

Strategies for Effective Management of Depression in Primary Care

Based on a presentation by Michael S. Klinkman, MD

Presentation Summary

The diagnosis and treatment of depressive disorders are challenges to the primary care physician because of the condition's high prevalence and chronicity, the frequent occurrence of medical and mental health comorbidities, patients' unwillingness to disclose a mental health history, and cost. Primary care physicians also cite lack of time and managed care policies as major barriers to improving outcomes in patients with depression.

A potentially more effective approach to treating depression is health management, rather than traditional disease management. In this approach, the focus of care is patients' functional status and

quality of life rather than the treatment of a specific health condition in isolation; patients are actively involved with care, and care choices are driven by competing demands.

Another approach that may help improve outcomes in depression is the Recognize, Assess, Categorize, and Treat (ReACT) strategy, which is an efficient way to detect and triage patients with depressive disorders according to the severity of illness. Adjunctive aids, such as the use of support staff, monitoring systems, and collaborative care with mental health specialists, also have great potential for improving primary care physicians' effectiveness in treating depression.

The high prevalence, low detection rate, and inadequate treatment rate of depressive disorders in primary care have been extensively documented.^{1,3} However, the awareness of a disparity in the recognition and management of depressive disorders in primary care versus psychiatric practice is increasing. The challenges facing primary care physicians in dealing with their patients; psychosocial problems, and some practical ways of addressing these challenges were discussed by Michael S. Klinkman, MD, an Associate Professor in the Department of Family Medicine,

University of Michigan Medical Center, Ann Arbor, Michigan.

Psychosocial Problems in Primary Care

The five "Cs"—Common, Chronic, Comorbid, Concealed, and Costly—define psychiatric problems in primary care, said Dr. Klinkman.

Depression is very common; it is one of the top 10 problems seen in primary care, with prevalence estimated at 10% of primary care attenders.³

The chronic nature of depressive illness was highlighted in a 12-year prospective, naturalistic, long-term

study of the weekly symptomatic course of major depressive disorder in which 4 levels of symptoms were measured: 1) depressive symptoms at the threshold for major depressive disorder (MDD); 2) depressive symptoms at the threshold for minor depressive (minD) or dysthymic disorder; 3) subsyndromal or subthreshold depressive symptoms (below the thresholds for minD and MDD); and 4) no depressive symptoms.⁴ This study showed that patients were symptomatically ill in 59% of the weeks; 59% of patients spent weeks at all 4 levels of symptoms, with an average of 2 symptom level changes each year; symptoms of minor and subsyndromal depression were 3 times more common over the course of time; and patients in their first MDD episode had a more benign course of illness. These findings support a model of unipolar MDD as a clinically homogeneous illness in which major, minor, and subsyndromal depressive symptoms commonly alternate as different levels of illness severity.

Consequently, in primary care, physicians must deal with patients who have varying degrees of dysfunction at different times and who may not always need treatment.

“A lot of the work that has looked at depression in primary care is cross-sectional. So we’re catching people at various stages of this chronic illness and trying to figure out how they should be treated based on a single time point,” said Dr. Klinkman.

Primary care patients are also very likely to have comorbid medical and mental health problems under active treatment, which makes it necessary to establish and modify priorities for treatment.

In addition, primary care patients often do not tell the physician that they have a mental health history. Data from the Michigan Depression Project revealed that a majority of patients whose depression was undetected at the index visit did not disclose previous mental healthcare to their primary care physician, whereas patients whose depression was detected were willing to disclose this information (Table 1).⁵ Similar results were obtained 4½ months later when patients returned to the physician and were surveyed again. The fact that patients wish to remain undetected—perhaps because of the stigma attached to mental health diagnoses—may partially explain why rates of detection of MDD are low in primary care.

Depression is costly in 2 ways. First, the direct costs of treating depression (ie, medication, office visits, and hospitalizations) are very high, as shown by Wayne Katon, MD and his colleagues at Group Health Cooperative. Second, the indirect costs of decreased productivity and absence in the workplace are just becoming known but are potentially far greater than the known direct costs, Dr. Klinkman stated.

Primary Care Physicians’ Views on Managing Depression

A few of the key themes on the management of depression that have emerged from focus groups Dr. Klinkman and his colleagues have con-

Table 1. Disclosure of Care Received

	Detected	Undetected	P value
Prior to Index Visit (n=65)			
Talk to physician about any MH issues?	89%	62%	0.014
Disclose outside MH care to physician?	76%	30%	<0.001
Disclose formal outside MH care?	84%	33%	0.002
After Index Visit (n=56)			
Talk to physician about any MH issues?	73%	43%	0.025
Disclose outside MH care to physician?	73%	30%	0.006
Disclose formal outside MH care?	72%	36%	0.060

MH = Mental health.
Source: Reference 5.

ducted with primary clinicians include the following (Table 2)⁶: 1) Detection is based on function and severity and not on diagnostic criteria. 2) There is a high level of patient resistance to diagnosis and treatment that requires physicians to carefully consider the implications for the patient before broaching the subject. 3) Initiation and continuation of treatment require considerable time and negotiation. Patients need to be convinced they have a problem that can be treated. To do this requires extensive interaction with the patient. 4) Managed care, which reduces the access of physicians to mental health expertise when needed, limits primary care physicians' options for improving outcomes in depression. Care also may be fragmented because of behavioral health carveouts or because depression management must compete against other healthcare priorities.

The Emergence of Health Management

“Any solution to improving outcomes in depression in primary care must go beyond isolated disease management,” stated Dr. Klinkman. As an example, he described the Competing Demands Model, in which the management of chronic illness is defined as an ongoing cycle of negotiation and priority setting between a patient with a set of attitudes and beliefs and a clinician with another set of skills, beliefs, and attitudes, occurring within a practice environment.⁷ As opposed to traditional disease management that imposes set guidelines, the central premise of the above-mentioned model is that primary care encounters present a variety of competing demands for the attention of the clinician, and that choices, such as type and length of therapy, are influenced by the patient, clinician, and practice environment.

Applying such a concept to the treatment of mental health problems in the managed care setting has major

implications, noted Dr. Klinkman. Using the competing demands idea, disease management would undergo a change and emerge as health management (Table 3).

Disease management is disease-centered, with clear disease-specific clinical boundaries and outcomes. Disease management is characteristically a top-down process, in which a managed care plan or a group of advocates creates a guideline and imposes it on the system. As a result, the disease or disorder is managed in isolation, Dr. Klinkman noted. Under this approach, relevant costs are easily determined because the resources expended can be attached to the spe-

Table 2. Primary Care Physicians' Views on Managing Depression

<ul style="list-style-type: none"> ■ Detection is based on function and severity, not diagnostic criteria ■ There is a high level of patient resistance to diagnosis and treatment ■ Initiation and continuation of treatment require considerable time and negotiation ■ Managed care creates a major barrier to diagnosis and treatment

Table 3. Disease Management Versus Health Management

Disease Management	Health Management
<ul style="list-style-type: none"> ■ Disease-centered ■ Single focus ■ Clinical boundaries clear ■ Outcomes: disease specific ■ Relevant cost: easily determined ■ Referral criteria “clear” ■ “Top-down” ■ Isolation 	<ul style="list-style-type: none"> ■ Person-centered ■ Priorities for care ■ Clinical boundaries unclear ■ Outcomes: function/quality of life ■ Relevant costs: often hidden ■ Referral criteria negotiable ■ “Bottom-up” ■ Integration

cific condition, and referral criteria can be clearly set by guidelines or carveouts.

In contrast, a health management approach focuses on the patient, not only the disease; therefore, priorities for care are negotiated between patient, physician, and the managed care organization. Health management is a bottom-up process that is initiated at the locus of care and seeks to integrate needs across several diseases or priorities, such as preventive services. With this approach, restrictions in the type of clinical therapies prescribed are less clear, and functional and quality-of-life outcomes gain importance. Referral criteria also are negotiable. However, costs are more difficult to assess, as they are not disease-centered.

Certain principles become clear when applying the concepts of health management to patients with depression: patients are partners in care and their involvement is crucial. The patients become active participants in healthcare; they are not passive recipients of physician education or medication. The main focus is the overall health, satisfaction, and quality of life of the individual rather than just the depressive symptoms.

However, when there is a focus on one disease, the consequences for other diseases must also be considered, and because the clinician's time is the most limited resource in the system, setting priorities becomes critical. Often in managed care, the highest priority is given to those problems (whether biomedical or mental health) that have the largest impact on a patient's health and that can be effectively treated. This principle affects all health issues of the patients. The practitioner's priority is the focus on the long-term well-being of the patient regardless of changes in healthcare plans.

The ReACT Strategy

How can health management be applied in the management of mood disorders? Dr. Klinkman along with Marcia Valenstein, MD, from University of Michigan, developed the Recognize, Assess, Categorize, Treat (ReACT) strategy, which is used to teach primary care physicians how to identify and manage mental health problems (Table 4).⁸ Physicians in training are taught to recognize the presence of distress, an often complicated and difficult process. Once distress has been identified, the type and severity of the underlying problem need to be assessed (for example, whether it is a primary mental health problem or a medical problem that has consequences for mental health). After a mental health problem has been identified, an initial triage is performed to assess its severity using 6 factors: level of distress, presence of identifiable stressors, level of impairment, duration of the episode, potential for self-harm, and need for specialized care.

Based on the initial severity assessment, patients can be assigned to 1 of 3 management categories. The first category consists of patients with limited symptoms and distress, who just need acknowledgment and talk. These patients may have an adjust-

Table 4. The ReACT Strategy

R ecognize presence of distress
A ssess type and severity of problem
■ level of distress
■ presence of an identifiable cause or stressor
■ level of impairment
■ duration of episode
■ potential for self-harm
■ need for specialized treatment
C ategorize the problem
■ Patients needing acknowledgment and talk
■ Patients needing assessment and monitoring
■ Patients needing immediate intervention and treatment
T reat

Source: Reference 8.

ment reaction and simply need to have their experiences normalized; they do not usually require follow-up. The next group of patients has more significant distress; these patients require assessment and monitoring. They may have a major depressive episode of moderate severity and may need treatment or follow-up with watchful waiting (that is, clinicians do not intervene but monitor the problem over a period of time to determine if intervention is warranted). The final group consists of patients who require immediate intervention and treatment. Such patients have severe depression, may be unable to function, and may have a high potential for self-harm.

Placing patients in these 3 categories helps clinicians set priorities, so that less time is spent with patients in the first group (who do not require specific interventions) and the third group (who are referred to psychiatrists) and more time is spent on patients in the middle group, who can be managed in the office. In all categories, patient involvement in the decision-making process is of central importance. Patients in many cases are asked to disclose difficult personal feelings and accept a diagnosis of depression, and may be asked to take mood-altering medications. "These are very difficult tasks and will most often not occur without active physician-patient interaction," stated Dr. Klinkman.

Increasing Effectiveness

The use of support staff can greatly extend the primary care physician's efficiency, although the most effective way to use a support staff's services has yet to be determined. Training medical assistants or nursing staff to recognize distress may be more valuable than formally screening patients for mental health diagnoses, which does not necessarily identify patients needing help. Support staff may be used to implement disease-specific protocols, but the ability of a primary

care practice to implement multiple specific screening protocols is limited because the staff in most cases is already fully occupied and can not take on more tasks without giving up others.

A more promising use of support staff is monitoring adherence. Once clinicians have identified patients who need to take medication or who need clinical follow-up, the most efficient use of resources is to use non-clinician personnel or office systems to follow-up. Because patients can ally with the practice as well as with a clinician, outreach is most successful if performed by someone patients know from the practice or by a known representative from the practice. "It helps that they know the nurse. It helps that it's not coming from a disembodied voice at the end of the telephone," noted Dr. Klinkman. This approach can be expensive (estimated at about \$22 per phone call) and must therefore be used judiciously.

Systems for monitoring outcomes, such as Interactive Voice Response, pen and paper, face-to-face, or telephone interview, are critical for optimum time management. The chief problem with outcomes monitoring is that the proper assessment tool has not been defined. Some health systems have used the MOS SF-36 health assessment instrument; others have used a more specific disease-based questionnaire, but the optimum length and specificity of outcome measurement instruments is not yet known.

Collaborative care involving primary care physicians and mental health professionals has been proven effective in controlled clinical trials and has shown improved outcomes for patients with major depression.^{9,10} However, little is known about how collaborative care works in the clinical world. To evaluate how such an approach works in community practice, a recent study surveyed family physicians on their experiences with collaborative care. An Index of Collaborative

Care was determined on the basis of the following elements: percentage of patients cotreated with mental health professionals; the primary care physician's comfort level in providing cotreatment; quality of working relationships; satisfaction with collaborative care; closeness of working relationships; and frequency of direct communications with mental health professionals.¹¹ Multivariable regression analyses were performed to determine factors associated with increased collaboration. Physical colocation of the primary care practitioner and mental health professional ranked the highest (Table 5).

Having an increased proportion of managed care patients in a practice was also a negative predictor of collaborative care, although these data were not statistically significant. (Table 6). Ease of contacting mental health professionals, trust in their care, and the quality of working relationships between primary care physicians and mental health profes-

sionals were all rated lower for managed behavioral healthcare than for nonmanaged care. The only item rated as better under managed healthcare was the patient's ability to afford mental health treatment. "Collaborative care has great potential, but in primary care practice, we're not quite there yet," said Dr. Klinkman.

Dr. Klinkman concluded that health management, in which patients are partners in care, is an effective approach to treating depression. In the primary care setting with its competing demands, the ReACT strategy may help physicians manage their time by providing them with an efficient means to detect and triage mental health issues. The use of support staff and monitoring systems, as well as collaboration between primary care and mental health specialists, offer great potential for improving outcomes for depressed patients treated in the primary care setting.

...DISCUSSION HIGHLIGHTS ...

Therapeutic Trials as an Aid to Diagnosis

Dr. Rabins: I would conceptualize your categories slightly differently; there are some patients who we are confident have major depression and in whom we can begin treatment right away. There are other patients who we believe don't have major depression who may be demoralized or have an adjustment disorder and need some type of brief intervention, reassurance, and support. Then there's that middle group that we're not sure what's wrong with. We assume over time that if we follow them, they'll go one way or another. I think they can go 1 of 3 ways. They can either clearly get better on their own, in which case it was an adjustment disorder or demoralization; they can develop major depression; or they will have chronic symptoms that we really still

Table 5. Factors Associated With Increased Collaboration

Predictor	Regression Coefficient	95% CI	P value
Colocation of FP/MHP	0.851	[0.27, 1.44]	0.005
Rural practice location	-0.582	[-1.09, -.07]	0.028
MD (versus DO) degree	0.482	[-0.07, 1.03]	0.089
More managed care patients	-0.386	[-0.97, 0.20]	0.199
Very busy practice	0.323	[-0.41, 1.06]	0.393
Less busy practice	0.077	[-0.76, 0.92]	0.858
Male gender	0.103	[-0.48, 0.69]	0.732
Year of graduation	0.001	[-0.02, 0.03]	0.926

CI = Confidence interval; DO = doctor of osteopathy; FP = family physician; MHP = mental health practitioner; MD = doctor of medicine.
 Source: Valenstein M, Klinkman MS, Becker S, et al. Concurrent treatment of patients with depression in the community: Provider practices, attitudes, and barriers to collaboration. *J Fam Pract* 1999;48:180-187. Reproduced with permission.

can't categorize using our current models.

Dr. Klinkman: Some of the people in that middle group will have a diagnosable mood disorder that is amenable to treatment. In that group, there are times when it's good to apply the screening instruments so we can find out if those patients really warrant treatment. Some of them will, but many others will not meet criteria for mood disorder but will warrant an intervention. That may be the group of patients that we tend to simply treat with SSRIs [selective serotonin reuptake inhibitors] because we want to do something. We know they're in distress; we know they're impaired by their distress, yet they don't quite meet diagnostic criteria if we apply them rigorously. It makes some sense to take a shortcut, and instead of spending a lot of time observing, see if the medication works.

Dr. Rabins: I think that's reasonable. But when they don't seem to respond to one drug, what do you do? In my practice, when I become convinced that they have a mood disorder, I continue to try them on different treatments. However, sometimes as I see them, I become less convinced they have a mood disorder. I'm always performing a differential diagnosis. They are somatizers who need a brief visit every 2 to 3 months for reassurance and support. I keep them in that category unless they change. One of the things that I want to emphasize is that we're always performing a differential diagnosis because sometimes we're not sure how to categorize people. Sometimes we have to act and wait. I don't want to give others the idea that the category of major depression is not useful. We have to emphasize to residents that just as in general medicine, we have people with vague complaints, and the syndrome may or may not express itself in weeks, months, or maybe years.

Dr. Klinkman: Time is an incredibly important element in primary care. It pervades everything. We use time much the way people who have limited contact or limited time contact with patients may use other diagnostic tests. It is a relatively inexpensive and efficient test.

Dr. Katon: It is a combination of time and sometimes pharmacologic probing. A lot of times it's easier in primary care to give the easiest treatment first and then reevaluate or simply follow for a month and reevaluate. We all use pharmacologic probing sometimes as a way of testing whether depression is the cause of unexplained physical symptoms, and sometimes we're surprised.

Dr. Treisman: Take that one step further. If these drugs were quinidine, flecainide, or tocainide, our empiric clinical trials would be far less common than they are with drugs, such

Table 6. Effects of Managed Mental Healthcare on Collaboration: Nonmanaged Care Versus Managed Care*

Item	Nonmanaged Care	Managed Care	P value
Patients' ability to pay	4 [3,6]	7 [5,8]	<0.0001
Ease of contacting MHPs	6 [4,8]	5 [3,7]	<0.0001
Quality of working relationship	8 [5,9]	6 [4,8]	<0.0001
Trust in MHP's care	9 [7,10]	7 [5,9]	<0.0001
Satisfaction with collaboration	6 [4,8]	5 [4,7]	<0.0001
Expertise of available MHPs	8 [5,9]	7 [5,8]	<0.0006

*Results are expressed on a 1-10 rating scale; n = 95. MHP = mental health practitioner. Significant differences were not seen for the following items: availability of MHPs, accessibility of MHPs, closeness of working relationship, patient willingness to see MHP; MHP sees patient in timely manner. Source: Valenstein M, Klinkman MS, Becker S, et al. Concurrent treatment of patients with depression in the community: Provider practices, attitudes, and barriers to collaboration. *J Fam Pract* 1999;48:180-187. Reproduced with permission.

as fluoxetine or sertraline, where the worldwide experience is so extensive. If these agents were killing even 1 in 50,000 patients, as happened with chloramphenicol, we would have picked it up by now. This is a very benign clinical trial for most patients.

Dr. Klinkman: It is still a trial that you negotiate with a patient, because you're going to explain that the medicine has side effects, but it's worth taking because of the level of symptoms the patient has.

Dr. Rabins: I like your word negotiate because sometimes the patient may not be sure, in which case you suggest waiting 6 or 8 weeks and rediscussing the issue if there is no improvement. By waiting, the risk benefit equation changes, and the patient may be more willing to give the medication a try. This is then a bottom-up, bilateral decision.

Dr. Klinkman: At the time we were doing our collaborative models work,¹⁰ most of the patients our CL [consultation liaison] psychiatrist saw in referral from the family physicians were patients who fit in that middle group. These were patients who had significant distress, but the resident or faculty family physician was in a diagnostic and therapeutic dilemma because he or she had tried an SSRI, and the patient didn't improve. These doctors still weren't sure whether the patient met mood disorder criteria, and that was when the expert was especially helpful. I think that working together on patients who fit in the middle group will provide the best opportunity to develop relationships with mental health professionals.

Dr. Treisman: In a setting where you have no clear diagnosis and you are doing empiric treatment, what you find are the set point changes the longer there is a collaboration, and I

think in the clinical world it's a very useful thing. I think it's valid to do a clinical trial with somebody if you think about risk and benefit.

Dr. Klinkman: It's very good to have colocation or good access to mental health professionals, but it alters the balance a great deal if you're a primary clinician in a rural or relatively inaccessible practice. You don't have the mental health resources that may be available in a larger city and so you're more prone to carry your therapeutic trials out further because you haven't got anything else that you can do.

Dr. Wilson: The issue of professional isolation is a very good point. For example, in the Texas Medication Algorithm Project, out of the millions of dollars of resources that have been invested, the aspect that is perhaps most clearly beneficial is the availability of experts to consult with isolated public sector psychiatrists and practitioners. For example, telemedicine consultation as to specific diseases and treatment situations is highly valued by doctors in the field.

Economics and Societal Costs

Dr. Choksi: I like the saying "illness dynamics." Whether it's a migraine or bronchial asthma or depression, it's an illness and there's dynamics. Illness dynamics is an incredible instrument. The second thing is that I don't know how many family physicians or internists really think that way in the practice. Research data show that generally 50% of family physicians are much more conscious about depression but 50% are not, even though 80% of antidepressants are prescribed by them, statistically. So what happens to the education of those other family physicians who need to be ReACTIVE?

The economics of managed care in depression really depends on where

the dollar is coming from. I can tell you from my experience in private practice that during the early 1990s when capitation was a dominant factor in primary care, the primary care physicians infrequently recommended patients to a psychiatrist and attempted to treat patients themselves because ultimately the dollars came out of their pockets. In the past 4 or 5 years with the advent of the MBHOs [managed behavioral health organizations] and the carveouts, I hear few complaints. I think the economic aspect also decides whether a patient is seen by the psychiatrist or not.

Dr. Klinkman: Our collaborative care model grew out of the Ford Motor Company approaching us to try to find a way to look at long-term health issues in an integrated way in contrast to figuring out which carveouts work or the most efficient and effective way to put people into disease management programs. Their question was a broader one—How can we best improve treatment for people with chronic illnesses over time? It's a different question, and I think that led to a different set of principles in working it through.

Dr. Katon: In most instances, there's a cost aspect to that too. Ford Motor Company is like any other company. It wants to know, what is this going to cost? There is going to be some ceiling on what the company is willing to spend on this.

Dr. Choksi: The other issue is whether these costs are going to be generalizable. Some systems maintain their integrity for long periods. In some places there are lots of changes in relationships between systems and between providers.

Dr. Klinkman: As a physician, you hope that decisions you make for patients, regardless of insurance coverage, are going to be longer-term

decisions. The time lines may be quite a bit shorter from the point of view of the managed healthcare companies and the payers, and that's where negotiation also has to occur, because it's very difficult to work with patients whose insurance plans change from year to year. You can still do that, but if you think the patients are going to be out of your practice in a year, or a couple of months, it becomes harder.

Dr. Nichol: I think the thing that is most notable about the model that you are talking about is that it wasn't employer-generated, but the partnership certainly was initiated from the employer side, and they've got an obvious interest in the long-term well-being of the people who are in that system. So, you've got an investment on both sides of the table to try to make something positive happen.

Dr. Katon: That's also an economic incentive for the employer. I think there's more interest right now because it's hard to find good workers. In times of recession there is less interest.

Dr. Treisman: The long-term investment in keeping an employee for life has changed, and this has changed the way we see patients. Healthcare is part of that—with patients changing doctors 3 or 4 times over a 5-year period because the insurance plan changed. Patients with complex problems change providers often. It's the conceptualization of the relationship in healthcare that is different. This is a society-wide issue and demonstrating value in the relationship between patient and provider could conceivably help the system.

Dr. Wilson: I don't know whether corporations have yet come to realize that they're probably generating all sorts of hidden costs and false economies because of the ephemeral

nature of the doctor-patient relationship in some plans.

Dr. Treisman: The patient-doctor relationship is so crucial in populations of unemployed and disabled patients. There are all kinds of barriers to care, and rehabilitative care really requires a rehabilitation and not short cross-sectional treatment. You have to treat the depression and substance abuse; the person has to go to the pain center; the person has to get vocational rehabilitation and physical therapy, and then can go back to work. Who's going to see the big picture for that patient?

Dr. Katon: That's going to require society to look at the patients using health-care resources in an entirely different way. We have to start to capture societal cost, which we have not done so far.

Dr. Wilson: In public psychiatry, we have always had covert managed care capitation and collaborative community care. Basically, we have always been budgeted X dollars for Y number of patients. Even using that plan, the state legislatures are increasingly aware that not addressing healthcare costs appropriately, mental health in particular, just impacts somewhere else in the state budget—on criminal courts and corrections departments, in particular, but also in general Medicaid and urgent care. I'm intrigued by how little it's appreciated that the public mental health system in the United States has, for several decades really, had a continuum of care that's a lot like what is happening now in the private insurance industry.

Dr. Katon: Their case management systems are very similar to the nurse management systems that are being tried in primary care.

Conclusion

Dr. Choksi: We are going in the right direction with the National Committee

for Quality Assurance, the requirement for quality of life improvement, the Health Plan Employer Data and Information Set, and the requirement by the MBHOs to have a relationship between the primary care physician and the psychiatrist. We are heading in the right direction to really improve managed care and the treatment of the patient.

Dr. Rabins: In our clinical lifetimes, we have gone from having very few treatments to almost too many treatments. The questions we're asking now are how to most effectively and efficiently use those treatments to benefit the most patients. It's nice that we can start asking these kinds of questions, rather than just having to throw up our hands and hope that people get better with time, which, until 40 years ago, was all most doctors could do for any condition. Depression is among the many chronic illnesses for which we can now make a big difference. However, these treatments have brought about new problems. In the future, we'll make progress and solve them as well.

We need to continue to have these conversations among primary care physicians, specialists, system providers, economists, and pharmacists because each one of us really has a different input and there is no single way to solve this.

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