



Models for treating depression in specialty medical settings: a narrative review☆☆☆



Jessica Y. Breland, M.S., Ph.D.^{a,b,*}, Joseph Mignogna, M.S., Ph.D.^{c,e,f,g,h}, Lea Kiefer, M.P.H.^{c,f}, Laura Marsh, M.D.^{d,e,f}

^a Center for Innovation to Implementation, VA Palo Alto Healthcare System, 795 Willow Road (152-MPD), Menlo Park, CA 94025

^b Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, 401 Quarry Rd, Stanford, CA 94304

^c Houston VA Health Services Research and Development Center for Innovations in Quality, Effectiveness and Safety, (MEDVAMC 152), 2002 Holcombe Blvd., Houston, TX 77030

^d Mental Health Care Line, Michael E. DeBakey VA Medical Center (MEDVAMC 116), 2002 Holcombe Blvd., Houston, TX 77030

^e Baylor College of Medicine, One Baylor Plaza, BCM 350, Houston, TX 77030

^f Veterans Affairs South Central Mental Illness Research, Education, and Clinical Center (a virtual center)

^g Department of Veterans Affairs, VISN 17 Center of Excellence for Research on Returning War Veterans, Waco, TX

^h Central Texas VA Health Care System, Waco, TX

ARTICLE INFO

Article history:

Received 6 January 2015

Revised 13 April 2015

Accepted 14 April 2015

Keywords:

Integrated care

Depression

Cancer

HIV/AIDS

Multiple sclerosis

ABSTRACT

Objective: This review answered two questions: (a) what types of specialty medical settings are implementing models for treating depression, and (b) do models for treating depression in specialty medical settings effectively treat depression symptoms?

Method: We searched Medline/Pubmed to identify articles, published between January 1990 and May 2013, reporting on models for treating depression in specialty medical settings. Included studies had to have adult participants with comorbid medical conditions recruited from outpatient, nonstandard primary care settings. Studies also had to report specific, validated depression measures.

Results: Search methods identified nine studies (six randomized controlled trials, one nonrandomized controlled trial and two uncontrolled trials), all representing integrated care for depression, in three specialty settings (oncology, infectious disease, neurology). Most studies ($N=7$) reported greater reductions in depression among patients receiving integrated care compared to usual care, particularly in oncology clinics.

Conclusions: Integrated care for depression in specialty medical settings can improve depression outcomes. Additional research is needed to understand the effectiveness of incorporating behavioral and/or psychological treatments into existing methods. When developing or selecting a model for treating depression in specialty medical settings, clinicians and researchers will benefit from choosing specific components and measures most relevant to their target populations.

Published by Elsevier Inc.

1. Introduction

Of the 15.2 million adults in the United States who experience a major depressive episode each year, 37% seek care only from a primary care provider [1], indicating a clear need for mental health care in medical settings [2,3]. One way to address this need is through models that integrate depression treatment with general medical care [4–8]. In primary care settings, such programs usually include systematic

screenings for depression and direct access to depression treatments, as well as the use of medication treatment algorithms (e.g., Sequenced Treatment Alternatives to Relieve Depression) [9,10]. These programs may also include depression care managers who serve as patients' mental health points of contact and work to coordinate care by consulting with physicians and specialty mental health providers. Depression care managers may also provide psychotherapy or other low-intensity behavioral treatments [6,7].

A recent meta-analysis found that one specific model of care, collaborative care for depression, effectively treats depression when implemented in primary care settings [11]. However, not all patients with depression are managed in primary care settings; some patients, including those with chronic medical conditions, must be managed in specialty medical settings. The joint management of depression and chronic medical conditions is important because individuals with chronic medical conditions are more likely to develop depression than those without such conditions [12]. Furthermore, the relationship between depression and chronic medical conditions is bidirectional [12]. Chronic medical conditions can lead to depression through biological changes (e.g., vascular depression) or through the

☆ Funding acknowledgment: This material is the result of work supported with resources and the use of facilities at the Houston Veterans Affairs (VA) Health Services Research and Development (HSR&D) Center for Innovations in Quality, Effectiveness and Safety (CIN13-413) at the Michael E. DeBakey VA Medical Center. It was also supported by the Methods of Optimal Detection in Parkinson's disease grant (NIH-R01 MH069666). In addition, it was supported by the VA Office of Academic Affiliations and VA HSR&D Service in conjunction with a VA HSR&D Advanced Fellowship Program.

☆☆ Disclosure: conflicts of interest: none

* Corresponding author. Tel.: +1 650 493 5000x22105.

E-mail addresses: breland@stanford.edu (J.Y. Breland), joseph.mignogna@va.gov (J. Mignogna), lea.kiefer@va.gov (L. Kiefer), laura.marsh2@va.gov (L. Marsh).

negative psychosocial consequences of managing disease (e.g., loss of functioning, role disruptions) [13]. At the same time, depression can exacerbate chronic medical conditions, for example, depression is associated with insulin resistance [14], and individuals with depression are more sedentary [15] and less likely to adhere to chronic illness self-management behaviors than individuals without depression [12,16,17].

Given the bidirectional relationship between depression and chronic medical conditions, it is reasonable to hypothesize that patients would benefit from models of care that treat depression in specialty medical settings. However, to our knowledge, no reviews describe the efficacy or effectiveness of such programs. Therefore, this review provides preliminary answers to two questions: (a) what types of specialty medical settings are implementing models for treating depression, and (b) do models for treating depression in specialty medical settings effectively treat depression symptoms?

2. Materials and methods

2.1. Search strategy

One author and a research assistant conducted a search in PubMed/Medline using the following major search terms: *Depression or Depressive Disorder* in addition to any of the following MeSH terms alone or in combination: *Delivery of Health Care; Delivery of Health Care, Integrated; Rehabilitation; Patient-Centered Care; Health Promotion; Recreation Therapy and Cooperative Behavior*. All results were imported into RefWorks (a reference manager).

2.2. Selection strategy

Two authors independently reviewed articles identified during the initial search using RefWorks and the following inclusion criteria. All abstracts/articles had to (a) be published in a peer-reviewed journal between January 1, 1990, and May 22, 2013; (b) be written in English; (c) include adult (aged 18+) participants with a medical condition; (d) include participants recruited from an outpatient, non-mental-health setting, including specialty medical or nonstandard primary care settings (e.g., primary care specifically for individuals with HIV); (e) report a quantitative measure of depression severity as an outcome and (f) define and assess depression using standardized structured interviews [e.g., Patient Health Questionnaire-9 (PHQ-9); 18] or by specific cutoff scores on validated depression-symptom scales. If the article met these criteria, it was further assessed as a “model of care.” A model of care was defined as an inclusive, intentional, systematic approach grounded in theory and directed at a desired outcome [19]. Given the nascent area of the literature, we chose to include studies conducted in any specialty medical setting. Reviewers also applied the following exclusion criteria: (a) studies could not solely measure the effectiveness of specific interventions (e.g., a randomized controlled trial of cognitive behavior therapy), and (b) studies could not be prevention or screening studies, reviews, meta-analyses, dissertations, reports, meeting abstracts or case studies. The same two authors discussed results and any questions regarding inclusion/exclusion criteria, occasionally seeking a third opinion until consensus. Given the nascent area of this research, we did not include medical specialty search terms (e.g., oncology) in order to keep results as inclusive as possible.

2.3. Study characteristics

The authors used RefWorks to identify and remove duplicate abstracts and abstracts published before 1990. Abstracts were then divided among reviewers for review. Full articles were reviewed if abstracts lacked sufficient information on inclusion and exclusion criteria. Data were collected on study design, participant characteristics (e.g., comorbid medical conditions), model characteristics and depression outcomes.

3. Results

3.1. Trial flow and study characteristics

The original search resulted in 1115 abstracts (Fig. 1). Nine articles were identified for study inclusion: six randomized controlled trials (RCTs), one nonrandomized controlled trial and two uncontrolled trials (Table 1). All studies identified their interventions as “collaborative care models,” but no study provided enough information to determine whether the model of care met criteria for the foundational components of Collaborative Care as described by the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington (<http://aims.uw.edu/collaborative-care/principles-collaborative-care>). Therefore, the models assessed in this review are best described as integrated care models (i.e., models that integrate mental and medical services but do not meet all the criteria of Collaborative Care or do not provide enough information to make that determination). In addition, it should be noted that two articles described different follow-up time points of the same study [20,21]. Dwight and colleagues [22] described pilot work for those two studies [20,21], but because the pilot focused on a specific population (women), we considered it a distinct program for the purposes of this review.

3.2. Data synthesis

Different patient populations may have different treatment needs; therefore, results are first presented by disease type. In the final data-synthesis section, we present information on variability in model components across disease type in order to provide information that is translatable to clinical settings (Table 2). The number of components was not necessarily associated with better models or better patient outcomes.

3.2.1. Cancer

Five studies assessed integrated care for depression in oncology settings. All five studies were RCTs with significant, positive treatment effects. With the exception of a pilot study for patients with gynecological cancers, assessed by Dwight and colleagues [22], all studies included patients with any form of cancer. Results of the pilot study, conducted by Dwight and colleagues ($N=55$) [22], demonstrated that, after 8 months, patients receiving integrated care for depression in an oncology clinic were significantly more likely to have a 50% decrease in depressive symptoms as measured by the PHQ-9 [18] compared to patients receiving usual care in that clinic [22]. The two studies ($N=472$) [20,21] based on this pilot work [22] had similar results over a longer follow-up period: after 24 months, patients receiving integrated care in an oncology clinic were significantly more likely to have a 50% decrease in depressive symptoms as measured by the PHQ-9 [18] than those receiving enhanced usual care in that clinic. (In this study, enhanced usual care included providing patients with pamphlets about depression, providing didactics on depression to treating oncologists and informing treating oncologists of a patient's depression status.) There were no significant differences in antidepressant medication rates between integrated care and enhanced usual care at 24 months. However, antidepressant medication rates were significantly higher in the integrated care group at the 12-month follow-up. Consistent with these findings, two additional studies in oncology settings ($N=405$ and $N=200$, respectively) [23,24], with shorter follow-up time periods (12 and 6 months, respectively), found significant decreases in depression-symptom severity as measured by the Symptom Checklist-20 (SCL-20; [25]) in integrated care compared with usual care.

3.2.2. HIV/AIDS

Three studies investigated the effects of integrated care for depression in specialty settings for HIV/AIDS. Results of the two uncontrolled

Download English Version:

<https://daneshyari.com/en/article/6082107>

Download Persian Version:

<https://daneshyari.com/article/6082107>

[Daneshyari.com](https://daneshyari.com)