Collaborative care led to greater recovery, improvement, and adherence than usual care at 12 months in panic disorder

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Roy-Byrne PP, Katon W, Cowley DS, et al. ***A randomized effectiveness trial of collaborative care for patients with panic disorder in primary care****. Arch Gen Psychiatry 2001 Sep;**58**:869–76.*

QUESTION: In primary care patients with panic disorder, is collaborative care (involving pharmacotherapy) effective for improving clinical and functional outcomes?

Design
Randomised (unclear allocation concealment*), blinded (outcome assessors)*, controlled trial with 12 months of follow up.

Setting
3 primary care clinics in Seattle, Washington, USA.

Patients
115 patients who were 18–65 years of age (mean age 41 y, 57% women), met *DSM-IV* criteria for panic disorder with ⩾1 panic attack in the past month, spoke English, and had a telephone. Exclusion criteria were presence of illnesses that were life threatening or limited patient participation, current psychiatric treatment, or disability benefit claims. Follow up was 80% at 6 months and 79% at 12 months (random regression analysis was used to include all patients in the analysis).

Intervention
Patients were allocated to a multifaceted collaborative care intervention (n=57) or usual care (n=58). The collaborative care intervention comprised an initial psychiatric visit at which paroxetine was prescribed (10 mg/d to start, with increases to a maximum of 40 mg/d), an educational videotape on panic disorder, 2 follow up psychiatric telephone calls, and an offer of a second visit if necessary in the first 8 weeks. The primary care physician received a consultation note after each psychiatric visit. Psychiatrists telephoned the patients 5 times during months 3–12.

Main outcome measures
Recovery (Anxiety Sensitivity Inventory score <20) and improvement (40% reduction in Panic Disorder Severity Scale).

Main results
Analysis was by intention to treat. More patients in the collaborative care group than the usual care group were recovered or improved at 6 and 12 months (table). Patients in the collaborative care group were more likely to adhere to medication than those in the usual care group at 6 months (table).

Conclusions
In patients with panic disorder, collaborative care was better than usual care for clinical improvement and recovery and promoting adherence.

*See glossary.

Collaborative care v usual care for panic disorder†

Outcomes	Collaborative care	Usual care	RBI (95% CI)	NNT (CI)
Recovery at 6 months	49%	17%	185% (57 to 435)	4 (3 to 7)
Recovery at 12 months	47%	21%	129% (32 to 310)	4 (3 to 11)
Improved at 6 months	75%	38%	99% (41 to 191)	3 (2 to 6)
Improved at 12 months	81%	59%	38% (8.0 to 80)	5 (3 to 19)
Adherent >25 days at 6 months	49%	26%	90% (16 to 219)	5 (3 to 19)
Adherent >25 days at 12 months	44%	31%	41% (–12 to 130)	Not significant

†Abbreviations defined in glossary; RBI, NNT, and CI calculated from data in article. Recovery defined as Anxiety Sensitivity Inventory score <20; Improvement defined as 40% reduction in Panic Disorder Severity Scale score.

COMMENTARY

Panic disorder is responsible for huge costs to society as well as a great deal of personal suffering. Although treatment (both psychological and pharmacological) is broadly successful, only a minority of sufferers actually get effective help, and they do not usually receive treatment until several years after the onset of their disorder. Although many programmes for improving primary care for depressive disorders have been tested (with differing results in different contexts), such programmes for anxiety disorders are rare. The study by Roy-Byrne *et al* describes a multifaceted intervention that improves clinical outcomes for patients with panic disorder in primary care. The high level of psychiatric and medical comorbidity of the study sample reflects the real world of primary care.

During recruitment, a high proportion of patients was lost for reasons that might be related to the nature of the intervention–it might have been considered "too psychiatric" or "too pharmacological". A recent study, however, indicates that a high proportion of patients with panic disorder in primary care are willing to see a psychiatrist or a psychotherapist or to take psychotropic medication.[1]

The intervention, designed for an American primary care context, will probably need to be adjusted when transferred to other settings, for example the European situation where general practitioners work individually or in smaller group practices.

In the light of higher relapse rates after pharmacotherapy and the good acceptability of cognitive behavioural interventions, the use of psychological interventions, based on a developmental model of panic disorder, may be of value in patients who have an initial panic attack.[2] Therefore, a programme that follows a "stepped care" philosophy, incorporates elements of the intervention in the study by Roy-Byrne *et al* and simple psychological interventions (eg, a self help manual), and takes patient preferences into account may be cost effective.

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1 Johnson MR, Gold PB, Siemion L, *et al.* Panic disorder in primary care: patients' attributions of illness causes and willingness to accept psychiatric treatment. *Int J Psychiatry Med* 2000;**30**:367–84.
2 Swinson RP, Soulios C, Cox BJ, *et al.* Brief treatment of emergency room patients with panic attacks. *Am J Psychiatry* 1992;**149**:944–6.