

TREATING DEPRESSED PATIENTS

Primary care physicians (PCPs) are often the first, and many times the only, clinicians to encounter individuals suffering from depression. While patients may present with depression as a chief complaint, vague somatic problems such as “fatigue” or “headache” are much more likely to be given as reason for the visit. Which physician hasn’t explored such presenting problems only to later discover “the real issue,” and then re-schedule or extend the examination to sort things out? This *CD Summary* issue reviews new information about best practices and the advantages of collaborative care in treating depression.

IMPACT OF THE ILLNESS

Data from the Oregon 1999 Behavior Risk Factor Surveillance System indicate that overall, 42% of adults reported that they had felt “sad, blue, or depressed” for one or more days during the last 30 days. This percentage was higher for women (46%) than men (37%) and was inversely related to age: 56% of those 18-29 years; 47% of those 30-44 years; 40% of those 45-64 years; and 23% of those 65 years and older.

National data demonstrate a high prevalence of physician-diagnosed depressive disorders in the general population; up to 15% of people experience major depression sometime during their life. In primary care settings, the prevalence of major depression may range from 5-14%; it is even higher in patients with comorbid conditions, such as hypertension (30-35%), or asthma (50%)¹. Since most individuals experience recurrences, depression should be considered a chronic disease.

Depression takes a huge toll on individuals and society. Depressed employees incur more disability days than patients with chronic back pain, heart disease, hypertension and diabetes. Suicide related to depression is among the top 10 causes of death in the U.S. The symptoms of depression contribute doubly because

hopelessness, lack of energy, and low self-esteem may interfere with an individual’s ability to seek treatment. In developed countries, the disease burden of depression, as measured by lost years of healthy life (including those due to disability and death), is second to only ischemic heart disease². Add to this the impact on the health care system associated with increased medical costs from delayed or improper treatment, increased non-psychiatric health service utilization, and increased visits to emergency departments and hospitals, and it is not surprising that the annual cost of depression in the U.S. is comparable to that of heart disease³.

TREATMENT

It may be surprising that the treatments for depression work very well, at least as well as those for most other medical conditions. Up to 90% of individuals suffering from major depression can be treated successfully⁴. Effective response rates for medication treatment of depression in primary care settings range between 60%-65%⁵. The increasing number of effective antidepressants is matched by improved and effective time-limited psychotherapy techniques.

CHALLENGES FOR PRIMARY CARE PROVIDERS

Unfortunately, up to 2/3 of persons with depression either do not seek or do not receive any treatment (often because their illness goes undetected). Of the remaining 1/3 who do receive treatment, many get improper treatment (e.g. benzodiazepines) or insufficient treatment (e.g., sub-therapeutic doses or premature termination of antidepressants or lack of referral to mental health care)⁶. PCPs would appear to be in the best position to intervene in the care of depressed patients, but a number of factors make this difficult. Of course, screening for depression (often masked as substance abuse, domestic violence, or somatization) during a 15-minute visit for a cardiac patient whose

insurance won’t cover expensive antidepressants or psychotherapy, even if it were available, is frustrating. PCPs may avoid asking about a patient’s mood, fearing that there is no help. Even when mental health providers are involved in a patient’s care, frustrating protocol or confidentiality barriers can prevent effective communication. It is understandable, then, that one study of depression outcomes showed: 50% of patients were screened, 25% received initial treatment, 12.5% had adequate acute treatment, 8.5% showed a treatment response and only 5% were on continued treatment after six months⁷.

NEWER APPROACHES TO IMPROVE CARE

With growing awareness of the concerns cited above, researchers, clinicians, and policy makers are working steadily to provide solutions for patients, providers and the health care system overall.

Practice Guidelines

The Agency for Health Care Policy and Research introduced the gold standard for assessment and treatment of depression in primary care settings⁸. These guidelines identified screening and evaluation questions, diagnostic criteria, treatment interventions, and recommended intervals for monitoring patient improvement that were supported by evidence-based research. More recent guidelines, including those created by the American Psychiatric Association, have updated recommendations for the use of medications and psychotherapy⁹.

Screening and Diagnostic Supports

Several systems for quickly and conveniently screening patients for risk of depression and other psychiatric and substance use disorders have been developed over the years. Among the best is the PRIME-MD, a patient questionnaire that can screen for most conditions encountered in primary care settings, including depression. The questionnaire can be completed before the patient sees the



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provider and can be computer scored so that the results are quickly available to the provider when the patient is seen¹⁰. Another useful support is the Diagnostic and Statistical Manual of Mental Disorders, Primary Care Version (DSM-IV-PC), a user-friendly diagnostic guideline. It was developed in a broad collaboration of primary care and psychiatric organizations and is oriented to the kinds of conditions seen by the PCP.

Newer Medications

There has been a dramatic surge in the development of newer antidepressants and mood stabilizers in the past 15 years. Many newer medications have different mechanisms of action than older ones and have far fewer side effects. These improvements allow both PCP and patient to be more comfortable with proper medications and at doses that are generally effective.

Psychotherapy

Advances in the development of cognitive and behavioral approaches to psychotherapy can benefit many patients in a relatively short amount of time (8-20 sessions). Psychotherapy alone may be effective for some patients, while psychotherapy combined with medications may be the most effective approach for more severe forms of depression.

Collaborative Teams

Many PCP clinics are developing vital consultation relationships with psychiatrists and other mental health professionals. An on-site mental health professional can provide a wide range of services, from triage and assessment, to on-site treatment, to facilitation of referrals to mental health providers. The on-site consultant provides greater opportunities for PCPs to obtain valuable and timely

curbside consultations. OHSU's Physician Consultation Service is a statewide resource to which PCPs can call 800/245-6478 to obtain such curbside psychiatric consultations.

Improved System Supports

Many PCPs are finding that care managers (usually nurses or well-trained support staff) can be used to monitor patient progress and maintain contact. This can improve adherence to treatment, remind patients of follow-up appointments or the need for medication refills, and can be part of clinical and satisfaction outcome assessments. Improved clinical office-information software systems incorporate more convenient and effective clinical task reminders and tracking methods, for example in electronic medical record systems.

CONFERENCE ANNOUNCEMENT

Incorporating these best practices into office-based treatment of depression remains challenging. To provide a forum for PCPs and mental health professionals to enhance their skills in treating depression, the Department of Human Services, Office of Mental Health Services, together with a broad range of professional and provider organizations, is putting on a conference, entitled "Making it Work: Primary Care and Mental Health." It will be held October 13-14 in Portland. PCPs throughout the state are encouraged to attend. For further information on the conference and the reduced "Partner up!" rates (for a PCP registering with a local mental health provider), call 503/947-4217.

GUEST AUTHORS

The Health Division does not claim any particular expertise in diagnosing and treating depression. In a rare deviation from our "in-house" and anonymous authorship policy, we are happy to acknowledge that this article was contributed by two physicians who work for the the Department of Human Services, Office of Mental Health Services, to whom additional questions may be directed: David Pollack, MD and Rupert Goetz, MD, at 503/945-2989.

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