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Editorial

Depression: We've Come a Long Way!

Recently, *The Journal of the American Medical Association* (*JAMA*) devoted an issue (Vol 289:23; June 18, 2003) to presenting new developments in our understanding of depression and its epidemiology, neurochemical basis, impact, and management. Such attention reflects the importance of depression in our society and globally and the potential that its treatment, and improvements in treatment, holds for bettering the lives of those suffering from depression and comorbid conditions. A key message from the issue is that depression is, first and foremost, a disease that must be recognized and managed in primary care, integrated into the comprehensive care we otherwise provide our patients. While our care of depression has improved significantly over the past decade, further improvement is still greatly needed.

The lead article reports findings from the National Comorbidity Survey Replication (NCS-R), conducted during 2001–2002,[1] which updates the findings of the original National Comorbidity Survey conducted in 1990–1992[2] and the Epidemiologic Catchment Area (ECA) study of the early 1980s.[3] Current estimates are that about 34 million Americans (16.2%) have suffered from major depressive disorder (MDD) at some point in their lives, and about 13.6 million (6.6%) within the past year. Almost 80% of those with depression experience anxiety, substance abuse, or impulse-control disorders as well. Anxiety predominantly develops prior to depression, raising the possibility that early recognition and treatment of anxiety disorders might prevent subsequent depression.

A hopeful note is that 57.3% of MDD sufferers in the past year received treatment,[1] a 37% increase from treatment rates of the early 1980s. Of all those with depression in the past year, 27.2% received treatment in the "general medical sector" (including from primary care sources), with 41.3% of these receiving at least 4 visits for pharmacotherapy, a criterion used to assess adequacy of treatment. This measure has been used to castigate primary care physicians for their inadequate response in treating depression.[4] However, it does not take into account the portion of primary care patients referred for treatment nor the reality that insurance companies have carved out rules requiring that such treatment, for the patient to be reimbursed, be provided by mental health professionals. Nor does it consider the difficulties in moving patients who either reject the diagnosis or fear the stigma and possible consequences of such labeling in the workplace. An additional group of difficult patients are those for whom the primary care physician is really the "quaternary care" physician, i.e., patients who have dropped out of specialty or subspecialty care, or for whom treatment with specialists has failed, and who have simply returned to the compassion provided by their family doctor.

The issue also provides a report from the ENRICHD (Enhancing Recovery in Coronary Heart Disease Patients) randomized trial,[5] the largest trial of psychotherapy ever completed. Although the trial failed to show that either cognitive-behavioral therapy (CBT) or a pharmacotherapeutic intervention to increase social support improved cardiac outcomes when started soon after myocardial infarction (MI), the accompanying editorial[6] articulates well the major advance that the trial represents in our ability to investigate such interventions. Reasons articulated for the failure of the trial rest in the assumptions upon which it was designed, including the unrealistic expectation that such interventions could achieve a 30% reduction in cardiac events, when the current standard for other direct interventions such as smoking cessation or lipid reduction is 15%.

An intriguing finding of the ENRICHD study relates to those patients who had high (< 24) Hamilton Rating Scale for Depression scores at entry or who failed to improve by at least 50% within the first 5 weeks of receiving CBT.[5] Such patients were offered treatment with sertraline, switching to other selective serotonin reuptake inhibitors as necessary. While about 10% received treatment initially, by the end of the 3-year study, over a quarter were receiving pharmacotherapy. Thus, it is likely that those with more severe depression received such treatment (in both intervention and usual-care groups). These patients achieved a 43% reduction in cardiac death or nonfatal MI

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(95% CI = 0.38 to 0.85), very similar to the reduction achieved in the SADHART study[7] among those with recurrent or severe depression. Although patients were not randomized for such antidepressant treatment, this result substantially increases our confidence that treating depression post-MI will have a major protective effect on cardiac status.[8]

In mid-2002 the U.S. Preventive Services Task Force changed its long-standing finding that the evidence available did not support screening for depression in primary care.[9] In recommending that primary care practices initiate screening, because recent evidence now finds that it can result in meaningful improvement in outcomes, the Task Force provided one caveat: such improvement occurs only in practices that can then actively manage their depressed patients, initiating and modifying treatment as needed, and then fostering sustained adherence to long-term treatment. For primary care practices ready to initiate such systems, the *JAMA* issue provides an excellent review of such management strategies.[10] Provision of patient and physician education and physician guidelines is necessary, but not enough. Practices must adopt additional active-management techniques that continue contact with patients by monitoring treatment and patient status and responding promptly to patient concerns and need for treatment modification. There are a variety of such strategies, ranging from quality improvement and case management to collaborative care and other complex models that improve patient outcomes.

Also in the *JAMA* issue, Martin Keller provides a provocative discussion[11] regarding what we should consider, and accept, as adequate and optimal outcomes in the treatment of depression. Interwoven in such considerations are the dimensions of symptom relief (as measured by symptoms scores), improvement in function (e.g., social, work, family) and resultant quality of life, and prevention of recurrence. As Keller summarizes, we have some evidence that improvement in function lags symptom relief but does occur. Although the evidence is not conclusive, optimal treatment might also decrease chronicity and recurrence. Yet to be refined or widely adopted in the management strategies necessary for effective primary care are the clinical measurement tools by which such outcomes can be assessed.

This issue of *JAMA* coincides with the release of the President's Mental Health Commission's final report—*Achieving the Promise: Transforming Mental Health Care in America* (available at http://www.mentalhealthcommission.gov/reports/reports.htm).[12] Both emphasize the need for our nation's mental health provision to move out of institutions and center on community-based strategies responsive to the needs of individual patients and their families. Primary care must be a core component of such a national strategy. The take-home message for primary care is clear: continuing "treatment as usual" for depression, anxiety, and other mental health disorders is simply perpetuating poor quality care. To achieve the potential to improve patient quality of life, reduce the burden of suicide, and lower the substantial directly related and labor productivity–related costs of depression and other disorders,[13] we must actively manage our patients, i.e., initiating and then actively managing treatment until it is successful. Whether patients suffer from cardiac and other chronic diseases or simply depression, we need to manage treatment of the depression as if our patient's life depends on it—because it does.

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