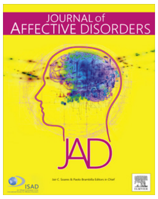
Journal of Affective Disorders 202 (2016) 145–152

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad



Research Paper

Pharmacological and psychosocial treatment of depression in primary care: Low intensity and poor adherence and continuity

Maria S. Vuorilehto [a,b], Tarja K. Melartin [a,b], Kirsi Riihimäki [a,c], Erkki T. Isometsä [a,b,*]

[a] *Mental Health Unit, National Institute for Health and Welfare, Helsinki, Finland*
[b] *Department of Psychiatry, University of Helsinki and Helsinki University Hospital, Helsinki, Finland*
[c] *Health Care and Social Services, City of Järvenpää, Järvenpää, Finland*

ARTICLE INFO

Article history:
Received 29 February 2016
Accepted 22 May 2016
Available online 24 May 2016

Keywords:
Primary care
Depression
Treatment
Adherence
Follow-up
Outcome
Antidepressants
Psychosocial support

ABSTRACT

Background: Primary health care bears the main responsibility for treating depression in most countries. However, few studies have comprehensively investigated provision of pharmacological and psychosocial treatments, their continuity, or patient attitudes and adherence to treatment in primary care.
Methods: In the Vantaa Primary Care Depression Study, 1111 consecutive primary care patients in the City of Vantaa, Finland, were screened for depression with Prime-MD, and 137 were diagnosed with DSM-IV depressive disorders via SCID-I/P and SCID-II interviews. The 100 patients with current major depressive disorder (MDD) or partly remitted MDD at baseline were prospectively followed up to 18 months, and their treatment contacts and the treatments provided were longitudinally followed.
Results: The median number of patients' visits to a general practitioner during the follow-up was five; of those due to depression two. Antidepressant treatment was offered to 82% of patients, but only 50% commenced treatment and adhered to it adequately. Psychosocial support was offered to 49%, but only 29% adhered to the highly variable interventions. Attributed reasons for poor adherence varied, including negative attitude, side effects, practical obstacles, or no perceived need. About one-quarter (23%) of patients were referred to specialized care at some time-point.
Limitations: Moderate sample size. Data collected in 2002–2004.
Conclusions: The majority of depressive patients in primary health care had been offered pharmacotherapy, psychotherapeutic support, or both. However, effectiveness of these efforts may have been limited by lack of systematic follow-up and poor adherence to both pharmacotherapy and psychosocial treatment.

1. Introduction

Treatment of depression is a major challenge for primary care (PC). Altogether 30 million Europeans are estimated to suffer from depression, and depression is likely to be the most important illness in Europe in terms of disability-adjusted life-years (Wittchen et al., 2011). Marked efforts have been made to improve recognition, treatment, and outcome of depression in PC. These include education of PC doctors (Sikorski et al., 2012), use of depression screens (Thombs et al., 2012), and application of service delivery models such as collaborative (Sighinolfi et al., 2014; Thota et al., 2012) or stepped (Firth et al., 2015) care. Furthermore, a large-scale national initiative to promote psychological treatment in PC in the UK (Clark, 2011) and guidelines produced by national health care organizations (Leitlinien, 2015; National Board of Health and Welfare, 2010; NICE, 2010) or professional societies (American Psychiatric Association (APA), 2010; Cleare et al., 2015; Kennedy et al., 2009; The Finnish Medical Society Duodecim and Finnish Psychiatric Association, 2014) have been implemented. In addition, over the last 25 years, use of antidepressants (ADs) has risen in Europe, which at least on an ecological level is associated with a decline in suicide mortality (Gusmao et al., 2013). However, evidence for a major positive change in terms of public health is limited and uncertain.

General population studies consistently show that the majority of individuals suffering from depression either do not seek treatment or receive adequate care (Demyttenaere, 2003; Gabilondo et al., 2011; Hamalainen et al., 2009; Kessler et al., 2003; Wang et al., 2005). In epidemiological studies, a significant proportion of individuals with depressive syndromes do not perceive themselves as suffering from a mental disorder (Hamalainen et al., 2004). Both anosognosia and the often somatic complaints in PC (Vuorilehto et al., 2005) are obstacles to recognition of depression.

---

[*] Correspondence to: Professor of Psychiatry, Department of Psychiatry, University of Helsinki and Helsinki University, Hospital P.O. Box 22, 00014 University of Helsinki, Finland.

E-mail address: erkki.isometsa@hus.fi (E.T. Isometsä).

http://dx.doi.org/10.1016/j.jad.2016.05.035
0165-0327/

The likelihood for recognition increases with depression severity (Thompson et al., 2001). The quality of treatments is central from the point of view of public health. However, limited comprehensive studies exist in PC, mainly focusing on pharmacotherapy and follow-up monitoring (Coyne et al., 1997; Gilchrist and Gunn, 2007; Limosin et al., 2004; Lin et al., 2000; Ronalds et al., 1997; Rost et al., 1995, 1998; Simon et al., 2001, 2004). Besides reports from the UK Improved Access to Psychological Therapies (IAPT) project (Richards and Borglin, 2011), few clinical epidemiological studies exists on the availability, type, and quality of psychological treatments. While national guidelines commonly instruct referral to specialized psychiatric care, the actual patterns of referral have seldom been investigated.

Whatever the treatment modality, patient adherence is crucial for any benefits to materialize (Chong et al., 2011; Lynch et al., 2011; Raue et al., 2009; Thompson et al., 2000a). Depending on their attitudes, patients may immediately decline treatment, ostensibly accept it but not start, discontinue at a later phase, or participate too irregularly for any benefit to be gained (Melartin et al., 2005). Thus, the adherence to treatment is likely to play an important role in the adequacy of treatment (Chong et al., 2011; Lynch et al., 2011; Raue et al., 2009; Thompson et al., 2000a, 2000b). However, most studies address the issue by reporting on the quality of care merely in terms of treatment provision, neglecting the potential shortcomings due to poor adherence. Moreover, not all patients believe that ADs are helpful (Edlund et al., 2008), and some prefer no treatment to an unacceptable treatment modality (Morey et al., 2007). Adherence to the chosen treatment modality may be less than optimal if a patient is obliged to use a modality that he/she does not desire (Raue et al., 2009). The few PC studies investigating adherence mainly focus on pharmacotherapy, although psychological treatments in PC are known to be equally effective for mild or moderate depression (Cuijpers et al., 2009) and are often preferred (Raue et al., 2009; van Schaik et al., 2004; Vuorilehto et al., 2007). Moreover, most reports are based on treatment trials with selected patient populations. Despite chronicity and the recurrent nature of depression necessitating continuity of care, naturalistic studies comprise only short follow-ups of acute depression. According to these studies, a significant proportion of patients fail to start an AD prescribed. Discontinuation is very common at the beginning of pharmacotherapy, especially among young patients, a fact of which the clinician is often unaware (Bambauer et al., 2007; Demyttenaere, 2003; Hunot et al., 2007; Lin et al., 1995; Maddox et al., 1994; Simon et al., 1993). Thus, although patient adherence is a precondition for any treatment benefits, the role of attitudes towards treatments and the types of adherence problems encountered in PC have been relatively poorly studied.

Overall, despite abundant guidance, specific treatments and service delivery models, knowledge of actual treatment provision for depression in PC is fragmentary and crude. In this study, we followed 100 PC patients with MDD for 18 months and observed their treatment. We investigated their contacts with PC doctors, the pharmacological and psychosocial treatments offered, and the factors predicting treatment provision. We also examined treatment attitudes, different types of adherence problems encountered, and factors related to referral to psychiatric services.

2. Methods

The Vantaa Primary Care Depression Study (PC-VDS) is a naturalistic and prospective cohort study on depressive disorders. The study protocol was approved by the pertinent ethics committee in December 2001. The PC-VDS forms a collaborative research project between the Department of Mental and Alcohol Research of the National Institute of Health and Welfare and the City of Vantaa, Finland. The catchment area comprises a population of 63 400, served by 30 general practitioners with population-based responsibility. The methodology have been described in detail elsewhere (Vuorilehto et al., 2005, 2009).

2.1. Screening and baseline evaluation

In the first stage, between 2 January and 31 December 2002, a total of 1119 consecutive patients aged 20–69 years received the screening questionnaire of PRIME-MD (Spitzer et al., 1994) in general practitioners´ waiting rooms. Altogether 375 patients answered “yes” to at least one of the two questions concerning depressed mood or anhedonia during the last month (1. feeling down, depressed, or hopeless or 2. having little interest or pleasure in doing things). Over the telephone, we ensured that at least one core symptom of MDD was present according to the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I/P) (First et al., 1997). We excluded patients with psychosis (other than depressive) or bipolar or organic mood disorder or those currently receiving treatment in psychiatric care. After the telephone interview altogether 175 patients remained potentially eligible to the study.

In the second stage, after receiving written informed consent, we interviewed all 175 potentially eligible patients face-to-face using the SCID-I/P with psychotic screen. Inclusion criteria were current MDD, subsydromal MDD with two to four depression symptoms (minimum one core symptom), and lifetime MDD and minor depression. Distress or functional impairment was required for all. The joint diagnostic reliability for current depressive disorders was 100% (kappa 1.0 for depression diagnoses). Patients who refused to participate (15%) did not differ significantly in age or gender from those who consented. Altogether 137 patients were included in the cohort (Vuorilehto et al., 2005).

2.2. Other research instruments

Current and lifetime psychiatric disorders were assessed by using the SCID-I/P and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) (First et al., 2002). Observer and self-report scales included the Hamilton Depression Rating Scale (Ham) (Hamilton, 1960) and the Occupational Functioning Assessment Scale for DSM-IV (SOFAS) (Goldman et al., 1992). Self-report scales included the 21-item Beck Depression Inventory (BDI) (Beck et al., 1961), the Beck Anxiety Inventory (BAI) (Beck et al., 1988), and the Perceived Social Support Scale – Revised (PSSS-R) (Blumenthal et al., 1987). A self-report questionnaire, medical records, and an interview were used for chronic medical illnesses. In addition, all available data, including medical and psychiatric records, were gathered to reconstruct the lifetime course for depression.

2.3. Attitudes

Attitudes towards ADs and psychotherapeutic treatment were rated with the following items: patient 1) actively approves, 2) passively accepts, 3) has reservations, 4) has definitely negative attitudes, or 5) could not answer. Attitudes were analysed in two groups: 1) favourable attitudes comprising those who actively approve of or passively accept treatment and 2) negative attitudes comprising those who have reservations about or negative attitudes towards treatment.

2.4. Follow-up

After baseline, patients were followed up with a graphic life-