



Research report

Mental health interventions and future major depression among primary care patients with subthreshold depression



Sandra K. Davidson ^{a,*}, Meredith G. Harris ^b, Christopher F. Dowrick ^c,
Caroline A. Wachtler ^{a,d}, Jane Pirkis ^e, Jane M. Gunn ^a

^a Department of General Practice, University of Melbourne, Australia

^b School of Public Health, The University of Queensland, Australia

^c University of Liverpool, UK

^d Centre for Family Medicine, Karolinska Institute, Sweden

^e Melbourne School of Population and Global Health, University of Melbourne, Australia

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ABSTRACT

Background: Subthreshold depression is prevalent in primary care and is associated with poorer quality of life, higher health care use and increased risk of major depressive disorder (MDD). Currently, it is unclear how subthreshold depression should be managed in primary care and no studies have investigated the relationship between current models of care and the development of MDD. This study aimed to describe usual care over a six month follow-up for primary care patients with subthreshold depression and to investigate the relationship between usual care and the development of MDD.

Methods: Data were derived from 250 participants with subthreshold depression from the *diamond* study, a longitudinal cohort study of primary care patients. Participants completed questionnaires at three and six months on their health care use, the interventions they received and their depression status. Interventions were categorised according to the NICE guidelines for the management of depression in adults. Generalised estimating equation (GEE) models and logistic regression were used to estimate the association between receiving an intervention and MDD over six months.

Results: Four fifths (80.8%) of participants received a mental health intervention. Therapeutic listening, reassurance, pharmacotherapy and advice to exercise were most common. Subsequent MDD was predicted by history of depression, baseline depressive symptom severity and receiving a mental health intervention.

Limitations: Usual care was assessed via patient self-report.

Conclusions: Primary care physicians deliver mental health interventions to most subthreshold patients. However, it appears that current interventions are not averting MDD. Further research to identify effective interventions which are feasible in primary care is needed.

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1. Introduction

Subthreshold depression, where depressive symptoms are present but do not meet standard diagnostic criteria for major depressive disorder (MDD) (NCCMH 2010), is prevalent in primary care. Estimates of prevalence range from 9% in health maintenance organisations (Simon and Von Korff, 1995) to 35% in a university-based primary care practice (Wagner et al., 2000). The subthreshold population is heterogeneous and includes people in partial remission from a major depressive episode, people with persistent subthreshold symptoms

and people with recent onset of symptoms (Druss et al., 2007). Compared to people with no depressive symptoms, those with subthreshold depression have significantly higher functional impairment (Wagner et al., 2000) and are at increased risk of developing MDD (Cuijpers and Smit, 2004; Pietrzak et al., 2013). Moreover, people with subthreshold depression and a history of depression are at significantly higher risk of MDD than people with subthreshold depression and no history of depression (Karsten et al., 2011). At the same time, there is a high natural recovery rate with approximately 70% of the subthreshold population not progressing to MDD (Hermens et al., 2004; Pietrzak et al., 2013).

There are two schools of thought as to how health professionals should respond to subthreshold depression (Ackermann and Williams, 2002). On the one hand, proponents of treatment draw on the small number of psychological trials showing that treating subthreshold

* Correspondence to: Department of General Practice University of Melbourne 200 Berkeley Street, Carlton, Vic. 3053 Australia. Tel.: +61 3 8344 7276; fax: +61 3 9347 6135.
E-mail address: sdav@unimelb.edu.au (S.K. Davidson).

depression in primary care has the potential to avert new cases of major depressive disorder (MDD) (Cuijpers et al., 2014, 2007; Morgan et al., 2012; Willemse et al., 2004), albeit with high numbers needed to treat (NNT) (16 in Willemse et al. (2004) and 25 in Morgan et al. (2012)). On the other hand, the high rate of natural recovery (Hermens et al., 2004; Pietrzak et al., 2013), combined with large NNT, suggests that treating subthreshold depression may subject many people who have normal, self-remitting emotional distress to unnecessary, burdensome and potentially stigmatising treatment (Dowrick and Frances, 2013). It is further argued that providing intensive treatments to people with subthreshold depression may represent a misallocation of scarce resources with interventions diverted toward those with the least need, thus contributing to the treatment gap for those with a diagnosable mental disorder (Druss et al., 2007; Wang et al., 2005).

In 2009, the NICE guidelines included the management of persistent subthreshold depressive symptoms for the first time. However, they acknowledge that the empirical evidence supporting these recommendations is very limited (NCCMH, 2010). Currently, the guidelines recommend a stepped care approach beginning with general sleep hygiene advice and, if necessary, progressing to active monitoring which includes discussing the presenting problem, providing psychoeducation and conducting follow-up. For people with continued symptoms, low intensity psychosocial interventions such as a group exercise programme, a peer support group, guided self-help based on the principles of cognitive behavioural therapy (CBT) or computerised CBT are recommended. If symptoms still persist, high intensity psychosocial interventions comprising multiple sessions of CBT or Interpersonal Therapy (IPT) are recommended. Antidepressants are only recommended for people with persistent (i.e. more than two years) symptoms or for those whose symptoms persist after other interventions (NCCMH, 2010).

The caveat in the NICE guidelines is that the evidence base on the effectiveness of psychological treatments is too small to support clear recommendations. This caveat underpins their subsequent call for further research to examine the efficacy of counselling and low intensity CBT compared to usual care in the treatment of subthreshold depression. Of course, this suggests that the nature of usual care for subthreshold depression is known. In fact, no studies have examined usual care in the primary care setting for people with subthreshold depression or investigated the relationship between usual care and depression outcomes. The current study aims to address this gap by describing: the proportion of primary care attendees with subthreshold depression who received a mental health intervention over six months; the type of intervention they received and the relationship between receiving an intervention and subsequent development of MDD. In order to estimate whether an individual has persistent symptoms, and is more likely to need the interventions described later in the stepped care model, we separate people with subthreshold depression into those with a history of depression and those without.

2. Method

2.1. Procedure

Data were derived from an ongoing longitudinal cohort study: Diagnosis, Management and Outcomes of Depression (*diamond*) (Gunn et al., 2008). *diamond* is designed to document the experiences, service use, treatment and health outcomes of primary care patients with a broad range of severity of depressive symptoms. Its rationale and methods have been described previously (Gunn et al., 2008). Assessments consist of written questionnaires and telephone interviews. The present study reports data from baseline, three and six months. A six month follow-up was chosen as we considered that this was a reasonable time frame for general practitioners (GPs) to respond to patients with subthreshold symptoms. Exclusion

criteria for the study were: unable to read English; the presence of a terminal illness, not residing in the community and outside the age range of 17–76 years.

2.2. Participants

A list of 200 randomly selected GPs, stratified by population distribution to ensure a representative rural and metropolitan sample and who had provided at least 1500 consultations in the previous year, was provided to the researchers by the Australian Health Insurance Commission. Thirty GPs from this list, all from different practices, agreed to participate in the study. Prior to patient recruitment, the GPs completed a questionnaire describing their practice setting, mental health education or skills training and areas of interest.

Between 2005 and 2006, 17,780 patients aged between 18 and 75 years listed with the 30 study GPs were sent a screening survey which included the Centre for Epidemiologic Studies Depression Scale (CESD) (Radloff, 1977). A total of 7509 (42.2%) people returned a completed survey, 1793 (23.9%) of whom scored ≥ 16 on the CESD, indicating the presence of depressive symptoms. The prevalence of 24% for depressive symptoms is consistent with other studies of primary care practices (Gilchrist and Gunn, 2007) which suggest that the practices in *diamond* are representative in regards to the proportion of patients with depressive symptoms. People with a score of ≥ 16 on the CESD were invited to participate in *diamond* and 789 (44.0%) agreed.

At baseline, all patient participants completed the questionnaire administered Primary Health Questionnaire depression module (PHQ-9) (Kroenke et al., 2001) and 726 (92%) completed the telephone administered Composite International Diagnostic Interview (CIDI) (Kessler and Ustun, 2004). Of the 789 participants who completed the PHQ-9, 211 (26.7%) met the criteria for major depressive disorder using the algorithm scoring method to assess the presence of major depression in the past two weeks. Of the 726 who completed the CIDI, 370 (51.0%) met the criteria for major depression over the past 12 months (Kessler and Ustun, 2004). In total, 494 (62.6%) participants met the criteria for major depressive disorder on either the PHQ-9 or the CIDI and were excluded from the present study. The remaining 295 participants were classified as having subthreshold depression.

The sensitivity of the algorithmic scoring method of the PHQ-9 is rather low at 0.77 (Wittkamp et al., 2007) and may miss some patients with depressive disorder. On the other hand, the CIDI has been shown to have a high false positive rate, generating a diagnosis of depression when a true case of depression does not exist (Kurdyak and Gnam, 2005). By using both the PHQ-9 and the CIDI to identify probable depression it is unlikely that participants classified as having subthreshold depression were true cases of depression.

Of the subthreshold group, 250 (84.7%) completed surveys at three and six month follow-up. Of these, 118 (47.2%) had previously been told by a doctor or a psychologist they had depression and were considered to have a history of depression. The remaining 132 (52.8%) reported never having been told by a doctor or psychologist that they had depression and were classified as not having a history of depression. Participant's scores on the PHQ-9 and CIDI were not disclosed to GPs.

2.3. Measures

2.3.1. Baseline sociodemographic and clinical characteristics

Information on a range of sociodemographic and clinical characteristics was collected at study entry including gender, age, education, employment status, reliance on a government pension, marital status, living arrangements, baseline depression severity, chronic illness, life events, smoking status, hazardous alcohol consumption, anxiety disorder and suicidal ideation. The PHQ-9 continuous score was used

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