Review: comprehensive organisational and educational interventions appear to be effective for managing depression in primary care


Do organisational and educational interventions improve management of depression in primary care settings?

**METHODS**

**Data sources:** Medline, PsycLIT, EMBASE/Excerpta Medica, CINAHL, Cochrane Controlled Trials Register, UK National Health Service Economic Evaluations Database, Cochrane Depression Anxiety and Neurosis Group register, and Cochrane Effective Professional and Organisational Change (EPOC) Group specialist register (all from inception to March 2003); experts; and bibliographies of included studies.

**Study selection and assessment:** Randomised or non-randomised controlled trials, controlled before and after studies, or interrupted time series studies that examined organisational or educational interventions targeted at primary healthcare professionals and patients for management of depression. Exclusion criteria: studies that examined only the efficacy of patient level interventions or only screening strategies for depression.

**Outcomes:** Depression, health related quality of life, and direct and indirect costs.

**MAIN RESULTS**

36 studies were selected: 29 randomised or non-randomised controlled trials, 5 controlled before and after studies, and 2 interrupted time series studies. Most studies were done in US primary care practices. Studies were heterogeneous, with many using multifaceted interventions including guidelines (22 studies), changes in delivery system design (19 studies), attention to the information needs of patients (11 studies), ready access to necessary expertise (21 studies), and information support systems (10 studies). 19 studies were randomised by clinician or clinical practice. 21 studies had positive results for the primary outcomes.

2 randomised trials examined complex organisational and educational interventions of patient screening, clinician education, patient specific reminders, nurse case management, and integration with specialist care. They reported improved medication adherence and depression outcomes at 6 and 12 months. At 24 months, improved medication adherence and global outcome persisted, but benefits on depression outcomes did not.

Studies showed that depression outcomes improved with case management by primary care nurses, practice counsellors, or graduate psychologists. In these studies, nurses or trained counsellors were involved in either brief patient education and medication counselling, telephone support, or as core components of a complex strategy (eg, patient education and ongoing support and monitoring).

4 randomised trials of collaborative care between primary care teams and specialists showed improved outcomes and lower overall costs. This model was also effective for relapse prevention and treatment of resistant depression.

Depression management guidelines and strategies to implement them were generally ineffective unless educational interventions were accompanied by comprehensive organisational interventions, such as nurse case management or collaborative care.

**CONCLUSIONS**

Most studies examining the effectiveness of organisational and educational interventions for the management of depression in primary care settings use multifaceted interventions. Complex organisational and educational interventions, or the enhanced involvement of nurses or trained counsellors in case management, appear to improve depression outcomes. The sole use of simple guidelines is generally ineffective.

A modified version of the abstract appears in Evidence-Based Medicine.

**Commentary**

Depression will become the second largest cause of global disability by 2020, with 95% of treatment occurring in primary care. Nevertheless, patients continue to have inadequate access to effective treatment. The systematic, narrative synthesis of organisational and educational interventions by Gilbody et al used rigorous and reproducible procedures. The review methods were pleasingly transparent, with multiple reviewers and clear inclusion and exclusion criteria. Although heterogeneity may have prevented the use of meta-analysis, effect size calculations could have assisted the interpretation of the findings.

The numerous studies investigating these complex interventions suggest that multifaceted approaches appear to be effective. Given the worldwide attention to clinician education and guideline development for depressive illness, the findings that these are ineffective when delivered alone are important for policy makers, educators, and clinicians.

Multifaceted interventions may also require resource reallocation from other competing healthcare priorities. Perhaps the most important finding is that effective interventions combine nurse case management models with collaboration between primary and secondary care providers. Added telephone medication counselling and scheduled patient follow up are also successful components of the effectiveness mix.

Implementing these core components will require that primary care nurses and others work with an information technology system to support collaborative relationships; have shorter, less traditional contacts with patients; and focus more attention and skill on the mental health needs of patients. These findings are vital to those planning effective system wide approaches for depression treatment in primary care.

Finally, although a large number of trials were included in this review, most were done in the US, highlighting an urgent need to evaluate collaborative care models in the UK, Europe, and other healthcare systems.

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