Inflammatory Bowel Disease (IBD) and Mental Health Pathway

Quick links: Pathway primer | Provider resources | Patient resources | Advice options

GASTROENTEROLOGY

1. Suspected anxiety or depression symptoms:
   - Patient reported symptoms

Anxiety / Depression

2. Complete GAD-2

Score 0-2: Patient not at risk for anxiety; continue to monitor

Score 3+: Complete GAD-7 (www.mdcalc.com/calc/1727/gad7-general-anxiety-disorder7)

2. Complete PHQ-2

Score 0-2: Patient not at risk for depression; continue to monitor

Score 3+: Complete PHQ-9 (www.mdcalc.com/calc/1725/phq9-patient-health-questionnaire9)

3. Alarm features:
   - Responded positively in response to the final question of PHQ-9: "Thoughts you would be better off dead, or of hurting yourself in some way"

Yes: Direct patient to emergency department or instruct them to call 911. Non-urgent Mental Health Helpline at 1-877-303-2642

No

REFER TO PRIMARY CARE

PRIMARY CARE

If no primary care provider available, direct patient to contact mental health and well-ness center in their community or call Mental Health Helpline at 1-877-303-2642

4. Management (all severities):
   - Self-management resources: direct to recommended self-management tools
   - Physician-guided programs: refer to psychological support programs
   - Psychological therapy: refer to behavioural health specialist

Monitor symptoms using PHQ-9 and GAD-7

5. Specific approaches for Severe Depression (PHQ-9 Score ≥15) or Severe Anxiety (GAD-7 Score ≥15):
   - Pharmacological therapy: consider adding a pharmacological agent to reduce symptoms

This primary care pathway was co-developed by primary and specialty care and includes input from multidisciplinary teams. It is intended to be used in conjunction with specialty advice services, when required, to support care within the medical home. Wide adoption of primary care pathways can facilitate timely, evidence-based support to physicians and their teams who care for patients with common low-risk gastrointestinal (GI) conditions and improve appropriate access to specialty care, when needed. To learn more about primary care pathways, check out this short video or click here to visit Primary Care Supports webpage.

INFLAMMATORY BOWEL DISEASE (IBD) AND MENTAL HEALTH PATHWAY PRIMER

- The occurrence of depression and anxiety symptoms is common for patients with IBD. There may be many reasons for these symptoms, but they can often be directly related to the disease.
- In the absence of alarm features, these psychological symptoms should be managed by the patients' primary care provider.
- **Depression Symptom Inventory: Patient Health Questionnaire-2 and 9 (PHQ-2 and PHQ-9)**
    - This questionnaire can be self-administered.
    - The PHQ-2 is a shortened version of the PHQ-9. The PHQ-2 is the first two questions of the PHQ9.
    - The PHQ-9 uses 9 questions to assess meaningful symptoms of depression. Questions are scored on a scale of 0-3 with 0 indicating "not at all" and 3 indicating "nearly every day".
- **Anxiety Symptom Inventory: Generalized Anxiety Disorder Assessment-2 and 7 (GAD-2 and GAD-7)**
    - This questionnaire can be self-administered.
    - The GAD-2 is a shortened version of the GAD-7. The GAD-2 is the first two questions of the GAD7.
    - The GAD-7uses 7 questions to assess meaningful symptoms of anxiety. Questions are scored on a scale of 0-3 with 0 indicating "not at all" and 3 indicating "nearly every day".

	Checklist to guide in-clinic review of your patient with IBD and Depression or Anxiety Symptoms
☐	Complete a symptom inventory by administering the PHQ-2 and GAD-2 questionnaire.
☐	If scores on the PHQ-2 or GAD-2 are high, complete the full symptom inventory by administering the PHQ-9 or GAD-7, respectively (see algorithm Box 2)
☐	Confirm absence of alarm features (see algorithm Box 3) If alarm features are identified, refer to emergency services.
☐	Evaluate the severity of anxiety and depression symptoms (see algorithm Box 2). If depression score corresponds to moderately severe or greater, consider pharmacological treatment.
☐	If symptoms worsen despite management strategies, consider referring to psychiatry. Otherwise, continue to monitor symptoms.

EXPANDED DETAILS

1. Diagnostic criteria

- There is a bi-directional relationship between symptoms of psychological distress the symptoms and disease course of IBD.
    - Psychological factors such as psychosocial stressors, underlying depression, anxiety, somatic disorders, history of trauma, eating disorders, and poor coping skills can all trigger or amplify inflammation and the symptoms of IBD.
- The initial assessment should include a detailed history and medication review. ○ History should include investigations to rule out potential differential diagnoses including panic disorders, phobias, PTSD, ADHD, OCD, and substance use disorder.
    - A significant percentage of patients with IBD have a history of trauma (e.g. sexual assault or physical and psychological abuse) or PTSD. This type of trauma may contribute to symptoms through the brain-gut axis, so it is important to explore this in a compassionate manner. Undergoing endoscopy may trigger a negative response in survivors of trauma; addressing this possibility may be appropriate if considering a referral for endoscopy when the clinician is aware of a history of trauma. For additional information, see Abuse, Trauma, and GI Illness: Is There a Link? and Trauma-informed care.
    - It is important to recognize the impact IBD medication may have on mood. Corticosteroids can contribute to mood changes and the development of adverse psychiatric effects.

2. Complete Depression Symptom Inventory and/or Anxiety Symptom Inventory

- **Depression Symptom Inventory: Patient Health Questionnaire-2 and 9 (PHQ-2 and PHQ-9 (PHQ-2 and PHQ-9)**
    - The PHQ-2 can be self-administered and uses 2 questions to screen for patients who may be at risk for depression. Questions are scored on a scale of 0-3 with 0 indicating “not at all” and 3 indicating “nearly every day”.
    - PHQ-2 scores can be interpreted as follows:
        - Score 0-2: Not likely at risk for depression
        - Score 3-6: At risk for depression; administer PHQ-9 ○ The PHQ-9 can be self-administered and uses 9 questions to assess meaningful symptoms of depression. The first 2 questions of the PHQ-9 are the same questions that make up the PHQ-2. Questions are scored on a scale of 0-3 with 0 indicating “not at all” and 3 indicating “nearly every day”.
    - PHQ -9 Scores can be interpreting as follows:
        - Score 0-4: none or minimal depression symptoms
        - Score 5-9: mild depression symptoms
        - Score 10-14: moderate depression symptoms
        - Score 15-19: moderately severe depression symptoms
        - Score: 20-27: severe depression symptoms
- **Anxiety Symptom Inventory: Generalized Anxiety Disorder Assessment-2 and 7 (GAD-2 and GAD-7)**
    - The GAD-2 can be self-administered and uses 2 questions to screen for patients who may be at risk for anxiety. Questions are scored on a scale of 0-3 with 0 indicating “not at all” and 3 indicating “nearly every day”.
    - GAD--2 scores can be interpreted as follows:
        - Score 0-2: Not likely at risk for anxiety
        - Score 3-6: At risk for anxiety; administer GAD-7 ○ The GAD- questionnaire can be self-administered and uses 7 questions to assess meaningful symptoms of anxiety. The first 2 questions of the GAD-7 are the same questions that make up the GAD-2. Questions are scored on a scale of 0-3 with 0 indicating “not at all” and 3 indicating “nearly every day”.
    - Scores can be interpreting as follows:
        - Score 0-4: none or minimal anxiety symptoms
        - Score 5-9: mild anxiety symptoms
        - Score 10-14: moderate anxiety symptoms
        - Score 15-21: severe anxiety symptoms

3. Alarm features

If both of the following alarm features are identified, refer to emergency services.

- Positive response (Several, most, or nearly all days) to question 9 of the PHQ-9 ("Thoughts you would be better off dead, or of hurting yourself in some way").
- Patient indicates they feel they are unable to keep themselves safe from life-threatening and self-inflicted harm.

4. Management

In most cases, symptoms should be managed by the patient with support from their primary care provider.

If the patient does not have a primary care provider they may use the following Alberta-based resources to receive help managing their symptoms:

- There are mental health and wellness services available in communities across Alberta. A list of services by location is available. Select 'mental health and wellness' as the service type and find locations by postal code or by city.
- HealthLink can be reached by dialing 811. HealthLink can direct the patient to the nearest mental health and wellness service in their community.
- AHS Mental Health Helpline (24/7) is another provincial resource that can help with patient navigation 1-877303-2642

Non-pharmacological therapy	
These modifications may be all that is required in those with mild or moderate symptoms.	
Self-management resources	• Effective long-term management of stress, anxiety, and depression requires engagement from patients. • Tools (link to resources from project) that empower patients to self-manage their mental health can improve symptoms. • Emphasize starting with small changes and picking a resource that fits the patients' schedule.
Provider-guided programs and resources	• Provider-assisted programs may be beneficial for patients who want more guidance managing their mental health symptoms. • Stress, anxiety, and other coping workshops are available by referral from Primary Care Network. • Skill building workshops are available with referral from the Canadian Mental Health Association.
Psychological therapy	• Referral to a behavioral health specialist can be helpful in reducing symptoms. The Psychologists' Association of Alberta has a tool that can help match patients with an appropriate clinician.

5. Specific approaches for severe depression (PHQ-9 Score ≥ 15) or severe anxiety (GAD-7 Score ≥ 15)

Pharmacological management may be necessary for patients with severe depression or severe anxiety. **Pay special attention to any side effects related to the gastrointestinal tract.**

Pharmacological management recommendations can be found within the following resources:

- Decision support tool for prescribing antidepressant therapy from the College of Family Physicians of Canada
  - Figure 1A and 1B contains considerations for prescribing different types of antidepressants o Table 2 provides dosing recommendations for first-line antidepressants
- Canadian Clinical Practice Guidelines for the management of anxiety, posttraumatic stress and obsessivecompulsive disorders
  - Table 23 and Table 24 (page 24) provide a summary of the strength of evidence for different types of pharmacotherapy options for the treatment of generalized anxiety disorder

If you are concerned about how an antianxiety or antidepressant therapy may interact with your patient's inflammatory bowel disease therapy, consult a medication information and interaction resource (such as Lexidrug (formerly Lexicomp) or Micromedex) or your patient's pharmacist.

6. Edmonton Virtual Mindfulness-Based Stress Reduction (MBSR) Group

MBSR is an intensive 8-week once weekly group program based on the Mindfulness-Based Stress Reduction (MBSR) Group developed by Dr. Jon Kabat-Zinn and associates at the University of Massachusetts Medical Centre in the late 1970's.

- The curriculum is based on the emerging field of Mind-Body Medicine.
- Through intensive training in a combination of mindfulness, cognitive behavioral and self-regulation skills, participants learn to mobilize their deep inner resources to facilitate learning, growth, healing, enhance self-care, and make positive shifts in attitudes, behaviors and relationships.

Uses: Participants may be referred with diverse conditions such as heart disease, lung disease, GI distress, headaches, sleep disturbance, fatigue, skin disorders, cancer, high blood pressure, diabetes, chronic pain, anxiety, panic and stress, and a history of trauma. **If a history of trauma is present the patient must have had a mental health assessment and must have a primary therapist.**

Referrals: Patients will be contacted to attend an individual screening appointment and an orientation group with a group facilitator prior to being accepted to an 8-week MBSR Group. The waiting list for assessment varies from weeks to months, depending on the number of pending referrals. Referral sources will be notified that the referral has been received, and of the outcome of the assessment.

Upcoming MBSR Programs: MBSR Groups are run in the fall, winter, and spring. Occasionally, a summer program will be offered. Pre-group assessment/orientation appointments are held about 2-6 weeks before start of a group. Groups are held online using Zoom, 1 afternoon for 8 weeks, 2:00 – 4:30 pm, 1 Saturday, 9:00 – 4:00 pm. Morning or evening groups may be held in the future, depending on demand.

Edmonton Virtual Mindfulness-Based Stress Reduction (MBSR) Group Referral Form
Referrals can be faxed to 780-509-2886.

PROVIDER RESOURCES

- For recommendations for the treatment of mental health in primary care, see this document, by the College of Family Physicians of Canada.
- For recommendations for mobile apps that may help with addiction and mental health, visit this link, from Alberta Health Services. See section 3.0 and 4.0 for recommendations for mobile apps for depressive disorders and anxiety disorders, respectively.

Advice Options

Non-urgent advice for gastroenterology is available to support family physicians.

- Electronic advice is available across the province via Alberta Netcare eReferral. Advice requests can also be submitted online via Specialist Link (Calgary Zone), and ConnectMD (Edmonton & North Zones). Visit their webpages for more information.
- Non-urgent telephone advice connects family physicians and specialists in real time via a tele-advice line. Family physicians can request non-urgent advice from a gastroenterologist:
    - Calgary Zone: Submit request via Specialist Link or call 403-910-2551
    - Edmonton & North Zones: Submit request via ConnectMD or call 1-844-633-2263

PATIENT RESOURCES

- IBD and mental health patient pathway

References
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Katzman, M.A., Bleau, P., Blier, P. *et al.* Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. *BMC Psychiatry* **14** (Suppl 1), S1 (2014). https://doi.org/10.1186/1471-244X-14-S1-S1

BACKGROUND

About this Pathway

- Digestive health primary care pathways were originally developed in 2015 as part of the Calgary Zone's Specialist LINK initiative. They were co-developed by the Department of Gastroenterology and the Calgary Zone's specialty integration group, which includes medical leadership and staff from Calgary and area Primary Care Networks, the Department of Family Medicine, and Alberta Health Services.
- The pathways were intended to provide evidence-based guidance to support primary care providers in caring for patients with common digestive health conditions within the patient medical home.
- Based on the successful adoption of the primary care pathways within the Calgary Zone, and their impact on timely access to quality care, in 2017 the Digestive Health Strategic Clinical Network (DHSCN) led an initiative to validate the applicability of the pathways for Alberta and to spread availability and foster adoption of the pathways across the province.

Authors & Conflict of Interest Declaration

This pathway was reviewed and revised under the auspices of the DHSCN in 2024, by a multi-disciplinary team led by family physicians and gastroenterologists. For more information, contact the DHSCN at Digestivehealth.SCN@ahs.ca or AlbertaPathways@ahs.ca.

Pathway Feedback and Review Process

Primary care pathways undergo scheduled review every three years, or earlier if there is a clinically significant change in knowledge or practice. The next scheduled review is Summer 2027 however, we welcome feedback at any time. Please email comments to MyIBDCare@ahs.ca.

Copyright Information

Disclaimer

This pathway represents evidence-based best practice but does not override the individual responsibility of healthcare professionals to make decisions appropriate to their patients using their own clinical judgment given their patients' specific clinical conditions, in consultation with patients/alternate decision makers. The pathway is not a substitute for clinical judgment or advice of a qualified health care professional. It is expected that all users will seek advice of other appropriately qualified and regulated health care providers with any issues transcending their specific knowledge, scope of regulated practice or professional competence.