Is co-location essential? Delivering collaborative care in practice for people with depression and long term conditions; a qualitative study.

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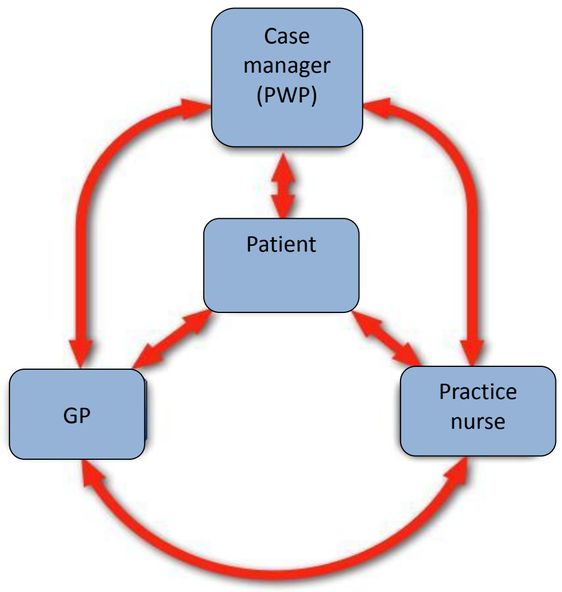
Background

Comorbid depression in people with long term conditions (LTCs) is associated with increased disability and poorer outcomes than either depression or LTCs alone (1). In UK primary care, case finding for depression is incentivised by the Quality and Outcomes Framework (QOF) (2), but detection and management remain suboptimal in this population, with lower treatment rates reported for patients with comorbid LTCs such as diabetes and coronary heart disease (CHD) (3).

Collaborative care (CC) is an enhanced depression care model in which the patient, GPs and other specialists collaborate to design and deliver a structured care programme for the patient. There is solid evidence from the US that shows that collaborative care improve outcomes for both depression and LTCs (4), but relatively little is known about the delivery of CC in routine practice in the UK.

Collaborative Care Relationships



Aim

To explore the acceptability of a collaborative care intervention to improve the identification and management of depression in people with depression and diabetes/ CHD in NW England. This pilot study informs a randomised control trial of CC for depression and LTCs in primary care.

Methods

- 18 semi-structured interviews conducted with 6 psychological well-being practitioners (PWPs) and 12 Practice Nurses (PNs)
- Interviews conducted 3 months following delivery of training and setting up the service.
- Topic guides used with a focus on experiences of working within a the CC framework with patients with depression and diabetes/CHD.
- Interviews recorded and transcribed verbatim.
- Transcripts analysed thematically using constant comparative technique.

Results

Emerging themes from the initial analysis relating to the importance of co-location of professionals to the delivery of CC are presented below.

1. Co-location and collaboration

PWPs and PNs differed in their accounts about how important direct liaison is to the success of CC. PWPs felt that face-to-face contact with PNs in addition to the formal collaboration was necessary to the success of CC, and felt that opportunities for informal collaboration were increased by their presence within the GP practices.

> *I just keep turning up like a bad penny every time I'm meant to be there, hanging around at the sort of communal bits, bumping into people…But it's got to be done face to face, otherwise you just don't get them…like I phoned a nurse one day and it's taken days and days to get a response, because they're just too busy… So if you don't get them face to face, you don't get them at all. PWP2*

> *Unfortunately I haven't been working on the same day as [PWP] for a few weeks, but she has left me little notes, and obviously we can email if we need to. She does know that if she needs anything she just has to let me know, like she left me more leaflets and that the other week…and she's got a tray, an input tray, upstairs like all of us, so, you know… And I think the system's there in place that if she wants to contact us, she's got my mobile number. PN 12*

PNs did not view informal face-to-face contact as necessary. This was partly because they worked days when the PWP was not present, or that the PNs and PWPs timetables clashed, leading to fewer opportunities for informal collaboration.

Formal collaboration in team meetings therefore assumed greater importance for both PNs and PWPs, although PWPs still found it difficult to fully integrate within the practice in some cases. This was possibly because PWPs were still visiting staff rather than permanently co-located within the practice.

> *…they don't even have a regular GP meeting, so, integrating into that surgery is a lot more difficult… there's very much an 'us and them' feeling, within the surgery… the surgery staff and admin staff are so used to other practitioners being in…we're not really noticed, so, it's more difficult, for me, to get myself noticed. PWP4*

However, even formal collaboration was fractured in some cases. Although intended to include both practitioners and the patients, PWPs often reported that the PNs only attended the end of their planned joint session, suggesting limited collaborative work, even when pre-arranged.

> *well the patient and I will have had an assessment and then at the second session half an hour of it is just me and then reviewing that, concreting goals and expectations and then what questions do we have for the nurse… so then the nurse comes in just for the last fifteen minutes, otherwise she'd be bored rigid and she has better things to do than listen to, you know, me doing my bit. PWP2*

These views suggest that co-location may facilitate informal collaboration, but only when PWPs are fully integrated within the practice and where efforts are made to co-ordinate timetables to allow for such opportunities to occur. Formal collaboration may only prove useful if both parties can see the benefit of such meetings, and are willing to attend.

2. Overcoming mind-body dualism

PWPs and PNs did however think that co-location was likely to benefit patients, by increasing familiarity with staff and easing logistical burdens.

> *All the things I've just mentioned, getting over their problems, and issues, it's based in the surgery, they're not going to a strange place, they're familiar with the person, they're meeting me with one of their sessions, so, they don't feel intimidated, it's not something strange and new and it works well, part of a, you know, being in the same building, definitely, than going somewhere else. PN10*

> *…and obviously if some of the patients are quite aware of the physical and not anything else, so by coming to like the GP's surgery to see someone about their mental health, it kinda breaks that barrier. PWP2*

Furthermore, professionals felt that arranging appointments for both mental and physical health problems at the same location may go some way to reducing the stigma attached to the diagnosis of mental health problems for patients with comorbid health problems, as well as enabling patients to realise the link between the two conditions.

> *…the de-stigmatisation of going to see somebody who's a mental health person, they're on site, you could be coming and having your big toe painted or whatever you're coming to have done, nobody knows what…you're just coming to see the doctor, and so I think that de-stigmatises it a little bit, and I think that's a big plus, and that's how in a lot of ways I sell it. PN9*

Therefore, these results suggests that adopting a more holistic approach to care through the co-location of professionals may be important in encouraging patients to access and attend such services.

Conclusions

We found that successful professional collaboration is contingent on the extent to which PWPs were integrated within GP practices. Co-location of professionals may increase chances for informal communication. Moreover, because PNs are often unavailable, PWPs found that attending team meetings was necessary to bring about formal collaboration. In addition to possibly improving communication, co-location may also be more acceptable to patients and may go some way to reducing the stigma attached to receiving mental health care. As such, the CC framework may offer a more holistic approach to the care of people with depression and LTCs. Further professional and patient interviews are planned, which will be important in further establishing the importance of professional co-location. These findings have important implications for understanding acceptability and feasibility of managing depression in LTCs using a CC framework – a key policy initiative of the UK government (5) .

References

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