

December 26, 2005

# **Changing the Landscape: Depression Screening and Management in Primary Care**

A Policy Paper

Division of Mental Hygiene  
New York City Department of Health and Mental Hygiene

December 30, 2005



## Executive Summary

Depression is a chronic medical illness, much like diabetes, heart disease and hypertension; it is common, recurrent and costly. More than 35 million people are diagnosed and living with depression right now in the United States.<sup>1</sup> Depression is considered the leading cause of disability in developed nations and is the leading cause of disease-related disability in women.<sup>2</sup>

Despite the prevalence of depression, the effectiveness of treatment, and its personal, community and economic consequences, a great many Americans with depression spend years undiagnosed and untreated. Untreated depression causes unnecessary suffering, poor quality of life, and can lead to a wide range of negative and costly consequences including lost worker productivity, unemployment, and poor physical health.<sup>3</sup>

It is well-known that early diagnosis and effective treatment of depression can improve the health and quality of life for individuals and families living with this illness as well as reduce the social costs of this widespread disease. Unfortunately, too many people living with depression do not receive adequate treatment, if they receive any at all.<sup>4</sup> Moreover, individuals who belong to ethnic or racial minorities are less likely to seek or obtain treatment for depression and are also less likely to receive adequate treatment than their white counterparts. There are also groups of individuals who are at higher risk for developing depression, such as individuals with HIV/AIDS, those with chronic medical conditions, pregnant women, and the elderly. Because these groups of people are often not screened, diagnosed, treated or are unable to access care in a timely and appropriate manner they unnecessarily suffer from poorer outcomes.<sup>5</sup>

Barriers to depression treatment are very common. Many times people hesitate to seek mental health services because of the stigma attached to their conditions and to mental health services. In some cultures, it is considered taboo or a sign of weakness to have a mental illness. In others, a mental illness brings dishonor to family and community: people fear being labeled as crazy or being fired from their jobs if their condition is discovered. Others do not seek treatment because they do not understand their symptoms, or because of a lack of knowledge and awareness of available treatment options.<sup>6</sup> Depression can often manifest itself as physical symptoms including fatigue or persistent vague pain symptoms, thus many people fail to recognize their symptoms as being related to a mental illness. Oftentimes, there is inadequate or absent health insurance coverage. In a City like New York, there are many language barriers that make accessing information and care even harder than it needs to be.

We know that a person's physical and mental health are intertwined, interdependent and in fact inseparable. In 1999, the Surgeon General of the United States stated that "there is no health without mental health."<sup>7</sup> Overwhelming clinical evidence tells us that in order to improve the outcomes from all diseases, the health care industry must increasingly focus on the whole person – mind and body – and understand the unique needs of each individual.

In the U.S., primary care physicians (PCPs) are both the first line of defense and the major source of ongoing care for most health problems. People are more likely to go to their family doctor than to a mental health professional, a psychiatrist or a psychologist, even for a mental

health problem.<sup>8</sup> About half of the care for common mental disorders today is delivered in general medical settings and depression is one of the most commonly seen conditions in primary care. Notably, greater than 65% of all prescriptions for antidepressant medications are prescribed by PCPs, yet the vast majority of depressed patients receive less than minimally adequate treatment.<sup>9</sup>

PCPs are thus in a unique position to provide early detection and ongoing care for persons with depression. Unfortunately, PCPs fail to diagnose depression in up to 50% of their depressed patients and when they do, diagnosis and treatment seldom conform to current treatment guidelines.<sup>10</sup> This is not because of the lack of intent of PCPs, but instead reflects a problem at the systems level of medical care.

The New York City Department of Health and Mental Hygiene (DOHMH) has adopted an aggressive ten-point strategy called **Take Care New York (TCNY)**. **TCNY** is a public health and public behavioral health policy that prioritizes specific actions by which individuals, health care providers, and New York City as a whole can improve the health and mental health of the City's residents. Launched in March 2004, **TCNY** is an ambitious policy that identifies 10 key areas, each of which causes significant illness and death but which are amenable to interventions and are focused on undeserved communities with disproportionately high disease burden in order to reduce health disparities. Depression is one of the 10 key areas. No other city has taken on such a systematic public health effort.

**TCNY** item # 5 is "Get Help for Depression." This public mental health initiative includes the following objectives:

- 1) Improve treatment of depression by educating the public to recognize the symptoms of depression and to ask their doctor or health care provider to administer a simple screening test for depression.
- 2) Advocate for behavioral health insurance parity and the elimination of limitations on Medicaid mental health services in New York State (the Medicaid Mental Health Neutrality Cap) as well as influence purchasers and health plans to include depression screening and management as standard practice in primary care.
- 3) Educate, train and promote depression screening, referral, and management of depression in public and voluntary hospital primary care settings as well as other venues, such as university health clinics and federally qualified health clinics.

Screening for depression improves patient's outcomes. Screening, diagnosing and managing depression in a primary care setting is not only possible, it is simple, cost effective, and crucial to the overall health and wellbeing of all of a doctor's patients. Through the use of a low burden, self-administered screening tool, the Patient Health Questionnaire (PHQ 9) (Appendix 1), specifically designed for PCPs in order to identify depression in their patients, this can be accomplished.<sup>11</sup>

The "Get Help for Depression" **TCNY** initiative follows the growing trend of using research evidence in the development of health policy and incorporates elements of the chronic disease

management principles and pathways to care models. The U.S Preventive Services Task Force recently reported that patients have better outcomes when their primary care physicians screen and detect for depression and ensure they receive appropriate treatment in primary care or through referral to appropriate community-based mental health care.<sup>12</sup>

In order to successfully promote the use of the PHQ 9 in primary care settings, physicians and the public need to be educated. Increasing awareness and access to treatment helps to decrease the stigma associated with depression. In addition, public policies must be promulgated to improve depression detection in primary care clinics. Only a truly collaborative effort that transcends labels, service sectors, political parties, and cultural and linguistic boundaries can we overcome the challenges necessary to achieve better mental and physical health for all New Yorkers.

We aim to change the landscape of how depression is detected, treated and managed in NYC, and beyond. By promoting, educating, enabling and implementing effective screening and management of depression in primary care practice we will achieve our goal of increasing the rates of treated depression in New York City by 10% from their existing baseline by 2008.

## **Introduction: The Problem**

Few families in the United States are unaffected by mental illness. The recent National Comorbidity Survey-Replication showed that nearly half of all Americans will suffer from a mental/substance abuse disorder in their lifetime and three-quarters of those will be affected before the age of 24. About 60% of those Americans have a moderate to severe form of disorder and more than half have not received treatment in the past 12 months. The NCS-R also demonstrated that in those patients with a mental or substance abuse disorder, of those that did receive care only one-third received what was deemed minimally adequate care. Of note, is that in many cases it took upwards of 8 years for people with a mood disorder to access and receive mental health treatment, with delays and inadequate treatment being more common in people who are poor, poorly educated and of color.<sup>13</sup>

Depression can affect anyone, of any age, at any time. It affects children, adolescents, adults and especially older adults. It affects people of all racial, ethnic, religious and socioeconomic levels, as well as both sexes. The most recent data from the 2004 National Survey on Drug Use and Health (NSDUH) found an estimated 35.1 million people (14.7% of the population) aged 12 or older had at least one major depressive episode in their lifetime. Similarly, 17 million people aged 18 and above (8% of the population) had at least one major episode of depression during the past year.<sup>14</sup> Data from the 2004 NYC Health and Nutrition Exam Survey (NYCHANES) showed that 8% of the NYC population had a diagnosis of major depression at the time of the survey.<sup>15</sup>

What is considered clinical depression is different than the occasional blues or the grief people experience after the loss of a loved one. Clinical depression is a psychiatric illness that can include some or all of the symptoms below (Table 1). The number of symptoms and their severity vary from individual to individual. Depression can become chronic or recurrent, can be

associated with anxiety or psychotic symptoms (such as hallucinations or delusions), and very often leads to substantial impairment in a person's ability to work, attend school, or take care of oneself and one's family. Chances are that you, someone in your family, a colleague, or a friend will have had an experience with depression at some point in your life.

**Table 1**

**DSM-IV TR Signs & Symptoms of Depression:<sup>1</sup>**

Depressed or sad mood  
Loss of interest in or pleasure  
Loss of appetite and/or weight, or conversely, overeating and/or weight gain  
Fatigue or loss of energy  
Difficulty sleeping or oversleeping  
Difficulty concentrating, making decisions or remembering  
Irritability, restlessness or feeling slowed down and lethargic  
Feelings of worthlessness or guilt  
Frequent thoughts of death, suicidal ideation or a suicide attempt

The depressive symptoms described above are part of a larger family of depressive disorders, which include dysthymia (a chronic low-grade depression), minor depression, major depression and bipolar disorder. A major depressive episode (MDE) is diagnosed if an individual has 5 of the 10 symptoms listed above, including depressed mood and loss of interest or pleasure. The symptoms must be present for at least 2 weeks and be accompanied by a significant impairment in functioning. Depression is debilitating and very painful, for the individual suffering and for that person's family and friends. Although some people experience a single episode of depression, in the vast majority (75 to 85%) it recurs and, if left untreated, chronic depression and even suicide are the preventable consequences. In patients with MDE, close to 50% report feelings of wanting to die, 33% consider suicide and 8.8% report a suicide attempt.<sup>16</sup>

**Who is affected?**

Young adults, women of childbearing age (including those who are pregnant or new mothers), people with chronic medical conditions such as diabetes and heart disease, and adults over age 55—including seniors living in nursing homes—are at high risk for depression.<sup>17</sup> The most recent data from the 2004 NSDUH reported lifetime prevalence for MDE was highest among adults aged 18 to 25 (10%). According to the Surgeon General's report, 1 in every 5 people 55

or older experiences a mental disorder – which is not a normal part of aging - and this figure is expected to double by 2030.<sup>18</sup> Rates of depression in nursing homes are reported to range from 15% to 25%.

The NSDUH showed higher rates of depression among females than among males (10.6 vs. 5.5 per cent), consistent with the NYC HANES where the rates of depression were 9.1% for women and 5.5% for men.<sup>19</sup> Approximately 12 million women in the United States experience depression each year. About one in every eight women can expect to develop depression during her lifetime. Depression occurs most frequently in women aged 25 to 44.<sup>20</sup> Approximately 10%-12% of pregnant women experience depression.<sup>21</sup> Women that are depressed during pregnancy are at risk for post-partum depression.<sup>22</sup> Depression in women is misdiagnosed approximately 30 to 50 percent of the time and most tragically, fewer than half of the women who experience depression will ever seek care.<sup>23</sup> Several studies have found a higher rate of depressive symptoms and psychological distress among African-American and Latino women, compared with white women.<sup>24</sup>

In primary care settings, patients with cardiac disease, stroke, diabetes, and many other chronic medical conditions have poorer outcomes, greater morbidity and mortality and higher utilization of costlier health services when the person also suffers from depression. Conversely, people with depression are far more apt to suffer from chronic medical conditions. It is estimated that major depression affects 5 to 13% of medical outpatients - yet in about 50% of cases it remains undetected and untreated; even when correctly diagnosed it is infrequently treated properly.<sup>25</sup>

Most people who complete suicide make contact with health services in the days to months before their death. Nearly 20 percent make contact with primary care providers in the *week* before suicide, nearly 40 percent make contact within the month before suicide, and nearly 75 percent see a medical professional within their last year.<sup>26</sup> Among older people, the rates are higher, with about 70 percent making contact within the month before.<sup>27</sup>

## **Barriers**

Too many people with depression do not get the help they need. Many are deterred from seeking treatment because of fear of stigmatization, lack of available resources, myths and misconceptions about mental illness, and lack of awareness about available treatment.<sup>28</sup>

There is a persistent, and inaccurate, belief that depression impacts people of different races at different rates. In fact, it is not race that accounts for the different rates that are sometimes seen, but poverty. When socioeconomic factors are taken into account, the prevalence difference between Whites and African Americans disappears. The socioeconomic status-adjusted rates of mental disorder among African Americans are the same as those of whites. Thus it is the greater rates of lower socioeconomic status of African Americans that places them at higher risk for mental disorders, not their race.<sup>29</sup> However, it may be that the functional impact of mental disorders leads to lower socioeconomic circumstances and leads us back to race as a risk factor; more work on this problem needs to be done. Moreover, there is a disparity in insurance coverage, access to and quality of treatment received across racial and ethnic lines; for example,

the utilization of psychiatric inpatient care by African-Americans is about *double* that of Whites.<sup>30</sup> This is but one example of the unfortunate result of poor access to appropriate screening and early detection as well as preventative care resulting in illness progression to the point of requiring hospital level of care. African-Americans and Latinos are more likely than other ethnic groups to be misdiagnosed and overmedicated.<sup>31</sup> African-Americans are repeatedly misdiagnosed with schizophrenia, and in Latinos depressive disorders are often under-diagnosed.<sup>32</sup>

Studies have shown that Latinos with self-reported depression were significantly less likely to receive any treatment for depression, to fill an antidepressant prescription, or to receive an adequate course of psychotherapy or counseling than Caucasians.<sup>33</sup> Among Latinos with mental disorders fewer than 1 in 11 contact a mental health care specialist. Among Hispanic immigrants with mental disorders fewer than 1 in 20 use services from mental health specialists. Latinos tend to mistrust the conventional medical system, have deep rooted cultural stigma and taboo about mental illness and the need to seek care, and fear medications and possible side-effects, especially the prospect of becoming “addicted” to medications. Latinos also tend to delay mental health treatment because they do not consider their symptoms as those of mental illness until they become severe. They tend to view mental illness as a manifestation of a weakness of character.<sup>34</sup>

These, as well as language differences, health literacy barriers, somatic presentations, use of cultural idioms of distress, and taboos about mental disorders are all barriers to effective detection and treatment of depression among Latinos and other minorities.<sup>35</sup>

The impact of these ethnic and racial differences, however they are produced, results in limited access to mental health care for millions of Americans. In a recent study by the NYC DOHMH, only 37% of New Yorkers with depression were receiving mental health treatment. Of those New Yorkers with depression who are in treatment only a quarter were African Americans and Hispanics (26% and 27% respectively) compared with nearly half (49%) of Whites.<sup>36</sup>

The President’s New Freedom Commission on Mental Health (2003)<sup>37</sup> as well as two reports by the US Surgeon General (The Surgeon General’s Report on Mental Health (1999)<sup>38</sup> and the 2001 Mental Health: Culture, Race, and Ethnicity)<sup>39</sup> assert that the stigma and discrimination associated with mental illness and its treatment have a substantial negative impact on the lives of individuals, families, and communities. The Surgeon General’s Mental Health Report concluded that despite the existence of effective treatments for mental disorders, the fear of stigmatization often deters individuals from acknowledging their illness, seeking help, and remaining in treatment. Similarly, the World Health Organization (WHO) states that the “single most important barrier to overcome in the community is the stigma and associated discrimination towards persons suffering mental health disorders.”<sup>40</sup>

Financial obstacles are repeatedly cited as being among the foremost reasons why people do not seek care for mental illnesses. According to the 2004 NSDUH survey, less than half of those with no insurance (41%) received treatment for depression compared with 70% of those with private insurance.<sup>41</sup>

The lack of health insurance parity for mental health disorders perpetuates the false dichotomy between physical health outcomes and mental health outcomes. It has been many years already since the Surgeon General’s Report on Mental Health made plain that “there is no health without mental health,” but arbitrary and discriminatory policies of many insurance companies and corporations that determine what mental health benefits they will support persist, including depression. Not only does this limit access to necessary care, it also perpetuates the stigma associated with mental illnesses, thereby preventing people from even attempting to access care.

In addition to lack of private insurance coverage for mental health, the increasing role of Medicaid in reimbursing mental health care further jeopardizes the availability of mental health services. In New York State, a cap on State Medicaid expenditures for mental health limits the needed expansion of the public mental health system to meet the needs of a growing population and increases in disorders affecting specific populations like children, adolescents and seniors. No other sector of New York State’s Medicaid program is subjected to a similar cap, so mental health services are discriminated against even in State regulations. Concurrently, as states around the country identify savings by converting previously State-only funded mental hygiene services to Medicaid funding (which adds Federal dollars and thereby reduces state expenditures), the total amount of State dollars spent on mental health is shrinking. At the same time, the Federal government is seeking to cut, cap, and limit Medicaid spending in ways that would drastically impact the mental health service system in New York City and around the country.<sup>42</sup>

## Costs

Depressive disorders are projected to become the leading cause of disability and the second leading contributor to the global burden of disease by 2020.<sup>43</sup> One of the most tragic and preventable consequences of undiagnosed, untreated or under-treated depression is suicide. Suicide is one of the leading causes of death in the United States.<sup>44</sup> The World Health Organization (WHO) recently reported that suicide worldwide causes more deaths every year than homicide or war.<sup>45</sup> (Table 2)

### Estimated global violence-related deaths, 2000

Type of violence	Number <sup>a</sup>	Rate per 100 000 population <sup>b</sup>	Proportion of total (%)
Homicide	520 000	8.8	31.3
Suicide	815 000	14.5	49.1
War-related	310 000	5.2	18.6
Total <sup>c</sup>	1 659 000	28.8	100.0
Low- to middle-income countries	1 510 000	32.1	91.1
High-income countries	149 000	14.4	8.9

Source: WHO Global Burden of Disease project for 2000, Version 1.

<sup>a</sup> Rounded to the nearest 1000.

<sup>b</sup> Age-standardized.

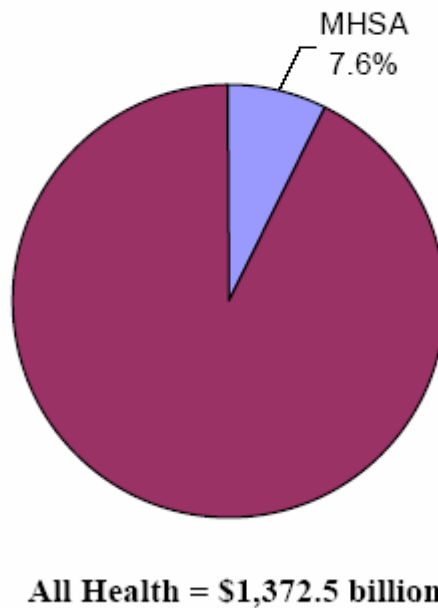
<sup>c</sup> Includes 14 000 intentional injury deaths resulting from legal intervention.

In the U.S., older persons (65 years and above) have the highest suicide rates of any age group. The suicide rate for individuals age 85 and older is the highest, at about 21 suicides per 100,000, a rate almost twice the overall national rate of 10.6 per 100,000. The high suicide rate among older people is largely accounted for by white men, whose suicide rate at age 85 and above is about 65 per 100,000. More than 90% of those who commit suicide have a diagnosable psychiatric illness at the time of death, usually depression, alcohol abuse or both.<sup>46</sup>

In addition to the personal suffering caused by untreated depression, the costs to society are substantial. Mental health problems and their accompanying physical health problems are linked to increased use of expensive emergency care, homelessness, substance abuse, incarceration, high Medicaid utilization, unemployment, and low work performance. Studies have shown that depression in the parent can affect the development of children resulting in later problems with behavior and school performance. Early diagnosis and treatment of depression can prevent these negative outcomes and the costs associated with them.

In the United States the substantial public health and economic impact of this chronic illness is reflected by the considerable utilization of healthcare visits and tremendous monetary costs. The most recent data from the “National Expenditures for Mental Health and Substance Abuse (MHSA) Treatment” indicates that the U.S. spent \$104 billion on mental health and substance abuse treatment in 2001. To put this number in perspective, it is useful to compare it to national spending on health care for all types of conditions. Total national health services and supplies expenditures were \$1,373 billion in 2001, of which MHSA spending made up 7.6 percent (Figure 3). Depression clearly has a significant economic impact on society. For example, the estimated total costs of depression in the US were nearly \$43.7 billion in 1990 dollars.<sup>47</sup> The majorities (72%) of costs were indirect costs in the form of reduced productivity, absenteeism, and mortality. Medical care costs (inpatient, emergency and outpatient medical and/or psychiatric care) comprise 25% and medications are approximately 3% of overall costs.

**Figure 2.1: MHSAs Expenditures as a Percent of Total Health Care Expenditures, 2001**



### **Depression Screening and Management in Primary Care**

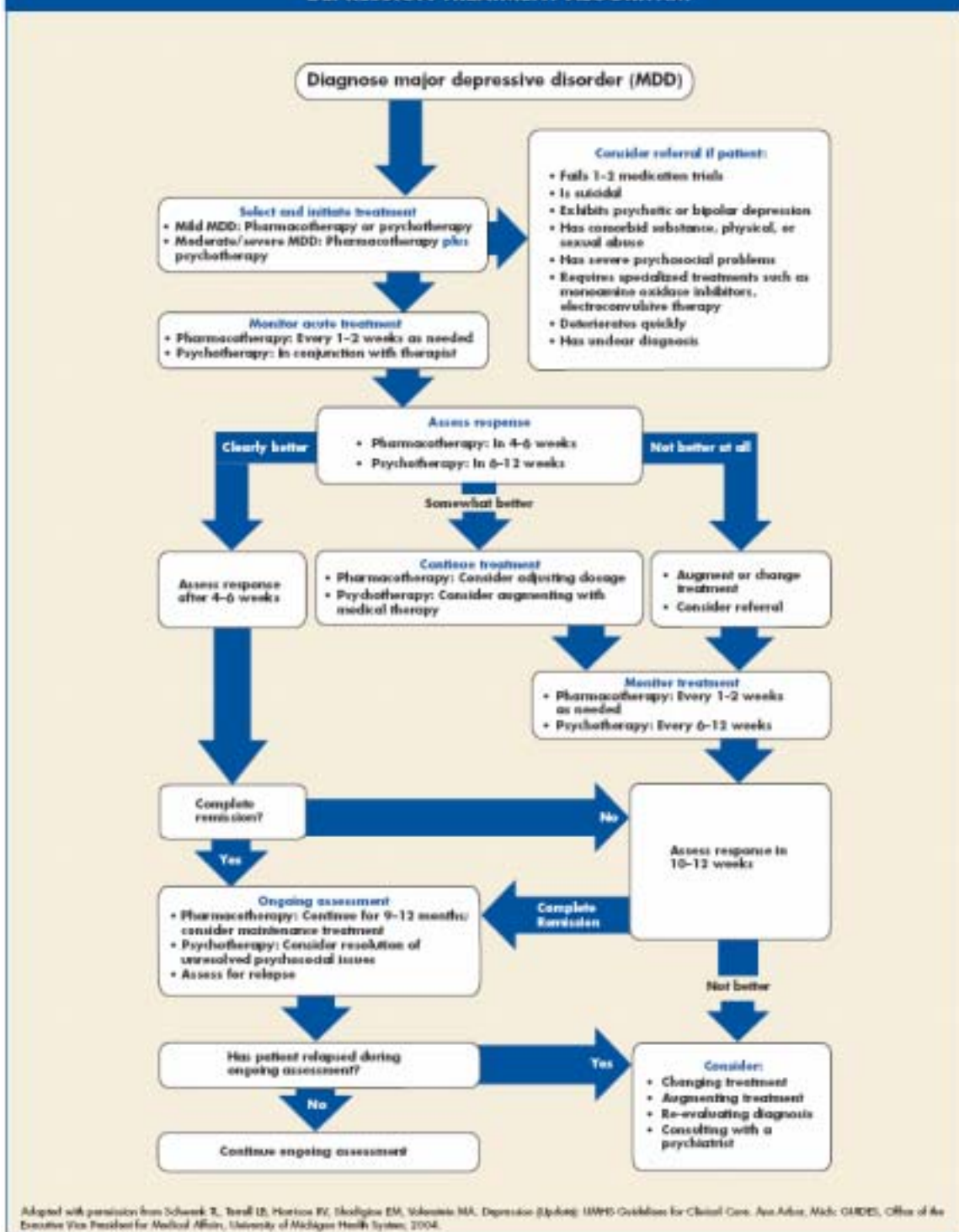
Depression is one of the most common conditions seen in primary care. PCPs are the initial health care contact for most people with depression. Studies have shown that 6 to 9% of patients in a primary care practice have a treatable depressive disorder. Depression exacerbates the symptoms of physical illnesses and physical illnesses exacerbate the symptoms of depression. The risk of death from heart disease, stroke or respiratory disorders is higher among people with depression. Additionally, depressed people are more likely to engage in behaviors that contribute to poor health, such as smoking, drug use, overuse of alcohol, limited or no exercise, poor eating habits and are likely to have a greater difficulty managing their physical health conditions resulting in greater utilization of health care services.<sup>48</sup>

Depression can be effectively detected in primary care settings with the use of the Patient Health Questionnaire 2 and 9 (PHQ 2 and PHQ 9). The PHQ is a self-report questionnaire designed for use in primary care settings; it is available in multiple languages and has been shown to be equally effective among White, Hispanic and African American populations. The 9 survey questions correspond with criteria for depression found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The PHQ 2 can be used as a simple, low burden initial screening tool. It asks two questions, one about mood and the other about interest and motivation. A positive score is a yes on either item and has a sensitivity of 83% and a specificity of 92% for major depression. The PHQ 9 provides a score of 0 – 27 as a person responds to each question with not at all to all the time (0-3 for each question) and has a sensitivity of 88% and specificity of 88% for major depression. The PHQ 9 can be used independently or for follow-up for those patients who score “positive” on the PHQ 2\* The PHQ 9 is positive for depression if

someone scores 10 or higher; scores over 20 represent severe depression. For patients who score positive and who are then diagnosed as depressed by their primary care doctor, the PHQ 9 can be used to monitor response to treatment since its scores are sensitive to change when depressive symptoms improve. The PHQ 9 enables the patient and doctor to quantify depression by giving it a number, much like a patient would receive for blood pressure, lipid levels or if diabetic the hemoglobin A1c. A score of 22, for example, is much like a blood pressure of 190/120. Both doctor and patient know that their condition is severe and must be treated. When their condition improves the number returns to normal: to 130/85 for the hypertensive and to under 10 for the depressed person. In addition to helping PCPs to better detect and monitor treatment for depression in their patients, the treatment protocols and patient self-management techniques that accompany the PHQ 9 are meant to improve the appropriateness of care for people with depression.

It is clear that the management of depression must occur in primary care settings since patient preferences insist on it: for example, more than half of those referred to specialty mental health settings do not complete more than one visit. Not all depression care, however, can be done in primary care so PCPs must be trained to know when to refer to a mental health specialist, such as in patients with depression and psychosis, with suicidal ideation, serious substance abuse or who fail to respond to treatment.

## DEPRESSION TREATMENT ALGORITHM



Fortunately, depression is treatable and many effective treatments exist for this disorder. About 70 to 80% of depressed people improve with appropriate treatment.<sup>49</sup> The most common treatment options for depression are psychotherapy (interpersonal and cognitive-behavioral psychotherapy are the best studied) and antidepressant medications; medications and therapy are often combined in mental health care though not likely to occur when the patient is seen in primary care alone. Still, with appropriate medication treatment and the introduction of self-management goals, such as increasing physical activity or changes in a person's diet or eating

habits, many can experience a full recovery and remain free of recurrence. For some people treatment will need to be extended over years or even life long – though this is typical of other chronic diseases such as diabetes, heart disease and asthma. Under any circumstances, appropriate care can reduce the pain and suffering as well as the economic costs of the illness to patients, families and communities. Self-management techniques are very important in the management of all chronic illnesses since this is all about the individual's ability to manage his/her symptoms and life limitations, treatment, and make the lifestyle changes needed to live well with a chronic condition. It support goal-setting and emphasizes the participant's responsibility in managing their condition. It also provides individuals with self-care action plans by encouraging them to select a small number of achievable goals to work on each week that will make a difference in their mood or functioning. As noted above, these goals can include engaging in physical activity or other pleasurable or relaxing activities, spending time with supportive people, or reducing behaviors that worsen their condition such as drinking too much or overeating.

### **Aims of Depression Screening and Management in NYC**

The Department of Health and Mental Hygiene aims to make depression screening and disease management standard practice in all primary care settings in this large, diverse urban metropolis.

Our plan is to introduce routine depression screening and management in primary care practices in adults 18 and older. In the spring of 2006, the City's municipal hospital system, Health and Hospital Corporation, 11 hospitals that serve one in six New Yorkers, especially the poor and people of color, will have the PHQ 9 as a necessary annual screen for all primary care practices. Other hospitals, Federally Qualified Health Centers (FQHCs), and University Health Centers are also joining our initiative. By introducing screening and management of depression in primary care we can for the 1<sup>st</sup> time change the landscape by which primary healthcare works with a mental health condition. We believe that this will further allow the normalization of depression in primary care when it is a routine screen, just like blood pressure, lipid levels and screening for a variety of other diseases.

In a perfect world, everyone would have insurance and all insurers would cover mental health care no differently from any other medical condition, and care would be adequately funded. Stigma would be minimal or eliminated and along with it people's fears, misconceptions, and lack of understanding of the nature of mental illnesses (like depression) and the causes, symptoms and treatment options would be understood and appreciated. Public health campaigns would educate everyone about depression and how to identify the symptoms and know that effective treatments are available. In a perfect world, treatment would be culturally competent, socially acceptable, readily accessible, and of the highest quality.

Perfect worlds are hard to come by, but in the newly fashioned landscape we aim to introduce, all PCPs would use the PHQ 9 and understand how to detect and effectively manage depression. Patients would insist that their doctors measure and monitor their depression score as closely as they do their blood pressure, cholesterol, and blood sugar levels. In this new and exciting landscape, PCPs would have a comprehensive knowledge of the available mental health treatments as well as understand when to refer their patients when needed. In this changed

landscape, every individual with depression would be screened, diagnosed and treated early and effectively, preventing unnecessary illness and death, family and social burden, and economic cost.

We still have a long way to go. But there are steps we can take now to bring us closer to the perfect world.

### **Changing the Landscape - Action Steps:**

- 1) Support depression screening and management in primary care and university health settings.
- 2) Combat stigma. Engage in public education campaigns and other efforts to enable those with a mental illness, including depression, to appreciate that depression is a treatable illness, and that they should seek care as they would for any condition.
- 3) Support mental health insurance parity and fairness in funding for mental health services.

### **Conclusion**

Depression is an illness that is common, often chronic and costly. It can be reliably diagnosed and treated, improving the health and quality of life for the families and individuals suffering from it and reducing burden and cost to our society. The effectiveness of treatment is well documented. However stigma, fiscal, cultural and systems barriers mean that today appropriate care is seldom provided.

Primary care physicians, as the point of access for most Americans for their healthcare needs, are the keys to screening, treating and monitoring depression. The PHQ 2 and 9 are simple, low burden screening tools that make this possible. Public education, physician training, and health care system changes, supported by progressive public policy, are necessary to widely implement depression screening and management in primary care settings. It is now more important than ever to take these steps. Allowing depression to continue undetected and untreated will lead to significant distress for individuals and families—suicide being the most feared and deadly of consequences – ongoing losses in the productivity of employees, and ever increasing societal costs. Success in achieving these goals will require a change in the primary care landscape in which the artificial barriers that have been erected between physical and mental healthcare are removed; systematic collaboration between PCPs and mental health providers to assure that patients receive guideline consistent care; and that insurance parity and fairness is achieved. While these are ambitious goals, the cost of not achieving them is a price too great to continue to pay.

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