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General Hospital Psychiatry 29 (2007) 91–116
General Hospital Psychiatry

Psychiatry and Primary Care

Recent epidemiologic studies have found that most patients with mental illness are seen exclusively in primary care medicine. These patients often present with medically unexplained somatic symptoms and utilize at least twice as many health care visits as controls. There has been an exponential growth in studies in this interface between primary care and psychiatry in the last 10 years. This special section, edited by **Jürgen Unutzer, M.D.,** will publish informative research articles that address primary care-psychiatric issues.

Systematic review of multifaceted interventions to improve depression care☆

John W. Williams Jr., M.D., M.H.S.[a,b,*], Martha Gerrity, M.D., Ph.D.[c], Tracey Holsinger, M.D.[a], Steve Dobscha, M.D.[c], Bradley Gaynes, M.D., M.P.H.[d], Allen Dietrich, M.D.[e]

[a]*Center for Health Services Research in Primary Care, Durham VA Medical Center, Durham, NC, USA*
[b]*Department of Medicine, Duke University Medical Center, Durham, NC 27705, USA*
[c]*Portland Veterans Affairs Medical Center and Oregon Health Sciences Center, Portland, OR 97239, USA*
[d]*Department of Psychiatry, University of North Carolina, Chapel Hill, NC, USA*
[e]*Department of Community and Family Medicine, Dartmouth Medical School, Hanover, NH, USA*

Received 27 September 2006; accepted 5 December 2006

Abstract

Objective: Depression is a prevalent high-impact illness with poor outcomes in primary care settings. We performed a systematic review to determine to what extent multifaceted interventions improve depression outcomes in primary care and to define key elements, patients who are likely to benefit and resources required for these interventions.
Method: We searched Medline, HealthSTAR, CINAHL, PsycINFO and a specialized registry of depression trials from 1966 to February 2006; reviewed bibliographies of pertinent articles; and consulted experts. Searches were limited to the English language. We included 28 randomized controlled trials that: (a) involved primary care patients receiving acute-phase treatment; (b) tested a multicomponent intervention involving a patient-directed component; and (c) reported effects on depression severity. Pairs of investigators independently abstracted information regarding (a) setting and subjects, (b) components of the intervention and (c) outcomes.
Results: Twenty of 28 interventions improved depression outcomes over 3–12 months (an 18.4% median absolute increase in patients with 50% improvement in symptoms; range, 8.3–46%). Sustained improvements at 24–57 months were demonstrated in three studies addressing acute-phase and continuation-phase treatments. All interventions involved care management and required additional resources or staff reassignment to implement; interventions were delivered exclusively or predominantly by telephone in 16 studies. The most commonly used intervention features were: patient education and self-management, monitoring of depressive symptoms and treatment adherence, decision support for medication management, a patient registry and mental health supervision of care managers. Other intervention features were highly variable.
Conclusion: There is strong evidence supporting the short-term benefits of care management for depression; critical elements for successful programs are emerging.
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Keywords: Depressive disorder; Care management; Literature synthesis

This work was presented, in part, at the Annual Veterans Affairs Quality Enhancement Research Initiative meeting, Alexandria, VA, December 11, 2003, and at the Twenty-Seventh Annual Meeting of the Society of General Internal Medicine, Chicago, IL, May 13, 2004.

☆ The views expressed in this manuscript are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs, Center for Medicare and Medicaid Services or The John D. and Catherine T. MacArthur Foundation.

* Corresponding author. Center for Health Services Research in Primary Care, Durham VA Medical Center, Durham, NC, USA. Tel.: +1 919 668 0300.
E-mail address: Jw.williams@duke.edu (J.W. Williams).

0163-8343/$ – see front matter © 2007 Elsevier Inc. All rights reserved.
doi:10.1016/j.genhosppsych.2006.12.003

1. Introduction

According to projections from the World Health Organization, depression will be the second leading cause of disability in the developed world by 2020 [1]. Primary care clinicians (PCCs) care for approximately two thirds of depressed individuals [2] but frequently fail to recognize depression or undertreat it when recognized [3,4]. This may be due to the many challenges faced by PCCs in providing care to depressed patients [5–12]. Patients often present with somatic complaints that distract clinicians from recognizing depression [7,8]. Patients who are recognized as being depressed may resist the diagnosis or referral to a mental health specialist [5]. Those who are treated with medications may be prescribed inadequate doses of antidepressants [13,14] or may not fill their prescriptions [5]. Depressed patients may become discouraged and discontinue care because of the time required to achieve response, or they may quit taking their medications when they begin to feel better [5].

The US Preventive Services Task Force recommends screening for depression in primary care, but only if there is a system for treatment and follow-up [15]. However, it is not clear what these systems should include and how best to address the challenges faced by PCCs. Several single-component interventions, including clinician education and screening, failed to improve patient outcomes [16–18]. A growing number of randomized trials of multifaceted interventions suggest that enhancements to the care process may improve patient outcomes in primary care settings [16,18,19], and recent reviews suggest that multifaceted interventions that include patient-related care processes are more likely to improve depression outcomes than single-component interventions [16,18,20–22].

However, questions remain regarding the necessary and sufficient components and the applicability of these research findings across primary care settings [18,22,23]. Wagner's Chronic Care Model (CCM) provides one framework for analyzing these complex interventions [21,24,25]. The CCM includes six interrelated components: decision support for clinicians, self-management support for patients, delivery system redesign, clinical information systems, health care organization and community resources.

We performed a systematic review to determine: to what extent multifaceted interventions improve depression outcomes in primary care; to define key elements using the CCM; and to identify patients who are likely to benefit and the resources required for these interventions. A synthesis of the literature, with descriptions of the key components of these interventions and the resources they require, will inform health care organizations as they consider improving their depression care. Prior reviews of interventions to improve depression outcomes did not provide this information [18,20,26–30], occurred before recent randomized controlled trials (RCTs) of multifaceted interventions [8,17,31,32] or were not systematic reviews [16,33].

2. Methods

2.1. Data acquisition

We searched Medline, HealthSTAR, CINAHL, PsycINFO and a specialized registry of depression trials [34] for English-language medical literature published from 1966 to February 2006. Search terms included: (a) the MESH terms "depressive disorder" and "depression"; (b) a series of terms validated to identify clinical trials [34,35]; and (c) a series of MESH terms and text words designed to identify studies using one or more elements of care management (Appendix A). Other sources were references identified from pertinent articles and contacts with experts in the field of depression and health services interventions.

Of 1464 articles identified, 138 were deemed potentially relevant. These were reviewed to identify RCTs meeting the following selection criteria: (a) samples comprising adult patients with a depressive disorder who were cared for in a primary care setting; (b) interventions needed to augment usual care by incorporating at least one patient-directed element from the CCM (e.g., patient self-management, active follow-up); and (c) studies had to report clinically meaningful outcomes, such as change in depressive symptoms. Interventions directed solely at the clinician (e.g., clinician education or performance feedback) or health care system (e.g., automated clinical reminders) were not included.

2.2. Data extraction

Pairs of independent reviewers (S.K.D., A.J.D., J.W.W., J.D., T.H. and B.N.G.) abstracted articles. Elements of the intervention were abstracted using features of Wagner's CCM [21,24,25] and included: (a) setting (health care organization and practice characteristics) and subjects (clinician and patient characteristics); (b) components of the intervention (decision support, self-management support, delivery system redesign including care management and enhanced mental health involvement, and clinical information systems) and support for implementing the intervention; (c) care management functions and process; and (d) outcomes. We defined "care management" as any systematic or structured management of patient care that included coordination and communication among treating health care providers, patient education, monitoring of symptoms and adherence to treatment plans, self-management support or psychological treatments [36,37]. Outcomes abstracted included the proportion of subjects who had a least a 50% decrease in depressive symptomatology or remission in symptoms based on a validated questionnaire, mean change in depressive symptoms and antidepressant adherence. When key information was missing or unclear, we contacted the primary author for clarification; 22 of 24 authors contacted responded to our request. Two investigators (M.S.G. and J.W.W.) reviewed areas of disagreement. The final classification was based on the consensus of all investigators.

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