National Conference on Shared Mental Health Care

Calgary, Alberta

May 2006

Identifying Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence Base

Marilyn Craven MD PhD
McMaster University

Roger Bland MB FRCPC
AMHB and
University of Alberta

Supported by CCMHI

7th National Conference on
Shared Mental Health Care

May 11- 13, 2006
Calgary, Alberta

Definition of Collaborative Care

Collaborative care involves **providers …. working together** … to ensure that **individuals receive the most appropriate service** …, **as quickly as necessary**, and with a minimum of obstacles. Collaboration … involves … **communication**, … **personal contacts**, **sharing of clinical care**, joint educational programs and/or joint program and system planning.

Purpose of this study

- To identify and summarize the current experimental literature (RCTs and intervention studies with outcome measures) on the impact of collaborative practices in the delivery of mental health care in the primary care setting.

Methods

- Review of more than 900 articles
- 38 studies were identified which investigated the impact of collaborative mental health care in the primary care setting and using experimental methodologies (RCTs and intervention studies with outcome measures).
- These studies were systematically reviewed and analysed.
- Recent trends in collaborative mental health care research are summarized.
- Widely differing methodologies did not permit combining results to perform meta-analysis

Recent research trends (1)

- Moved from purely descriptive accounts of collaborative models and enthusiastic reports of early program evaluation findings to more rigorous experimental studies.
- The focus of these studies has shifted:
  - earlier studies were most concerned with the **impact of collaboration on system outcomes** such as service utilization, referral rates to specialty mental health clinics and rates of inpatient admission.
  - Recent studies have focused more on **patient-level outcomes**, often combining collaborative interventions with guideline-driven treatment protocols in an effort to improve care processes.

Recent research trends (2)

- Another shift in the research has seen **collaboration** paired with **chronic disease management** and **quality improvement** initiatives.
  - Most of these studies have focused on depression and have entailed varying degrees of practice or service reorganization to achieve their outcomes.
- A fourth “wave” of research is now examining the ability of such research-based programs to be translated into “real world” settings.

Recent research trends (3)

- Collaborative interventions **targeted at specific patient populations** (eg serious and persistent mental illness, depression, the depressed elderly, substance abusers, high users of medical care),
- Involving professionals with different skill sets, different resource requirements and a range of implementation methods, including consumers, psychologists, social workers, occupational therapists, pharmacists
- Using a sufficiently powerful intervention that a difference from usual care could be detected, problems however:

Recent research trends (4) some problems however:

- Populations noticeably absent from the experimental literature include aboriginal communities, the homeless, and rural communities.
- Diagnostic groups which are under-represented include anxiety disorders, personality disorders, eating disorders, attention deficit disorder and dementia.

Findings (1)

1. **Collaborative relationships between primary care physicians and other mental health care providers do not happen instantly or without work. They require preparation, time and supportive structures.**
   - Two of the studies reviewed[13,31] had potentially good interventions which failed because of poorly implemented collaboration. In contrast, a study which built on pre-existing relationships in the primary care practice, resulted in high levels of collaboration and good patient outcomes[16]. **Ideally, collaborative care arrangements will grow out of pre-existing clinical relationships.**

Findings (2)

2. Co-location is important for both providers and patients.

- Providers who have not met face to face and/or do not have pre-existing clinical relationships are less likely to engage in a collaborative care relationship[16,48].
- From the patient's point of view, offering patients specialty mental health care within the primary care setting appears to produce greater engagement of patients in mental health care, a sina qua non for better patient outcomes[24,47,].
- Collaboration between mental health specialists and primary care providers is likely to be most developed when clinicians are co-located.
- Most effective when the location is familiar and non-stigmatizing for patients. This may be particularly true for patients with substance abuse problems.

An emerging literature on co-location/integration of substance abuse treatment and primary care suggests that patients in integrated models do significantly better, and those with poorer health benefit the most [26,52,53].

Findings (3)

3. Degree of collaboration does not in itself appear to predict clinical outcome.

- Although there was a trend toward positive outcomes occurring more often in studies with moderate or high levels of collaboration, some studies with lower levels of collaboration also had positive outcomes [6,9,12,22,37].

Findings (4)

4. **The pairing of collaboration with treatment guidelines appears to offer important benefits over either intervention alone in patients with depressive disorders.**

- **studies with positive outcomes in this patient population included decision support instruments, usually in the form of a research protocol, and/or established clinical treatment guidelines.**
- **trials of clinical guidelines, treatment protocols or algorithms without collaborative interventions have not shown improvements in patient-level outcomes [54,55,56].**

Findings (5)

5. **Collaboration paired with treatment guidelines for depression may have a differential effect on outcome, with patients with more severe disorder responding better.**
   - Several of the studies reviewed showed improved outcomes only in subgroups of patients with higher depression severity scores [7,9,13,14]
   - At present, there is more evidence to support targeting collaborative interventions at major depressive disorders.

Findings (6)

6. **One of the most powerful predictors of positive clinical outcomes in studies of collaborative care for depression was the inclusion of systematic follow-up as part of the study protocol.**
   - In the studies reviewed, follow-up was delegated to another clinician or care manager, with varying degrees of collaboration with the primary care physician and for varying lengths of time.
   - Those which included systematic follow-up and a mechanism for treatment to be altered when patients were not responding well (often a stepped approach), had positive outcomes[6,7,9,11,12,16,18,22,33,35,37,39,41,47].

Findings (7)

7. **Efforts to increase medication adherence through collaboration with other health care professionals (eg practice nurses) were also a common component of many successful studies.**
   - **Although improving medication adherence has strong face validity, analysis of these studies found no clear direct relationship between medication adherence and clinical outcome [10,11, 14,15,19,21].**

Findings (8)

8. **Collaboration alone has not been shown to produce skill transfer or enduring changes in primary care physician knowledge or behaviours in the treatment of depression.**

- One study [4] demonstrated that the improvement in outcomes achieved during a multifaceted intervention for depression[5] were not due to physician education alone, but required extensive service restructuring in addition.

Findings (9)

9. **Enhanced patient education about mental disorders and their treatment (usually by a health professional other than the primary care physician) was a component of many of the studies with good outcomes.**

Findings (10)

10. **Collaborative interventions established as part of a research protocol may be difficult to sustain once the funding for the study is terminated** [4,16] .

Findings (11)

11. **Patient choice about treatment modality may be an important factor in treatment engagement in collaborative care.**

- Research has shown that, given a choice, 26%-66% of primary care patients with major depression would prefer to be treated with psychotherapy rather than medication [57].

Conclusions

- A body of experimental literature evaluating the impact of enhanced collaboration on patient outcomes - primarily in depressive disorders - now exists. Better practices in collaborative mental health care are beginning to emerge.

Clinical Implications

1. Collaboration is most successful when built on pre-existing clinical relationships.
2. Enhanced collaboration should be paired with disorder-specific treatment guidelines.
3. Skill transfer in collaborative relationships requires service restructuring to support behavioural change.

Limitations

1. The number of experimental studies is relatively small.
2. Enhanced collaboration should be paired with disorder-specific treatment guidelines.
3. Skill transfer in collaborative relationships requires service restructuring to support behavioural change.

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Roger Bland [waterloo@shaw.ca]

Funding for CCMHI was provided by Primary Health Care Transition Fund – Health Canada

Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

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