Introduction

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Depressive illness is common in the general population and is associated with significant morbidity, mortality, and societal costs. Although specific pharmacologic and psychotherapeutic interventions have been found to be effective in treating major depression, only a minority of individuals with depression currently receive such treatments; this undertreatment is due in part to lack of recognition and diagnosis of depression and in part to provision of inadequate treatment even when depression is correctly diagnosed. Most patients with depression initially present in the primary care setting with somatic complaints or comorbid conditions, and the majority of patients who do receive some type of treatment for depression do so in primary care. That this will continue to be the case for the foreseeable future is ensured by the emergence of managed care systems and associated policies that encourage individuals to seek and receive health care in the primary care setting. As a consequence, there have been numerous initiatives to improve the detection, treatment, and management of depression in primary care, including the development of physician and patient education programs and sophisticated programs designed to assist the primary care physician in recognition and treatment of depression. While these laudable and much needed efforts continue, the psychiatric specialty must continue to define its role in the treatment of individuals with depressive illness. It seems very likely that collaboration of specialty care with primary care in the current environment will ultimately prove to be a model of care that provides optimal benefit to both patients and society as a whole.

The contributions to this supplement to *The Journal of Clinical Psychiatry* address the several opportunities and challenges faced by primary care physicians and psychiatrists in the current climate. There are numerous barriers to appropriate care for depression in the primary care population. John P. Docherty, M.D., discusses barriers to effective recognition of depression in primary care and methods to improve diagnosis and treatment in this setting. Lack of prescribing of adequate dosages and durations of treatment is a significant problem in current care for depression. Even when this problem is addressed, however, lack of adherence to prescribed pharmacologic regimens remains a major barrier to effective treatment. Ellen Frank, Ph.D., discusses the problem of adherence and outlines steps for the forging of an alliance among clinicians and patients and their families that she and her colleagues have found to be successful in maximizing adherence to treatment.

Clinical practice improvement (CPI) research, as described by Susan D. Horn, Ph.D., permits assessment of a large number of patient and treatment variables in care as it actually occurs in the clinical setting today and thus, in theory, allows analysis of the content and timing of individual steps of a medical care process in order to achieve superior medical outcomes for the least necessary cost over the continuum of a patient's care. Some preliminary findings with regard to psychiatric medication use and outcome in a large health maintenance organization (HMO) population studied in the Managed Care Outcomes Project are discussed, highlighting the potential for the use of the CPI methodology to

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define an optimal process of care for depressed patient. Other information on optimizing care for depression is derived from prospective clinical trials of collaborative care models performed by Wayne Katon, M.D., and colleagues. These studies have demonstrated that integration of psychiatric specialty care into the primary care setting, with the psychiatrist present in the clinic in one model and working with a team of psychologists, as well as the primary care physicians in another, results in improved treatment outcomes and satisfaction with care. These and other findings point to an emerging collaborative role of the psychiatrist in treating depression: the psychiatrist may serve both as teacher/trainer in the primary care setting and as mental health care specialist, including functioning as provider through referral and as supervisor and/or consultant in care administered through primary care.

As noted by Kenneth B. Wells, M.D., M.P.H., in his article on policy issues surrounding depression and its treatment, depression satisfies the criteria for a socially important illness and a target of health care policy, given the high social costs associated with the disorder. Dr. Wells reviews data from the Medical Outcomes Study showing that: (1) shifting of patients from specialty care to primary care under current care practices results in decreased expenditure for treatment but significantly worsened outcomes and (2) use of a quality improvement model in primary care, consisting of specific measures for improvement, would serve to increase cost of treatment modestly but with a highly significant improvement in treatment outcome that would appear to be associated with reduced societal costs for depressive illness. Other issues that need to be taken into account in considering policy for treatment of depressive illness are also discussed.

It is hoped that the contributions to this supplement, including the question and answer session appended, prove to be of interest and serve to stimulate further thought, debate, and research on how to improve care for depression in this country.

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