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

Collaborative care versus TAU
ROY-BYRNE2010

Telephone based collaborative care versus TAU
ROLLMAN2005

Characteristics of Included Studies

Methods	Participants	Outcomes	Interventions	Notes
ROLLMAN2005 Study Type: RCT Study Description: Examined whether telephone-based collaborative care for panic and GAD improves outcomes more than usual care provided by primary care physicians. Type of Analysis: ITT Blindness: Open Duration (days): Followup: 2, 4, 8, &12-months (extractable) Setting: Four Pittsburgh area primary care practices linked by a common electronic medical record system. Notes: RANDOMISATION: computer-generated random assignment sequences, allocated in 3:2 ratio. Randomly set blocks of 25-30. Placed in opaque sealed envelopes 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.	n= 191 Age: Range 18-64 Sex: 36 males 155 females Diagnosis: 10% Panic disorder by DSM-IV 42% Generalised Anxiety Disorder (GAD) by DSM-IV 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) Notes: The rest had co-morbid PD with GAD (48%) & 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 & scored 14 or higher on SIGH-A. Baseline: Mean SIGH-A (SD): Intervention = 20.1 (6.4), Usual care = 20.6 (6.4), Total = 20.3 (6.4)	**Data Used** SF-12 (PCS)- Quality of life SF-12 (MCS) HDRS (Hamilton depression rating scale) SIGH-A (anxiety) PDSS (Panic Disorder Severity Scale) Response (40% reduction on SIGH-A) Notes: Outcomes taken at 2, 4, 8, & 12 months. Chose non-behavioural specialists (1 with undergraduate degree in psychology & other with a MSc in communication disorders to increase generalisability of findings to non-research settings.	**Group 1 N= 116** 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. **Group 2 N= 75** Usual care provided by primary care physicians - Involved notification alone of the anxiety disorder to patients and their physicians	FUNDING: National Institute of Mental Health grant R01 MH09421. Quality assessed: low risk of bias for selection & detection, unclear risk of bias for performance & attrition.

Results from this paper:

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.

Intervention (contd.): 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.

Conclusions: 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.

ROY-BYRNE2010				
Study Type: RCT Study Description: Examined whether a flexible treatment delivery model for multiple primary care anxiety disorders would be better than usual care. Type of Analysis: ITT: Maximum likelihood approach Blindness: Open Duration (days): Range 70-84 Followup: 6, 12 & 18 months (extractable) Setting: 17 primary care clinics:US. Referred from 148 primary care professionals, purposively selected (clinician interest, space, sample size & diversity) Notes: RANDOMISATION: Automated computer programme, stratified by clinic and presence of co-morbid major depression using a permuted block design (masked). 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 difficulities, refusing to participate, current CBT or other.	n= 1004 Age: Mean 43 Range 18-75 Sex: Diagnosis: 47% Panic disorder by DSM-IV 75% Generalised Anxiety Disorder (GAD) by DSM-IV 40% Social phobia by DSM-IV 18% Posttraumatic stress disorder by DSM-IV 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. 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, & 2/3 with co-morbid depression. Baseline: Both intervention and comparison groups were comparable on all baseline characteristics	**Data Used** Remission (score of less than 5 on OASIS) Response (at least 50% reduction on BSI-12) Brief symptom inventory Notes: Monitoring outcomes: Used real time web-based system by entering OASIS scores and 3 items version of PHQ-9. Those who were sympomatic could receive more of the same modality or the alternate modality for up to 3 more steps of treatment.	**Group 1 N= 503** 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. **Group 2 N= 501** 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.	FUNDING: National Institute of Health. Quality assessed: low risk of bias for selection, attrition & detection, unclear for performance.
Results from this paper: 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. Conclusions: Therapists: Anxiety clinical specialist including 6 social workers, 5 nurses, 2 master psychologists, 1 doctoral psychologist. CALM Training & treatment components: 6 half days of didactics, which focused on mastering CCBT package, & motivational interviewing to enhance engagement, outreach strategies for ethnic-racial and impoverished minorities. Also included role-playing & 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.				

Characteristics of Excluded Studies

References of Included Studies

ROLLMAN2005 (Published Data Only)

Rollman, B. L., Belnap, 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