness-based cognitive therapy, CBT for insomnia) are now available for those who have completed six or more sessions of the original program. Participants are also invited to register in a CBT skills group as many times as they desire. Other quality improvements being tested are group sessions of 2 hours in length and skills programs with more than eight sessions.

While this quality improvement project suggests CBT skills groups are a cost-effective and accessible intervention for patients in primary care, more research is needed. This might include formal, randomized, controlled trials with an intention-to-treat analysis and

longitudinal follow-up to more robustly assess the potential benefits of this short-term intervention.

Summary

The CBT Skills Group program was implemented to provide early, destigmatizing, equitable, and timely mental health intervention on a large scale and to enhance collaboration between psychiatrists and physicians. The self-report data collected from September 2015 to April 2018 suggest participants experienced a reduction in symptoms of depression and anxiety. However, these results must be interpreted cautiously because data were not collected for research purposes but for program quality improvement. Average participant satisfaction rated on a 5-point Likert scale was 4.66, and a wait-time analysis showed that the majority of participants entered a group within 3 months of referral. The cost of physician-led group time compared favorably to the cost of individual family physician appointments, making the skills groups a cost-effective way to deliver early intervention services. ■

Competing interests

None declared.

References

1. Mental Health Commission of Canada. Strengthening the case for investing in Canada's mental health system: Economic considerations. 2017. Accessed 4 September 2018. www.mentalhealthcommission.ca/sites/default/files/2017-03/case_for_investment_eng.pdf.
2. McRae L, O'Donnell S, Loukine L, et al. Report summary: Mood and anxiety disorders in Canada, 2016. *Health Promot Chronic Dis Prev Can* 2016;36:314-315.
3. Lam RW, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 clinical guidelines for the management of adults with major depressive disorder: Introduction and methods. *Can J Psychiatry* 2016;61:506-509.
4. Provincial Health Services Authority. BC community health data. Accessed 5 September 2018. <http://communityhealth.phsa.ca/GetTheData/SearchByLocation>.
5. Cuijpers P, Weitz E, Twisk J, et al. Gender as predictor and moderator of outcome in cognitive behavior therapy and pharmacotherapy for adult depression: An "individual patient data" meta-analysis. *Depress Anxiety* 2014;31:941-951.
6. Bandelow B, Seidler-Brandler U, Becker A, et al. Meta-analysis of randomized controlled comparisons of psychopharmacological and psychological treatments for anxiety disorders. *World J Biol Psychiatry* 2007;8:175-187.
7. Katzman M, Bleau P, Chokka P, Blier P. Canadian clinical

practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. *BMC Psychiatry* 2014;14:S1.

8. von Rueden U, Gosch A, Rajmil L, et al. Socioeconomic determinants of health-related quality of life in childhood and adolescence: Results from a European study. *J Epidemiol Community Health* 2016;60:130-135.
9. Canadian Mental Health Association. Mental health in the balance: Ending the health care disparity in Canada. Posted 14 September 2018. Accessed 12 February 2019. <https://cmha.ca/news/ending-health-care-disparity-canada>.
10. Doctors of BC. Find a doctor. Accessed 12 February 2019. www.doctorsofbc.ca/resource-centre/find-doctor.
11. BC Ministry of Health. Medical Services Commission payment schedule. Updated 1 November 2018. Accessed 19 February 2019. www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msc-payment-schedule-november-2018.pdf.
12. Kirby M, Keon W, and the Standing Senate Committee on Social Affairs, Science, and Technology. Out of the shadows at last: Highlights and recommendations. Report of the Standing Senate Committee on Social Affairs, Science and Technology. 2006. Accessed 18 February 2019. https://mdsc.ca/documents/Publications/Out%20of%20the%20Shadows_Highlights_EN.pdf.
13. Link B, Phelan J. Stigma and its public health implications. *Lancet* 2006;367(9509):528-529.
14. Organisation for Economic Co-operation and Development. Making mental health count: The social and economic costs of neglecting mental health care. OECD Health Policy Studies. 2014. Accessed 19 February 2019. www.oecd.org/publications/making-mental-health-count-9789264208445-en.htm.
15. Barlow DH, Farchione TJ, Fairholme CP, et al. Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide. New York: Oxford University Press; 2011.
16. Kroenke K, Spitzer RL. The PHQ-9: A new depression and diagnostic severity measure. *Psychiatric Ann* 2002; 32:509-515.
17. Spitzer R, Kroenke K, Williams J, Lowe B. A brief measure for assessing generalized anxiety disorder: The GAD-7. *Arch Intern Med* 2006;166:1092-1097.
18. Zahra D, Qureshi A, Henley W, et al. The work and social adjustment scale: Reliability, sensitivity and value. *Int J Psychiatry Clin Pract* 2014;18:131-138.
19. Leon AC, Olfson M, Portera L, et al. Assessing psychiatric impairment in primary care with the Sheehan Disability Scale. *Int J Psychiatry Med* 1997;27:93-105.
20. Sheehan K, Sheehan D. Assessing treatment effects in clinical trials with the discan metric of the Sheehan Disability Scale. *Int Clin Psychopharmacol* 2008;23:70-83.
21. Burlingame GM, Strauss B, Joyce AS. Change mechanisms and effectiveness of small group treatments. In: MJ Lambert, editor. *Bergin and Garfield's handbook of psychotherapy and behavior change*. 6th ed. Hoboken, NJ: Wiley; 2014. p. 640-689.
22. Butler A, Chapman J, Forman E, Beck AT. The empirical status of cognitive behavioral therapy: A review of meta-analysis. *Clin Psychol Rev* 2006;26:17-31.
23. Cuijpers P, van Straten A, Warmerdam L. Are individual and group treatments equally effective in the treatment of depression in adults: A meta-analysis. *Eur J Psychiatry* 2008;22:38-51.
24. Huntley AL, Araya R, Salisbury C. Group psychological therapies for depression in the community: Systematic review and meta-analysis. *Br J Psychiatry* 2012;200:184-190.
25. Fernandez E, Salem D, Swift J, Ramtahal N. Meta-analysis of dropout from cognitive behavioral therapy: Magnitude, timing, and moderators. *J Consult Clin Psychol* 2015;83:1108-1122.
26. Harandi TF, Taghinasab MM, Nayeri TD. The correlation of social support with mental health: A meta-analysis. *Electron Physician* 2017;9:5212-5222.
27. BC Ministry of Health. Medical Services Commission payment schedule. Updated August 2013. Accessed 20 February 2019. www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/7-general-practice.pdf.

