EDITORIAL

Is collaborative care best for depression in chronic disease?

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COLLABORATIVE CARE IMPROVES DEPRESSION OUTCOMES AND CHRONIC DISEASE CONTROL IN patients with depression and poorly controlled diabetes and/or CHD, an American primary care study has found.[1] Moreover, patients had a better quality of life and were more satisfied with their care.

Poor control was defined as BP persistently above 140/90 mmHg, an LDL cholesterol >3.4 mmol/L or a glycated haemoglobin (HbA_{1c}) level ≥ 8.5%. Nearly 10,000 eligible patients were sent a PHQ-2 questionnaire and those with a positive screen were asked to complete the PHQ-9 by telephone interview. There were 317 patients with a PHQ-9 score ≥ 10, of whom 214 agreed to participate in the study.

Collaborative care is an intensive form of case management which involves collaboration between the patient, their primary care physician and a professional case manager, under the supervision of a senior mental health professional.[2] In this study, the intervention was provided by experienced diabetes nurses who had attended a two-day training course on depression and chronic disease management. A total of 106 patients were randomised to the 12-month programme which incorporated treatment protocols, intensive follow-up and weekly supervision meetings attended by a psychiatrist and psychologist. The remaining 108 patients were advised to consult their primary care physician with regard to their depression and poor chronic disease control.

'Patients had a better quality of life and were more satisfied with their care'

At 12-month follow-up, patients in the intervention group showed greater overall improvement in the four primary outcome measures: HbA_{1c}, LDL cholesterol, systolic BP and the symptom checklist 20 (SCL-20) depression score. The unadjusted differences between the intervention and control groups were as follows: HbA_{1c} 0.58%; LDL cholesterol 0.2 mmol/L; systolic BP 5.1 mmHg; and SLC-20 score 0.4. The results were combined to give a single overall treatment effect which was significantly greater in the intervention group.

Overall, 86% of the participants had diabetes. The improvement in glycated haemoglobin levels is comparable with the results of a meta-analysis of quality improvement strategies for diabetes which found that team changes (e.g. recruiting a nurse specialist or forming a multidisciplinary team) improved HbA_{1c} levels by 0.67%.[3] The improvements in LDL cholesterol and systolic BP were only modest.

The SCL-20 comprises 20 items which are scored and averaged to provide a measure of depression severity with a range from 0 to 4. A cut-off score ≥ 1.75 is generally used to indicate major depression; the mean baseline scores for the intervention and control groups were 1.74 and 1.65 respectively. Over the 12 months, the average score fell by 0.91 in the intervention group and 0.51 in the control group, which was a highly significant difference. Patients in the intervention group not only had a better quality of life but were also more satisfied with their care for their chronic condition and their depression.

The effect size on depressive symptoms was moderate (0.67). This compares favourably with recent meta-analyses of collaborative care which have yielded a range of effect sizes from 0.25 to 0.75, with the majority at the lower end of the range.[2]

Our practice nurses already play a role in identifying patients with chronic conditions who are depressed. Should we also ask them to collaborate in the care of those patients they identify?

It can be argued that they should either perform both roles, or neither: depression case finding is of no benefit unless it is combined with some form of enhanced care.[4] However, collaborative care is very time consuming: in the present study, patients from the intervention group had a mean of 10 face-to-face and 10.8 nurse telephone contacts over the 12-month period. Nurses may not wish to work with patients with psychological problems[3] and the results of collaborative care are better when case managers have a mental health background.[5] Enhanced liaison with secondary care is unlikely to be feasible in most UK settings.

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