Improving quality of primary care reduces depression and improves quality of life in adolescents


What are the effects of improving quality of primary care in adolescents with depression?

**METHODS**

- **Design:** Randomised controlled trial.
- **Allocation:** Concealed.
- **Blinding:** Unblinded.
- **Follow up period:** Six months.
- **Setting:** Six primary care centres in the US: two public sector; two managed care; two academic health programmes.
- **Patients:** 418 adolescents aged 13–21 years, presenting at clinic with either of two criteria: endorsed “stem items” for major depression or dysthymia from 12 month Composite International Diagnostic Interview (CIDI-12), one week or more of depressive symptoms in the past month, and a total Center for Epidemiological Studies Depression Scale (CES-D) score of >16; or a CES-D score of >24. Exclusion criteria were: not English-speaking, clinician not in the study, or sibling already in the study.
- **Intervention:** Participants were randomised to a quality improvement intervention or usual care. The quality improvement intervention included: expert leader teams at each site to implement and adapt intervention; care managers to support primary care clinicians with evaluation, education, medication, and psychosocial treatment, and linking with specialised mental health services; training care managers in manual cognitive behaviour therapy (CBT) for depression; and access to participant clinician choice of treatment (CBT, medication, combined CBT and medication, care manager follow up, or referral). Usual care was enhanced with training and education materials on depression evaluation and treatment. Participants receiving usual care were treated at the same centres, but did not have access to trained care managers.
- **Outcomes:** Depression: CES-D total score, CES-D score >24 (range 0–60); quality of life: Mental Health Summary Score (MCS-12) (range 0–100); satisfaction with mental health care score (range 0 to 5).
- **Patient follow up:** Quality improvement 81% v usual care 84%.

**MAIN RESULTS**

In adolescents with depression, quality improvement intervention reduced depression, and increased mental health quality of life and satisfaction with mental health care compared with usual care (see http://www.ebmentalhealth.com/supplemental for table).

**CONCLUSIONS**

Improving quality of primary care by providing extra support to clinicians and increasing access to treatments reduces depression and improves mental health quality of life in adolescents.

**Commentary**

Untreated depression in teenagers contributes to school and relationship difficulties, family problems, alcohol and substance abuse, and increased suicide rates, and can herald the onset of a lifelong disorder. Primary care can be an effective place to identify depressed teens and initiate treatment. This study demonstrates that it is feasible to introduce into primary care settings a treatment programme for teenagers. The authors developed a chronic illness model for treating teenage depression, incorporating an innovative and flexible intervention, patient choice of treatment options, a move towards evidence-based care, and—most importantly—organisational changes to support the programme (however, the role of the “expert leaders” responsible for this at each site is not expanded upon). The intervention involved many components: providing information about depression; offering the participants choices of treatments; providing someone for the teen to talk to; the cognitive behaviour therapy itself; and organisational changes. It would have been useful to assess which of these components had the greatest impact on outcomes, and whether any of their effects were synergistic.

One outstanding question remains: how best to identify teenagers in primary care who are depressed. In this study 4034 teens were screened. As 18 more teenagers in the intervention group improved, if the intervention had been available to everyone in the study, by extrapolation one for every 112 teenagers screened. While evidence regarding the benefits of screening teenagers is lacking, incorporating two questions concerning mood and anhedonia in a primary care provider’s assessment can be as effective as administering a full screening instrument. Organisational changes in primary care settings that lead to all primary care providers asking these two questions routinely each time they see a teen may prove to be the most efficient way to identify depressed teenagers.

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