Enhanced primary care may encourage remission in depression

Rost K, Nutting P, Smith J *et al.* *Managing depression as a chronic disease: a randomised trial of ongoing treatment in primary care.* *BMJ* 2002 Oct; 325: 934–40.

QUESTION: What effect does enhanced primary care, including ongoing telephone contact with nurses, have on depression?

Design

Randomised controlled trial. It was not possible to blind participants or clinicians to treatment allocation. Telephone assessors were blinded.

Setting

Twelve primary care practices, United States; recruitment April 1996–September 1997.

Participants

Participants were 211 adults beginning a new treatment episode for major depression in primary care (DSM-III-R criteria). Mean age 43 years; 84% women; 84% white. Exclusion criteria were pregnancy; postpartum period; life threatening physical illness; cognitive impairment; treatment resistant depression, bereavement; mania; alcohol dependence; no access to a telephone, and no plans to use clinic as usual source of treatment.

Intervention

Participants received enhanced or usual care. In enhanced care, office staff screened patients before they saw a doctor to identify those who may be depressed. When doctors concurred with the possibility of depression, they asked patients to return the following week. At the next visit a nurse reassessed the participant's depressive symptoms, provided information about treatment options, asked the patient to complete tasks to encourage engagement in active treatment and arranged subsequent contacts. Nurses telephoned participants to follow up depressive symptoms throughout the 24 month study period. The usual care group received no regular contact from nurses and doctors were not systematically informed when patients screened positive for depression.

Main outcome measures

Remission and functioning were assessed using participant self reports.

Main results

At 24 months, people receiving enhanced care had improved symptoms and functioning compared to usual care. Remission was improved by 33% (95% CI 7% to 46%), emotional functioning by 24% (95% CI 11% to 38%) and physical functioning by 17% (95% CI 6% to 28%).

Conclusions

Enhanced primary care was associated with improved remission and emotional and physical functioning after 2 years.

Source of funding:
National Institute of
Mental Health.

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COMMENTARY

Particular strengths of this study are its pragmatic design, the use of both cognitive and functional measures, the duration of the intervention and follow up and the low attrition rate. In order to examine the implications of the trial, it is important to consider both the population studied and the components of the intervention itself. The study used a screening approach to identify cases. While this is an efficient research methodology, the population selected does not accurately represent that encountered in clinical practice. Less severe cases and recurrent episodes are more likely to be detected with this approach. The randomised design and analytical techniques ensured that both groups were similar in composition, but the results may not be generalisable to a routine clinical population.

The most significant impact of screening, however, was on the intervention itself. Clinicians in the intervention group were informed of the screening results whereas those in the control group were not necessarily. Disclosure may enhance recognition and diagnosis, resulting in increased active treatment rates. It might be argued that this aspect of the intervention alone improved outcomes, although previous research suggests that disclosure of screening is not sufficient to improve outcomes for depression in primary care.¹

The second main component of the intervention was nurse-led patient education. Other studies of nurse-led support for depression have found improved antidepressant uptake, although such benefits are not usually maintained.² The key difference in this study is that participants received nurse-led follow up to assess symptoms for the duration of the study. The most important new finding from this study is therefore that some form of continuing reassessment *might* help reduce relapse and recurrence rates, probably by earlier reactivation or enhancement of treatment regimens. The optimum frequency of follow-up and the cost-effectiveness of such an intervention requires further evaluation, as does its application within a routine clinical population. It is too early to recommend widespread implementation of continuing follow-up programmes for depression on the basis of these results alone.

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- 1 Dowrick C, Buchan I. Twelve month outcome of depression in general practice: does detection or disclosure make a difference? *BMJ* 1995; **311**: 1274–6.
- 2 Mann AH, Blizard R, Murray J *et al.* An evaluation of practice nurses working with general practitioners to treat people with depression. *Brit J Gen Pract* 1998; **48**: 875–9.

Author's response

Samples produced by consecutive screening approximate the clinical sample seen by physicians. The study results were virtually unchanged when we re-ran the analyses on a sample where frequent attenders were downweighted. Consecutive samples do pick up less severe patients, however, our results suggest that those patients benefit from enhanced depression treatment.

Previous studies suggest that providing depression screening results to primary care physicians does not change the process or outcome of care. It is therefore unlikely that this component of the programme was solely responsible for differences between groups. Many healthcare systems consider instituting depression screening programmes alone, yet there is little evidence that they produce any improvement in outcomes.

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