



Collaborative Care for Depression and Stress in Cancer Patients

Fifteen to 25% of cancer patients are affected by comorbid depression, with men and women being equally affected.¹ Depression not only affects the patient, it has a major negative impact on their families. Major depression affects approximately 25% of cancer patients. Additionally, nearly a third of cancer patients have a mood disorder other than depression (anxiety, dysthymia, adjustment disorder, significant stress).² These problems not only affect quality of life for patients and their families, it affects the adherence to treatment regimes and outcomes.

Successful interventions to improve care for depression have a number of common features, commonly referred to as *collaborative care*.

The collaborative care model focuses on treatment in general medical settings (vs. specialty behavioral health care settings) for most patients. For cancer patients, this is the physician and treatment team coordinating their care. Collaborative care includes and combines several quality improvement strategies, such as screening, case identification, and proactive tracking of clinical (e.g., depression) outcomes, clinical practice guidelines and provider training, support of the primary provider treating depression by a depression care manager (e.g., a nurse, clinical social worker, or other trained staff), and collaboration with a behavioral health specialist (e.g., a psychologist or a psychiatrist).

Collaborative care interventions have *two* key elements. The *first is case management* by a nurse, social worker, or other trained staff, to facilitate screening, coordinate an initial treatment plan and patient education, arrange follow up care, monitor progress, and modify treatment if necessary. Case management can be provided in the clinic and/or by telephone. The *second is consultation* between the case manager, the primary provider, and a consulting psychiatrist, in which the psychiatrist advises the primary treatment team about their caseload of depressed patients. This consultation is intended to maximize the cost-effectiveness of collaborative care, by facilitating a process described as “stepped care,” where the treatment algorithm starts with relatively low-intensity interventions such as antidepressant medication prescribed by the primary provider and treatment team and telephone case management, with patients who fail to respond being shifted to progressively more intensive approaches including specialty behavioral healthcare.

¹ Miaskowski C: Gender differences in pain, fatigue, and depression in patients with cancer. J Natl Cancer Inst Monogr (32): 139-43, 2004. [\[PUBMED Abstract\]](#)

² Massie MJ, Holland JC: The cancer patient with pain: psychiatric complications and their management. Med Clin North Am 71 (2): 243-58, 1987. [\[PUBMED Abstract\]](#)

More than ten large trials, in a wide range of settings, have demonstrated the feasibility of improving depression treatment and outcomes, relative to usual care.^{3,4}

The documented benefits of collaborative depression care include:

- Higher rates of evidence-based depression treatment (i.e., antidepressant medication and/or psychotherapy);
- Better medication adherence/compliance;
- Reduction in depression symptoms, and earlier recovery from depression;
- Improved quality of life;
- Higher satisfaction with care; and
- Improved physical functioning.

Collaborative care has typically been found to increase direct healthcare costs slightly, relative to usual care, mainly by increasing the use of evidence-based depression treatment. *However, this investment yields substantial improvements in patients' health status and functioning, so that collaborative care is more cost-effective than usual care for depression and has very favorable cost-effectiveness compared with other accepted medical interventions.*

³ Gilbody S. Whitty P. Grimshaw J. Thomas Educational and organizational interventions to improve the management of depression in primary care: a systematic review. *JAMA*, 2003; 289(23): 3145-51.

⁴ Neumeier-Gromen A. Lampert T. Stark K, Kallischnigg G. Disease management programs for depression: a systematic review and meta-analysis of randomized controlled trials. *Med Care*, 2004; 42(12): 1211-21