EDITORIALS

Managing Patients with Depression: Is Primary Care Up to the Challenge?

Over the past 20 years we have seen the development of several new medications to treat depression. Short-term specific forms of psychotherapy have been refined and proven to improve outcomes. New modes of delivering care for primary care patients with depression have been proven to be effective in clinical trials.[1–3] Yet despite all this, little has changed. Most individuals with depression are seen in general medical offices and not by mental health specialists. Evidence suggests that the care of patients with depression provided by primary care physicians has not improved. Recognition and treatment of patients with depression is substantially below the standards set by practice guidelines. The evolution of health care delivery and the development of new mental health carveout arrangements have added new challenges.

The impact of depression on overall function is still substantial.[4] Evidence is building that depression is a risk factor for the development of coronary artery disease and other diseases.[5] Management of other chronic diseases is complicated by co-occurring depression. The article by Mancuso et al.[6] documents that patients with asthma and depression report lower health-related quality of life than patients with asthma who do not have depression. One could be more confident of such relationships if the data were collected prospectively and if there were objective measures of function. Patients with depression tend to be overly pessimistic and may underestimate their performance. Understanding the mechanisms for these relationships is important since it has been difficult to demonstrate that treatment of depression in primary care patients improves physical functional status scores.

Although the findings are based on an administrative database, the report by Sambamoorthi et al.[7] is one of the few to demonstrate that treatment of depression can reduce general medical costs. Patients with HIV infection are very high utilizers of health care services, which may account for the ability of this study to detect the change. Most remarkable is that the decrease in total health expenditures after treatment for depression was accompanied by better quality of care as evidenced by the higher receipt of antiretroviral treatment.

Wang et al. analyzed data from the MIDUS survey sampled from the US population with a telephone in 1996.[8] Their results indicate that there has been little change in the patterns of care for depression since the Epidemiologic Catchment Area survey in the 1980s[9] and the National Comorbidity Survey in the 1990s.[10] Almost half of those with current major depression have received no care in the last year and the general medical sector remained the predominant site for care. Even with relatively generous methods for classifying guideline-concordant care for depression, only one-third or fewer of those with depression seeing a general medical provider reported being on an antidepressant and having 4 or more visits to that provider. Minority patients, those without insurance for mental health visits, and those with the lowest severity of mental illness were most likely to report not receiving adequate care.

Either the methodology used in these large surveys is inappropriate to measure quality of care or large problems in health care delivery remain. Whooley et al. report on one attempt to improve care for older adult patients with depression.[11] They found that an intervention of screening older adults for depression and offering them a series of organized educational group sessions on coping with depression had no impact on depression scores. As has been found in other studies relying solely on screening for depression, the intervention has little impact on recognition or treatment of depression. It is possible that they may have detected small differences in depression scores if they had assessed outcomes at some point before 2 years, but other studies using more intensive interventions have generally found that care and outcomes return to baseline relatively quickly when the depression care intervention is phased out.[12]

So what is the responsibility of the primary care physician for care of those with depression? Primary care physicians are probably doing the best they can in a system in which the number of visits and length of visits are fixed, patients have shorter relationships with their physicians, communication with mental health specialists is becoming more difficult, costs of antidepressant medications are increasing, and the public still is confused about the concept of depression as it applies to their life struggles. Primary care physicians must begin to realize that they will always struggle to achieve the level of care they desire for all of their patients with depression in the current environment. However, models of health care delivery have been developed and tested that do improve outcomes for patients with depression. While most of these models are most appropriate for staff model managed care primary care practices, creative adaptations of these models for more isolated practices are within sight. Depression care teams with expertise in mental health and primary care, active follow-up of patients, and more visits than usual for primary care are the hallmarks of success-

ful programs. Primary care physicians have the obligation to learn about these programs and advocate for more widespread implementation. While these programs will not guarantee that all patients with depression will have resolution of their symptoms, they can be the foundation to learn more about why many patients do not receive guideline-concordant care or respond to treatment. If primary care physicians are going to have a substantial role in any organized system of care for patients with depression, a set of skills that all primary care physicians possess needs to be defined. Primary care physicians who believe it is acceptable to take a very limited or no role in the care of patients with depression compromise efforts to build systems of care that clarify for both patients and physicians who is responsible for recognition, acute care, and continuing care of individuals with depression.

Resources directed at the care of depression provide good value.[13] The public continues to look to primary care physicians for help in the care of depression. With the large body of research available on care of patients with depression, primary care physicians are in a position to take a leadership role in disseminating these models of care and helping to improve the quality of life of their patients with depression. I hope the profession can meet the challenge.—**DANIEL E. FORD, MD, MPH,** *Johns Hopkins Medical Institutions, Baltimore, Md.*

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