

DIFFERENCES BETWEEN TRAINING GPs TO MANAGE DEPRESSION IN PRIMARY CARE AND ISSUING THEM WITH GUIDELINES, AND A SYSTEM OF COLLABORATIVE CARE IN THE TREATMENT OF DEPRESSION BETWEEN PRIMARY AND SECONDARY CARE

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SUMMARY

Here we describe the differences and similarities between training General Practitioners (GPs) to manage depression in primary care and issuing them with guidelines, and a system of Collaborative care in the treatment of depression between primary and secondary care.

From these we deduce the reasons why collaborative care may offer better treatment outcomes than the issuing of guidelines to GPs.

Key words: Collaborative care - treatment guidelines - depression

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INTRODUCTION

Depression is a very common condition in Primary Care. It is reported that there is a 14.9% lifetime prevalence of Major Depressive Disorder in the U.S. (Kessler 1996).

As a consequence, much work has been done to attempt to improve the treatment of depression in primary care.

There is an ongoing perception that General Practitioners may under-diagnose and under-treat depression (Goldberg 1987, Donoghue 1996). A number of different initiatives have been devised in order to improve treatment of depression in primary care.

An initial development has been teaching programmes, in which GPs attended a series of lectures on the treatment of depression. Subsequently proxy measures, such as the reduction of suicide rates were measured. This public health approach is typified by the Gotland Project (Rutz 1990, Rutz 1992) and similar projects in Germany (Hegerl 2006), Sweden (Henriksson 2006) and Hungary (Szanto 2007), and indeed it has here been shown that suicide rates are reduced in the areas where the training courses were carried out, and for some years later. In the UK, Tylee developed a system for working with individual general practices, working on the basis of developing the capacity of practices to deal with mental health problems through the process of adult learning applied to the whole practice team (Tylee 1999, Turton 1995, Singleton 1996, Kerwick 1997). Our own team has in the past applied a combination of both such approaches to general practices in Luton and Bedfordshire (Agius 2000).

However neither of these approaches has demonstrated any improvement in the outcome of the treatment of depression, in terms of improving response to treatment and achieving better remission rates.

AIM

In order to achieve such improvement in response to treatment and better remission rates, two parallel approaches have been devised. First, developing guidelines for GPs and their teams and accompanying these by a training programme to implement the guidelines. Second, collaborative care between primary and secondary care teams in order to achieve these goals. The aim of this paper is to point out the similarities and differences between these two approaches.

METHOD

The differences and similarities between the two approaches will be illustrated by referral to the descriptions of these two methods as outlined in the papers in which these two methods were first proposed and trialled.

RESULTS

The method of developing guidelines for GPs and their teams as well as accompanying these by a training programme to implement the guidelines, is archetypally described in the Hampshire Depression Project. In this project, a guideline was developed which included

advice on practice organization, the role of non-medical professionals, and other general and local information. Evidence-based primary care data was highlighted, and secondary care-based evidence and consensus guidelines were also used in the guideline development. Tricyclic antidepressants, with a target dose of 150mg were regarded as first line, with advice to change to a more tolerable dose when necessary. The education team consisted of a GP, a practice nurse, and a community mental health nurse. Seminars were given in groups of 20, at the beginning of the project, and all members of the community health team were invited to attend. Each practice received four hours of seminars, and sometimes several practices were educated together. Teaching was supplemented with videotapes to illustrate assessment and counseling skills, small group discussion of cases, and role play as necessary (Thompson 2000). The educators remained available to the practice teams for nine months after the seminars to give further help and information, facilitate implementation of the guideline and promote teamwork.

In contrast, shared collaborative care involves a multi-professional approach to patient care involving a GP, mental health specialists, and a case manager (a professional providing regular contacts with the patient and psychosocial support). In addition, a structured patient management plan including brief psychological therapy, medication management, scheduled patient follow-ups is created. This allows for 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. 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 et al. 2009). In the first descriptions by Katon (Katon 1995), the intervention was described as follows; ‘Intervention patients received increased intensity and frequency of visits over the first 4 to 6 weeks of treatment (visits 1 and 3 with a primary care physician, visits 2 and 4 with a psychiatrist) and continued surveillance of adherence to medication regimens during the continuation and maintenance phases of treatment. Patient education in these visits was supplemented by videotaped and written materials (Katon 1995). While all collaborative care studies have involved patients to whom antidepressant medication has been prescribed, there originally were two models of collaborative care. In the first, patients were co-managed by a GP and a psychiatrist with experience in providing services in primary care (Von Korff 1998). The patients receiving Collaborative Care were given a 20-minute videotape of depression management as well as two booklets on the use of antidepressant medications and on cognitive-behavioural techniques for depression management. The patients were visited alternately by the GP and the

psychiatrist, over a 4- to 6-week period, with visits spaced 7 to 10 days apart (Von Korff 1998). The two psychiatric visits occurred in the primary care clinic. The two primary care visits focused on the management of depression. If needed, Collaborative Care patients received a third or a fourth psychiatric visit. The psychiatrist educated the patient about the use of antidepressant medications and managing side effects (Von Korff 1998). If severe side effects or treatment resistance were encountered, the psychiatrist and the GP worked with the patient to change the patient to a medication regimen which reduced side effects or enhanced efficacy (Von Korff 1998). The psychiatrist used automated pharmacy data to continue to monitor patient adherence to the medication regimen, and notified the general practitioner if there appeared to be poor compliance with medication (Von Korff 1998).

In the second model, patients were co-managed by the GP, and a psychologist, who provided a brief (four to six sessions) cognitive-behavioral therapy program and counselling to improve medication adherence (Von Korff 1998). The psychologists consulted regularly with a psychiatrist regarding medication management and provided feedback about medications to the patient and the general Practitioner (Von Korff 1998). Brief psychotherapy in the primary care setting was based on a treatment manual developed specifically for the purpose. Psychotherapy included both teaching cognitive-behavioural skills to manage depression and counselling to improve medication adherence (Von Korff 1998). The total treatment time ranged from 2.5 to 3.5 hours. This was provided as in a 1-hour initial evaluation/planning meeting and three to five subsequent half-hour visits (Von Korff 1998). The psychologists also carried out telephone contact with study patients 2, 4, 12, and 24 weeks after the direct contact phase of treatment was complete. This brief psychotherapy model was solution-focused and multimodal (Von Korff 1998). Thus, in both models, a psychiatrist was involved, but in the second model, it was through the medium of the psychologist, who also took on the role of a case manager. The Collaborative Care programmes thus included physician training, patient education, and reorganization of services, including on-site mental health staff who were available to co-manage depressed patients with their GPs, including monitoring of medication adherence. (Lin 1999)

DISCUSSION

From the above descriptions of ‘training and guideline provision’ and ‘collaborative care, it is clear that there are major differences between the two systems.

In ‘training and guideline provision’, guidelines are provided from outside of the practice, and a training

team gives an educational input to the General Practice team. The training team is entirely primary care staff, possibly with the exception of the community psychiatric nurse. Secondary care is not involved in any way. The Training team are only available for a subsequent nine months to act as facilitators. It is unclear, although they were involved in the training, what the role of staff other than GPs is in depression treatment. The medication prescribed is specified as tricyclics, with modification of treatment to medication with less side effects if necessary. There is no possibility of the provision of other medication options such as augmentation of antidepressants if necessary, because secondary care is not involved in the system.

In 'Collaborative Care', there is a restructuring of services so that secondary care is involved in an ongoing way. This means that primary and secondary care are able to work together to common protocols. Either GPs work in tandem with consultant psychiatrists, seeing patients on alternate visits, or they work with psychologists who report to the psychiatrists and function as case managers who monitor medication concordance. In both models of collaborative care, psychological interventions of a cognitive behavioural type are provided to the patients as well as psycho-education. There is the possibility of more complex pharmacological interventions, including possibly augmentation strategies for resistant depression to be provided within the system because the GPs are working in direct collaboration with the psychiatrists.

CONCLUSION

The developing of guidelines for GPs and their teams and accompanying these by a training programme as described in the Hampshire Depression Project was well received by the General Practice teams, who expected that their treatment of depression would improve. However, outcomes of depression treatment at six weeks (response) and six months (remission) did not improve (Thompson 2000).

In the collaborative care studies, 74% of intervention patients with major depression showed 50% or more improvement on the Symptom Checklist-90 Depressive Symptom Scale compared with 43.8% of controls ($P < 0.01$), and the intervention patients also demonstrated a significantly greater decrease in depression severity over time compared with controls ($P < 0.004$). This was not the case with patients who only suffered minor depression, suggesting that collaborative care is more effective in major than in minor depression. Indeed, all collaborative care patients expressed great satisfaction with the treatments received (Katon 1995, Katon 1996, Von Korff 1998, Lin 1999).

In other studies, the distribution of guidelines to GPs does not appear to have improved treatment of depression (Upton 1990, Croudace 2003).

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