A study has demonstrated that collaborative care for people with depression, provided by a multiprofessional team in GP practices, offers improved outcomes in comparison with usual treatment.

The case for collaboration in primary care for depression

In this article...

- Results of a study exploring the clinical effectiveness of a collaborative care intervention for people with depression in primary care
- Expert commentary on the implications of this evidence for health professionals

The term “collaborative care” encompasses complex interventions that incorporate a multiprofessional approach to patient care; a structured management plan; scheduled follow-ups; and enhanced communication between health professionals. Evidence suggests collaborative care is more effective than usual care at improving depression and anxiety outcomes (Archer et al, 2012).

Current advice

National Institute for Health and Care Excellence guidance suggests that collaborative care could be provided for adults with moderate-to-severe depression, and a long-term physical health problem and associated functional impairment, whose depression has not responded to initial high-intensity psychological interventions, pharmacological treatment, or a combination of psychological and pharmacological interventions.

The interventions require a coordinated approach to mental and physical healthcare, and a dedicated coordinator, who is part of a multiprofessional team. The plan of care, long-term coordination and follow-up should be jointly determined.

New evidence

Richards et al (2013) conducted a cluster randomised controlled trial to test the clinical effectiveness of a collaborative care intervention in primary care. Adults with moderate-to-severe depression were identified from GP records in England. Practices were then randomly assigned to provide these people with collaborative care or usual care.

Collaborative care consisted of drug management, behavioural activation (a form of cognitive behavioural therapy), symptom assessment and enhanced communication between health professionals, as well as usual care. Care managers conducted between six and 12 face-to-face and telephone contacts over 14 weeks.

Usual care was the GPs’ standard clinical practice for people with depression, including prescription of antidepressants and referral for other treatments.

A total of 51 practices recruited 581 participants, 505 (87%) of whom were followed up at four months and 498 (86%) at 12 months. More than half (56%) had moderately severe depression, 30% had severe depression and 14% had mild depression; 73% were women. Almost two-thirds (64%) also had a longstanding physical illness, and 83% were taking antidepressants.

At four months, participants in the collaborative care group (n=276) were less severely depressed than those in the usual group (n=305). This difference was maintained at 12-month follow-up. Collaborative care had little long-term effect on symptoms of anxiety and quality of life, although people in the collaborative care group were more satisfied with their treatment than were those receiving usual care.

Among the limitations of the study were the method of cluster randomisation was not clearly described and the nature of the intervention did not allow for blinding of GPs, participants and care managers.

Adapted from NICE bulletin Eyes on Evidence (May 2014); tinyurl.com/EoE-NICE. Reproduced with permission. Study sponsorship: UK Medical Research Council

Helen Jaques is a medical writer in Evidence Information Services, National Institute for Health and Care Excellence

References


BOX 1. COMMENTARY

This study demonstrates that collaborative care for depression offers significant improvements in outcomes over usual practice. The authors carefully adapted a US model, recruiting existing primary care mental health workers with minimal training as care managers. These health professionals continued working in their usual NHS role after five days’ training and were supervised weekly by mental health specialists.

The authors suggest their protocol could be integrated into the Improving Access to Psychological Therapies (IAPT) services already established throughout the UK. However, implementation through IAPT would require considerable expansion of current provision. Only around 6% of people who could benefit are currently referred to these services and, of those, only around 50% receive treatment (the others do not engage or are given advice only).

Depression is so common in primary care that IAPT staff could accommodate only a fraction of patients, even assuming they are willing to be referred.

Tony Kendrick, professor of primary care, University of Southampton

www.nursingtimes.net / Vol 110 No 50 / Nursing Times 10.12.14 23