

DOES SHARED CARE HELP IN THE TREATMENT OF DEPRESSION?

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SUMMARY

Introduction: Shared or Collaborative Care in the treatment of Depression is an evidence based intervention which has been shown to be more effective than ordinary general Practitioner care in the treatment of Depression, however, it is not yet Government policy in the United Kingdom. We aimed to bring together in one place all the studies which have been carried out, up till mid 2009, in order to demonstrate the evidence that shared collaborative care has important advantages in terms both of depression outcomes and cost benefits, in order to argue for the adoption of this approach in the United Kingdom and n Europe.

Methods: We carried out a literature search using PUBMED in order to identify and describe all trials, systematic reviews and Metanalyses which have been carried out on shared care until mid 2009. We also described a shared care service for depression which some of us had been involved in developing and working in in Luton in the late 1990's. We have excluded papers which describe trials which have not yet been carried out, and instead focussed on the trials which have reported.

Results: It has been demonstrated in numerous recent studies that shared care in the treatment of depression, which includes the training of General Practitioners in the treatment of depression, and the provision in Primary Care of a Nurse specialist or another professional who will impart psycho-education, ensure concordance with medication, and may provide psychotherapy, leads to both improved treatment outcomes and increased doctor and patient satisfaction, as well providing some cost-benefits, despite somewhat increased immediate costs. This is the case in both adult and adolescent patients, while in the case of diabetic patients depression is improved, despite the lack of improvement in glycaemic control. The shared care intervention continues to be useful in the case of patients with resistant depressive symptoms, though a longer input will be necessary in such cases. Patients with subthreshold depression will not benefit as much, and patients expressed more satisfaction when psychological interventions were offered. It is also the case that collaborative or shared care is effective in treating depression in the elderly. This is shown by studies which include older patients who also suffer from multiple health conditions, arthritis, diabetes, anxiety and PTSD, the poorer, those with suicidal ideation, and also in Ethnic Minorities.

Discussion: The results described above are mostly based on studies carried out in the USA, but similar studies have been reported from the United Kingdom, and are consistent with the experience of the service in Luton which we describe. From these results it would seem important that shared, collaborative care, with primary and secondary care doctors (General Practitioners and Psychiatrists) working as part of a single team, with the help of mental health practitioners attached to primary care, but with easy access to secondary care is a productive way of optimising the treatment of depression. In the UK, however, it has not yet been possible to develop such a service for the whole population. This is because in the UK, General Practice is managed by Primary Care Trusts, while Secondary Care, including Psychiatry, is managed by Mental Health Trusts. This has led the National Institute of Health and Clinical Excellence, and indeed local commissioners of care to focus on a Stepped Model for the treatment of depression, with one key issue being access (or referral) to secondary care, and discharge back to primary care, with a group of Mental Health workers focussing on the facilitation (or gate-keeping) of these processes, rather than focussing on actually optimising outcomes of care.

Conclusion: The Evidence argues for the development of collaborative care between primary and secondary care for the treatment of Depression. This will require common medication guidelines across both Primary and Secondary Care, easy access so that General Practitioners can receive advice from Psychiatrists about patients, and the use of Mental Health Professionals to provide patients with psycho-education, support of concordance with treatment, and psychotherapy. It may be that, in order for this to be achieved, services may need to be re-structured, to allow easy communication between professionals.

Key words: Collaborative Care – depression - management of services – psychotherapy - anti-depressants - medication compliance

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Introduction

Shared or collaborative care in depression has been shown to be more effective than treatment as usual in treating depression in Primary care (Boardman 2009, Gilbody 2006, Richards 2008, Bower 2006, Gilbody 2008). Shared Care involves (a) a multi-professional approach to patient care involving GP, mental health specialists, and a case manager (a professional providing regular contacts with the patient and psychosocial support); (b) a structured patient management plan with both brief psychological therapy and medication management where appropriate; and (c) scheduled patient

follow-ups and systematic routine data collection to inform supervision and decision making about treatment plans. This provides an integrated coherent model of care, which is necessary to optimise the effectiveness of case-finding.

Methods

We carried out a literature search using PUBMED in order to identify and describe all trials, systematic reviews and Metanalyses which have been carried out on shared care until mid 2009.

Results

The benefits of the cohesive collaborative shared care approach suggests that the way in which treatment is delivered is as important as the treatment itself (Boardman 2009).

We first developed a shared care system for depression in Luton in the first year of the National Service Framework. It was based on a theoretical paper which had been written and presented at the conclusion of the first Luton Mental Health Conference that year (Agius 1999, Agius 2000, Agius 2003).

This was part of a Beacon Project for improving primary care psychiatry. In it my premise had been that Community Psychiatric nurses could be deployed so as to be part of both the primary (GP) and secondary care teams, and attend the meetings of both. Thus they could give advice to primary care and carry messages between primary and secondary care. This would lead to Consultants, through their Community Psychiatric Nurses, giving advice to GPs about the next steps to take in the management of difficult patients, thus reducing the number of referrals. The idea was a re-elaboration of the idea of a consultation-liason service, where Consultants might visit GP surgeries over lunch and discuss problem patients with the GPs. It was felt that consultants would not have the time to do this, but that Community Psychiatric Nurses (CMHNs), being greater in number and part of the Consultant's Community Mental Health Team, would have the time. It was also supposed that these CMHNs would be able to liaise with Health Visitors and Midwives regarding Postnatal Depression, with District and Practice Nurses regarding Depression, and with Practice Nurses regarding the delivery of Depot Medication. This model was later published as a book chapter.

The outcome of this work was the development of a team of 6 staff, 5 nurses and a social worker, who were very experienced personnel. (Drinkwater 2003) They were deployed to the individual GP Practices in Luton. They were also attached to the four Luton CMHTs, and attended the team meetings, so that they had direct access to the consultant staff. In the practice they saw all patients referred to them by the GPs, with mental health problems, mostly, but not exclusively depression. They were trained to case manage patients and also to offer them Cognitive Behaviour Therapy and Medication Management and psycho-education where necessary. In the practice, they functioned semi-autonomously, running their own clinics, often in their own rooms. They brought to the secondary care CMHTs problems which arose for themselves or the GPs, and received advice from the consultants and the rest of the CMHT, which they then transmitted to primary care. This service was funded from Health Action Zone Money, and continued for some years after the Health Action Zone was wound up, however, it was eventually closed by Commissioners in Luton as a Cost Saving Measure. An evaluation by the University of Luton

(Now Bedfordshire) showed that this form of care was considered acceptable by both the GPs and the Patients (Drinkwater 2003). Both GPs and service users demonstrated high levels of satisfaction with several aspects of this service. Thus, 87% of General Practitioners agreed that the presence of the Case Managers reduced the need for referral to mental health services and also the need to prescribe anti-depressants or to refer to counselling services. Patients were equally appreciative of the service, and 86% of those who responded to the questionnaires stated that the psycho-education which they received was useful and that the help which they received from the case managers had enabled them to solve their problems (Drinkwater 2003). However, evaluation of the service did not demonstrate, nor did it attempt to demonstrate, that there was an improvement in the actual relapse and remission rate of depression in the patients treated by the service. Also, the evaluation did not demonstrate, nor was it designed to demonstrate, that there was an improvement in rational prescription of antidepressants and effective delivery and compliance with therapy, be it psychological or pharmacological, during the time that the project was in existence. Thus it is not possible to demonstrate from the available data on the Luton project, which of the elements of a collaborative or shared care model for the treatment of depression are most important in improving the treatment of depression.

It has also been reported that the case managers involved in the Luton Project were very well able to identify early psychotic symptoms when these existed, and were able to arrange an assessment of such symptoms by the then existing early intervention service within 48 hours. The nurses always made appropriate referrals when they identified a patient as in fact having psychotic symptoms (Agius 2007).

The project described in Luton can be argued to be analogous to the system described from Seattle (Katon 2004, Katon 1995), and from Manchester (Chew-Graham 2007) and York (Richards 2008), in that the main elements of the intervention consisted of easy access for the primary care team, particularly the General Practitioner, to support from the secondary care team, including the psychiatrist, and case management, psychoeducation, some brief cognitive interventions, and monitoring of Medication compliance by a case manager based in primary care.

Shared care between primary care and psychiatry had been widely discussed in the literature. Most papers look favourably on using this method. Tylee and Haddad (2007) reviewed current trends in primary care management of mental disorders and concluded they should be treated in the same way as chronic medical problems, with the same management strategies, as for example, used in Diabetes Mellitus.

Shared care has been a topical issue for many years and has been trialled and used in the UK for the last 10 years. Craven and Bland (2006) analysed how often collaborative practices were used in mental health care.

They found that this practice is increasing. Katon et al. (1996, 2001) showed that collaborative care between psychiatrists and primary care doctors resulted in a sustained improvement in antidepressant adherence. A systematic review of primary care interventions to improve antidepressants adherence concluded that collaborative care increased adherence and improved clinical outcomes (Vergouwen et al. 2003). Lin et al. (2000) highlighted the fact that the treatment of depressed patients with an on call psychiatrist collaborating with a primary care physician made improvements in functional outcome. A Meta analysis of collaborative care has shown that this is more effective than normal practice in improving depression outcomes in the short and long terms (Gilbody et al. 2006). It does increase cost but has been shown to be cost effective when used for patients with major depression (Von Korff et al. 1998).

Studies focusing on shared care between GPs, psychologists and nurse specialists have also found improvements in outcomes. King et al. (2002) found that the benefit of brief psychotherapy compared to usual general practitioner care was beneficial in the management of depression at 4 months. However, this difference was not seen at 12 months and both groups assigned to psychotherapy or usual GP care had improvement on the Beck Depression Inventory. Wells et al. (2000) looked at quality improvement (QI) programs for the management of depression in primary care. QI programs consisted of, for example, training local experts, nurse specialists and patient education. Mental health outcomes improved for patients managed in a primary care practices that implanted the QI programs. Vines et al. (2004) investigated a collaborative approach between primary care teams and clinical psychologists. The collaborative approach improved scores in DASS and GHQ scales

The shared care approach has been proven to be effective in improving the care of elderly patients with depression. Collaborative programs, such as IMPACT, have cost effectiveness and have improved outcomes for elderly patients (Katon et al. 2005). Levine et al. (2005) reported that primary care physicians were satisfied that the collaborative approach of IMPACT was useful in treating older people with depression. The IMPACT collaborative care approach has also been found to be useful in elderly adults with low incomes (Araon et al. 2007) and elderly adults with or without medical co morbidities (Harpole et al. 2005). A study that looked at usual treatment of depression in the elderly, in a primary care setting compared to an intervention involving a psychiatric nurse lead self help group, found that the intervention was more beneficial than usual care. Patients in the intervention group were less likely to suffer from depression at follow up (Chew-Graham et al. 2007). The collaborative approach has been shown to reduce suicidal ideation and the potential risk of suicide in the older population in a study which assessed suicidal ideation in 1800 adults over the age of 60 (Unutzer et al. 2006).

Shared care had been shown to be effective, not only in depression, but in other psychiatric disorders. Callahan et al. (2006) showed that collaborative care, in the form of care given by an interdisciplinary team led by an advance practice nurse, improved quality of care in patients with Alzheimers disease. Likewise, Vickrey et al. (2006) showed that guideline-based dementia care improved outcomes for these patients. This is important as the treatment of dementia is complex and patient and carer satisfaction can be low. Improving outcomes in patients with dementia is a government key issue at present. Similarly, Rollman et al. (2005) showed that a telephone based collaborative approach was also effective in the treatment of panic and generalised anxiety disorder in primary care. Psychological and behavioural symptoms were reduced.

Discussion

The results described above are mostly based on studies carried out in the USA, but similar studies have been reported from the United Kingdom, and are consistent with the experience of the service in Luton which we describe. From these results it would seem important that shared, collaborative care, with primary and secondary care doctors (General Practitioners and Psychiatrists) working as part of a single team, with the help of mental health practitioners attached to primary care, but with easy access to secondary care is a productive way of optimising the treatment of depression. In the UK, however, it has not yet been possible to develop such a service for the whole population. This is because, unlike in the case of Health Maintenance Organisations in the USA, where Primary and Secondary care are managed together, in the UK, General Practice is managed by Primary Care Trusts, while Secondary Care, including Psychiatry, is managed by Mental Health Trusts,. This has led the National Institute of Health and Clinical Excellence, and indeed local commissioners of care to focus on a Stepped Model for the treatment of depression, with one key issue being access (or referral) to secondary care, and discharge back to primary care, with a group of Mental Health workers focussing on the facilitation (or gate-keeping) of these processes, rather than focussing on actually optimising outcomes of care.

Conclusion

In conclusion, shared care had been shown to be effective in depression in the working age population and in the elderly population and in dementia care and anxiety disorders. It improves concordance with treatment and reduces psychological and behavioural symptoms. It has been shown to reduce the risk of suicide. Our own finding in Luton reciprocates this. It has been shown to be cost effective in the treatment of major depression. It is therefore important that this approach is adopted throughout the UK to improve patient care.

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