Patients with coronary heart disease or type 2 diabetes are at higher risk of depression. When these patients are depressed they have lower quality of life, increased disease burden and higher mortality. Depression in the presence of chronic disease is under-diagnosed and under-treated despite the recommendation of guidelines. There is a need for changed systems of care delivery in general practice to manage this problem. At the start of this story three changes were occurring in general practice that would go on to have a profound effect: practices were increasingly computerised for prescribing and recording patient data; practices were employing nurses; and incentive payments were established for chronic disease management activities. Australian general practice was primed for the introduction of a changed system of health delivery called collaborative care. This thesis describes the steps required to introduce this system of care and the outcomes of collaborative care compared with usual care in a randomised trial. The work is presented as a series of published papers.

Collaborative care was both feasible and acceptable in an Australian setting for patients with co-morbid depression and coronary heart disease or diabetes, or both. Practice nurses were successfully trained to detect and monitor depression and they were able to assist patients with lifestyle modifications using goals setting and problem solving techniques. Nurses coordinated protocol-driven scheduled care for patients and assisted doctors by collating clinical information. Patients received a care plan that summarised their medical problems, personal goals and medical management. There were improvements in depression scores, quality of life, levels of exercise, calculated 10-year cardiovascular risk and adherence to guidelines.

Collaborative care is a suitable model for delivery of primary care in Australia to better manage diabetes, coronary heart disease and depression.