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The role of coping in depression treatment utilization for VA primary care patients

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ABSTRACT

Objective: To examine the impact of Veterans' coping strategies on mental health treatment engagement following a positive screen for depression.
Methods: A mixed-methods observational study using a mailed survey and semi-structured interviews. Sample included 271 Veterans who screened positive for depression during a primary care visit at one of three VA medical centers and had not received a diagnosis of depression or prescribed antidepressants 12 months prior to screening. A subsample of 23 Veterans was interviewed.
Results: Logistic regression models showed that Veterans who reported more instrumental support and active coping were more likely to receive depression or other mental health treatment within three months of their positive depression screen. Those who reported emotional support or self-distraction as coping strategies were less likely to receive any treatment in the same time frame. Qualitative analyses revealed that how Veterans use these and other coping strategies can impact treatment engagement in a variety of ways.
Conclusions: The relationship between Veterans' use of coping strategies and treatment engagement for depression may not be readily apparent without in-depth exploration.
Practice implications: In VA primary care clinics, nurse care managers and behavioral health providers should explore how Veterans' methods of coping may impact treatment engagement.
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1. Introduction

Major depression is the third most prevalent DSM-IV disorder, affecting 6.7% of U.S. adults [1] and 5–13% of patients seen by primary care physicians in the Department of Veterans Affairs (VA) [2]. Depression treatment utilization has increased over the last 20 years [3,4], with most cases of depression diagnosed and treated by primary care physicians [5]. Approximately 88% of people diagnosed with major depression eventually seek treatment; however, there remains a large gap between time of diagnosis and treatment. Only 37% seek treatment within a year of receiving the diagnosis and the median duration between initial diagnosis and depression treatment initiation is 8 years [6]. Although the percentage of patients who do not seek depression treatment is lower in the VA than in the general population [7], the number of veterans who do not receive treatment remains high, with rates ranging from 44% to 68% [8,9]. When left untreated, depression can have a heavy disease and societal burden, contributing to physical health issues, suicide, marital problems, and loss in job productivity [2,10]. Thus, it is important to identify factors contributing to delays in treatment engagement.

Coping strategies, which can be positive or negative, are resources and behaviors that are used to manage personal demands and distress [11,12]. Examples include seeking social support, engaging in pleasant activities, religious practice, emotional avoidance, self-blame, and substance use [13–16]. According to the self-regulation model of illness behavior [17] (Fig. 1), an individual develops coping strategies that are related to his/her symptoms, illness perceptions and emotional responses. The individual then makes judgments about the effectiveness of the coping strategies and either continues to employ these strategies in lieu of seeking treatment or opts for an alternative

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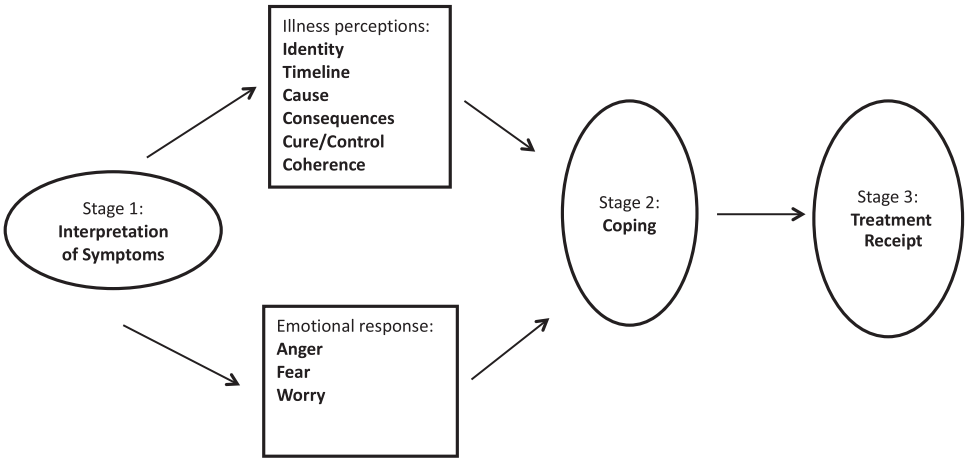

Fig. 1. The self-regulation model of illness behavior.

course (e.g., seeks treatment if previously avoiding treatment). Social support is a form of coping that has been extensively studied. Its presence can have a positive impact on health and mental health, functioning and well-being [18–20] while its absence or poor quality can compound health issues [21]. The presence of social support and social networks can also increase the likelihood of obtaining treatment [22], increase medical treatment adherence [23,24], and lead to better treatment outcomes [25,26].

Other coping strategies exist [11] but have not been as extensively examined with respect to their impact on treatment seeking. The self-regulation model indicates that the ways in which one copes with illness can have a significant impact on treatment engagement. Thus, more studies are needed to understand the nature and direction of the relationship. The current study is a mixed-methods study that examined the role of coping for VA primary care patients who screen positive for depression. Specifically, we used quantitative analyses to identify coping strategies used by these patients and examined their relationship to treatment-seeking for depressive symptoms three months after screening positive. We also conducted an in-depth exploration about how patients cope with their symptoms.

2. Methods

2.1. Participants and recruitment

Veterans from three VA medical centers in the U.S. Northeast and their affiliated community-based outpatient clinics were eligible to participate in this study if they: (1) screened positive for depression on the Patient Health Questionnaire-2 or 9 (PHQ-2 or PHQ-9) [27,28] during a primary care visit, (2) had not received a diagnosis of depression in the previous 12 months, and (3) had not received a prescription for anti-depressants in the previous 12 months. A waiver of the U.S. Health Insurance Portability and Accountability Act (HIPAA) authorization, which sets the parameters of the privacy of identifiable health information, was obtained to review the electronic medical records of all patients screened to determine eligibility. We also received a Certificate of Confidentiality from the federal government to protect participants' responses to questions about depression and substance abuse. Each week from May 2009 to June 2011, 838 eligible patients were identified through the VA electronic medical record and mailed letters to invite them to participate in the study. The study involved completing a mailed questionnaire including measures of demographics, depression treatment history in the past five years, and coping. If they did not want to participate, the letter indicated that they should check and return an enclosed, pre-paid, pre-addressed "opt-out" postcard. If no postcard was received, patients were mailed questionnaires with a pre-paid envelope and were asked in a cover letter to mail the completed questionnaires within 10 days. Those who did not return the questionnaire received a reminder letter two weeks later and a reminder phone call one week after that if they still had not returned the questionnaire [29]. Patients who completed and returned the questionnaire (N = 275; 32.3% response rate) received a $15 gift card.

Veterans interested in participating in a face-to-face interview (by checking a box on the mailed questionnaire) were contacted by phone after the post-screening depression treatment data was collected from the medical record. After treatment utilization data was obtained (at least 3 months after enrollment), these veterans were contacted to schedule the face-to-face interview. Interviews (n = 23) were conducted until thematic saturation was reached (i.e., no new information was derived from subsequent interviews) [30]. The interviews were audio-recorded and professionally transcribed, and written informed consent was obtained prior to the start of the interview. Interviewed Veterans received an additional $15 gift card. All procedures were approved by the institutional review boards at the participating VA medical centers.

2.2. Measures

2.2.1. Sample characteristics

Participants' age, gender, race/ethnicity, education, and employment status were assessed in the mailed survey with questions used in previous VA research [31]. Participants also completed a question reporting whether or not they had received any treatment for depression from a VA or a non-VA provider in the past five years.

2.2.2. Coping

The Brief COPE [13], a 28-item version of the original, longer COPE inventory [11], was included in the mailed questionnaire. It consists of 14 two-item subscales—self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame. Subscale examples are provided in Table 1. Patients were asked to indicate how they coped with depressive symptoms in the past month. Response options range from 1 – I have't been doing this at all to 4 – I've been doing this a lot. Cronbach's alpha for the scale was 0.71 and ranged from .36 to .89 for the subscales.

2.3. Data collection

After participants returned completed questionnaires, their treatment status was determined three months later using two indicators of depression treatment adopted as performance measures by the VA as well as a review of provider notes in their medical record. The indicators were: (1) *optimal practitioner contact*, defined as at least three outpatient mental health follow-up encounters within the 84 day acute phase period from diagnosis; and (2) *effective medication coverage*, defined as continuity of antidepressant medication treatment during 84 of the 114 days from the index diagnosis date or index prescription date [7]. These performance measures were further categorized into four types of depression treatment utilization by the study team (guideline-concordant depression treatment, any depression treatment not within guidelines, any mental health treatment but not for depression, and no mental health treatment) through a review of the patients' VA electronic medical records three months after the depression screen. During the record review, the following eight questions were used to categorize the treatment received: (1) Does the patient have a depression diagnosis? (2) When was depression diagnosis given? (3) Did the provider refer the patient to mental health services? (4) Was depression discussed with the patient? (5) If there is no evidence of depression being discussed, do words such as "mood, sad, down, or suicide" appear in a free text search and do these suggest evidence of discussion with provider about depression or treatment? (6) Did patient have any follow-up appointments with a provider about depression? (7) Was the patient prescribed antidepressant medication? (8) If the patient was prescribed antidepressant medication, did he/she refill the medication?

Face-to-face, semi-structured interviews of the subset of participants were used to further explore patients' method(s) of coping with symptoms of depression. Interviews were conducted using a flexible guide that included key questions; however, interviewers also followed up on issues raised by patients. Interviewers asked questions such as, "People do a lot of things for their depression. I'd like to know what you are doing" and "Who did you turn to for help?" Veterans were also asked about their definition of depression, the onset of their depressive symptoms, the impact of their symptoms on their daily lives, and discussions about depression with their VA provider.

2.4. Data analysis

2.4.1. Quantitative

To examine the effect of each Brief COPE scale, we fit two sets of multiple logistic random effects regressions, one for each binary response of depression treatment (target group compared to the remaining three groups). The predictors consisted of all 14 coping scales, demographic variables (age, gender, and race), and self-reported depression treatment in the past five years. These analyses were performed using PROC GLIMMIX in the SAS statistical analysis package Version 9.2 [32] with VA site as a random effect in the models. To check for multicollinearity in our regression models, we computed variance inflation factors (VIF) for each of the 14 coping scales [33]. Any scales with VIF > 10 were omitted from the regression analyses.

Table 1
Sample items for Brief COPE subscales.

Subscale	Sample item
Self-distraction	"I've been turning to work or other activities to take my mind off things."
Active coping	"I've been taking action to try to make the situation better."
Denial	"I've been refusing to believe that it has happened."
Substance use	"I've been using alcohol or other drugs to make myself feel better."
Use of emotional support	"I've been getting comfort and understanding from someone."
Use of instrumental support	"I've been getting help and advice from other people."
Behavioral disengagement	"I've been giving up trying to deal with it."
Venting	"I've been saying things to let my unpleasant feelings escape."
Positive reframing	"I've been trying to see it in a different light, to make it seem more positive."
Planning	"I've been trying to come up with a strategy about what to do."
Humor	"I've been making jokes about it."
Acceptance	"I've been accepting the reality of the fact that it has happened."
Religion	"I've been trying to find comfort in my religion or spiritual beliefs."
Self-blame	"I've been blaming myself for things that happened."

2.4.2. Qualitative

We analyzed the interviews using grounded thematic analysis and organized them in NVivo 8 [34]. Five team members coded three interviews to create an initial code book, which was refined throughout the analysis process. Each of the remaining 20 interviews were coded by two different team members and discussed by the team. Any disagreement was discussed by the team until consensus was reached. Coping strategies used to deal with symptoms of depression were captured by a "what they're doing" code. We then examined the data captured by this code for responses that appeared to correspond to the Brief COPE subscales. Table 2

Table 2
Mixed methods cross-walk of strategies used to cope with depression.

Brief COPE subscales (quantitative)	Sample interview questions corresponding to "What They're Doing" code (qualitative)	Veterans' specific coping strategies (qualitative)
Instrumental support: seeking advice, assistance, or information.	Who did you turn to for help? Is there anything your doctor recommended or prescribed for your depression?	"...my adopted sister. She started noticing it...she says you're scaring me. You need to get some help now."
Active coping: the process of taking active steps to try to remove or circumvent the stressor or to ameliorate its effects.	Tell me what you do for your depression? What helps? Can you tell me how your treatment is going?	"I just kind of work through it. I really just try to take one thing at a time and you know, master that task and go on to the next task and the next task."
Emotional support: getting moral support, sympathy, or understanding.	What do your family and friends say about depression? What about your military friends? Have you told them that you were depressed?	"Yeah, she [my wife] knows that I'm depressed because she said it doesn't seem I am the same. I talk to her about it, you know, she just basically say hang in there you know."
Self-distraction: using a wide variety of activities to take one's mind off a problem/stressor.	Tell me what you do for your depression? What helps? Can you tell me how it's been going without treatment?	"...you start to think about the things that suck instead of the things that are good. I'll go out and push the cook outta the way and start cooking or something."

Table 3
Characteristics of the study's survey population and interview sub-population.

	Survey sample $N=271$	%	Interview sample $n=23$	%
Age[a]				
20–50	65	24.2	6	26.1
51–60	74	27.5	9	39.1
61–70	70	26.0	7	30.4
71+	60	22.3	1	4.4
Gender[a]				
Male	251	93.3	21	91.3
Female	18	6.7	2	8.7
Race[a]				
White	244	92.8	19	82.6
Other	19	7.2	4	17.4
Education[a]				
Less than 12th grade	16	5.9	0	0
12th grade or equivalent	65	24.2	6	26.1
Trade/tech/vocational	32	11.9	2	8.7
Some college	83	30.9	8	34.8
Associate/bachelor degree	55	20.5	7	30.4
Post-graduate/professional	18	6.7	0	0
Marital status[a]				
Married/with partner	135	50.0	10	43.5
Divorced	42	15.6	5	21.7
Never married	40	14.8	3	13.0
Widowed	31	11.5	4	17.4
Separated	22	8.2	1	4.4
Past treatment for depression				
VHA and non-VHA (past 5 years)[a]	103	38.4	13	56.5
Treatment following positive depression screen				
Guideline-concordant depression treatment[b]	92	34.0	11	47.8
Depression treatment not within guidelines[b]	51	18.8	3	13.0
Other mental health treatment (not for depression)	10	3.7	2	8.7
No mental health treatment	118	43.5	7	30.4

[a] To account for missing data among the overall sample, $n=269$ for age, gender, and education, $n=263$ for race, $n=270$ for marital status, and $n=268$ for past treatment.
[b] HEDIS guidelines include optimal practitioner contact, defined as three or more outpatient mental health follow-up encounters with a mental health or non-mental health practitioner within the 12 week acute treatment phase of depression; and effective medication coverage, defined as continuity of antidepressant medication treatment during 84 of the 114 days following the index anti-depressant prescription date.

described the relationship between the quantitative Brief COPE subscales (only those that were significantly related to treatment) and examples of corresponding qualitative interview questions and Veterans' responses.

3. Results

Characteristics of the participants are displayed in Table 3. Across three VA medicals centers, 275 primary care patients completed and returned a questionnaire. Four participants were excluded due to missing data, leaving a sample of 271. Of those, 23 were interviewed. The full sample was 93% male and 93% White; 76% were over the age of 50. Thirty-eight percent reported that they received depression treatment in the past five years, but based on sample eligibility criteria, no past treatment occurred in the year prior to the positive depression screen according to chart review and Veteran self-reports. Nearly 44% of the sample had not received any treatment after screening positive for a new episode of depression.

3.1. Predictors of treatment following a positive depression screen

There was no multicollinearity among the Brief COPE subscales. Table 4 presents the three logistic regression (random effects) models predicting depression treatment by Brief COPE subscale, including covariates of age, gender, race, and self-reported past treatment in the past five years. Only the covariates and significant predictors are shown in Table 4. Two coping strategies (instrumental support and active coping) each significantly predicted a higher likelihood of some level of treatment engagement. Instrumental support significantly predicted all three treatment categories and was the strongest predictor for each. Those who reported instrumental support were more likely to receive any type of depression treatment three months post positive screen: guideline-concordant, not guideline-concordant, or mental health treatment not specific to depression. Veterans who used active coping were more likely to receive depression treatment not within the guidelines or other mental health treatment. Two other coping strategies predicted treatment engagement in the opposite direction. Veterans who reported using emotional support or self-distraction were significantly less likely to receive non-guideline concordant or other mental health treatment. The other 10 coping strategies did not significantly predict treatment.

Self-reported depression treatment in the past 5 years also significantly predicted engagement in treatment. Those who reported past treatment were more likely to engage in any mental health treatment within three months of screening positive for depression than those who did not report past treatment. However, the four coping strategies discussed above remained significant even with self-reported past depression treatment as a predictor.

3.2. Strategies used to cope with depressive symptoms

Similar to the full study sample the interview sample ($n=23$) was mostly White (83%) and mostly male (91%). Eleven received guideline-concordant depression treatment, 3 received non-guideline depression treatment, 2 received other mental health treatment, and 7 received no mental health treatment within three months of screening positive for depression. Unlike the quantitative results, patients described coping with symptoms of depression using techniques that were similar to those of instrumental

Table 4
Logistic regression (GLIMMIX) predicting likelihood of treatment within three months following a positive depression screen.

Variable	Guideline-concordant depression treatment ($n=81$) vs. others ($n=161$)[a]		Depression treatment not within guidelines ($n=114$) vs. others ($n=128$)[a]		Any mental health treatment ($n=138$) vs. no treatment ($n=104$)[a]	
	Beta	SE	Beta	SE	Beta	SE
Active coping	0.26	0.24	0.61*	0.26	0.62*	0.26
Emotional support	−0.27	0.21	−0.67**	0.22	−0.58*	0.22
Instrumental support	0.80**	0.24	1.00***	0.27	0.98***	0.27
Self-distraction	−0.05	0.21	−0.55*	0.22	−0.50*	0.22
Age 20–50	0.75	0.52	1.05	0.49	1.14	0.49
Age 51–60	0.72	0.51	0.74	0.48	0.67	0.47
Age 61–70	0.44	0.50	0.69	0.45	0.48	0.44
Gender (male)	−0.55	0.62	−0.11	0.65	0.02	0.67
Race (White)	−0.09	0.64	0.03	0.65	−0.35	0.67
Depression treatment (past 5 years)	0.98**	0.34	0.86*	0.35	0.98**	0.36

SE – standard error. Only covariates and variables that were significant across any of the three models are included in the table.
[a] Lower numbers are due to missing data.
* $p<.05$.
** $p<.01$.
*** $p<.001$.

support, active coping, emotional support, and self-distraction whether or not they received treatment. During the interviews, patients provided specific examples of how they used strategies to handle their depressive symptoms. Examples are presented below and summarized in Table 2.

3.2.1. Instrumental support

Several of the patients who engaged in some level of treatment following a positive depression screen noted that they followed the advice of a provider. Patients who engaged in guideline-concordant depression treatment indicated that a family member or friend advised them to seek treatment. One Veteran stated the following: "My adopted sister... she started getting scared because of the fact that I used to be all happy go lucky. One day she just looked at me... she says you're scaring me. You need to get some help now." He sought treatment thereafter, and engaged in guideline-concordant depression treatment.

3.2.2. Active coping

Patients reported active coping strategies including taking "one thing at a time" in order to gain mastery in tasks and exercising since "getting your heart rate up high releases more endorphins...that help make your body feel better." Exercise was also reported as a strategy that alone was sufficient for coping with symptoms of depression. For one patient, a morning walk was "a little form of therapy" for him: "*I live right near a state park, which is beautiful, a state park. And I'll go out at 6:30 in the morning because I love the morning smell to the air, the morning dew. It's just so pretty...I do a lot of thinking and I walk. And I just enjoy that.*" He opted not to engage in any mental health treatment following his positive depression screen.

3.2.3. Emotional support

Several patients interviewed shared that they received emotional support from a spouse/partner, family members, and friends. One patient stated, "*My wife was my big support because as bad as I got, she would put up with me and she would get me sitting down and say you gotta take a handle of this. You're gonna lose it, and she was right. And so I would sit down, me and her, and we'd get over it.*" For him, this emotional support was sufficient for dealing with his depressive symptoms.

Emotional support was also gained from pets. One patient who reported using several self-distraction techniques also shared that he found emotional comfort in his dogs: "*I have two dogs. Together they are a joy. They can bring me outta the deepest darkest mood you ever saw. They're just so much fun. I will sit and talk to 'em like I'm talking to you. You know I kinda treat 'em almost like they're human.*" Others, who also engaged in guideline-concordant depression treatment, shared the sentiment that their pets "keep them going."

3.2.4. Self-distraction

Self-distraction was a common technique reported by Veterans. Patients reported distracting themselves with walks, reading, watching TV, and thoughts of humorous things. For many, these activities were beneficial in helping them to manage their symptoms; however, some also engaged in depression treatment. One patient, who owns a restaurant, shared how distraction helps him: "*If I'm in the office working and you know you can feel it coming on you know. I got a thing now I just bounce out of the chair. Get my mind off the down side of things you know.*" He reported having long-standing depression and treatment has helped him to challenge problematic thoughts and "pinpoint the stressors".

Self-distraction can also be perceived as an effective coping strategy that replaces depression treatment. One patient, who did not engage in any treatment in the three months following his positive depression screen, said, "*Now I know enough about me and what I can do and what I can't do and when you get depressed, and the only way I could do it is through music. If you want to get yourself into a real tizzy, you can dwell on that. And I have to get myself out of it and it's through music...so, ah, but that's been my doctor.*"

3.2.5. Substance use

Although other forms of coping were not significant predictors of treatment engagement in the regression analyses, one patient reflected on his substance use as a method of coping. He shared the following: "*I think I'm getting to the point that I do have to [get treatment], cause I'm self-medicating, it's not helping...it's not going away. I thought maybe, you know, a few weeks I'll be okay. A few weeks, a few months went by and I'm still not.*" He reported significant isolation and indicated that emotional support from his children and self-distraction (e.g., watching TV) had been ineffective. He had not engaged in any mental health treatment following the positive depression screen.

4. Discussion and conclusion

4.1. Discussion

Quantitatively, a higher level of instrumental support (e.g., advice from others) was the strongest predictor of receiving any

mental health treatment and that patients with instrumental support were more likely to receive treatment for their depressive symptoms that was within VA guidelines. This highlights the importance of tangible support which is consistent with Dew and colleagues' finding that individuals with depression who received recommendations from friends or family members to seek help were more likely to utilize treatment [22]. Notably, having someone who provides help or advice was not frequently reported during the interviews. This may partially explain why half of the interview sample did not engage in guideline-concordant treatment.

The quantitative results suggested that Veterans who used more active coping strategies (e.g., making efforts to improve their depression) were more likely to receive some depression-related or other mental health treatment, even though it was not concordant with VA guidelines. Other than treatment engagement, other forms of active coping were not highly reported during the interviews. This may be due to the fact that engaging in treatment can be considered taking action to improve one's condition [35].

Emotional support and self-distraction had the opposite effect on treatment engagement based on the quantitative results. Veterans, who used more emotional support (e.g., understanding from others) or distraction, were less likely to engage in any mental health treatment. Having others provide comfort, support, and understanding can lead to improvements in mental health. Yet, both the quantitative and qualitative results suggest that some patients may gain this support from non-mental health providers (e.g., spouse, pets), and as a result, decide not to engage in treatment. It is possible that the emotional support received from others alleviates the depression enough to decide that professional treatment is not necessary.

Patients who tried to distract themselves from their depressive symptoms (e.g., using activities so that they think less about their depression) were less likely to engage in any mental health treatment. Self-distraction techniques (e.g., watching TV, cooking, reading) were reported by several patients during the interviews. For some, self-distraction was a helpful strategy in addition to treatment. For others, self-distraction, like emotional support, was perceived as therapeutic and sufficient in meeting their coping needs. Self-distraction is often defined as a temporary break from stressors or problems. For some Veterans, enjoyable activities such as listening to music are an important part of their depression management, not a short-term solution. This finding is consistent with cognitive-behavioral therapy, an evidence-based psychotherapy for depression that includes behavior activation to help patients to re-engage in pleasant activities. Taken together, it appears that the link between self-distraction and emotional support and depression treatment engagement may not be direct—the patient's perception of whether these techniques meet their needs may be an important factor to consider when discussing treatment options. This is consistent with the self-regulation model which asserts that an individual's evaluation of his/her coping impacts treatment engagement.

This study is not without limitations. First, we did not have diagnosis information about the study participants. It is possible that some of the Veterans who screened positive for depression did not meet criteria for a diagnosis of major depressive disorder and therefore would not be referred for treatment. In the VA, the integration of mental health treatment into primary care clinics provides an opportunity for Veterans to undergo a more-detailed assessment of depression following a positive screen to ensure diagnoses and development of an appropriate treatment plan [36]. Second, nearly 44% of the current sample did not receive any mental health treatment within three months of screening positive for depression. At six months post-screening, the treatment engagement rate was similar. However, it is possible that waiting longer to determine treatment engagement, more Veterans would have initiated treatment given that individuals with depression can wait an average of 8 years before seeking treatment [6]. Lastly, the sample was mostly male and mostly White. A more diverse sample may have yielded different results. For instance, there is evidence that women are more likely to engage in mental health treatment than men [4]. There is some evidence that African Americans use religion to cope with depressive symptoms [37]. Despite these limitations, these study findings can assist primary care providers in understanding the coping strategies that their patients may use to manage their depression.

4.2. Conclusion

Given the current findings, providers should encourage their patients who screen positive for depression to seek instrumental support (e.g., advice, information) as this can boost their engagement in depression treatment that may be indicated. Primary care providers are also encouraged to engage their patients in a discussion about which coping strategies their patients are using and the purpose they serve (e.g., using music as their "doctor" or going for walks to temporarily relieve symptoms). For patients who report using emotional support and self-distraction strategies, it will be important for providers to discuss with patients their perceptions of the benefits of these strategies and whether engaging in treatment will improve these benefits. Furthermore, providers should inquire about other strategies (e.g., substance abuse) that may impact treatment engagement.

4.3. Practice implications

With many patients delaying treatment for months and years, individualized assessments are necessary to gain an in-depth understanding about the ways in which patients cope with their depressive symptoms and whether these coping strategies are sufficiently addressing their symptoms or whether additional services such as depression treatment are indicated. VA primary care clinics operate in teams that include nurse care managers and/or behavioral health providers who have been trained to address mental health concerns such as depression. They can facilitate these important discussions with patients which can uncover coping strategies that are adequately addressing their symptoms, or leading to delays in appropriate treatment. Policymakers may be consider implementing guidelines for conducting individualized assessments of coping strategies as a way to reduce delays in treatment engagement.

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