

## Characteristics table for the clinical question: In the treatment of GAD, what are the risks and benefits associated with the following collaborative care treatments?

### Comparisons Included in this Clinical Question

<b>Collaborative care versus TAU</b>	<b>Telephone based collaborative care versus TAU</b>
ROY-BYRNE2010	ROLLMAN2005

### Characteristics of Included Studies

Methods	Participants	Outcomes	Interventions	Notes
<p><b>ROLLMAN2005</b></p> <p>Study Type: RCT</p> <p>Study Description: Examined whether telephone-based collaborative care for panic and GAD improves outcomes more than usual care provided by primary care physicians.</p> <p>Type of Analysis: ITT</p> <p>Blindness: Open</p> <p>Duration (days):</p> <p>Followup: 2, 4, 8, &amp; 12-months (extractable)</p> <p>Setting: Four Pittsburgh area primary care practices linked by a common electronic medical record system.</p> <p>Notes: RANDOMISATION: computer-generated random assignment sequences, allocated in 3:2 ratio. Randomly set blocks of 25-30. Placed in opaque sealed envelopes</p> <p>Info on Screening Process: 542 screened by telephone assessment, 351 excluded as did not meet criteria, refused, unable to contact or disagreement ovre PRIME-MD.</p>	<p>n= 191</p> <p>Age: Range 18-64</p> <p>Sex: 36 males 155 females</p> <p>Diagnosis: 10% Panic disorder by DSM-IV</p> <p>42% Generalised Anxiety Disorder (GAD) by DSM-IV</p> <p>Exclusions: Patients at high risk of an alcohol use disorder, if they had dementia, psychotic illness or an unstable medical condition, 3 or more positive responses on the Patient questionnaire, language or communication barrier, receiving treatment from a mental health professional, had a history of bipolar disorder or had plans to leave the study practice within the following year. If did not have at least moderate levels of anxiety severity as defined by a score of 14 or higher on the 14-item structured interview guide for the Hamilton Anxiety Rating Scale (SIGH-A)</p> <p>Notes: The rest had co-morbid PD with GAD (48%) &amp; 57% had major depression. To be eligible must have scored 7 or higher on PDSS (PD) or had GAD alone or co-morbid with PD &amp; scored 14 or higher on SIGH-A.</p> <p>Baseline: Mean SIGH-A (SD): Intervention = 20.1 (6.4), Usual care = 20.6 (6.4), Total = 20.3 (6.4)</p>	<p><b>Data Used</b></p> <p>SF-12 (PCS)- Quality of life</p> <p>SF-12 (MCS)</p> <p>HDRS (Hamilton depression rating scale)</p> <p>SIGH-A (anxiety)</p> <p>PDSS (Panic Disorder Severity Scale)</p> <p>Response (40% reduction on SIGH-A)</p> <p>Notes: Outcomes taken at 2, 4, 8, &amp; 12 months. Chose non-behavioural specialists (1 with undergraduate degree in psychology &amp; other with a MSc in communication disorders to increase generalisability of findings to non-research settings.</p>	<p><b>Group 1 N= 116</b></p> <p>Telephone-based care management intervention - Non-mental health professionals provided patients with psychoeducation, assessed preferences for guideline-based care, monitored treatment responses, and informed physicians of their patients' care preferences and progress via an electronic record system.</p> <p><b>Group 2 N= 75</b></p> <p>Usual care provided by primary care physicians - Involved notification alone of the anxiety disorder to patients and their physicians</p>	<p>FUNDING: National Institute of Mental Health grant R01 MH09421. Quality assessed: low risk of bias for selection &amp; detection, unclear risk of bias for performance &amp; attrition.</p>
<p><b>Results from this paper:</b></p> <p>At 12-month follow-up, intervention patients reported reduced anxiety and depressive symptoms; improved mental health-related quality of life and led to larger improvements relative to baseline in hours worked per week than usual care patients.</p> <p><b>Intervention (contd.):</b> Patients could choose any combination of the following treatment components: (1) a workbook designed to impart self-management skills for managing PD42 or GAD43 with care manager follow-up to review lesson plans; (2) a guideline-based trial of anxiolytic pharmacotherapy, primarily a selective serotonin reuptake inhibitor or serotonin-norepinephrine reuptake inhibitor, selected according to our treatment algorithm by patient preference, prior use, insurance coverage, and adjusted per patient response; or (3) referral to a community mental health specialist in keeping with the patient's insurance coverage.</p> <p><b>Conclusions:</b> Telephone-based collaborative care for panic disorder and generalised anxiety disorder is more effective than usual care at improving anxiety symptoms, health-related quality of life, and work related outcomes.</p>				

<p><b>ROY-BYRNE2010</b></p> <p>Study Type: RCT</p> <p>Study Description: Examined whether a flexible treatment delivery model for multiple primary care anxiety disorders would be better than usual care.</p> <p>Type of Analysis: ITT: Maximum likelihood approach</p> <p>Blindness: Open</p> <p>Duration (days): Range 70-84</p> <p>Followup: 6, 12 &amp; 18 months (extractable)</p> <p>Setting: 17 primary care clinics:US. Referred from 148 primary care professionals, purposively selected (clinician interest, space, sample size &amp; diversity)</p> <p>Notes: RANDOMISATION: Automated computer programme, stratified by clinic and presence of co-morbid major depression using a permuted block design (masked).</p> <p>Info on Screening Process: 1620 screened. 558 excluded: low severity index, no anxiety diagnosis, anxiety not primary, substance use disorder, psychosis/bipolar disorder, suicidal, cognitive difficulties, refusing to participate, current CBT or other.</p>	<p>n= 1004</p> <p>Age: Mean 43 Range 18-75</p> <p>Sex:</p> <p>Diagnosis:</p> <p>47% Panic disorder by DSM-IV</p> <p>75% Generalised Anxiety Disorder (GAD) by DSM-IV</p> <p>40% Social phobia by DSM-IV</p> <p>18% Posttraumatic stress disorder by DSM-IV</p> <p>Exclusions: Persons unlikely to benefit from CALM (ie, unstable medical conditions, marked cognitive impairment, active suicidal intent or plan, psychosis, bipolar I disorder, and substance abuse of dependence except for alcohol and marijuana abuse) were excluded. Patients already receiving ongoing CBT or medication from a psychiatrist were excluded, as were persons who could not speak English or Spanish.</p> <p>Notes: Numbers may total more than 1004 as patients could have more than 1 disorder. All scored moderately on the overall anxiety severity and impairment scale (OASIS). More than half had at least 2 anxiety disorders, &amp; 2/3 with co-morbid depression.</p> <p>Baseline: Both intervention and comparison groups were comparable on all baseline characteristics</p>	<p><b>Data Used</b></p> <p>Remission (score of less than 5 on OASIS)</p> <p>Response (at least 50% reduction on BSI-12)</p> <p>Brief symptom inventory</p> <p>Notes: Monitoring outcomes: Used real time web-based system by entering OASIS scores and 3 items version of PHQ-9. Those who were symptomatic could receive more of the same modality or the alternate modality for up to 3 more steps of treatment.</p>	<p><b>Group 1 N= 503</b></p> <p>Coordinated Anxiety Learning and Management (CALM). Mean dose 10-12 weeks - Used a web-based monitoring system modelled on IMPACT with newly developed anxiety content and a CCBT programme (8 modules). Flexible delivery, allowing choice of medication, CCBT or both. Guided CCBT was delivered by a non-specialist. Continued care.</p> <p><b>Group 2 N= 501</b></p> <p>Treatment as usual. Mean dose 10-12 weeks - Continued to be treated by their physician in usual manner i.e. medication, counselling (limited mental health resources) or referral to mental health specialist.</p>	<p>FUNDING: National Institute of Health. Quality assessed: low risk of bias for selection, attrition &amp; detection, unclear for performance.</p>
<p>Results from this paper:</p> <p>All outcome measures were significantly better for intervention group except physical health and satisfaction with medical care. Resulted in small-moderate effect sizes which were greatest at 12 months.</p> <p>Conclusions: Therapists: Anxiety clinical specialist including 6 social workers, 5 nurses, 2 master psychologists, 1 doctoral psychologist. CALM Training &amp; treatment components: 6 half days of didactics, which focused on mastering CCBT package, &amp; motivational interviewing to enhance engagement, outreach strategies for ethnic-racial and impoverished minorities. Also included role-playing &amp; successful completion of 2 training patients over several months. A local study psychiatrist provided single session medication management training to clinicians using a simple algorithm. For medication management, adherence monitoring alongside counselling was offered.</p>				

**Characteristics of Excluded Studies**

**References of Included Studies**

**ROLLMAN2005** (Published Data Only)

Rollman, B. L., Belpap, B. H., Mazumdar, S., et al. (2005) A randomized trial to improve the quality of treatment for panic and generalized anxiety disorders in primary care. Archives of General Psychiatry, 62, 1332-1341.

**ROY-BYRNE2010** (Published Data Only)

Craske, M. G., Rose, R. D., Lang, A., et al. (2009) Computer-assisted delivery of cognitive behavioral therapy for anxiety disorders in primary-care settings. *Depression and Anxiety*, 26, 235-242.

Sullivan, G., Craske, M. G., Sherbourne, C., et al. (2007) Design of the Coordinated Anxiety Learning and Management (CALM) study: Innovations in collaborative care for anxiety disorders. *General Hospital Psychiatry*, 29, 379-387.

\*Roy-Byrne, P., Craske, M. G., Sullivan, G., et al. (2010) Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. *JAMA*, 19, 1921-1928.

**References of Excluded Studies**

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