EDITORIALS

Competing Demands

Does Care for Depression Fit in Primary Care?

Major depression ranks fourth among diseases in its global impact on disability-adjusted life years, and it is projected to move up to second place by the year 2020.[1] Much of the care for depression, perhaps the majority, is provided in the general medical sector rather than the mental health sector. Unfortunately, the care in either setting is too often suboptimal.

In this issue, Katz et al. add to our understanding of the problems with care by comparing the rates of mental health care and the appropriateness of care between the United States and Canada.[2] One of the most important differences between these systems is access to health care. In the United States, many individuals lack health insurance, and even those with coverage usually have greater constraints on mental health coverage than on coverage for physical problems. Canadians have universal health coverage that includes generous mental health benefits. The key findings of Katz et al.'s study were as follows: (1) although "appropriate management" for major depression was low in both countries, individuals living in the United States were 40% as likely to receive appropriate management as Canadians; (2) the lower rates of appropriate care in the United States were predominantly due to fewer visits in the general medical sector; (3) almost 40% of depressed persons did not perceive a need for services; and (4) more Americans perceived care as too expensive or were uncertain where to go for care.

These findings add to the substantial literature documenting that care for major depression is not ideal. In theory, depression can be treated effectively. In practice, it often is not. Further, the results suggest that economic barriers are an important reason for low rates of appropriate care. In the United States, the Mental Health Parity Act requires employers to increase dollar limits for mental health coverage to those for medical care and thus may lower the economic barriers. However, the major difference between countries in the Katz et al. study was fewer primary care visits for mental health care in the United States. To improve mental health care in the United States, primary care coverage must be expanded.

Greater insurance benefits are necessary but not sufficient. We must learn how to improve care for those who have access and seek care. Among those seeking care, only about one quarter in either country received appropriate care. Recognizing that primary care physicians provide the majority of mental health care, thoughtful groups have sponsored educational programs, such as the Depression Awareness Recognition and Treatment program and clinical guidelines targeted at improving primary care physicians' knowledge. Their exact impact is uncertain, but less than half of primary care physicians have seen the guidelines, and care remains suboptimal.[3] The persistent deficits in care for depression have left some to wonder if primary care physicians should or can include treatment for depression as part of routine practice. After all, how many guidelines and how many issues can be squeezed into the average 13-minute patient visit?

SHOULD PRIMARY CARE PHYSICIANS TREAT MENTAL DISORDERS?

The Institute of Medicine defines primary care as the "provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, which include physical, mental, emotional, and social concerns."[4] DeGruy says the only sensible vision of primary health care has mental health care woven into its fabric.[5] In fact, a significant proportion of our clinical enterprise involves interactions between mind and body, for example, negotiating care plans with patients who have diabetes mellitus and contracting for smoking cessation with patients who have heart disease. To attempt management of physical disorders without addressing psychosocial issues is a prescription for failure.

We should be prepared to recognize and in many instances treat the 6% to 10% of patients in our practice with major depression. Patients believe we are an appropriate resource for mental health problems, and in some studies we were considered more appropriate than mental health specialists.[6] Even if mental health benefits are expanded in this country, these data and my own experience suggest that a large number of depressed patients will prefer treatment by their primary care physician rather than a mental health specialist. For this highly prevalent, morbid, and costly category of illness, the issue is not whether we should attempt to treat, but how we will meet the need.

IMPROVING CARE FOR MENTAL DISORDERS

The primary care physician has multiple roles. During any given visit, one may need to prioritize acute symptoms, chronic medical problems, psychosocial problems,

preventive services, counseling for behavior change, and administrative aspects of care. With such complex roles, more than 1,500 printed guidelines, and 13 minutes on average to see each patient, rational physicians could be forgiven for despairing over yet another demand—to provide quality, responsive care for their depressed patients. A theoretical model, suitably named "competing demands," explicitly considers these tensions.[7] The model describes three domains that directly influence the outcome of each clinical encounter: the clinician, the patient, and the practice ecosystem. The services delivered are the result of the competition between these demands. The model is useful because it highlights the need to consider all three factors in any attempt to improve care for depression.

How should interested primary care physicians invest their time to improve care of the depressed patient? Previous research suggests emphasizing the following knowledge and skills.[8] First, increase your sensitivity to nonverbal cues and consider routinely asking patients about their mood. Second, practice supportive listening and empathetic communication. Brief, targeted communication courses have led to positive changes in physician behavior and improved emotional outcomes for patients.[9] Third, learn educational messages that improve treatment adherence: "Take your medication daily. The medication takes 2–4 weeks to take effect. Don't stop the medication without calling me. Continue the medication even when you feel better. If you think you have side effects, remember what we discussed." Fourth, understand the concepts of staged management, which includes acute, continuing, and maintenance phases as outlined in the Association for Health Care Policy and Research (AHCPR) guidelines.[10] Fifth, understand your limits, and establish an effective referral relationship with mental health specialists. For example, patients with "dual diagnoses" such as alcohol dependence and major depression are beyond the knowledge and skill of most of us.

Patients also bring knowledge and beliefs to each encounter. However, our understanding of patient preference and knowledge is limited. In the Katz et al. study, approximately 40% of patients with major depression did not perceive the need for professional help. In another community-based study, 84% of adults found it appropriate to see their primary care physician for depressed mood, but only 33% of those with symptoms of depression had discussed these symptoms with their physician.[11] An Australian study found that more people regarded antidepressant medication as potentially harmful (42%) than helpful (29%).[6] These data suggest that we may be putting up barriers that prevent patients from telling us about their emotional health, which explains why some clinicians in our practice are wearing lapel buttons that say "Ask me about treating the blues." Giving explicit permission to discuss these issues may be a necessary condition for improving care. Until we understand these issues more fully, the proportion of patients receiving appropriate management most likely will remain low.

The current practice environment can feel hostile to primary care physicians trying to care for depressed patients. Visits are brief and mental health services often are not available or well integrated with primary care. For many patients, their mental health benefit is "carved out" to a behavioral health care company. For these patients, the primary care provider is reimbursed for diagnosis but not for treatment, which is a direct economic disincentive encouraging the primary care provider not to provide care but to give the patient a "1-800" number. These arrangements are prevalent because they reduce costs, but they should be reconsidered. Incentives must be constructed to promote quality care, not just contain costs. In addition, our office resources and organization must be improved. Better information systems and improved educational materials for patients may help our productivity (yes, we probably can squeeze a little more into the 13-minute visits), but additional or different human resources are needed. The ideal staffing structure is not yet clear, but having psychologists in the primary care setting has improved the care for major depression.[12] Ongoing studies of nurse specialists, decision-support software, and better coordination with mental health specialists will better define the needed resources.

Care for depressed patients is a natural for primary care physicians. However, current training, practice structures, limits on insurance coverage, and uncertainty about patient preferences make it difficult to provide that care. To overcome these barriers, we should advocate for expanded insurance coverage and for benefit packages that permit the primary care physician to treat depression. We should take stock of our own skills and address our weaknesses. Finally, we should monitor the ongoing research to define better methods of organizing our practices to meet the needs of patients with depression.—**JOHN W. WILLIAMS, JR., MD, MSC,** *University of Texas Health Science Center, San Antonio.*

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