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Controlled trial of problem-solving therapy and consultation-liaison for common mental disorders in general medical settings in Taiwan

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Abstract

Objective: Common mental disorders (CMD) are prevalent high-impact illnesses seen in general medical settings worldwide. There has been no investigation on the efficacy of enhanced care in Chinese societies. The aim of this study was to compare the outcome of three interventions for treating CMD: usual care (UC), problem-solving therapy plus UC (PST-UC), and psychiatric consultation plus UC (PC-UC).
Method: The sample for this randomized controlled trial consisted of 254 patients with CMD being managed in general medical care settings. Clinical and functional assessments were done at baseline and at 16 weeks.
Results: Two hundred six patients had complete data at 16 weeks (66 in the UC group, 63 in the PST-UC group, 77 in the PC-UC group). All patients had significant improvement on all scales over time, with no significant differences among the three treatment groups.
Conclusion: This trial failed to demonstrate the efficacy of enhanced care with consultation-liaison by mental health professionals for patients with CMD in general medical settings in Taiwan. Improved outcomes may require more integrated interventions.

Keywords: Enhanced care; Problem-solving therapy; Consultation-liaison; Common mental disorders; Primary care; Controlled trial

1. Introduction

Common mental disorders (CMD) are major sources of personal distress and social disability [1,2]. Recent findings from Taiwan and other developing countries report a prevalence of CMD exceeding 30% in general medical settings, and most patients do not receive appropriate treatment [3,4]. A series of randomized controlled trials in Western countries have shown that enhanced care in the primary care setting improves outcomes [5–7]. To date, however, there have been no such studies in Taiwan or in other Chinese societies. It may be that findings from the West are not generalisable to Asia, since the health care systems and cultures differ substantially. We designed this study to examine whether two models of enhanced care would lead to improved outcomes for patients with CMD being managed in general medical settings in Taiwan.

2. Methods

2.1. Design and participants

This study was a randomized controlled trial of three treatments for patients with CMD being managed in general medical clinics in a general hospital in Taipei. Independent

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assessments were carried out at baseline and after 16 weeks. The study was approved by the institutional review board of Mackay Memorial Hospital, Taipei, Taiwan.

Study participants were recruited from among patients referred for evaluation of CMD detected by nonpsychiatric physicians. They were interviewed by a research assistant who described a new program to improve treatment of depression and anxiety within the general medical clinic. After the subjects agreed to participate and signed informed consent, they underwent a complete evaluation conducted by a trained interviewer who was blinded to the treatment group to which the subject was assigned. Enrollment criteria required (a) evidence of CMD as defined by a score of 12 or more points on the Chinese version of the Revised Clinical Interview Schedule (CISR) [8], (b) age 18 to 70 years, and (c) willingness to participate and the capacity to give informed consent. Exclusion criteria included psychotic disorders or symptoms, bipolar disorder, alcohol or substance dependence, organic brain damage, major suicide risk, or current treatment by a psychiatrist.

2.2. Intervention

After completion of the baseline assessment, patients who met the entry criteria were randomly assigned to one of three trial groups: (1) usual care (UC), (2) problem-solving therapy plus UC (PST-UC), or (3) psychiatric consultation plus UC (PC-UC). All three groups of patients were free to consult their usual physicians throughout the course of the study, and these physicians could prescribe psychotropic drugs if they felt they were indicated. The two active interventions were designed for delivery over 16 weeks. Randomization was based on computer-generated numbers by means of a blocked procedure to ensure balanced group assignments.

2.2.1. Usual care

Patients in the UC group continued seeing their treating physicians as usual. They were permitted to see mental health professionals if they or their treating physicians chose to.

2.2.2. Problem-solving therapy plus usual care

Those randomized to the PST-UC group were offered up to six sessions of problem-solving therapy (PST) in addition to UC from their primary physicians. PST is a brief structured psychological treatment that has been shown in controlled studies in primary care settings to be as effective as antidepressants for patients with moderate depressive disorders [9–11]. It is suitable for use in primary care because it is relatively brief and can be easily taught to a range of health professionals, e.g., community nurses. PST has three main steps: the patient's symptoms are linked with their problems, the problems are defined and clarified, and an attempt is made to solve the problems in a structured way. Each session included setting an agenda, homework, and client feedback. The intervention in this study began with the introduction of the PST model to patient. The treatment involved active collaboration between patients and therapists. The latter included four experienced faculty psychologists, two senior psychiatric social workers, and a registered psychiatric nurse, all of whom had worked in psychiatric services for at least 6 years. All had completed a 4-day training programme in PST prior to commencement of the trial, followed by at least 1 year of continuous group supervision. Training workshops utilized small group work, while video and role play allowed the practice of relevant techniques. An educational book and videotape on the PST model were translated into Chinese for reference. PST was standardized with guidelines provided to all therapists in the study in a booklet which was used during training and at the beginning of the intervention.

2.2.3. Psychiatric consultation plus usual care

Patients in the PC-UC group had psychiatric consultation provided by a board-certified psychiatrist. The psychiatrist assisted the nonpsychiatric physicians with clinical assessment, prescription of medications, and maintenance of treatment until remission was achieved. A report was forwarded to the patient's treating physician including recommendations for further management as indicated. Follow-up visits to the psychiatrist were at his or her discretion based on clinical judgment. Six staff psychiatrists participated. All psychiatrists received 2 hours of orientation before starting the study. Guidelines on medication and maintenance treatment were provided to all psychiatrists providing psychiatric care for the study. Group discussions were held every 1 to 2 weeks in the first 4 months after implementation of the study.

2.3. Measures

Independent assessments took place on entry into the study (Week 0) and at the end of the intervention (Week 16). The assessor was blinded to the subjects' treatment assignment.

At the initial interview, sociodemographic and clinical information was collected. Both self-report and interviewer-rated instruments were completed at baseline and at 16 weeks. The primary outcome measure was the Chinese version of the CISR, a standardized, structured interview to assess CMD in the community and primary care settings [8]. The CISR has been used extensively in developing countries. Translation of and field experience with the CISR in Taiwan have been described [3,4]. CMD was diagnosed in subjects who scored 12 or more on the CISR. CISR responses are analyzed by a computer programme, the PROgrammable Questionnaire System (PROQSY), which applies an algorithm based on the ICD-10 diagnostic criteria. Case diagnoses were established according to ICD-10 research diagnostic criteria and included current depression (mild, moderate, or severe), generalized anxiety disorder, panic disorder, agoraphobia, simple phobia, social phobia, obsessive compulsive disorder, and mixed anxiety depressive disorder.

Remission at 16 weeks was defined as a CISR score of 11 or lower. This absolute decrease in symptom score, rather than a percentage reduction, was chosen to ensure that no