Collaborative care for depression

A cluster randomised controlled trial in English general practices suggests that collaborative care delivered by mental health workers acting as care managers is more effective at reducing depression than usual care.

**Overview:** Depression is characterised by persistent low mood, loss of pleasure in most activities, and a range of associated emotional, cognitive, physical and behavioural symptoms. Nearly 1 in 5 (19%) adults in the UK experience symptoms of anxiety or depression, with the prevalence higher in women (21%) than in men (16%, Office for National Statistics 2013). Depression is the third most common reason for consultation in general practice in the UK, and is projected to become one of the 3 leading causes of global burden of disease by 2030 (Mathers and Loncar 2006).

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

See the NICE Evidence Services topic page on depression for a general overview of this condition.

**Current advice:** NICE guidance on depression in adults with a chronic physical health problem suggests that collaborative care could be provided to people with moderate to severe depression and a chronic physical health problem with 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, which involve all sectors of care, require a coordinated approach to mental and physical healthcare, as well as a dedicated coordinator of the intervention located in and receiving support from a multi-professional team, joint determination of the plan of care, and long-term coordination and follow-up. Collaborative care for people with depression and a chronic physical health problem should normally include:

- case management that is supervised and has support from a senior mental health professional
- close collaboration between primary and secondary physical health services and specialist mental health services
- a range of interventions consistent with those recommended in this guideline, including patient education, psychological and pharmacological interventions, and medication management
- long-term coordination of care and follow-up.

The NICE Pathway on depression brings together all related NICE guidance and associated products on the condition in a set of interactive topic-based diagrams.
New evidence: Richards et al. (2013) conducted a cluster randomised controlled trial to test the clinical effectiveness of a collaborative care intervention for people with depression in primary care. Adults with moderate to severe depression were identified from the electronic records of general practices in Bristol, London and Greater Manchester. 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 brief cognitive behavioural therapy), symptom assessment and enhanced communication between health professionals, as well as usual care. Collaborative care was provided by care managers at 6–12 face-to-face and telephone contacts with participants over 14 weeks. Usual care was the GPs’ standard clinical practice for people with depression, including treatment with antidepressants and referral for other treatments.

A total of 51 practices recruited 581 participants, 505 (87%) of whom were followed up at 4 months and 498 (86%) at 12 months. More than half (56%) of participants had moderately severe depression, 30% had severe depression and 14% had mild depression; 73% were women. Almost two-thirds (64%) of people also had a longstanding physical illness (for example, diabetes, asthma or heart disease). At baseline, 83% of participants were taking antidepressants.

At 4 months, participants in the collaborative care group were less severely depressed than those in the usual care group (adjusted difference in mean depression score on ‘Patient Health Questionnaire 9’=-1.33 points, 95% CI −2.31 to −0.35 points, p=0.009). This difference between groups was maintained at 12-month follow-up (adjusted difference=−1.36 points, 95% CI −2.64 to −0.07 points, p=0.04). 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 (p<0.001).

Limitations of the study included that the method of cluster randomisation was not clearly described and the nature of the intervention meant that blinding of GPs, participants and care managers was not possible. Additionally, the use of behavioural activation as the psychological therapy may have reduced the effectiveness of the collaborative care intervention because therapy seems to be of a lower intensity than recommended in guidance.

Commentary: “This study demonstrates that collaborative care for depression, developed in the USA, offers significant improvements in outcomes over usual practice in the UK. The authors carefully adapted the US model, recruiting existing primary care mental health workers with minimal training as care managers. These healthcare professionals continued working in their usual NHS role after 5 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.

“Assuming collaborative care is cost effective (which the authors have yet to report), referral criteria need to be developed to target treatment to those most likely to benefit. Feasible ways to improve usual care by GPs, practice nurses and primary care mental health workers will still be needed for the large majority of people with depression.” – Professor Tony Kendrick, Professor of Primary Care, University of Southampton

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