A collaborative care management programme in a primary care setting was effective for older adults with late life depression


QUESTION: In older adults with late life depression, is a collaborative care management programme offered in a primary care setting effective?

Design

Randomised (allocation concealed)*, blinded (outcome assessors)*, controlled trial with 1 year of follow up.

Setting

18 primary care clinics from 8 healthcare organisations in 5 states in the US.

Patients

1801 patients ≥60 years of age (mean age 71 y, 65% women) who met the DSM-IV criteria for major depression or dysthymia or both and were planning to use general medical care from 1 of the participating clinics. Exclusion criteria were drinking problems, bipolar disorder or psychosis, current treatment by a psychiatrist, severe cognitive impairment, or acute risk of suicide. Follow up was 90%.

Intervention

906 patients were allocated to the Improving Mood-Promoting Access to Collaborative Treatment (IM-PACT) management programme, which comprised ≤12 months of access to a depression care manager (a nurse or psychologist who was supervised by a psychiatrist and a liaison primary care physician). The depression care manager worked with the patient and primary care practitioner to prepare a treatment plan based on the preference of the patient and the patient’s primary care practitioner: antidepressant treatment or brief structured psychotherapy (Problem Solving Treatment in Primary Care [PST-PC]). 895 patients were allocated to usual care.

Main outcomes

Treatmen response, defined as a ≥ 50% reduction in the baseline Symptom Checklist (SCL)-20 score (20 depression items from the SCL-90); complete remission of depressive symptoms, defined as a SCL-20 score < 0.5; self reported use of antidepressants or psychotherapy; health related functional impairment; and quality of life.

Main results

17% of participants had major depression, 30% had dysthymic disorder, and 53% had major depression and dysthymic disorder. Analysis was by intention to treat. The intervention group had higher rates of treatment response, complete remission of depressive symptoms, any use of antidepressant medications or psychotherapy, and satisfaction with depression care (table) than the usual care group. Also, the intervention group had less health related functional impairment (p<0.001) and greater quality of life (p<0.001) than those in the usual care group.

Conclusion

In older adults with late life depression, a collaborative care management programme offered in a primary care setting improved outcomes more than usual care.

*ASee glossary.

Main outcome measures

<table>
<thead>
<tr>
<th>Outcomes at 12 months</th>
<th>Intervention</th>
<th>Usual Care</th>
<th>RBI (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment response</td>
<td>45%</td>
<td>19%</td>
<td>132 (99 to 172)</td>
<td>4 (3 to 5)</td>
</tr>
<tr>
<td>Complete remission of depression symptoms</td>
<td>25%</td>
<td>8.3%</td>
<td>201 (135 to 286)</td>
<td>6 (5 to 8)</td>
</tr>
<tr>
<td>Any antidepressant or psychotherapy use</td>
<td>82%</td>
<td>61%</td>
<td>35% (27 to 44)</td>
<td>5 (4 to 6)</td>
</tr>
</tbody>
</table>

**AAbbreviations defined in glossary; RBI, NNT, and CI calculated from data in article.

Commentary

The article by Unutzer et al reports results that are consistent with a number of randomised controlled trials: comprehensive and multifaceted care for people with depression can lead to a marked improvement in outcome. Despite these positive results, the approach is not often implemented. Why is there such a reluctance to adopt this approach in primary care?

One explanation is that these interventions are costly and require some input from secondary care, which is often in short supply. The study by Unutzer et al reported that the direct costs of the intervention were US $553 per patient per year, although this did not include antidepressant costs. Depression is a relatively common condition in primary care, and thus for a reasonable sized general practice in the UK of about 10 000 patients, about 2–3% of people may have depression. The cost for such a practice may be US $150 000 a year.

It is not clear exactly how these interventions work. A therapeutic effect may be achieved with the additional monitoring and support provided by the case worker. Unutzer et al found that the intervention group was more likely to receive antidepressants or psychotherapy (82% in intervention group v 61% in usual care group), raising the possibility that improved outcomes are a product of traditional psychiatric approaches, and that the case worker increases the patient’s willingness to participate in these approaches. The study did not attempt any explicit investigation of this. Clearly, there is a need to develop cost effective methods of improving the treatment of depression in primary care. For many countries, such comprehensive interventions are unaffordable and impractical, though some modifications of this approach could be feasible.

Understanding how multifaceted interventions achieve improved outcomes will be a prerequisite before they are widely implemented.

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