Collaborative care for depression

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Abstract

Depression can be a chronic and relapsing condition. Most people with depression are managed in primary care, based around a model of 'stepped care', which recommends interventions depending on severity of symptoms. Collaborative care (CC) is a model of care originating from the United States, which has an increasing evidence-base for effectiveness and acceptability in the UK. CC includes a multi-professional approach to patient care delivered by a GP and at least one other health professional. A structured patient management plan that facilitates delivery of evidence-based interventions, scheduled and pro-active patient follow-ups, either face-to-face or by remote communication and enhanced inter-professional communication between team members who share responsibility for the care of the patient.

Background

Depression is often a long-term and relapsing condition: it is likely to become the second largest cause of global disability by 2020 (1). The responsibility for management in 90 - 95% of patients rests with primary care (2).

The management of depression in primary care in England is based around the 'stepped-care model' (3). The principle of this model is that the intervention offered should be the least intrusive and most appropriate to the level of severity (see Box 1). The stepped-care model is useful in guiding response to different levels of severity of symptoms.

Box 1: Stepped care for depression

Focus of the intervention	*Nature of the intervention*
STEP 4: Severe and complex depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care
STEP 3: Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, **collaborative care** and referral for further assessment and interventions
STEP 2: Persistent sub-threshold depressive symptoms; mild to moderate depression	Low-intensity psychological and psychosocial interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

The NICE guideline recommends that the model of CC should be available at 'step 3', offering a framework for the management of people with persistent sub-threshold depression and comorbid depression in people with long term conditions (LTCs).

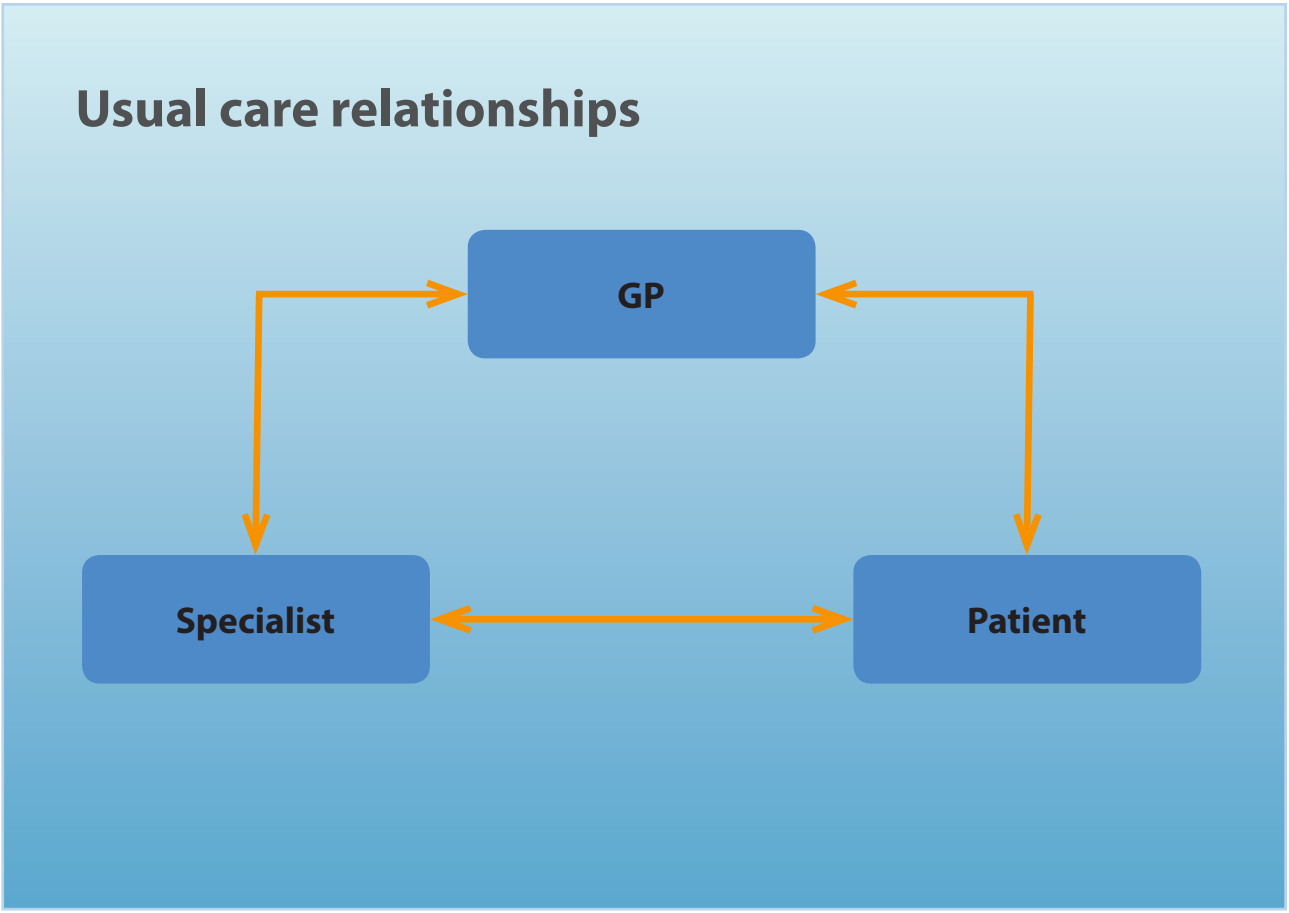
Collaborative care

Over 90% of people with depression are managed in primary care (2) but the organisation of care in this setting is not optimal for managing depression, with barriers between generalist and specialist professionals in mental health, poor patient adherence to pharmacological treatment (4) and limited specialist support for patients (5). Evidence is developing for the role of organisational interventions in improving the management of a range of chronic conditions. Their application to the management of depression includes "collaborative care", a complex intervention developed in the United States incorporating a multiprofessional approach to patient care; a structured management plan; scheduled patient follow-ups; and enhanced interprofessional communication (6).

Box 2: Collaborative care framework (6)

- A multi-professional approach to patient care delivered by a GP and at least one other health professional (e.g. a nurse, psychologist, psychiatrist, or pharmacist).
- A structured patient management plan that facilitates delivery of evidence-based interventions (either phamacological or 'talking treatments').
- Scheduled and pro-active patient follow-ups, either face-to-face or by remote communication (e.g. telephone).
- Enhanced inter-professional communication between team members who share responsibility for the care of the patient (e.g. team meetings, case conferences, supervision).

Figure 1: Comparison of usual care and collaborative care models



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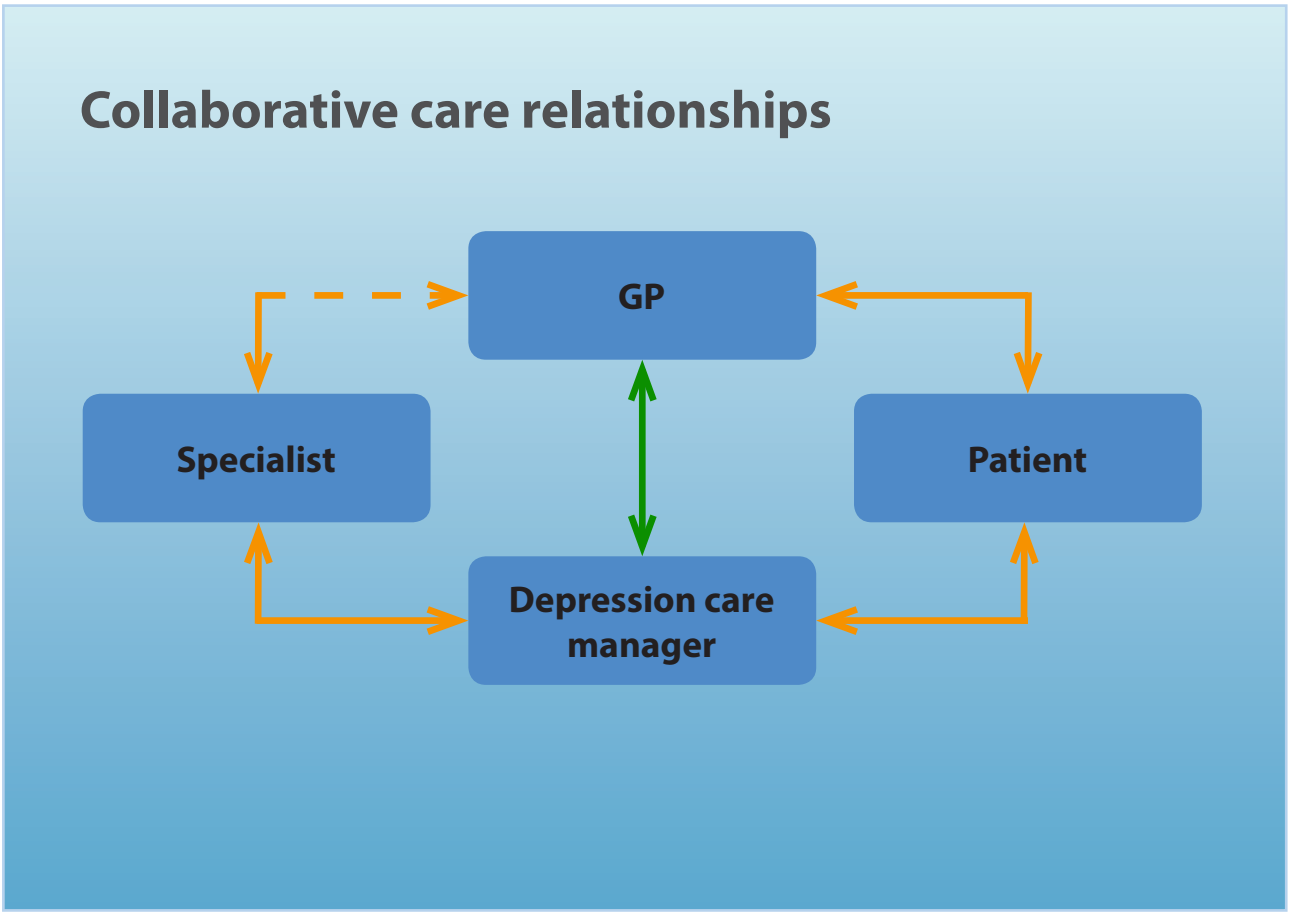

CC has been shown to improve depression in people who have depression co-occurring with other long term conditions, but most studies have been conducted in the United States, have recruited highly-selected groups of patients without multiple morbidity, and have used elite academic teams to deliver and supervise interventions. There is emerging evidence that CC can translate to non-US settings, but there is uncertainty about whether these benefits are realisable in more routine settings and among patients with multiple morbidity. The CADET study (7) in the UK showed that CC had persistent positive effects up to 12 months after initiation of the intervention and was preferred by patients over 'usual care'. The study team suggested that the CADET CC intervention resulted in a slightly higher recovery rate than that reported by the UK Improving Access to Psychological Therapies (IAPT) programme, which has been described in a Nature editorial as a "world-beating standard" (8). Recovery rates of about 45% have been achieved in IAPT after an investment of £700m (€812m; $1085m) over six years (9). Integration of our CADET protocol into IAPT services might enhance outcomes for patients receiving treatment for depression.

The COINCIDE trial (10) added to the evidence base for CC in the UK, showing that a model of CC that integrates a brief 'low intensity' psychological treatment within primary care can reduce depression and improve self-management in the short term in people with multimorbidity. Compared with previous CC trials, COINCIDE tested a broader range of psychological treatments (including behavioural activation, cognitive restructuring, graded exposure, and lifestyle approaches) and they were tailored to meet the needs of patients with long-term conditions, thus enhancing the integration of physical and mental healthcare.

The COINCIDE trial also demonstrated that mental health practitioners and practice nurses with limited training in, and experience of, CC can be trained to deliver high-quality and patient-centred integrated healthcare for people with mental and physical multimorbidity. The benefits of CC extended beyond reductions in depressive and anxiety symptoms, with patients rating themselves as better self-managers. Self-management is increasingly seen as critical to the delivery of effective and efficient care for long-term conditions, but achieving effective self-management is a considerable challenge in patients with multimorbidity.

Knowles et al. (11), in relation to a nested qualitative study within the COINCIDE trial, reported that whilst

service level integration was achieved, therapeutic integration was not. Patients preferred a protected space to discuss mental health issues, and professionals maintained barriers around physical and mental health expertise. Findings therefore suggest that in the context of mental-physical multimorbidity, CC can facilitate access to depression care in ways that overcome stigma and enhance the confidence of multidisciplinary health teams to work together. However, such care models need to be flexible and patient-centred to accommodate the needs and preferences of patients who perceive that their depression is independent of their long-term condition.

Implications for policy and practice

The COINCIDE trial offers a template for how integrated CC can potentially be implemented within the context of routine chronic disease management with only minimal changes to the organization of primary care (12), and offers guidance to international mental health services that this model can be applicable outside the US. As with any new care model that is introduced, CC needs to be flexible and patient-centred to accommodate the needs, preferences and beliefs of patients.

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