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CLINICAL

Salomonsson, S., Santoft, F., Lindsater, E., Ejeby, K., Ljotsson, B., Ost, L.G., Ingvar, M., Lekander, M., Hedman-Lagerlof, E. (2018). Stepped care in primary care - guided self-help and face-to-face cognitive behavioural therapy for common mental disorders: a randomized controlled trial. *Psychological Medicine*, 48(10), 1644-1654. Doi: 10.1017/S003329171700312

- **OBJECTIVE:** Common mental disorders (CMD) cause large suffering and high societal costs. Cognitive behavioural therapy (CBT) can effectively treat CMD, but access to treatment is insufficient. Guided self-help (GSH) CBT, has shown effects comparable with face-to-face CBT. However, not all patients respond to GSH, and stepping up non-responders to face-to-face CBT, could yield larger response rates. The aim was to test a stepped care model for CMD in primary care by first evaluating the effects of GSH-CBT and secondly, for non-responders, evaluating the additional effect of face-to-face CBT.
- **METHOD:** Consecutive patients (N = 396) with a principal disorder of depression, anxiety, insomnia, adjustment or exhaustion disorder were included. In Step I, all patients received GSH-CBT. In Step II, non-responders were randomized to face-to-face CBT or continued GSH. The primary outcome was remission status, defined as a score below a pre-established cutoff on a validated disorder-specific scale.
- **RESULTS:** After GSH-CBT in Step I, 40% of patients were in remission. After Step II, 39% of patients following face-to-face CBT were in remission compared with 19% of patients after continued GSH ($p = 0.004$). Using this stepped care model required less than six therapy sessions per patient and led to an overall remission rate of 63%.
- **DISCUSSION:** Stepped care can be effective and resource-efficient to treat CMD in primary care, leading to high remission rates with limited therapist resources. Face-to-face CBT speeded up recovery compared with continued GSH. At follow-ups after 6 and 12 months, remission rates were similar in the two groups.

Link: <https://www.ncbi.nlm.nih.gov/pubmed/29095133>

Possemato, K., Johnson, E.M., Beehler, G.P., Shepardson, R.L., King, P., Vair, C.L., Funderburk, J.S., Maisto, S.A., & Wray, L.O. (2018). Patient outcomes associated with primary care behavioral health services: A systematic review. *General Hospital Psychiatry*, 53, 1-11. Doi:10.1016/j.genhosppsych.2018.04.002

- **OBJECTIVE:** This systematic review focused on Primary Care Behavioral Health (PCBH) services delivered under normal clinic conditions that included the patient outcomes of: 1) access/utilization of behavioral health services, 2) health status, and 3) satisfaction.
- **METHOD:** Following PRISMA guidelines, comprehensive database searches and rigorous coding procedures rendered 36 articles meeting inclusion criteria. The principle summary measures of odd ratios or Cohen's d effect sizes were reported.
- **RESULTS:** Due to significant limitations in the methodological rigor of reviewed studies, robust findings only emerged for healthcare utilization: PCBH is associated with shorter wait-times for treatment, higher likelihood of engaging in care, and attending a greater number of visits. Several small, uncontrolled studies report emerging evidence that functioning, depression, and anxiety improve overtime. There was no evidence of greater improvement in patient health status when PCBH was compared to other active treatments. The limited available evidence supports that patient satisfaction with PCBH services is high.

- **DISCUSSION:** The implementation of PCBH services is ahead of the science supporting the usefulness of these services. Patient outcomes for PCBH are weaker than outcomes for Collaborative Care. More rigorous investigations of patient outcomes associated with PCBH are needed to allow for optimization of services.

Link: <https://www.sciencedirect.com/science/article/pii/S016383431830063X>

Yu, J. S., Szigethy, E., Wallace, M., Solano, F., & Oser, M. (2018). Implementation of a guided, digital cognitive behavioral program for anxiety in primary care: Preliminary findings of engagement and effectiveness.

Telemedicine and e-Health. Epub ahead of print. Doi: 10.1089/tmj.2017.0280.

- **OBJECTIVE:** Implementation of digital behavioral health programs in primary care (PC) can improve access to care for patients in need. This study provides preliminary data on user engagement and anxiety symptom change among patients referred by their PC provider to a guided, mobile cognitive behavioral program, Lantern.
- **METHOD:** Adults aged 20-65 years with at least mild anxiety ($GAD-7 \geq 5$) during routine clinical screening in two PC practices were offered Lantern. The primary outcome was self-reported anxiety collected at baseline and 2 months. Linear mixed effects modeling was used to examine anxiety symptom reduction from baseline to 2 months. Post hoc analyses evaluated how number of units completed, number of techniques practiced, and days of usage impacted symptom change.
- **RESULTS:** Sixty-three participants signed up for Lantern and had both baseline and 2-month GAD-7. A mixed effects model adjusted for age, gender, medical complexity score, and physical health found a significant effect of time on GAD-7 ($\beta = -2.08$, standard error = 0.77, $t(62) = -2.71$, $p = 0.009$). Post hoc analyses indicated that mean number of units, techniques, and usage days did not significantly impact GAD-7 change over 2 months. However, there was significantly greater improvement in anxiety in participants who completed at least three techniques.
- **DISCUSSION:** Results benchmark to previous studies that have found statistically significant symptom change among participants after 4-9 weeks of face-to-face or Internet-based cognitive behavioral therapy (CBT). This study suggests that use of Lantern is associated with anxiety reduction and provides proof-of-concept for the dissemination and implementation of guided, CBT-based mobile behavioral health interventions in PC settings.

Link: <https://www.ncbi.nlm.nih.gov/pubmed/29480752>

OPERATIONAL

Colaiaco, B., Roth, C. P., Ganz, D.A., Hanson, M., Smith, P., and Wenger, N.S. (2018). Continuity of information between mental health and primary care providers after a mental health consultation. *Psychiatric Services*, 69(10), 1081-1086. Doi: 10.1176/appi.ps.201800025

- **OBJECTIVE:** Information sharing between mental health providers (MHPs) and primary care providers (PCPs) is important for persons with mental illnesses. The authors determined the level of information continuity between MHPs who saw a patient for a new consult and PCPs and whether continuity varied between providers with and without access to a shared electronic health record (EHR).
- **METHOD:** Data were analyzed for 141 randomly selected enrollees in six Medicare Advantage plans receiving a new outpatient mental health consultation in 2012. Medical records of MHPs and PCPs were abstracted to evaluate whether PCP records recognized the consultation, documented mental health

hospitalizations and emergency department visits, and acknowledged psychotropic medications. Measures were compared between patients whose providers used and did not use mutual-access EHRs.

- **RESULTS:** For 21% of patients, the PCP record documented communication from the MHP within three months of the consultation. The PCP record showed evidence of timely communication (within seven days) for 42% of mental health hospitalizations and emergency department visits. Of 152 medications recorded by MHPs, 103 (68%) were acknowledged in the PCP record by the next visit. For patients with mutual-access EHRs, provider communication about the consultation was documented for a greater percentage of patients, compared with those without mutual-access EHRs (46% versus 11%, $p < .001$), as was communication about psychotropic medication (100% versus 57%, $p < .001$).
- **DISCUSSION:** This small but detailed study of patients receiving new outpatient mental health consults found poor continuity of information between MHPs and PCPs. A mutual-access EHR facilitated but did not guarantee such information sharing.

Link: <https://www.ncbi.nlm.nih.gov/pubmed/30041587>

Petersson, A., Modin, S., Wahlstrom, R., Af Winklefelt Hammarberg, S., Krakau, I. (2018). The Mini-International Neuropsychiatric Interview is useful and well accepted as part of the clinical assessment for depression and anxiety in primary care: a mixed-methods study. *BMC Family Practice*, 19(1): 19. doi: 10.1186/s12875017-0674-5.

- **OBJECTIVE:** Psychiatric complaints are common among primary care patients, with depression and anxiety being the most frequent. Diagnosis of anxiety and depression can be difficult, potentially leading to over- as well as under-diagnosis. The diagnostic process can be facilitated by incorporating structured interviews as part of the assessment. One such instrument, the Mini-International Neuropsychiatric Interview (MINI), has been established and accepted in psychiatric care. The purpose of this study was to explore the experiences and perceptions of the paper-and-pen version of MINI version 6.0 among patients and staff in primary care centers in Sweden.
- **METHOD:** The MINI was introduced at three primary care centers and was conducted by either therapists or general practitioners. Patients presented with symptoms that could suggest depression or anxiety disorders. The duration of the interview was recorded. The experiences and perceptions of 125 patients and their interviewers were collected using a structured questionnaire. Global satisfaction was measured with a visual-analog scale (0-100). Semi-structured interviews were conducted with 24 patients and three therapists, and focus groups were held with 17 general practitioners. Qualitative content analysis was used for the interviews and focus groups. The findings across the groups were triangulated with results from the questionnaires.
- **RESULTS:** The median global satisfaction with the MINI was 80 for patients and 86 for interviewers. General practitioners appreciated that the MINI identified comorbidities, as one-third of the patients had at least two psychiatric diagnoses. The MINI helped general practitioners attain a more accurate diagnosis. Patients appreciated that the MINI helped them recognize and verbalize their problems and did not find it intrusive. Patients and interviewers had mixed experiences with the yes-no format of the MINI, and the risk of subjective interpretations was acknowledged. Patients, general practitioners and therapists stated that the MINI contributed to appropriate treatment. The MINI assessment lasted 26 min on average.
- **DISCUSSION:** The paper-and-pen version of the MINI could be useful in primary care as part of the clinical assessment of patients with problems suggestive of depression or anxiety disorders. The MINI was well accepted by patients, general practitioners and therapists.

Link: <https://www.ncbi.nlm.nih.gov/pubmed/29368585>

FINANCIAL

Camacho, E.M., Davies, L.M., Hann, M., Small, N., Bower, P., Chew-Graham, C., ... & Coventry, P. (2018). Long-term clinical and cost-effectiveness of collaborative care (versus usual care) for people with mental- physical multimorbidity: cluster-randomised trial. *The British Journal of Psychiatry*, 213(2), 456-463. doi: 10.1192/bjp.2018.70.

- **OBJECTIVE:** Collaborative care can support the treatment of depression in people with long-term conditions, but long-term benefits and costs are unknown. Aims were to explore the long-term (24-month) effectiveness and cost-effectiveness of collaborative care in people with mental-physical multimorbidity.
- **METHOD:** A cluster randomised trial compared collaborative care (integrated physical and mental healthcare) with usual care for depression alongside diabetes and/or coronary heart disease. Depression symptoms were measured by the symptom checklist-depression scale (SCL-D13). The economic evaluation was from the perspective of the English National Health Service.
- **RESULTS:** 191 participants were allocated to collaborative care and 196 to usual care. At 24 months, the mean SCL-D13 score was 0.27 (95% CI, -0.48 to -0.06) lower in the collaborative care group alongside a gain of 0.14 (95% CI, 0.06-0.21) quality-adjusted life-years (QALYs). The cost per QALY gained was £13 069.
- **DISCUSSION:** In the long term, collaborative care reduces depression and is potentially cost-effective at internationally accepted willingness-to-pay thresholds.

Link: <https://www.ncbi.nlm.nih.gov/pubmed/29761751>

Lavelle, T.A., Kommareddi, M., Jaycox, L.H., Belsher, B., Freed, M.C., & Engel, C.C. (2018). Cost-effectiveness of collaborative care for depression and PTSD in military personnel. *The American Journal of Managed Care*, 24(2), 91-98.

- **OBJECTIVE:** Collaborative care is an effective approach for treating posttraumatic stress disorder (PTSD) and depression within the US Military Health System (MHS), but its cost-effectiveness remains unstudied. Our objective was to evaluate the costs and cost-effectiveness of centrally assisted collaborative telecare (CACT) versus optimized usual care (OUC) for PTSD and depression in the MHS.
- **METHOD:** A randomized trial compared CACT with OUC. Routine primary care screening identified active-duty service members with PTSD or depression. Eligible participants (N = 666) were randomized to CACT or OUC and assessed at 3, 6, and 12 months. OUC patients could receive care management and increased behavioral health support. CACT patients could receive these services plus stepped psychosocial treatment and routine centralized team monitoring. Quality-adjusted life-years (QALYs) were derived from the 12-Item Short Form Health Survey. Claims and case management data were used to estimate costs. Cost-effectiveness analyses were conducted from a societal perspective.
- **RESULTS:** Data from 629 patients (320 CACT and 309 OUC) with sufficient follow-up were analyzed. CACT patients gained 0.02 QALYs (95% CI, -0.001 to 0.03) relative to OUC patients. Twelve-month costs, including productivity, were \$987 (95% CI, -\$3056 to \$5030) higher for CACT versus OUC. CACT was estimated to cost \$49,346 per QALY gained compared with OUC over 12 months. There is a 58% probability that CACT is cost-effective at a \$100,000/QALY threshold.
- **CONCLUSIONS:** Despite its higher costs, CACT appears to be a cost-effective strategy relative to OUC for managing PTSD and depression in the MHS.

Link: <https://www.ncbi.nlm.nih.gov/pubmed/29461856>

EDUCATION

Blaney, C.L., Redding, C.A., Paiva, A.L., Rossi, J.S., Prochaska, J.O., Blissmer, B., Burditt, C.T., Nash, J.M., Bayley, K.D. (2018). Integrated Primary Care Readiness and Behaviors Scale: Development and validation in behavioral health professionals. *Family, Systems, & Health*, 36(1), 97-107. doi: 10.1037/fsh0000310.

- **OBJECTIVE:** Although integrated primary care (IPC) is growing, several barriers remain. Better understanding of behavioral health professionals' (BHPs') readiness for and engagement in IPC behaviors could improve IPC research and training. This study developed measures of IPC behaviors and stage of change.
- **METHOD:** The sample included 319 licensed, practicing BHPs with a range of interests and experience with IPC. Sequential measurement development procedures, with split-half cross-validation were conducted.
- **RESULTS:** Exploratory principal components analyses (N = 152) and confirmatory factor analyses (N = 167) yielded a 12-item scale with 2 factors: consultation/practice management (CPM) and intervention/knowledge (IK). A higher-order Integrated Primary Care Behavior Scale (IPCBS) model showed good fit to the data, and excellent internal consistencies. The multivariate analysis of variance (MANOVA) on the IPCBS demonstrated significant large-sized differences across stage and behavior groups.
- **DISCUSSION:** The IPCBS demonstrated good psychometric properties and external validation, advancing research, education, and training for IPC practice

Link: <https://www.ncbi.nlm.nih.gov/pubmed/29608084>