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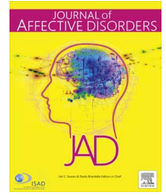

Review article

What are the barriers and facilitators to implementing Collaborative Care for depression? A systematic review

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ABSTRACT

Background: Collaborative Care is an evidence-based approach to the management of depression within primary care services recommended within NICE Guidance. However, uptake within the UK has been limited. This review aims to investigate the barriers and facilitators to implementing Collaborative Care.

Methods: A systematic review of the literature was undertaken to uncover what barriers and facilitators have been reported by previous research into Collaborative Care for depression in primary care.

Results: The review identified barriers and facilitators to successful implementation of Collaborative Care for depression in 18 studies across a range of settings. A framework analysis was applied using the Collaborative Care definition. The most commonly reported barriers related to the multi-professional approach, such as staff and organisational attitudes to integration, and poor inter-professional communication. Facilitators to successful implementation particularly focussed on improving inter-professional communication through standardised care pathways and case managers with clear role boundaries and key underpinning personal qualities.

Limitations: Not all papers were independent title and abstract screened by multiple reviewers thus limiting the reliability of the selected studies. There are many different frameworks for assessing the quality of qualitative research and little consensus as to which is most appropriate in what circumstances. The use of a quality threshold led to the exclusion of six papers that could have included further information on barriers and facilitators.

Conclusions: Although the evidence base for Collaborative Care is strong, and the population within primary care with depression is large, the preferred way to implement the approach has not been identified.

1. Background

- Description of the condition

  Depression is a mental illness with disabling functional, social and physical impacts. It is associated with poor self-care, adverse medical outcomes, increased mortality, and risk of suicide (Holm and Severinsson, 2012). The King's Fund defines long term or chronic conditions as those for which there is currently no cure and which are managed with medication or other treatments (TheKing'sFund, 2016). On this definition, depression can be considered a long term or chronic condition for many of the people who experience it (Kupfer, 1991). More than 50% of people who experience a first episode of depression will experience a second episode, and after the second and third episode of depression risk of relapse rises to 70% and 90% respectively (Kupfer, 1991). Co-morbidity between a LTC such as diabetes, respiratory disorders or coronary heart disease, and depression is associated with greater functional impairment, morbidity and increased healthcare costs (Brilleman et al., 2013; Naylor et al., 2012).

- Description of the intervention

  Collaborative Care (Gunn et al., 2006; Katon et al., 2001) (table 1) is a specific chronic illness management approach to the treatment of depression. It was developed from the Chronic Care Model (Bodenheimer et al., 2002), and is an approach to depression that is recommended within UK NICE Guidance (NICE, 2009). To date uptake within the UK has been limited, (DoH, 2011), and there

Abbreviations: CFIR, Consolidated Framework for Implementation Research; GP, General Practice (UK primary care provider); IAPT, Improving Access to Psychological Therapy; LTC, Long Term Conditions; NHS, National Health Service; NICE, National Institute for Health and Clinical Excellence; PCP, Primary Care Physician; PWP, Primary Wellbeing Practitioner; QIC, Quality Improvement Coordinator; QOF, Quality and Outcomes Framework; RE-AIM, Reach, Effectiveness, Adoption, Implementation and Maintenance framework

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Table 1
The key elements of Collaborative Care.

Collaborative Care (Gunn et al., 2006)
A multi professional approach to patient care (Including a minimum of two different professions working together)
A case manager (a named person who coordinates or delivers care to the depressed person (Coventry et al., 2014))
A structured management plan (including enhanced pharmacology and psychological interventions, must be more than just a screening program)
Scheduled patient follow ups
Enhanced inter-professional communication

appear to be issues of acceptability within the NHS primary care setting (Richards et al., 2006).

Collaborative Care is a primary care intervention which attempts to break down the silos inherent in health systems. It encourages different health professionals to work together by enhancing communication and utilising structured care planning and management of complex conditions. Although not specifically mentioned by Gunn the role of the case manager has been highlighted as crucial by later reviewers (Archer et al., 2012; Coventry et al., 2014; Gilbody et al., 2006). It ensures one professional is taking a lead keeping all other parties informed and following up patients. Collaborative Care is more than just co-locating mental and physical health services in the same building or implementing a screening program. It requires a level of interaction on the part of health professionals to ensure holistic care for their patients (Gunn et al., 2006).

The efficacy of Collaborative Care for depression was evaluated in a meta-analysis by the Cochrane Collaboration which included 79 randomised controlled trials involving 24,308 patients (Archer et al., 2012). All of their comparisons focused on the impact of Collaborative Care on measures of depression (Archer et al., 2012). On those measures a standardised mean difference of 0.25 (95% Confidence Interval 0.18–0.32) was identified at six months. An earlier meta-analysis found maintenance of gains for up to five years (Gilbody et al., 2006). Similarly a recent systematic review and meta regression reported that compared to usual care, Collaborative Care was associated with improvements in depression (Coventry et al., 2014).

- Barriers and facilitators to implementation

Understanding why evidence-based approaches such as Collaborative Care are successfully implemented in some settings but not others, is a key issue for successful implementation of those approaches. A theoretical framework to guide interpretation of research findings allows for the generalisation of those findings across settings. Process evaluation is an essential part of designing and testing a complex intervention (Moore et al., 2015) There is an extensive evidence-base and a large number of theoretical frameworks regarding the most effective approaches to implementing evidence-based approaches in healthcare (Rycroft-Malone and Bucknall, 2010). The Consolidated Framework for Implementation Research (CFIR) resulted from a review of the implementation science literature with the aim of integrating previously published theories into a single over-arching framework that would be useful to guide future implementation research. The CFIR includes 39 constructs known to be relevant to implementation organized into five domains (Damschroder et al., 2009), intervention, outer setting, inner setting, characteristics of individuals and process.

A review on the use of the CFIR in implementation research identified 429 articles citing the CFIR (to January 2015) with 26 articles meeting inclusion criteria (Kirk et al., 2016). The studies mainly employed either a mixed methods (n=13) or qualitative (n=10) design. Three used quantitative only designs. Studies had been undertaken across a wide range of healthcare settings. The CFIR was largely used during or post-implementation to identify barriers and facilitators to implementation of an innovation. CFIR can be classified as a determinant framework, the overarching aim of this is to understand the influences on implementation (Nilsen, 2015).

In the current study, implementation was broadly defined to include both reports of barriers and facilitators to setting up Collaborative Care within research studies, and the execution of the approach within routine healthcare settings.

- Why is it important to do this review?

The UK Department of Health Framework for co-morbidities (DoH, 2014) has emphasised parity of esteem between physical and mental illnesses, and identified the need to develop coordinated interventions that address both. However, despite Government backing and consistent evidence of efficacy (Archer et al., 2012; Coventry et al., 2014; Gilbody et al., 2006), the implementation of Collaborative Care is sparse both in the UK (DoH, 2011) and in the USA (Whitebird et al., 2013). This review will identify factors in the qualitative and mixed methods literature that may illuminate this situation and allow future research to focus on overcoming those barriers so as to provide wider access to this effective intervention.

- Research question

What patient, staff or organisational factors are barriers/facilitators to the implementation of Collaborative Care for patients with depression in primary care?

2. Methods

A systematic review of the literature was conducted to synthesize inquiries into the barriers and facilitators of implementation of Collaborative Care for depression within primary care health services, which may or may not be linked to randomised controlled trials, service evaluations or other implementation studies. Papers were sought that have attempted to implement and evaluate Collaborative Care for patients with depression with or without co-morbid physical health conditions. As this research did not directly involve human subjects, ethical approval was not sought. The protocol for the systematic review was not registered.

- Literature search

A systematic search of appropriate databases (Medline, Embase, Cinahl, Psychinfo and Cochrane) was conducted in February 2016 for all relevant English language publications. The search strategy was developed from combining search terms from previous systematic reviews looking at depression (Coventry et al., 2014), primary care (Kadu and Stolee, 2015) and collaborative care (Coventry et al., 2014) and combining them with acceptability outcome search terms adapted from Smith et al. (2012a, 2012b) and terms derived by the research team in an attempt to capture papers which reported barriers and facilitators. Key MeSH terms; included depression, and primary care, general practice and family practice. Since there were no MeSH terms for Collaborative Care a wide range of search terms capturing Gunn et al.'s (2006) components of Collaborative Care and their synonyms were used in combination and separately using the Boolean and proximity operators to ensure all variants were captured. This approach was adapted from Coventry et al.'s (2014) search strategy, see Appendix A for the full search strategy for Cinahl incorporating the adaptions made. In order to achieve a comprehensive search it was expected that qualitative data on barriers and facilitators to implementation may be nested within larger RCTs and research reports. A manual search of the reference lists of included studies and relevant systematic reviews was conducted to identify any missed relevant papers. Citations were downloaded and screened with the aid of Mendeley, reference management software. Two co-authors (EW and SO) independently screened the titles and abstracts against inclusion

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