Importance of primary care services in the reduction of depressive symptoms

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Abstract

Introduction: The rising prevalence of failure to provide timely care to depressed patients in primary care is evident today.

Objective: To determine the impact of low-intensity psychosocial interventions in promoting better care for depression.

Methods: A randomized controlled study was conducted with participants identified as depressed by their general practitioner in 28 primary care practices.

Results: planned comparisons indicated that participants in the PAI group reported significantly greater use of coping skills at the 1-month assessment (F = 6.35; df = 1, p = 0.016).

Conclusions: Patients with more severe symptoms may benefit from higher-intensity services provided in primary care.

Keywords: depression, behavioral disorders, primary care, general practitioners, treatment

source: DeCS

DOI Number: 10.14704/nq.2022.20.13.NQ88196 Neuro Quantology 2022; 20(13):1568-1573

Resumen

Introducción: La prevalencia en ascenso de la no atención oportuna a pacientes deprimidos en atención primaria es evidente en la actualidad.

Objetivo: Determinar el impacto de las intervenciones psicosociales de baja intensidad en la promoción de una mejor atención a la depresión.

Método: Se realizó un estudio controlado aleatorizado, con participantes identificados como deprimidos por su médico general en 28 prácticas de atención primaria.

Resultados: las comparaciones planificadas indicaron que los participantes en el grupo PAI informaron un uso significativamente mayor de habilidades de afrontamiento en la evaluación de 1 mes (F = 6,35; df = 1, p = 0,016).

Conclusiones: Los pacientes con síntomas de mayor gravedad podrían beneficiarse de servicios de mayor intensidad brindados en atención primaria.

Palabras clave: depresión, trastornos de a conducta, atención primaria, médicos generales, tratamiento.

Fuente: DeCS

Introduction

The modal prevalence of depression within primary care has been estimated to be between 8% and 14%, and most depressed patients do not receive timely care for depression[1,2]. While

many barriers to care to exist, patient beliefs about depression and using strategies to cope with personal demands and distress are important factors in treatment-seeking and treatment outcomes[3]. For example, using positive coping strategies (e.g., connecting with others, active problem solving) may promote treatment engagement, whereas negative coping strategies (e.g., avoidance) may lead to treatment delay.

Further study of strategies to positively influence patient coping strategies is necessary to improve primary care services for depressed patients[4]. Possible low-intensity strategies include the use of coping educational materials supported by the primary care physician (PCP) and possible ancillary primary care providers, such as a liaison psychiatrist (EP) or behavioral health clinician (BHC)[5]. For example, a study evaluating the use of brief educational materials (including an interactive booklet encouraging the use of evidence-based coping strategies) supported by their MAPs and two or more visits with a PE reported improved clinical outcomes, patient satisfaction, and medication adherence for primary care patients with major depression[6]. However, this combined intervention did not result in decreased depressive symptoms or improved satisfaction with care for patients with minor depression (58 % of the sample). In addition, this initial study did not measure the impact of the intervention on the rates of patients using specific coping strategies in the educational materials.

It was presumed that patients receiving this low-intensity treatment called an integrated care program (ICP) would differ significantly from those receiving usual care (HA). Specifically, the hypothesis was that patients with IAP would report higher rates of (1) using specific coping skills, (2) following relapse prevention plans, (3) taking antidepressant medications, and would also report greater satisfaction with depression care.

Method

A randomized controlled study was conducted with 153 participants identified as depressed by their primary care physician (PCP) who were assigned to EPI or usual care (HA management by PCP, including referral to specialists) in 28 primary care practices in the city of Ambato. Participants were adults aged 18 to 80 years, identified by their MAP as having "definite or probable major depression," willing to use antidepressant medication, and willing to consent to participate in a primary care study designed to improve care for depression. Inclusion criteria included a screening score of 0.75 or higher on a 20-item depression symptom checklist. Exclusion criteria included alcohol abuse, current psychotic symptoms, severe suicidal ideation or plan, dementia, pregnancy, and terminal illness. PAI and AH participants who completed 1-, 4-, and 7-month follow-up assessments constituted the research sample. This study describes the impact of PAI on patient-specific behavioral goals. This study was approved by the Universidad Regional Autónoma de Los Andes (UNIANDES).

MAPs were informed of participants' randomization status immediately after randomization and remained responsible and in charge of patient care regardless of randomization status. Patients randomized to AH received treatment for depression from their MAPs. In most cases, MAP care involves prescribing antidepressant medications and 2 to 3 visits during the first three months of treatment. Thus, referral to the HMO's specialty MH care was also an option for intensified services.

At the initial visit, the MSC helped the participant develop a conceptual model for understanding the symptoms of depression and introduced the concepts of planning specific behavioral experiments to improve quality of life. The MSCs also implemented a medication adherence protocol for participants who opted to use medication for depression.

Participants were assessed in person before treatment and by telephone 1, 4, and 7 months later. Pretreatment interviews occurred within one week of referral. Staff conducting the telephone follow-up assessments were unaware of the participant's randomization status. Participants were asked whether they had taken any antidepressant medication during the month prior to the follow-up interview. If they answered "yes," they were asked to estimate the number of days in the past 30 days that they had taken antidepressant medication at any dose.

At all follow-ups, participants' satisfaction with depression care was measured with a single question that asked about the care received

during the time intervals between interviews. In addition, participants rated the quality of care received on a Likert scale (5 = poor, 4 = fair, 3 = good, 2 = very good, 1 = excellent).

At the 4-month follow-up, participants indicated whether they were following a relapse prevention plan endorsed by their MAP. In addition, participants indicated whether they had discussed with the MAP in the previous two months the use of coping strategies to prevent depression and improve quality of life.

The study used an intention-to-treat analysis, in which all participants were included whether or not treatment was administered in full. Descriptive analyses were used to describe lower and higher severity groupings. In addition, parametric and nonparametric analyses were used to assess differences in the dependent variables for the ICP and HA groups. Database and statistical processing of the data were performed and analyzed in SPSS 26 statistical software (SPSS Inc., Chicago, IL, USA). Descriptive statistics were used for the results collection, presentation and interpretation.

Results

There were no statistically significant differences between PAI and AH in age, gender, educational level, marital status, employment, or rates of experience of previous episodes of depression. More than 60% of participants reported two or more previous episodes of depression.

Of the 153 randomized participants, 140 (91.5%) completed the 1-month follow-up, 128 (83.7%) completed the 4-month follow-up, and 117 (76.5%) completed the 7-month follow-up. Sixty (77.9 %) of the 77 IAP participants and 53 (69.7 %) of the 76 HA participants completed all three follow-ups (Chi-square = 1.33, p = 0.25). Therefore, data from the 113 (73.8%) participants who completed all three follow-ups were used to assess the effects of the intervention.

For participants with higher severity symptoms, planned comparisons indicated that participants in the PAI group reported significantly greater use of coping skills at the 1-month assessment (F = 6.35; df = 1, p = 0.016) but not at the 4-month assessment (F =7.12; df = 1; p = 0.11) and 7-month assessments (F = 3.16; df = 1; p = 0.083). A significant group-by-time interaction was observed for the lower severity group (Wilks' lambda = 0.841; F = 3.842; df = 3; p = 0.014). Planned comparisons between participants with lower severity symptoms in the AH versus PAI groups indicated that PAI participants reported greater use of coping skills at 1 month (F = 10.66; df = 1; p = 0.002), 4 months (f = 5.34; df = 1; p = 0.024), and 7 month assessments (F = 6.68; df = 1; p = 0.012).

Chi-square analyses were used to assess the effects of the intervention on relapse prevention activities assessed at the 4-month follow-up. Table 1 summarizes the chi-square test results on using a relapse prevention plan and discusses the plan with the MAP during the two months between the 1-month and 4-month follow-up assessments. Participants in the PAI group were significantly more likely to follow a relapse prevention plan (lower: p = 0.000; higher: p = 0.0001). In addition, PAI participants in the lower severity group were significantly more likely than HA participants in the lower severity group to report talking with their MAP about using coping strategies to improve quality of life and lessen the impact of depressive symptoms during the two months prior to the 4-month assessment (p = 0.05).

Table 1. Summary of chi-square tests on relapse prevention coping at 4-month follow-up.

	Increased severity				Lower gravity			
	PAI	AH	x2	p	PAI	AH	x2	p
Use of the Plan	74,1%	26,9%	11.783	0.001	89,5%	33,3%	24.77	0.000
Discussion with MAP	33,3%	23,1%	0.687	0.407	50,0%	27,8%	3.831	0.05

Source: statistical analysis, p ≤ 0.05

Cross-sectional ANOVAs were used to evaluate medication use data obtained at the three follow-up assessments. Sex and gender were entered as covariates in the model. Medication use was not significantly higher for participants with ICP than for participants with AH in the lower and higher severity groups at the 1-month follow-up. However, significant differences emerged at the 4-month follow-up for the lower and higher-severity depression groups.

A series of t-tests were performed to assess participants' satisfaction with the treatment. As can be seen in Table 2, IAP and HA participants were similar in pretreatment satisfaction ratings. However, low and high-severity IAP groups were significantly more satisfied than HA participants at all three follow-up assessments.

Table 2. Satisfaction with Depression Care

Evaluation	Increased severity				Lower gravity			
	PAI	AH	t	p	PAI	AH	t	p
Pretreatment	2.75	2.70	0.09	0.931	2.64	2.56	0.19	0.852
1 month	1.54	2.61	-3,33	0.002	1.60	2.46	-3,43	0.001
4 months	1.83	2.76	-2,58	0.014	1.91	2.63	-2,63	0.012
7 months	1.83	2.72	-2,21	0.035	1.78	2.84	-3,63	0.000

Source: statistical analysis, $p \leq 0.05$, satisfaction with care for depression measured on a Likert scale from 1 to 5, 1 = excellent, 2 = very good, 3 = good, 4 = fair, 5 = poor.

Discussion

PAI participants in both the low and high-severity groups rated MSC services positively and reported rates of use of specific coping strategies more frequently than HA participants one month after diagnosis and referral to PAI. Furthermore, total face-to-face MSC contact time with PAI patients during this first month was 2.5 hours, suggesting that low-intensity services provided in team-based care may be sufficient to achieve early improvements in coping among patients with lower and higher severity symptoms. In addition, the provision of services consistent with the EPI is increasingly feasible as more clinics adopt the behavioral health model of primary care[7,8].

The results of the current study suggest that using a relapse prevention plan developed by an MSC and endorsed by the MAP over 6 months may be a viable quality improvement strategy for the lower and higher severity groups. Ninety percent of lower severity and 74% of higher severity EIP participants reported efforts to follow their progress plan[9,10].

The EPI also appeared to improve patient satisfaction with depression care in the low and high-severity groups and positively impacted patient adherence to medications over time, particularly in lower-severity patients[11,12]. The availability of an MSC to guide how to cope with and support medication use may allow participants who do not use medication initially or discontinue medication early in treatment to start or restart within the first few months after diagnosis[13]. Depression is a risk factor for nonadherence to medical treatment[14,15], and additional investment of MSC time, particularly with higher severity patients, may be an important and feasible strategy to improve the overall health of higher-severity patients by boosting their use of positive coping strategies[21, 22].

The strengths of this study included its design, the setting, and the use of a well-described intervention. The design provided an opportunity to investigate the impact of depressive symptom severity on the behaviors of patients targeted for low-intensity treatment. In addition, the design was adapted to real-world care by incorporating MAP autonomy in directing care[16,17, 18]. The IAP intervention also assumed a team-based care approach and, in doing so, is consistent with the primary care approach of the patient-centered medical home[19,20].

Conclusions

Future investigators are encouraged to continue to explore low-intensity team-based treatment for depression. Patients with more severe symptoms may benefit from higher-intensity services provided in primary care, such as group medical visits that support ongoing coping strategies. Research that includes features of the EPI and adds options for ongoing contact with MSC (individual, classroom series, or group medical visits) by higher severity patients would provide valuable information on feasible strategies to address the needs of patients with more severe symptoms.

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