

Collaborative Care for Panic Disorder

Roy-Byrne PP, Katon W, Cowley DS, Russo J. A randomized effectiveness trial of collaborative care for patients with panic disorder in primary care. *Arch Gen Psychiatry* 2001;58:869–76.

Study Overview

Objective. To test the clinical effectiveness of panic disorder (PD) pharmacotherapy embedded in a disease management framework of collaborative care (CC) in primary care.

Design. Randomized clinical trial.

Setting and participants. 115 patients with PD (based on *Diagnostic and Statistical Manual-IV* criteria) from 3 Seattle, Washington, primary care clinics. Exclusion criteria included potentially life-threatening comorbidities or conditions that would limit participation in the study; current psychiatric treatment; applying for or receiving disability benefits; non-English speaking; or lack of telephone.

Intervention. Patients in the CC arm received educational videotapes and pamphlets, pharmacotherapy with paroxetine, 2 psychiatrist visits and 2 telephone calls in the first 8 weeks, and up to 5 telephone calls between 3 and 12 months' follow-up. Usual care patients were treated by their primary care physician.

Main outcome measures. Telephone assessments of panic, anxiety sensitivity, depression, and disability variables were performed at 3, 6, 9, and 12 months' follow-up using 6 measures: Panic Disorder Severity Scale (PDSS) total score, Anxiety Sensitivity Inventory (ASI) total score, the Agoraphobia subscale from the Fear Questionnaire, the Center for Epidemiological Studies Depression Scale (CES-D), and the Social Functioning and Role Impairment subscales from the SF-36. Adequacy of pharmacotherapy and adherence was assessed using a previously published algorithm for patient self-report.

Main results. 57 patients were randomized to CC and 58 to usual care (UC). The mean age was 40.8 years (range, 18 to 65 years), 57.4% were female, 67.3% were white, and 63.5% were employed. Participants had other psychiatric comorbidities, including major depression (50.9%), generalized anxiety disorder (43%), social phobia (38.6%), agoraphobia (38.6%), obsessive-compulsive disorder (16.7%), post-traumatic stress disorder (14.9%), and dysthymia (12.3%). 79% of the partici-

pants completed the 12-month assessment.

Patients in CC were more likely to receive adequate medication (ie, proper type, dose, duration) and to adhere to this medication at 3 and 6 months. Differences were not significant at 9 and 12 months due to a decline in CC patients. More CC patients were satisfied with quality of care received at the 6-month (82% versus 43%; $P < 0.001$) and 12-month follow-up (76% versus 52%; $P = 0.039$). Random regression analyses showed that CC patients' anxiety, depression, and disability measures improved significantly over time compared with those of UC patients, with the greatest effects apparent at 3 and 6 months. These differences decreased gradually between 6 and 12 months.

Conclusion. Compared with UC, CC interventions significantly improved both quality of care and clinical and functional outcomes in primary care PD patients. Clinical differences were greatest in the first 6 months, corresponding to the greater quality of care and the greater intensity of intervention.

Commentary

Panic disorder is a common problem in primary care and is frequently misdiagnosed and mismanaged. Patients with PD present with symptoms that mimic other serious clinical conditions. During the workup needed to differentiate the diagnoses, additional interventions and treatments are used that introduce their associated risks and that increase the cost of care. This study helps to demonstrate the complexity of adequate treatment and the need for substantial collaboration between primary care physicians and psychiatrists in order to better diagnose and treat these patients. The outcomes are not entirely encouraging, since the significant treatment effect seen during the first 6 months wears down to the usual care level thereafter.

The effect of the high prevalence of multiple psychiatric comorbidities, especially major depression, on the reported improved quality of care and responses to the psychiatric management is unclear. The impact of the intervention on health care cost was not evaluated in this study. The expected outcome would be a reduced utiliza-

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tion of the health care system for treatment of somatic symptoms. These savings would help to compensate for the additional cost and time needed to implement this model of care.

Applications for Clinical Practice

Collaborative care management between primary care and mental health providers is an effective model to provide primary care to patients with a variety of common psychiatric conditions, including depression and panic disorders. Barriers to generalizing this model to all primary care practices are multiple and complex, but the need for better care for patients affected with these conditions, the growing clinical evidence supporting the effectiveness of CC interventions, and the po-

tential to decrease health care costs should prevail. In the meantime, physicians should incorporate into their routine practices any available tools [1,2] for better screening and diagnosis of psychiatric problems in the primary care population.

—Review by Pedro J. Caraballo, MD

References

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2. Stein MB, Roy-Byrne PP, McQuaid JR, et al. Development of a brief diagnostic screen for panic disorder in primary care. *Psychosom Med* 1999;61:359–64.

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