Where you get depression care matters, study finds

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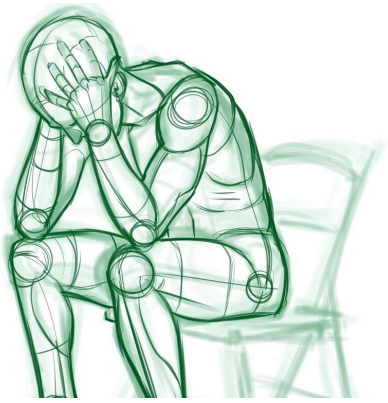

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In the United States, more than half of people living with a mental health disorder do not receive treatment, according to the National Institute of Mental Health, which is why primary-care clinics can play a leading role in depression care.

Research shows that collaborative care programs in which primary-care providers work with a depression care manager and a designated psychiatric consultant can more than double the likelihood of improving depression outcomes. But a new study published in *Health Affairs* shows that not all care is equal.

Looking at data from 11,003 patients in 135 primary care clinics in nine states, researchers found tremendous variation in how well clinics implemented collaborative care programs.

In some clinics, fewer than 25% of patients served had substantial improvements in depression after six months and in other clinics, more than 75% of patients had significant improvement.

"This is the largest study to date of collaborative care programs for depression in primary care," said lead author Jürgen Unützer, professor and chair of the Department of Psychiatry at the University of Washington School of Medicine, where the model was pioneered. "The differences are huge and it makes a big difference where you get your depression care."

Researchers said the reason for the large variation in success across clinics could be summed up in three major findings:

The most important finding, they said, is that it made a big difference how much help the clinics had with implementing collaborative care.

Clinics that received more intensive implementation support were almost twice as likely to achieve good depression outcomes as those with a basic level of implementation support, such as program literature and a one-time training. More intensive support included ongoing outcomes tracking and feedback from the UW Medicine AIMS Center (Advancing Integrated Mental Health Solutions) over a one-year period.

In other findings:

- Patients who are more severely depressed or sicker in other ways are less likely to have good depression outcomes.
- Patients who are poor and have fewer resources may also have worse depression outcomes. Clinics that treat low-income patients, such as Federally Qualified Health Centers, may have a harder time achieving good depression outcomes and may need extra help and resources to be successful.
- Clinics that had several years of practice with collaborative care achieved somewhat better outcomes than clinics that are still learning how to do collaborative care.

The collaborative care model was pioneered by the late Dr. Wayne Katon, who spent three decades

testing and developing approaches to improve depression treatment in primary care. More than 80 randomized controlled trials have validated the success of the collaborative care model.

One of the most powerful aspects of collaborative care is regular monitoring of patients' depression and systematic adjustment of treatments if patients are not improving as expected. Similarly, clinics that regularly monitor their patients' depression and make systematic adjustments in their programs if patients are not improving as expected may achieve substantially better outcomes for their patients.

More information: Jürgen Unützer et al, Variation In The Effectiveness Of Collaborative Care For Depression: Does It Matter Where You Get Your Care?, *Health Affairs* (2020). DOI: 10.1377/hlthaff.2019.01714

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