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REVIEW ARTICLE

Nurse-Led Interventions for Depression Management: A Review

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ABSTRACT

Depression is among the leading causes of disability worldwide and contributes substantially to the burden of common mental disorders in India, where the treatment gap for mental illness exceeds eighty per cent. Given the acute shortage of psychiatrists and clinical psychologists, task-shifted models that place nurses and trained lay counsellors at the centre of depression care have attracted growing attention. This narrative review synthesises evidence on nurse-led interventions for depression, drawing on collaborative care trials, telephone-based case management studies, and community counsellor-delivered psychological treatments conducted in high-income and low-resource settings, including India. Nurse-delivered collaborative care, in which a nurse care manager coordinates screening, psychoeducation, medication monitoring, and stepped referral under psychiatrist supervision, has been shown in large randomised trials to substantially improve recovery rates compared with usual care and to produce benefits that persist over one to two years. Telephone-delivered case management does not diminish these benefits and extends reach to patients unable to attend frequent clinic visits. In India, lay-counsellor and nurse-delivered brief psychological treatments, and stepped-care programmes such as MANAS, have produced clinically meaningful reductions in depressive symptoms among primary care attenders. Behavioural activation, a core component of several of these programmes, is amenable to delivery by trained nurses with brief instruction and supervision. Barriers to scale-up include limited pre-service training in mental health nursing, absence of defined career pathways for psychiatric nurses, supervision gaps, and stigma. Strengthening the psychiatric nursing workforce through structured training, supervision, and integration into stepped-care pathways is essential to closing India's depression treatment gap.

KEYWORDS

• Depression • Psychiatric-mental health nursing • Collaborative care • Nurse-led intervention • Task-shifting • Community mental health

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Key Messages

Nurse-led collaborative care and nurse- or counsellor-delivered brief psychological treatments substantially improve depression outcomes and are feasible in low-resource settings. Psychiatric nurses, trained in screening, psychoeducation, behavioural activation, and case management, can meaningfully narrow India's depression treatment gap when adequately supervised and integrated into stepped-care systems.

INTRODUCTION

Depression affects an estimated two hundred and eighty million people worldwide and is a leading contributor to years lived with disability. India's National Mental Health Survey found that nearly one in twenty adults had experienced a depressive episode[1], yet the treatment gap for common mental disorders remains above eighty per cent, reflecting an acute shortage of psychiatrists and clinical psychologists relative to population need. Task-shifting depression care to trained nurses and lay counsellors, within structured collaborative and stepped-care models, has emerged as a pragmatic response. This review examines the evidence base for nurse-led depression interventions and their implications for psychiatric nursing practice in India.

Burden of Depression and the Need for Task-Shifted Care

The World Health Organization's Mental Health Gap Action Programme was designed specifically to extend evidence-based care for depression and other priority conditions to non-specialist providers in settings where mental health specialists are scarce[2]. India illustrates this need starkly: specialist mental health human resources remain heavily concentrated in urban tertiary centres, while the vast majority of people with depression are seen, if at all, by primary care physicians, general nurses, and community health workers. Nurses represent the largest cadre of the health workforce and are present at nearly every point of contact with the health system, making psychiatric-mental health nursing a natural entry point for scaling depression care.

Models of Nurse-Led Depression Care

Collaborative Care and the Nurse Care Manager Role

The Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) trial remains the most widely cited model of nurse-led collaborative care. A depression care manager, usually a primary care nurse, worked alongside the patient's physician and a consulting psychiatrist (Figure 1) to deliver structured, stepped depression treatment over twelve months.[3,4] Compared with usual care, patients receiving collaborative care were substantially more likely to achieve a fifty per cent or greater reduction in depressive symptoms and reported greater satisfaction with their care[3]; these benefits persisted for at least one year after the active intervention had ended[4], and the model was also associated with a reduction in suicidal ideation among older primary care patients[5].

Telephone-Based Nurse Case Management

Because frequent face-to-face contact is not always feasible, several trials have tested telephone-delivered nurse case management for patients beginning antidepressant treatment, with favourable effects on adherence and symptom outcomes[6]. A systematic review and meta-regression of ninety-four collaborative care trials found that telephone-delivered case management did not diminish the effectiveness of collaborative care on depressive symptoms or antidepressant use relative to face-to-face delivery[7], supporting telephone and, by extension, tele-nursing-based follow-up as a scalable option for reaching patients in remote or under-served areas.

Nurse and Lay-Counsellor-Delivered Psychological Treatments

In Goa, India, the MANAS trial demonstrated that a stepped-care intervention led by lay health counsellors, working alongside primary care physicians, improved recovery from depression and anxiety among public-facility attenders: sixty-five per cent of participants receiving the intervention had recovered at six months compared with fifty-two point nine per cent receiving enhanced usual care[8], with benefits on clinical and disability outcomes sustained over twelve months[9]. A subsequent

trial evaluated the Healthy Activity Program, a brief behavioural activation treatment delivered by lay counsellors to patients with moderately severe to severe depression in primary health centres, and found significantly greater improvement in depressive symptoms and higher remission among those who received the programme in addition to enhanced usual care[10]. Behavioural activation itself has a strong independent evidence base: a meta-analysis of randomised trials found it to be as effective as cognitive therapy for depression while requiring simpler training, making it particularly suited to delivery by nurses and other non-specialist providers[11]. The principal trials discussed in this section are summarised in Table 1.

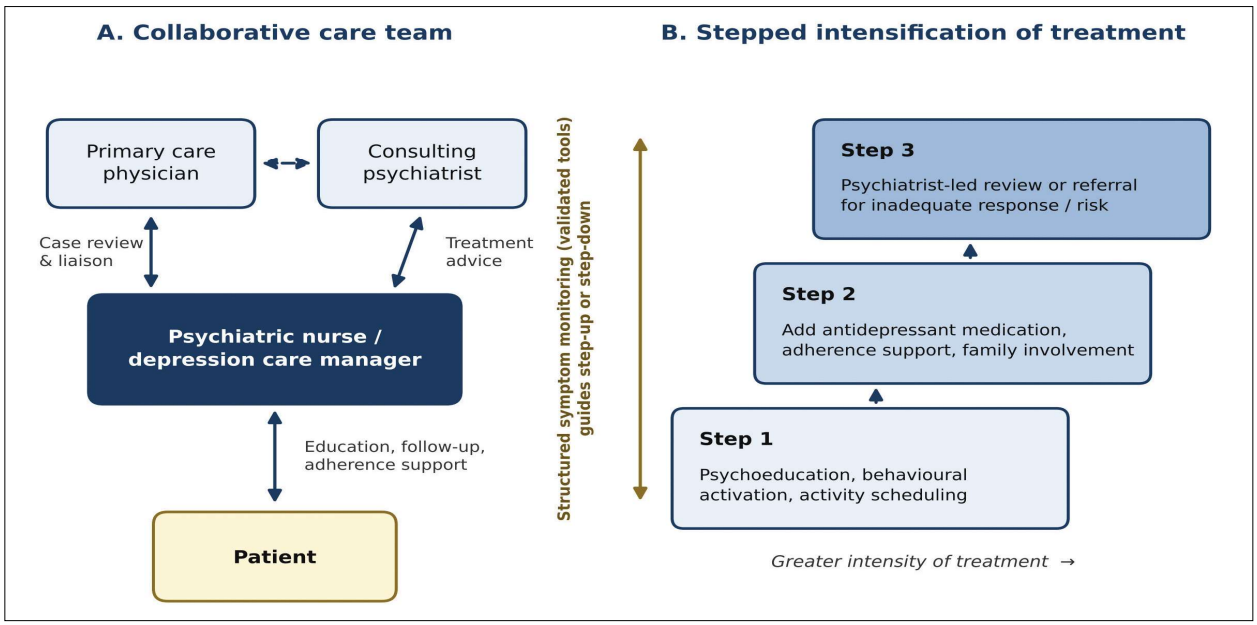


Figure 1: Stepped, collaborative care model for depression: the psychiatric nurse/care manager coordinates patient, primary care physician and consulting psychiatrist, with treatment intensified stepwise according to structured symptom monitoring.

Table 1: Selected trials of nurse or lay-counsellor-led interventions for depression

Study (reference)	Country	Design	Cadre delivering intervention	Key outcome
IMPACT[3]	USA	Cluster RCT, eighteen primary care clinics	Nurse depression care manager	Substantially higher rate of fifty per cent or greater symptom reduction versus usual care
IMPACT two-year follow-up[4]	USA	RCT with long-term follow-up	Nurse depression care manager	Benefits persisted one year after intervention withdrawal
MANAS[8]	India (Goa)	Cluster RCT	Lay health counsellor	Recovery in sixty-five per cent versus fifty-two point nine per cent with usual care at six months
Healthy Activity Program[10]	India (Goa)	RCT	Lay counsellor (behavioural activation)	Greater symptom reduction and higher remission versus enhanced usual care
Telephone case-management meta-regression[7]	Multinational	Systematic review/ meta-regression, ninety-four trials	Nurse/case manager (telephone)	Telephone delivery did not diminish effectiveness of collaborative care

Abbreviations: RCT = randomised controlled trial.

Psychoeducation, Behavioural Activation, and Relapse Prevention by Nurses

Across these models, the components most consistently delegated to nurses include structured screening with validated tools, psychoeducation about the nature and course of depression, activity scheduling and monitoring of the link between activity and mood, adherence support for antidepressant medication, family involvement, and relapse-prevention planning. None of these components require the depth of training of a specialist psychiatrist, but all require dedicated training, a structured protocol, and ongoing supervision if fidelity and safety are to be maintained.

Digital and Telehealth-Enabled Nurse-Led Care

The expansion of telehealth has created further opportunities for nurse-led depression care, including remote screening, video- or telephone-based follow-up, and structured messaging for adherence support. India's national tele-mental health programme, which links callers to trained counsellors and mental health professionals across a network of state cells, illustrates how nurse and counsellor cadres can be embedded within a telehealth-enabled stepped-care architecture to extend reach into rural and under-served districts.

Nurse-Led Depression Care in the Indian Context

India's District Mental Health Programme has historically relied on a small multidisciplinary team per district, with limited dedicated psychiatric nursing input. Strengthening the role of psychiatric-mental health nurses within this structure, and linking them with community health workers, general nurses in primary care, and tele-mental health services, offers a pragmatic pathway to extend depression care without requiring a proportional increase in specialist numbers. Undergraduate and post-basic nursing curricula in India increasingly include mental health nursing competencies, but structured, competency-based training in specific depression protocols, such as behavioural activation or collaborative care case management, is not yet standard and would need to be built into both pre-service curricula and continuing nursing education.

Barriers to Implementation

- Limited pre-service and in-service training in structured depression-specific protocols for nurses
- Absence of clearly defined career pathways and remuneration structures for psychiatric-mental health nurses functioning as care managers
- Inadequate supervision structures linking nurses to psychiatrists for case review and escalation
- Role ambiguity between nursing, counselling, and community health worker cadres
- Persistent stigma affecting help-seeking and disclosure by patients
- Documentation and workload burden competing with existing nursing responsibilities
- Uncertain long-term funding for dedicated depression care-manager positions

Implications for Psychiatric Nursing Practice, Education, and Policy

Nursing curricula and continuing education programmes should incorporate structured training in validated depression screening tools, behavioural activation, and collaborative care case management, with supervised practicum. Health systems should define a formal depression care-manager role for psychiatric-mental health nurses, with clear protocols for stepped referral to psychiatrists. Supervision structures, whether through regular case-review meetings or tele-mental health linkages, are needed to maintain fidelity and safety. Nurse researchers should be supported to generate India-specific evidence on the effectiveness, cost, and acceptability of nurse-led depression care models, given that most of the trial evidence reviewed here originates from either high-income settings or lay-counsellor rather than nurse-specific cadres.

CONCLUSION

Evidence from collaborative care trials, telephone-based case management studies, and lay-counsellor-delivered psychological treatments consistently supports the effectiveness of nurse-led and nurse-adjacent models of depression care. In a country such

as India, where the psychiatric workforce is heavily outnumbered by the scale of unmet need, deliberately building the capacity of psychiatric-mental health nurses to deliver structured, supervised depression interventions represents one of the most feasible strategies available for narrowing the treatment gap.

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Conflict of Interest: None declared

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