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Feasibility and acceptability of a telephone psychotherapy program for depressed adults treated in primary care☆

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Abstract

Objective: Telephone psychotherapy is an emerging model of care that appears feasible for extending the reach of evidence-based psychotherapy treatment without accruing the full costs of traditional office-based, mental health care. This manuscript describes the development, implementation and acceptance of a 12-month telephone psychotherapy program (TPP) for depressed adults not fully responding to standard antidepressant treatment in primary care.

Method: The TPP combined a population-based medication monitoring and information system with a structured cognitive-behavioral treatment (CBT) program. The TPP included 8–12 telephone sessions (eight core CBT sessions and three to four clinical booster sessions) delivered by a master-level therapist working in tandem with each patient's primary care physician (PCP).

Results: The TPP was well accepted (i.e., 80% completed the core program) by a population-based sample of adult primary care patients initiating antidepressant treatment. The mean duration of core telephone psychotherapy sessions was approximately 31 min during acute-phase treatment (0–6 months). Eighty-two percent of TPP patients maintained contact with their therapist during maintenance-phase treatment (6–12 months).

Conclusions: The practical and efficient nature of this TPP appears to sidestep many of the treatment barriers encountered in traditional office-based care. Implementation of this TPP program in other primary care settings may be valuable for enhancing standard pharmacotherapy treatment of adult depression, especially among populations facing greater barriers of care.

Keywords: Telephone psychotherapy program; Cognitive-behavioral; Primary care

1. Introduction

Improving the treatment and management of depression in primary care has been recognized as a health care priority for the 21st century, given the high prevalence, cost and significant impact of this disorder [1–3]. Although the arsenal of primary care treatments for depression often includes pharmacotherapy (e.g., antidepressant medication) and specialty care services, such as structured psychotherapy [4,5], epidemiological data indicate that few patients receive expert-recommended levels of these treatments or experience satisfactory clinical outcomes [6,7]. Deficiencies in this standard model of care exist on multiple levels—ranging from clinical challenges (e.g., misdiagnosis, poor appointment availability, miscommunication between primary care and specialty care providers) to patient barriers (e.g., early discontinuation or inconsistent adherence to antidepressant medication, poor education about depression, stigma and transportation problems) [4,8,9].

Evidence from randomized trials suggests that treating adult depression in primary care settings can be significantly enhanced with highly organized programs that facilitate expert-recommended levels of pharmacotherapy and psychotherapies [10–12]. Despite the availability of these programs of proven efficacy, dissemination into everyday practice has been slow due to the increased treatment

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expenditures and intensive resource commitments required [10,13,14]. Less-intensive and more economical interventions involving computerized feedback and telephone case management appear feasible, yet only modest gains have been made in clinical and functional outcomes [15–17].

This manuscript describes additional information from two previously completed telephone psychotherapy trials [18,19] that lie between less intensive care management and highly structured collaborative care treatment. Process and outcome data from these trials suggest phone psychotherapy is feasible and valuable for improving adult depression in primary care settings. Over 90% of community-based patients in these trials agreed to participate in the phone psychotherapy program, with approximately 85% completing the core program (i.e., six to eight cognitive behavioral sessions) during acute-phase treatment (i.e., 12–16 weeks). This attrition rate is significantly lower than in-person, psychotherapy attrition rates in real-world settings [20,21] and controlled trials [4,22,23]. When compared to treatment as usual, telephone psychotherapy participants from our most recent trial ($n=198$) [19] experienced lower mean Symptom Checklist (SCL) depression scores [0.98 (moderate severity range) vs. 0.65 (mild severity range)] ($P=.015$), and a higher proportion reported that depression was "much improved" (80% vs. 55%, $P<.001$) and were "very satisfied" with depression treatment (59% vs. 29%, $P<.001$) at 6-month follow-up. These outcomes appear consistent with other phone-psychotherapy trials [24–26], suggesting feasibility and efficacy for enhancing standard pharmacotherapy treatment for adult depression by telephone, rather than by traditional face-to-face modalities.

This manuscript illustrates an emerging adjunctive model for extending evidence-based depression treatment to depressed adults treated in primary care settings. Given the poor outcomes associated with standard primary care treatment for adult depression [1,6,7,9,10], this phone psychotherapy model appears to offer a cost-effective alternative for providers and patients facing barriers to care [4,6,8,9]. The nature of this model is multifaceted and incorporates key factors identified by Wagner et al. [27] for improving chronic conditions. We describe the theoretical background and key design elements of this multimodal program essential for implementation and service delivery. Qualitative data are presented to illustrate the nature of specific program components, while participation and completion rates are presented to address program feasibility.

2. Method

2.1. Development

Our study team designed a multifaceted, telephone-based intervention for depressed adults initiating pharmacotherapy treatment in primary care, who had mild or greater depression severity 1 to 3 weeks after filling their initial antidepressant prescription. During the course of 12 months, study team investigators (GS, EL, ST) met weekly as a task group for the purpose of modifying an existing six-session, telephone-based pilot intervention for depressed adults [18], designing a protocol manual for study therapists and training study therapists in the delivery of this enhanced intervention.

During the first 6 months, study team investigators modified the pilot intervention [18] into an eight-session protocol with greater depth (e.g., case vignettes with multicultural content, cognitive distancing and counterbalancing strategies) specificity (e.g., session agendas, tailored experimentation worksheets to complete between sessions) and staging (e.g., bound multi-tab/color workbook). Unlike traditional office-based and structured models for depression [10], this intervention was designed to be practical (i.e., 30 min or less) and affordable (i.e., $50 or less). Further, it was developed to provide tailored support to each patient at his/her present level of depression severity (remission to severe), pharmacotherapy adherence (discontinuation to full adherence) and level of participation in structured cognitive-behavioral experiments (none–active)—with the aid of a protocol manual.

During the remaining 6 months, study team investigators developed a semistructured protocol manual for telephone psychotherapists (TPs) to use during each telephone psychotherapy session. This protocol manual contains detailed time-limited objectives with corresponding cues and questions for each session. Each TP (ST and KL) received weekly training in the delivery of each session by study team psychiatrist (GS) and psychologist (EL). Although both ST and KL were master-level therapists skilled in cognitive-behavioral applications and population management of adults with clinical depression, additional training was also provided in the area of motivational interviewing (MI) [28–31] and use of a clinical monitoring and information system [16]. In this capacity, each TP (ST and KL) learned and practiced the basic elements of MI (i.e., expressing empathy, developing a discrepancy, avoiding argumentation, rolling with resistance and increasing self-efficacy) during weekly mock sessions that included biblio and video therapy [28–31]. Consistent feedback and evaluation were provided by study team specialists (GS and EL). A fidelity checklist and audiotaped telephone sessions were used near the end of this pretraining period to assess therapists' adherence to session content. Furthermore, each TP became proficient in the use of the clinical monitoring and information system with mock patients, which allowed ST and KL to input clinical data (e.g., depression severity, medication and visit data), monitor progress, generate feedback reports and coordinate care with the patient's primary care physician (PCP), based on a computerized medical algorithm [19].

In order to improve collaborative care efforts, the intervention emphasized a team-oriented care approach.