

Chapter 10

Promoting Treatment Engagement with Specific Populations: Depression

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Introduction

Depressive disorders were identified as a leading cause of burden in the Global Burden of Disease studies conducted in 1990, 2000, and 2010. In the 2010 study, major depressive disorder (MDD) was identified as a contributor of burden allocated to both suicide and ischemic heart disease (Ferrari et al., 2013). The World Health Organization (WHO) ranks MDD as the fourth leading cause of disability worldwide and predicts that by 2020, MDD will be the second leading cause of disability. Data on the prevalence and costs of depressive disorders worldwide are limited, but existing studies suggest that lifetime prevalence rates are between 1.5 % and 19 %, with higher rates occurring in higher income countries. Epidemiological studies have identified costs related to depression that impact living in four domains: education, marital timing and stability, child-bearing, and occupation (Kessler, 2012).

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) depressive disorders include major

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depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, disruptive mood dysregulation disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. Although these disorders differ in duration, timing, and presumed etiology, these disorders all share the presence of sad, empty, or irritable mood and cognitive, somatic, and behavioral changes that impair daily functioning. Diagnoses of depressive disorders are dependent on patients meeting a minimum number of a range of symptoms (American Psychiatric Association, 2013).

A variety of studies have reported that the majority of depressed patients report a preference for psychotherapy over antidepressant medication, but that only 20 % of patients referred for psychotherapy go on to initiate psychological treatment and that of those who do, approximately half drop out of treatment (Mohr et al., 2010). Such discrepancies indicate the need to assess treatment barriers and strategies to enhance treatment engagement. Research suggests that depressive symptoms are both an indicator for treatment and a barrier to receiving it. It has been hypothesized that the low motivation associated with depression may exacerbate other psychosocial barriers, and it has been found that perceived barriers to treatment are more common among depressed than nondepressed patients (Mohr et al., 2010). In geriatric populations, low energy and resignation resulting from depressive symptoms have been identified as factors that impede treatment engagement (Raue & Sirey, 2011).

Additional barriers to treatment engagement include those that affect the use of mental health services globally and across diagnoses. The most significant barriers to addressing mental health problems globally are scarcity, inequitable distribution, and inefficiency of resources. Other significant barriers are factors such as financial cost, difficulties associated with transportation, and the limited availability of competent providers (Saxena, Thornicroft, Knapp, & Whiteford, 2007).

Given these findings, the importance of identifying and implementing strategies for treatment engagement cannot be overstated. Depressive disorders are costly to the individual and society as a whole. The ideographic nature of symptoms that may account for any one diagnosis of a depressive disorder indicates the importance of careful assessment of individual symptoms and treatment preferences and the importance of individualized care. The existing literature on barriers to treatment engagement suggests that depressed individuals are especially vulnerable to failing to initiate treatment, and this same literature suggests that the first step in increasing treatment engagement is assessing and addressing treatment barriers.

The present chapter presents strategies for treatment engagement in a stepped-care model, first presenting the strategies that are the least invasive and that require the least provider involvement. Higher steps progressively reflect strategies that are more invasive and that require increased provider involvement. For further reading on stepped-care approaches to care, see *Stepped Care and e-Health: Practical Applications to Behavioral Disorders* (O'Donohue & Draper, 2011).

Step One: Screening, Assessment, and Planning

Screening for depression is the first step in implementing any strategy to increase treatment engagement and is necessary to develop a treatment plan. Screening is a brief process that is designed to evaluate the likelihood that depression or depressive symptoms are present. Screening is additionally utilized to determine whether assessment—that is, a more detailed evaluation to define the specific symptoms present, determine any relevant diagnosis, and to inform selection of an appropriate intervention—is warranted. Screening, assessment, and treatment planning are minimally invasive, require minimal patient engagement, and generally require relatively minimal provider involvement. As such, they are presented here as the first step in this review of strategies for increasing treatment engagement in a depressed population.

The American Psychological Association's practice guidelines for depression (2010) state that the "optimal treatment setting and the patient's likelihood of benefit from a different level of care should be reevaluated on an ongoing basis throughout the course of treatment." In a stepped-care model, assessment is crucial for developing an ideographic treatment plan and informing decision making, such as determining whether a higher level of care is necessary at any point during treatment.

Research indicates that despite the prevalence of depression, it is recognized only about 50% of the time in settings such as primary care (Gilbody, Richards, Brealey, & Hewitt, 2007). These findings are concerning, given that primary care physicians, rather than mental health professionals, treat the majority of patients with symptoms of depression (Sharp & Lipsky, 2002). As such, screening and assessment should be implemented during initial contact in any setting in which providers may come into contact with depressed individuals. In addition to initiating assessment promptly, it is crucial that providers conduct ongoing assessment of depressive symptoms. Ongoing assessment is particularly crucial when working with depressed individuals, as it allows for regular assessment of suicidal and self-harm behaviors and determination of worsening symptoms all of which may require transition to more intensive forms of treatment.

Screening and assessment can be accomplished through a combination of self-report and clinical interview measures. A wide range of screening and assessment tools have been developed and rigorously evaluated. These assessment measures vary in length and detail, with some involving as few as nine questions and some providing indicators of symptomatology (i.e., minimal, mild, moderate, or severe levels of symptoms). Commonly used and highly valid and reliable assessments for depression include the Beck Depression Inventory-II, Hamilton Rating scale for Depression, Structured Clinical Interview for DSM-IV, Children's Depression Inventory, Reynolds Adolescent Depression Scale, the Geriatric Depression Scale, and the Patient Health Questionnaire. Strategies for assessing suicidal behaviors, such as the Modified Scale for Suicidal Ideation, also have been developed (Brotten, Naugle, Kalata, & Gaynor, 2011).

Models of outpatient care that incorporate ongoing assessment and monitoring of symptoms have been developed. One such approach, termed the Wilford Hall

model, involves patient orientation to assess symptoms, provide psychoeducation, and evaluate individual treatment preferences. This orientation stage is followed by collaborative decision-making between patients and providers in order to select the most appropriate form of treatment based on assessment findings, treatment goals, and patient preferences. The Wilford Hall model includes ongoing assessment of symptoms and treatment satisfaction (Kelleher, Talcott, Haddock, & Freeman, 1996). While the Wilford Hall model was developed for use with a military population, the model's attention to severity of symptomatology, individual treatment goals and preferences, and inclusion of ongoing assessment suggest that it could be a useful tool in more broadly implementing a stepped-care approach to the treatment of depression across populations and a useful tool in increasing treatment engagement among depressed patients.

Research has investigated the utility of brief interventions designed to address barriers to treatment engagement that exist on the individual level. A variety of individualized treatment engagement interventions have been developed. Three such interventions described by Raue and Sirey (2011) are an *open door intervention*, a *shared decision making intervention*, and a *treatment initiation program in primary care*. While these interventions were developed to address depression in an elderly population, the success, innovation, and strong theoretical underpinnings of these intervention recommends the development of parallel interventions for use with other populations.

Open Door Intervention. In an NIH-funded randomized controlled trial, Raue and Sirey (2011) evaluated a brief psychosocial intervention that focused on early treatment engagement following assessment and diagnosis of depression. Intervention involved two, 30-min face-to-face sessions with a community provider and a follow-up session conducted via telephone. The focus of these two sessions was the identification of any tangible or psychological barriers to seeking treatment, such as transportation difficulties or the perception that depression is an inevitable part of aging. Following the identification of these barriers, the provider utilized psychoeducation, problem-solving techniques, and motivational interviewing to aid the depressed individual in decision analysis about seeking treatment.

In a pilot study, this intervention was offered to all older adults to who scored 10 or higher on the PHQ-9 and were receiving home meal delivery. Sixty-two percent of the participants in the Open Door Intervention accepted a referral and scheduled an appointment with a health care professional following the open door intervention, compared to the historical control rate of only 22% (Raue & Sirey, 2011).

Shared Decision-Making Intervention. Raue et al. (2010) additionally developed a shared decision-making intervention for depressed, low-income patients in an inner-city hospital. As in the intervention described above, this treatment focuses on early-stage engagement. Specifically, the Shared Decision-Making Intervention focuses on the point in care at which primary care providers identify depression and the need for treatment. Raue et al. developed this intervention to directly address depressive symptoms such as helplessness and hopelessness, to enhance patient autonomy and empowerment, and with the goal of indirectly improving clinical outcomes by increasing patient engagement and adherence.

The intervention is designed to be delivered by a nurse in a primary care setting and consists of a single 30-min, face-to-face meeting followed by two weekly follow-up telephone calls that average 10–15 min in duration. In these interactions, the nurse and patient discuss the patient's treatment experiences, values, preferences, and concerns. Psychoeducation is provided about various treatment approaches, including information about the effectiveness, speed of onset, cost, and side effects of available treatments. Handouts with easy-to-understand language are provided to patients during the initial meeting, and the nurse strives for a mutually agreed-upon treatment decision. The focus of follow-up telephone calls is reviewing agreed-upon treatment decisions, reviewing relevant barriers and strategies to overcoming them, and when necessary, reengaging the patient in the shared decision-making process (Raue et al., 2010).

Treatment Initiation Program. The third intervention developed by Raue and Sirey (2011) focuses on a later stage in the authors' model of treatment engagement. This stage involves adherence to antidepressant medication. The intervention program is designed to target psychological and tangible barriers that impact adherence.

The Treatment Initiation Program involves three 30-min individual meetings during the first 6 weeks of pharmacotherapy and two follow-up telephone calls. The brief individual meetings are designed to allow the provider to establish an alliance with the patient while maintaining brevity that fosters independence and contrasts with psychotherapy. The intervention involves six distinct steps: (1) review of symptoms, current treatment regimen, and psychological and tangible barriers to treatment, (2) definition of a personal goal achievable with treatment engagement, (3) provision of psychoeducation about depression and depression treatment, (4) collaborative discussion of barriers, (5) collaborative creation of an adherence strategy, and (6) facilitation of direct communication between patient and primary care provider about any treatment concerns (Sirey, Bruce, & Kales, 2010).

In a randomized controlled pilot study that included 70 elderly primary care patients in New York City, patients who were given this intervention had higher rates of adherence compared to the usual-care group at 6, 12, and 24-week follow-up assessments. At 12-week follow up, 82% of patients who had been enrolled in the Treatment Initiation Program were adherent to prescribed medication at 80% or above, compared to only 43% of the patients who received usual care. At 24-week follow up, program-enrolled participants also reported a greater decrease in depressive symptoms compared to patients in the usual care group (Sirey et al., 2010).

While the authors developed this particular engagement-enhancing intervention for use with psychopharmacological interventions, we present it here due to its potential to be applied to a variety of other interventions. The six steps of the intervention, which are reviewed below, could be applied in part or in whole to the initiation of any form of treatment, including those which are less invasive than psychotropic medication.

Assessment of Treatment Preferences. Research has investigated the effects of patient preference on treatment efficacy and other outcomes, such as patient drop-out rates. Practice guidelines provided by the American Psychiatric Association advocate that, whenever feasible, providers consider patient preferences regarding

treatment type, and that this consideration may be an effective strategy in improving both outcomes and adherence (Gelenberg et al., 2010). While some evidence suggests that patient who are able to exercise control over their health care decisions experience improved treatment outcomes (Geers et al., 2013), the majority of studies conducted in this area have not found a direct relationship between patient preferences and treatment outcome. However, a review of research conducted on the effects of patient preferences indicates that patient preferences may have an indirect effect on outcome through other factors, such as treatment engagement, dropout, and satisfaction (Winter & Barber, 2013). While more research in this area is needed, this data supports the APA's current guidelines and recommendation that patient preferences regarding treatment type be evaluated and, whenever possible, honored by providers.

Step Two: Minimal Provider Involvement

Within a stepped-care approach, the second level of treatment for depression involves minimal provider intervention. These strategies include watchful waiting, bibliotherapy, and psychoeducation. All three of these approaches may be used best in cases of mild depression or prior to trying more intensive treatments.

Watchful Waiting. Watchful waiting involves withholding active treatment for a specified period of time and consistently measuring and monitoring symptoms during that time period (Hegel, Oxman, Hull, Swain, & Swick, 2006). These continued assessments should assess severity and progression of symptoms to determine whether active treatment should be initiated. It is assumed that by engaging in watchful waiting a proportion of cases of depression will remit on their own without requiring further intensive treatment.

One study found that of 121 patients entered into a 1 month watchful waiting period prior to participating in a randomized control trial, 9–13% showed remission of symptoms (Hegel et al., 2006). They also found that the rate of remission was lower for individuals with avoidant coping styles and those who engaged in fewer pleasant activities prior to initiating the trial. These findings suggest that for certain individuals, simply monitoring symptoms and checking to make sure they do not progress to more severe levels may be adequate for treatment. In addition, for individuals with the identified risk factors of avoidant coping and avoidance of pleasant events, it may be that rather than engaging in a more intensive treatment approach, pleasant events scheduling, or problem focused coping skills training may be enough to reduce symptoms of depression (Hegel et al., 2006).

When considering watchful waiting as an early-stage intervention, it is important to evaluate the preferences of the patient with regard to watchful waiting versus a more active form of treatment. Johnson, Meredith, Hickey, and Wells (2006) assessed primary care patients' preferences for depression treatments including watchful waiting. In this study, 16% of patients preferred watchful waiting over active treatments. In addition, those individuals who preferred watchful waiting

were less likely to use antidepressant medications or attend individual counseling sessions (Johnson et al., 2006).

These findings suggest that individuals who prefer watchful waiting are less likely to initiate another form of active treatment, and that their preferences reflect their real-life treatment choices. Therefore, it is important to assess patient preferences before beginning active treatment to determine whether they may prefer a less intensive approach such as watchful waiting, as they are more likely to engage in their preferred form of treatment. The research presented in the Assessment of Treatment Preferences section above suggests that it is equally important to evaluate and honor patient preferences if individuals report a preference for a more active form of treatment instead of watchful waiting.

In addition to assessing preferences, the provider should spend time considering the patient's particular constellation of symptoms and how they may interfere with continued assessment and monitoring. For example, if an individual with mild depression is experiencing difficulties getting out of bed due to hypersomnia, to increase engagement it may be necessary to work around their schedule to plan appointments at times they are most likely to attend. Patients who continue to experience symptoms following a period of watchful waiting may be more likely to engage in other treatment approaches as a result of knowing that they have already tried the least-invasive approach.

A variety of strategies may be useful to increase engagement with watchful waiting. Regular patient contact will facilitate troubleshooting any potential barriers to engagement as they become apparent. The provision of a rationale for watchful waiting (i.e., a description of the potential benefits and particular advantages of a watchful waiting intervention) may serve a similar function as the psychoeducation interventions described below, thereby enhancing engagement or outcomes in watchful waiting. Another strategy for engaging patients in watchful waiting treatment may involve the use of motivational interviewing (MI) strategies to promote faithful attendance of appointments for ongoing assessment.

Bibliotherapy. Another intervention that requires minimal provider involvement is bibliotherapy. Bibliotherapy involves a patient self-administering at home treatments using self-help books, structured materials, or technology resources recommended by a provider (Gregory, Canning, Lee, & Wise, 2004). Bibliotherapy may also involve standardized treatment in book format that the patient completes independently (Cuijpers, 1997).

One commonly used example of bibliotherapy for depression is *The Feeling Good Handbook* by Dr. David Burns (1990) (Gregory et al., 2004). The "Feeling Good Program" was first developed in 1980 and research has demonstrated its efficacy in reducing depressive symptoms immediately following participant engagement in assigned bibliotherapy (Smith, Floyd, Scogin, & Jamison, 1997). Research has also shown that participants maintain improvements in symptoms at 3 year follow up (Smith et al., 1997). The primary components of *The Feeling Good Handbook* involve the use of cognitive and cognitive behavioral strategies for managing anxiety and mood disturbances. In particular the book outlines "forms of twisted thinking," commonly known as cognitive distortions, and teaches readers to alter their thoughts

to improve mood and anxiety. The book includes education about a variety of topics and possible causes of depression, as well as worksheets and activities to engage the reader in applying the information to their own condition.

Another example of a commonly used self-help text for depression and other emotional difficulties includes *Get Out of Your Mind and into Your Life* by Hayes (2005). In contrast to *The Feeling Good Handbook*, this book emphasizes an acceptance approach to emotional difficulties and distressing thoughts rather than attempting to change thoughts or feelings. Hayes's approach promotes being aware of emotions and thoughts and changing one's relationship with them rather than changing the thoughts or feelings themselves. This approach promotes the idea that the individual can live a valued life even if their symptoms of depression do not disappear entirely. While there is no current outcome data regarding the use of *Get Out of Your Mind and into Your Life* as bibliotherapy for depression, it is derived from Acceptance and Commitment Therapy (ACT), an intervention that is considered by the APA (2006) to be an empirically supported treatment with moderate support for the treatment of depression (2006).

In addition to text versions of bibliotherapy, there are an increasing number of electronic or internet-based forms of self-help resources that patients may benefit from using. This option may be particularly attractive for patients who do not have access to mental health providers in their area or those who live in rural locations. A few examples of forms of electronic self-help resources include support group websites, CBT self-help guides, and organization websites that compile links to electronic resources, such as those provided by the United States Department of Veteran Affairs website (<http://www.mentalhealth.va.gov/depression.asp>). A few examples of English-language programs of electronic self-help for depression are MoodGym (<https://moodgym.anu.edu.au>), This Way Up (<https://thiswayup.org.au>), MoodHelper (<https://www.kpchr.org/moodhelper>), COPE (<http://www.cope2thrive.com>), and Beating the Blues (<http://www.beatingtheblues.co.uk>).

Bibliotherapy has a number of advantages that make it an appealing intervention. It can be cost-effective and easily accessible (Mains & Scogin, 2003). For many individuals with depression, treatment may be too expensive or not covered by their insurance plans. Therefore, bibliotherapy may be particularly useful in underserved groups. In addition, allowing patients to complete bibliotherapy at home may reduce concerns about stigma associated with seeking treatment for depression. In many settings, providers can introduce the bibliotherapy rationale and material in one brief individual or group contact, therefore limiting the strain on providers (Gregory et al., 2004).

While many bibliotherapy resources have been designed for patients to utilize independently at home, a provider may combine it with additional interventions. Research suggests that this is quite common in practice today, with one study reporting that in 60–97% of cases, bibliotherapy is used in combination with psychotherapy to enhance psychotherapy outcomes (Mains & Scogin, 2003). Similar to the approach of watchful waiting discussed above, a provider may recommend bibliotherapy for a patient to use at home, but continue to touch base with the patient to monitor symptoms as they progress through their selected self-help program. These contacts with the therapist are generally supportive or facilitative in nature (Cuijpers, 1997).

Gregory et al. (2004) conducted a meta-analysis of 29 studies evaluating the effectiveness of cognitive bibliotherapy for depression. They found an average effect size of .77 across a broad range of studies. This effect size is similar to those found in studies assessing the effectiveness of individual psychotherapy. Another meta-analysis found an effect size of .83 for self-administered bibliotherapy. The same meta-analysis found that when cognitive versus behavioral bibliotherapies were compared, both forms performed better than a control group who received no intervention (Mains & Scogin, 2003). These findings demonstrate that not only is bibliotherapy one way of addressing a number of barriers to engagement in more intensive forms of treatment, it is capable of achieving high levels of effectiveness.

Despite its demonstrated effectiveness, there are certain patients with depression for whom bibliotherapy may be less suitable. Research indicates that bibliotherapy may be less effective for individuals with severe depression, suicidal ideation, and those who have complicating comorbidities. In addition, individuals who have a pattern of externalized coping or defensiveness may be less likely to benefit (Mains & Scogin, 2003). Therefore, the provider should conduct assessment of each patient to determine the suitability of bibliotherapy.

As noted by Dysart-Gale (2008), research on bibliotherapy has focused on outcomes and neglected factors such as individual engagement with assigned texts. Should providers detect that engagement is lacking, they may use a variety of strategies developed for use with other interventions. For example, employing aspects of the open door intervention, shared decision making intervention, or a treatment initiation program described previously may be useful in addressing any barriers to engagement as they arise. If regular check-in appointments are scheduled with the patient, the provider may utilize assessment in an ongoing manner to ensure continued appropriateness of the bibliotherapy intervention. The use of motivational interviewing (MI) strategies may also be useful for engagement with the bibliotherapy materials. Developed by Miller (1983), MI is a patient-centered therapeutic style designed to enhance readiness for change by facilitating exploration and resolution of patient ambivalence toward treatment.

Psychoeducation. Psychoeducation aims to help patients develop knowledge about a condition and to inform them of possible tools to help them cope with symptoms (de Souza Tursi, von Werne Baes, de Barros Camacho, de Carvalho Tofoli, & Juruena, 2013). Additional goals of psychoeducation are to empower the individual, and to increase awareness about symptoms, treatments, and techniques to improve coping. One benefit of utilizing psychoeducation is that it can be conducted in many settings and with a variety of populations who may experience a diverse range of conditions (Colom, 2011). Therefore, psychoeducation can be used by a wide range of providers ranging from those in medical and primary care settings to specialty mental health providers.

The format in which psychoeducation is delivered can vary widely and may consist of a single one on one session with a provider or it can be more involved such as a 12 session group with weekly structured class meetings. Psychoeducation can be provided in individual or group formats, and can also be provided over the internet or telephone (de Souza Tursi et al., 2013).

One example of a commonly used psychoeducational approach is Lewinsohn's "Coping with Depression" program (Lewinsohn & Clarke, 1984). This program emphasizes a group-based, educational, and didactic approach to teaching participants about depression as well as teaching them techniques and strategies for coping with their symptoms. The program is based on social learning theory and the techniques most closely resemble cognitive behavioral therapies for depression. Throughout 12 lessons, the therapist educates participants about different skills and activities that may help them to cope with depression. The course is advertised as a class rather than a therapy and is therefore considered a psychoeducational intervention rather than group CBT. Although not stated as a goal by the authors, this classification as an educational course rather than a therapy may reduce stigma for interested participants.

To test the efficacy of this program, Swan, Sorrell, MacVicar, Durham, and Matthews (2004) administered the "Coping with Depression" program in a group format to 76 individuals who had previously responded poorly to other treatments. Of the 31 who completed the program, 35% achieved remission of depressive symptoms and reported an improvement in quality of life (Swan et al., 2004).

The "Coping with Depression" program is just one example of a psychoeducation intervention. This program, as well as psychoeducation in general, may be provided alone, or in conjunction with individual psychotherapy. Lewinsohn and Clarke (1984) estimated that approximately 30–40% of participants in their courses are usually involved in some other form of treatment. Although psychoeducation can serve as a standalone intervention, psychoeducation is often included as one component of empirically supported treatments such as cognitive behavior therapy (Ong & Caron, 2008).

A number of studies have reported on the effectiveness of psychoeducation in various populations. Ong and Caron (2008) reviewed seven empirical studies that tested the effectiveness of psychoeducation for families and children with mood disorders. Following their systematic review of the literature, they determined that although rigorous trials of psychoeducation have not been conducted, the use of these interventions is "probably efficacious," in the treatment of depression in children and family systems. They found that across multiple studies, families and children who participated in psychoeducation showed improvements in attitudes and behaviors related to depression as well as a reduction in depressive symptoms (Ong & Caron, 2008). Another review reported on 15 studies that provided psychoeducation to participants with depressive symptoms. They found that across studies, the use of psychoeducation improved participants' reported clinical course of depressive symptoms, treatment adherence, and psychosocial functioning (de Souza Tursi et al., 2013).

There is a dearth of research regarding engagement in psychoeducation and strategies to facilitate increased engagement. As discussed in previous sections of the present chapter, the use of various elements of the three interventions developed by Raue and Sirey (2011) may be useful for enhancing patient engagement, and scheduling regular patient contact may increase opportunities to utilize these strategies.

Another strategy for engaging patients in psychoeducational treatment may involve the use of motivational interviewing (MI) strategies. Sherman et al. (2009)

utilized a brief 20- to 30-min, individualized MI session with Veterans experiencing severe mental health difficulties and their families prior to their enrollment in a long-term, family-based psychoeducation program. In this brief session providers reviewed a number of previous self-reported goals of the Veteran and identified the advantages and disadvantages of participating in the upcoming psychoeducation program. Therapists utilized a number of other MI strategies including rapport building, reflective listening, affirmation of Veteran's openness, and reinforcement of self-motivating statements. They found that 30 % of Veterans who completed this initial engagement session completed at least one session of the psychoeducation program, which is higher than the 2–13 % rates found in previous research on lower-intensity activities, such as attending a single psychiatrist appointment (Sherman et al., 2009; Sherman, Faruque, & Foley, 2005). Therefore, providers may consider using regular check in's as well as motivational interviewing strategies to increase the likelihood that their patients will engage in psychoeducational approaches.

Step Three: Increased Provider Involvement

Within a stepped-care approach, the third level of treatment for depression involves an increase in provider involvement. These strategies include a variety of technology-based interventions, primary care interventions, and cognitive behavioral therapy. All these approaches may be effective in the treatment of mild, moderate, or even severe depression and may be utilized prior to the use of more intensive treatments.

Technology-Based Interventions. In recent years, technology-based interventions have garnered increasing attention for a variety of reasons. Technology has the potential to increase the capacity of mental health services, and to overcome some of the barriers to accessing mental health services, including stigma, traveling time for rural patients, treatment delays, and the low availability of skilled providers. A growing body of evidence supports the efficacy of technology-based interventions and in particular supports the efficacy of computerized cognitive behavioral therapy (Titov, 2007).

Technology-based interventions vary in the amount of provider involvement and the degree of invasiveness. Research to date has suggested that predominately self-help computerized cognitive behavioral therapy interventions are efficacious in the treatment of sub-threshold mood disorders and offer a less-intensive, cost-effective way to deliver treatments, but that provider-assisted interventions are more efficacious (Newman, Szkodny, Llera, & Przeworski, 2011).

Telephone-Based Interventions. Telephone-based interventions may involve assessment or psychological interventions delivered via phone calls between the provider and patient. These sessions may vary widely in duration and focus. A variety of studies have evaluated the use of telephone-delivered interventions to increase treatment engagement.

A study conducted by Mohr et al. (2012) compared telephone-delivered CBT to face-to-face CBT. In this study, the two treatment groups followed identical treatment protocols and varied only in the modality used to deliver treatment. The results of this study indicated that while the telephone-delivered intervention improved adherence, it also resulted in some increased risk of poorer maintenance of gains following the conclusion of treatment.

Motivational interviewing (MI) provided over the phone has been investigated as a possible method to increase treatment engagement. A study conducted by Seal et al. (2012) evaluated the efficacy of telephone-delivered in enhancing treatment engagement in veterans with mental health concerns. The intervention involved four 20–30 min telephone MI sessions conducted at baseline and 2, 4, and 8 weeks. The baseline session involved personalized feedback regarding psychological assessment, open-ended questioning about concerns, and empathic reflective listening. Subsequent sessions focused on building motivation and strengthening commitment to treatment. The use of a MI intervention resulted in 62 % of Veterans engaging in treatment compared to only 26 % in the control group.

Another study evaluated a telephone-based referral care management program implemented in a population of African Americans between the ages of 22–83, of whom 39 % had severe depression comorbid with substance use. The intervention involved addition of one or two MI sessions, averaging 15 min per week, which involved discussing patient symptoms, goals, and attitudes toward treatment. These brief MI sessions were provided in addition to the usual-care model, which involved session scheduling and a letter and telephone reminder of the scheduled appointment. The telephone-based referral care management program resulted in 70 % of patients engaging in treatment, compared to 32 % in the usual-care group (Zanjani, Miller, Turiano, Ross, & Oslin, 2008).

Internet-Based Interventions. In recent years, there has been much interest in the potential of use of the Internet to increase the availability and cost-effectiveness of treatment for a variety of mental health issues. Internet-based interventions have also been investigated for their potential to increase treatment engagement. To date, research has indicated that attrition from randomized controlled trials of Internet-based interventions are low relative to dropout from open access websites. The reasons for discrepancy in attrition remain unclear, however, and researchers in this area have emphasized that the development of theoretical models of adherence is just as important in the area of Internet research as it is in the behavioral health literature (Christensen, Griffiths, & Farrer, 2009).

Online cognitive behavioral therapy (CBT) programs for the treatment of depression have been developed. Sharry, Davidson, McLoughlin, and Doherty (2013) evaluated an online, provider-assisted CBT program that was specifically designed to address treatment engagement. Engagement was addressed via a variety of program features, including personalization options such as a custom homepage, user choice of module order, an interactive program interface that included the opportunity for users to provide feedback, support provided via an assigned provider who provided reviews of progress, and social features such as the option to anonymously contact with other users of the program.

Sharry et al. (2013) found that inclusion of these features resulted in a high level of engagement and a significant reduction in self-reported depressive symptoms. At the target week 8 or later, 79% of users were engaged with treatment. The reviews provided by providers appeared to be well-received by users: 50% were read within 24 h. The overall dropout rate in the program was 37.5%, which compares favorably to a 74% dropout rate for an unsupported program. These robust effects were accomplished with minimal involvement from the providers, who devoted only 10–15 min per week per patient to providing reviews.

Primary Care Interventions. Depression is frequently identified and treated in primary care settings and is the third most common reason for primary care appointments (Gilbody, Whitty, Grimshaw, & Thomas, 2003). While depression is commonly seen in primary care settings, it is not necessarily properly managed. Primary care providers are capable of treating depression and often utilize antidepressant medications to do so. However, patient adherence with medication is poor, and there is a lack of psychotherapy provided in primary care (Gilbody et al., 2003). A systemic change that may help to improve treatment engagement in primary care settings is colocation of mental health specialists. By collocating mental health specialists within primary care settings, a mental health provider resides in the same office as primary care providers allowing a patient to receive mental health care in an office they already visit on a semi-regular basis.

One study focused on evaluating care of older adults found that collocating mental health services resulted in improved access to care when compared to enhanced referrals to specialty care (Raue & Sirey, 2011). While primary care providers can refer patients to specialty mental health providers outside of their office, the rate of follow up on these referrals is often below 50% (Kessler, 2012). Gallo et al. (2004) found that physicians preferred integrated care with colocated mental health specialist over enhanced referral care for older depressed adults. Physicians additionally reported a number of benefits of integrated care including facilitation of communication with mental health specialists, reduction in stigma for patients, and more effective coordination of mental and physical health care (Gallo et al., 2004). These findings suggest that colocation has the potential to address many barriers to treatment engagement and to improve the quality of care received by patients.

Engagement in services may be further improved by implementing routine screening procedures in primary care settings. In a study assessing a two-tiered screening approach of university students, Klein, Ciotoli, and Chung (2011) utilized the PHQ-2 and PHQ-9 to screen all patients presenting for care. After the screening the physician would determine the severity of their symptoms and initiate a range of treatments including watchful waiting, antidepressant medication, or referral to mental health services.

They found that patients were more likely to engage in the recommended treatment if their depression symptoms were more severe (Klein et al., 2011). However, of those patients with moderate to severe depressive symptoms 42.8% did not engage in treatment within 30 days of screening (Klein et al., 2011). This suggests that primary care providers may want to screen all patients and speak openly with patients to determine the severity of their symptoms and their preferences for a

range of care options. If symptoms are more severe, the physician may want to consider more involved treatments. Screening patients more regularly may also increase likelihood of engagement.

In addition to assessing preferences, primary care providers may want to consider tailored communication prior to appointments to increase engagement in treatment. One study by Kravitz et al. (2013) screened a sample of 6191 primary care patients for depression. Of those screened, 925 individuals met criteria for the study and chose to participate. The sample was then randomly assigned to receive one of two different tailored communication interventions or a control intervention prior to a primary care appointment. The tailored communication groups consisted of a depression engagement video (DEV) and an individualized multimedia computer program (IMCP). The DEV informed patients about depression symptoms and was personalized to sex and age, the IMCP was an interactive computer program that utilized a number of patient inputs such as depression severity to individualize feedback and provided links to personalized information, and the control intervention was a sleep hygiene video (Kravitz et al., 2013).

The outcome measures included the percentage in each group who received antidepressant medications or referral to specialty mental health in the appointment as well as the percentage of patients who broached the topic of depression in the subsequent appointment with their primary care provider. The IMCP group was significantly more likely to receive antidepressant medication or referrals to specialty services than either the control or DEV groups. In addition, both the DEV and IMCP groups were more likely to request information about depression from their primary care provider than the control group (Kravitz et al., 2013).

The results of this study suggest that by providing patients with individualized information about depression, it may increase their likelihood of seeking out, and engaging in available treatments for depression. This suggests that primary care offices should be actively screening for depression symptoms, and providing some form of tailored communication to patients to increase the probability of patient engagement.

Cognitive Behavioral Therapy. CBT is a highly efficacious treatment for depression, but low engagement in treatment impedes its utility for many individuals. An observational study by Brown et al. (2011) assessed patient preference, attrition, and the cost effectiveness of CBT delivered in individual or group format. Prior to treatment, 70% of patients stated a preference for individual CBT, while 10% preferred a group format and 20% stated that they had no preference between the two modalities.

At post-treatment, both treatments resulted in significantly decreased depression scores. The results of the study indicated that attrition was similar in both modalities, independent of stated treatment preference or reported satisfaction. By post-treatment, 53% of the patients enrolled in the study who had initially expressed a preference for individual therapy but had received group therapy changed their preference. Group CBT was additionally found to be more cost effective than individual CBT (Brown et al., 2011).

Other studies have investigated predictors of treatment change and engagement in group CBT. One such study assessed 48 individuals enrolled in group CBT for

depression and found that individuals with higher pretreatment hopelessness scores were significantly more likely to drop out of treatment than those with lower scores. These findings suggest that negative expectations about treatment outcome may lead to both low treatment benefit and engagement as well as a greater risk of premature termination of treatment. In turn, these risks indicate a need for early assessment of patient expectations and additional interventions to decrease risks. The authors recommend strategies such as motivational interventions, involving family or significant others, or challenging pessimistic or hopeless thoughts early in treatment (Westra, Dozois, & Boardman, 2002).

A number of studies have investigated the utility of integrated motivational strategies to enhance treatment engagement with CBT for depression. Swartz et al. (2007) evaluated the impact of an engagement session designed for the first clinical interaction with a patient. This engagement session involved integration of motivational interviewing and ethnographic interviewing. Preliminary reports of the efficacy of this intervention are promising. The authors reported that among depressed, pregnant women who were assigned to either standard treatment or the engagement strategy, 96% of women who receive the engagement strategy subsequently attended an initial treatment session. Among women who received standard care, only 25% attended an initial treatment session (Swartz et al., 2007).

These findings strongly suggest the effectiveness of motivational interviewing techniques for enhancing engagement in CBT. Particular features of motivational interviewing that have been theorized to be particularly useful in increasing engagement in CBT are its focus on increasing intrinsic motivation for behavior change, strategies for addressing ambivalence and resistance, and its facilitation of a respectful, flexible, and supportive relationship between provider and patient (Arkowitz & Westra, 2004). These authors have suggested three ways to integrate MI and CBT to enhance engagement: MI as a prelude to CBT, MI as a response to CBT nonresponders, and MI integrated throughout CBT.

Step Four: Most Invasive Treatments and Provider Involvement

Following a stepped-care approach, the final level of strategies are the most invasive treatments. These strategies involve the use of psychotropic medication or the use of inpatient hospitalization to treat depression.

Psychotropic Medication. Psychotropic medication is often used as the first line of treatment and is often more readily available than evidence-based psychological treatments (Brotan et al., 2011). Research suggests the use of psychotropic medications is on the rise. A 2011 report issued by Medco Health Solutions analyzed the use of psychotropic medications in the United States between 2001 and 2010 and concluded that one in five adult Americans used such medications in 2010. The report indicates that antidepressants were the most commonly used psychotropic medication and that usage increased 29% in women and 28% in men during this time period.

The same report indicated that use of antidepressants for the treatment of children increased at the beginning of the decade, but peaked in 2004. This peak correlates with the Food and Drug Administration's (FDA) issue of a black box warning in 2004 for SSRIs, which was motivated by evidence that these medications are associated with increased suicidality in children. However, in 2010, the number of children receiving antidepressant medications increased for the first time since the black box warning was issued (Medco Health Solutions, 2011).

Despite the prevalence of antidepressant medications used as treatment, research evidence to recommend psychotropic medication is mixed. The American Psychological Association's practice guidelines for depression (2010) cites a large body of research that supports the efficacy of SSRIs. However, other research has concluded that, when compared with placebo, new generation antidepressants do not produce clinically significant improvement in patients with moderate or even severe levels of depression, and show limited effects among the most severely depressed patients (Kirsch et al., 2008). These authors have concluded that there is "little evidence to support the prescription of antidepressant medication to any but the most severely depressed patients, unless alternative treatments have failed to provide benefit" (Kirsch et al., 2008, 266).

Research has indicated that adherence to prescription medications is poor, which in turn results in poor outcomes and treatment failure. A retrospective chart review of 367 individuals with diagnoses of major depressive disorder who were receiving outpatient treatment revealed that only 44% continued taking medication for longer than 6 months. Other reports of long-term noncompliance in patients with MDD have reported rates as high as nearly 50% (Navarro, 2010). Studies have indicated that these high rates of nonadherence may account for dose escalation in one-third of patients who receive antidepressant therapies, as physicians may interpret lack of symptom reduction as evidence of an ineffective dosage rather than poor adherence (Mahoney, 2010). These findings suggest a need for strategies to assess and address adherence problems.

Some common reasons cited for nonadherence are lack of confidence in the efficacy of the prescribed medication, lack of experienced efficacy, adverse effects, and accidental omissions. Navarro (2010) have stressed that to improve adherence to medication, prescribing physicians must support patients in complying with their medication regimen by establishing and maintaining a supportive therapeutic relationship.

The other engagement enhancing strategies presented throughout this chapter—such as motivational interviewing techniques and assessment of and collaborative problem-solving barriers to treatment engagement—may also be useful in increasing adherence to medication regimens. In particular, the Treatment Initiation Program developed by Raue and Sirey (2011) and described early in the chapter may be useful to providers who prescribe medication, as this intervention is specifically designed to address the psychological and tangible barriers that impact adherence to pharmacotherapy.

Inpatient Hospitalization. Inpatient care for individuals with depression is highly restrictive to the individual and is one of the most intense levels of care. The American Psychological Association's practice guidelines for depression (2010)

state that the provider should seek to determine the least-restrictive setting for treatment that be most likely will ensure the patient's safety and improve the patient's condition. Therefore, inpatient hospitalization should be considered only if alternative methods of treatment are judged to be unable to meet this requirement. Inpatient hospitalization is also a costly intervention, with typical cost per individual between \$400–600 per day in the United States in 2004 (Cotterill & Thomas, 2004).

While inpatient hospitalization provides a highly controlled environment in which the provider has many opportunities to strive for treatment engagement, barriers still exist. Some of these barriers include concerns about stigma, risk of damage to the therapeutic alliance, and risk that individuals may lose their jobs due to time missed during hospitalizations (Brotten et al., 2011). Another identified barrier to engagement in inpatient settings is discrepancy between patient and provider perspectives of user engagement. One study found that patients reported limited ability to have meaningful input on their treatment, while providers reported difficulty engaging patients in discussion of treatment planning (Storm & Davidson, 2010).

Research on strategies for increasing treatment engagement in inpatient settings is limited. The existing research on treatment engagement suggests that assessment of patient preferences, increased opportunities for patients to give input on their care, and increased efforts to build and maintain a caring, supportive therapeutic alliance would all increase treatment engagement. The use of previously discussed strategies, such as psychoeducation or shared decision-making intermissions may also be useful. However, typical inpatient care settings may not allow much flexibility in patient and provider interactions due to limited resources and high demands placed upon providers. As such, changes to facilitate treatment engagement may require system-wide changes before some strategies can be implemented.

Conclusion

Depressive disorders are pervasive and costly to the individual and society. While research has identified a wide array of efficacious treatments for depression that can be used in a wide range of treatment settings, the existing literature also suggests that there are many barriers to engaging individuals with depression in treatment.

Fortunately, there is an increasing focus on identifying and developing a diverse array of strategies for increasing treatment engagement in depressed populations. These strategies may be employed in a wide variety of settings and via various modalities, including in primary care settings and over the telephone. These strategies include simple interventions that are minimally invasive and require minimal provider involvement, such as bibliotherapy, as well as more complex, system-wide changes to how and where mental health care services are offered to individuals.

This chapter has presented strategies for treatment engagement in a stepped-care model, first presenting the strategies that are the least invasive and that

require the least provider involvement, then presenting higher steps that reflect strategies that are more invasive and that require increased provider involvement. However, it is important to recognize that these steps are not mutually exclusive. For example, minimally invasive strategies, such as psychoeducation or motivational interviewing, may be useful in promoting treatment engagement within more intensive levels of care, such as inpatient treatment. Flexible use of these strategies throughout treatment and idiographic application of these strategies to individual patients and treatment settings is crucial for optimal enhancement of treatment engagement.

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