The 'Usual Care' of Depression Is Not 'Good Enough'

MENTAL ILLNESS in primary care settings is costly, disabling, highly prevalent, and treatable.[1] Unfortunately, studies have shown that primary care physicians fail to recognize many patients with psychiatric disorders and frequently fail to treat adequately those they do.[2] Efforts to increase the recognition of mental illness by primary care physicians have not resulted in improved outcomes for the patients.[3] Because of this, interest has shifted away from improving recognition toward improving the intensity of psychiatric care provided by primary care physicians.[4] For example, the Agency for Health Care Policy and Research, Rockville, Md, has chosen depression as one of the first areas for the development of clinical practice guidelines.[5]

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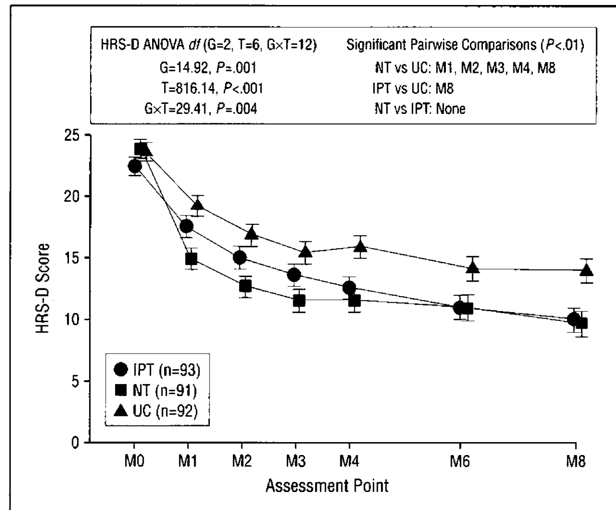
Findings from the study by Schulberg et al[6] further support the belief that intensive treatment of patients with major depression who are seen in primary care settings will result in better patient outcomes. They randomized patients with major depression who were seen in primary care practices to 1 of 3 arms: psychotherapy by a mental health care professional, medication management by a board-certified primary care physician, or "usual care" by the regular primary care physician. The results are presented in the **Figure**. Schulberg et al[6] found that psychotherapy and medication management were significantly more effective than usual care. Specifically, they found that medication management by the primary care physicians was as effective as the psychotherapy by the mental health care professionals, and both were more effective than usual care. The medication management arm was provided by board-certified family practitioners or general internists who were trained in pharmacotherapy protocol procedures from a manual.[7]

To my knowledge, this study by Schulberg et al[6] demonstrated for the first time that primary care physicians can treat major depression as effectively as nonphysician mental health care professionals if they follow a specific protocol. It is of particular interest that what constitutes "specific treatment" is reasonable and well within the reach of a busy clinical practice. Specific treatment can mean as little as increasing the frequency of office visits (biweekly until the patient responds, then monthly), educating the patient about antidepressants, and encouraging the patient to stay in treatment for 6 months. This is not unreasonable or excessive; yet, it seems to be more than typical usual care. The question remains: what is wrong with usual care? In this issue of the ARCHIVES,



Course of depressive severity from baseline (M0) to month 8 (M8) among intent-to-treat cohorts who were randomized to interpersonal psychotherapy (IPT), nortriptyline hydrochloride (NT), or usual care (UC). HRS-D indicates 17-item Hamilton Rating Scale–Depression; ANOVA, analysis of variance; G, group; and T, time.

Schulberg et al[8] give a better understanding of what constitutes the problems with usual care.

In this issue of the ARCHIVES, Schulberg et al[8] have analyzed the treatment of the 92 patients who were referred back to their primary care physicians as the control group in the previously cited study[6] (ie, usual care in the Figure). This article examines the treatment of these 92 patients as if this were a study of the natural history of usual care in primary care. All the patients met formal criteria for major depression, and all the physicians were informed of the diagnosis. The interventions by the primary care physicians and the outcomes for these patients are the results of this study.

The most important aspect of this study is that many of the interventions were "inadequate" when judged by accepted guidelines for the treatment of depression. Of the 92 patients, 25 (27%) did not receive any treatment, only 50 (54%) received antidepressants, and only 40 (43%) of those patients who were being treated with antidepressants received these drugs within current "state-of-the-art" guidelines; the average number of office visits for each patient ranged from 0.1 to 4.8 visits throughout the study. (The average number of office visits for the patients who were treated as part of the intervention study ranged from 9.8-13.8.) In general, the treatments were too little, too short, and without adequate follow-up.

There are many obstacles (eg, social stigma, lack of reimbursement, somatization, and limited office time) to the treatment of mental disorders.[9] The studies by

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Schulberg et al[6,8] show that, despite these difficulties, when patients are treated properly in a primary care setting, they respond better. In addition (and this is a conclusion that I have resisted reaching), primary care physicians—when left to themselves—are not properly treating the mental disorders in their patients.[3] In other words, the usual care is not "good enough."

One major confounding variable in this study[8] is the large number of patients who were seen in a primary care practice and who refused to participate. Of the 678 patients identified with major depression, 41% refused to meet with the psychiatrist. Susman et al[10] have noted that primary care physicians can be reluctant to discuss mental illness because patients will leave the practice. What happens to patients with mental disorders who get offended by intensive psychiatric treatment? Is it better to tread lightly around psychiatric issues and keep all the patients in the practice, or be more aggressive and have some patients refuse to return? The National Institute of Mental Health, Bethesda, Md, has funded 3 large interventions that may help to answer this question by testing "guidelines treatment" vs usual care in active clinical practices.[11] These studies should shed more light on the overall effectiveness of aggressive psychiatric treatment of patients who are seen in primary care settings.

There are several other shortcomings to the study by Schulberg et al[8] in this issue of the ARCHIVES. First, most of the physicians who treated the patients in the usual care arm were residents (78%), while the primary care physicians who followed the specific protocol were all board-certified. Second, the most widely used antidepressant was nortriptyline hydrochloride, which is not one of the newer antidepressants that have a better record of compliance. Third, the study was conducted in an academic setting that served patients from a lower socioeconomic class, and fourth, the physicians were not blinded to the diagnosis of the patients in usual care. These variables tended to decrease the generalizability of the results. However, there is no reason to believe that the usual care in this study was significantly different from the usual care in the community.

Primary care physicians are at a significant disadvantage when they are treating patients with emotional disorders. Not only is there no financial incentive for psychiatric treatments, but there is also no groundswell from patients who demand better mental health. Primary care physicians might benefit from tools that will provide appropriate feedback on the patients' progress or lack of progress. Such a tool may encourage the improvement of usual care.

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REFERENCES

1. Johnson J, Weissman MM, Klerman GL. Service utilization and social morbidity associated with depressive symptoms in the community. *JAMA.* 1992;267:1478-1483.
2. Katon W, von Korff M, Lin E, Bush T, Ormel J. Adequacy and duration of antidepressant treatment in primary care. *Med Care.* 1992;30:67-76.
3. Higgins ES. A review of unrecognized mental illness in primary care: prevalence, natural history, and efforts to change the course. *Arch Fam Med.* 1994; 3:908-917.
4. Katon W, Gonzales J. A review of randomized trials of psychiatric consultation-liaison studies in primary care. *Psychosomatics.* 1994;35:268-278.
5. Depression Guideline Panel. *Depression in Primary Care, I: Detection and Diagnosis: Clinical Practice Guideline, No. 5.* Rockville, Md: US Dept of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research; April 1993. AHCPR publication 93-0551.
6. Schulberg HC, Block MR, Madonia MJ, et al. Treating major depression in primary care practice: eight-month clinical outcomes. *Arch Gen Psychiatry.* 1996; 53:913-919.
7. Fawcett J, Epstein P, Fiester S, Elkin I, Autry J. Clinical management—imipramine/placebo administration manual. *Psychopharmacol Bull.* 1987;23:309-324.
8. Schulberg HC, Block MR, Madonia MJ, et al. The 'usual care' of major depression in primary care practice. *Arch Fam Med.* 1997;6:334-339.
9. Eisenberg L. Treating depression and anxiety in primary care: closing the gap between knowledge and practice. *N Engl J Med.* 1992;326:1080-1084.
10. Susman JL, Crabtree BF, Essink G. Depression in rural family practice: easy to recognize, difficult to diagnose. *Arch Fam Med.* 1995;4:427-431.
11. Ford DE, Rubenstein L, Rost K. *Depression Guidelines Cooperative Agreement Update.* Bethesda, Md: National Institute of Mental Health; 1996.

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