ONE MINUTE CONSULT

BRIEF ANSWERS TO SPECIFIC CLINICAL QUESTIONS

Q: Should primary care physicians screen for depression?

GEORGE E. TESAR, MD
Chairman, Department of Psychiatry and Psychology,
The Cleveland Clinic

Screen for depression in patients with diabetes, cardiovascular disease

A: Yes, as long as the time and personnel are on hand to ensure accurate diagnosis, effective treatment, and follow-up, according to current US Preventive Services Task Force (USPSTF) recommendations.[1] Unfortunately, this is uncommon in primary care settings. Numerous obstacles contribute to primary care physicians' failure to diagnose depression in up to 50% of their depressed patients.[2]

But failure to detect and treat depression leads to unnecessary suffering and disability and increases the use of health care services. The personal, clinical, and socioeconomic consequences of untreated depression oblige all physicians to detect it when it is present, and to adequately treat it when it is diagnosed. What is needed is a means of attaining these goals that fits the constraints of a typical primary care office practice.

OBSTACLES TO SCREENING FOR DEPRESSION

Practice-related factors

Time is the greatest obstacle to the detection of depression in the primary care setting: no more than 10 to 15 minutes is allotted to a typical office visit, which is barely enough time to determine and address the patient's medical needs, let alone make a diagnosis of depression and then discuss the diagnosis and treatment options with the patient. Medical problems take priority.

Patient-related factors

Primary care patients with depression tend to have less severe depression, which makes it easy to neglect. Primary care patients may be reluctant to discuss mental health problems with their primary care physician. They may fear being "labeled" with a mental health diagnosis in their medical or insurance records.

Capitation and cost

Given the current trends in managed health care, primary care physicians in the future will have even less time to spend on a typical patient visit. And when a primary care physician makes a diagnosis of depression, the managed care plan may not pay for necessary follow-up visits.[3]

MAKING SCREENING COST-EFFECTIVE

Assuming the availability of an effective depression treatment strategy such as the collaborative care model discussed below, is routine screening for depression cost-effective?

No, according to an examination of the cost-utility of screening for depression in a hypothetical cohort of 40-year-old primary care patients by Valenstein and colleagues.[4] The direct costs of screening are the costs of producing the screening instrument, patient time required to complete the instrument, and nurse and physician time required to score the instrument and assess the patient. Based on estimates from the literature and a "team model of care," the investigators assumed that a nurse would devote approximately 6 minutes and a physician 1 minute to the screening process, resulting in costs of approximately $5.00 per patient. Using cost and quality-adjusted life years to measure outcome, the researchers estimated that screening more than one time (eg, periodically or annually) would cost significantly more than $50,000 per quality-adjusted life year, an often-used benchmark for cost-effectiveness.

Goals of screening for depression

Since one-time screening for a typically episodic disorder such as depression is likely to be inadequate, a screening program must have the following goals to be cost-effective:

- A highly efficient screening procedure that is quick, simple, and informative[5]
- Restriction of screening to high-risk populations[6]
- Treatment of at least 80% of patients who screen positive for the disorder[1]
- At least 85% of those treated must have a remission.[4]

The first three are attainable, but the last usually is not.

A quick, simple screening procedure

Continuing advances in screening technology have significantly reduced the time and effort the practitioner needs to put into it, while at the same time expanding the amount and quality of clinically relevant information.

The Beck Depression Inventory and the Zung Depression Scale are widely used, but they screen only for depression and require clinician time for scoring, interpretation, and clinical correlation.

The Primary Care Evaluation of Mental Disorders (PRIME-MD) screening questionnaire for depression was developed not only to screen for depression and other psychiatric disorders common in primary care, but also to provide valid diagnostic information.[7] The original version was conducted and interpreted by the clinician, and the considerable clinician time required made it impractical for routine use and led to the development of a computerized and patient-rated version.[8]

Hand-held computers, interactive telephone systems. Similar structured interviews can be administered conveniently via hand-held computer[9] or a telephone-operated interactive voice-response system.[10] Computer-driven data analysis occurs immediately after the survey is completed. A printed report that contains valid diagnostic impressions, based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV), and a list of relevant symptoms and suicide risk are then delivered to the clinician within seconds or minutes.

Such screening techniques can also be used after a clinical evaluation (eg, to follow up a clinical hunch derived during the office visit) and for patient education (eg, to help challenge patient denial or other resistance to accepting a psychiatric diagnosis). Another advantage of computer-assisted information gathering is that patients are often more forthcoming with a computer than they are with a time-pressured clinician[9,10] (SA Lochner, personal communication, 2000).

Restricting screening to high-risk populations

Screening only those at high risk is more cost-effective. Depression is common in primary care clinics, but most primary care patients are not depressed. Specific subpopulations at especially high risk of depression and who should be targeted for screening include patients with cardiovascular disease[11] and diabetes,[12] and patients who are "high-utilizers" of medical care.[13]

Treating patients who are diagnosed

For depression screening to be cost-effective, a high percentage of diagnosed patients must receive the indicated treatment. Continuing medical education of primary care physicians has not been adequate to achieve this goal.[14] Instead, disease management programs such as those used in the treatment of other chronic disorders (eg, diabetes, hypertension, asthma) can be implemented to increase the availability and quality of treatment.[3] Collaborative care[14] (see discussion below) is one such approach. The addition of nonphysician facilitators (eg, nurse practitioners, physician's assistants) can help improve patient education, treatment adherence, and treatment monitoring.[3]

Patients may be more forthcoming with a computer than with a hurried clinician

Overcoming other obstacles to screening

Successful screening requires that both patients and physicians overcome common objections to screening. Destigmatization of mental illness and parity for mental health coverage could help overcome some of the existing barriers to the timely detection and treatment of depression and the other mental disorders commonly seen in primary care.

THE COLLABORATIVE CARE MODEL

Since patients diagnosed with depression in the primary care setting also require appropriate treatment, a cost-effective means of achieving depression care goals is needed.

Katon and colleagues[14] found that a collaborative care model—in which primary care physicians and mental health professionals work together to provide treatment of depression—improved outcomes[3,14,15] and patient satisfaction.[11] In this model, patients receive the services of a primary care physician and a mental health professional at increased intensity and frequency compared with usual care: for the first 4 weeks after receiving a diagnosis of depression, the patient sees a primary care physician in weeks 1 and 3 and a mental health professional in weeks 2 and 4. The goals are to provide adequate patient education and to ensure that antidepressant medication is prescribed in adequate dosage for sufficient duration (ie, 4 to 6 weeks).

However, while collaborative care is more cost-effective than usual care (ie, it costs more to achieve high-quality outcomes with a usual care approach), it costs more because it uses resources more intensively.[14] The continuing challenge for all primary care practices is to develop less costly treatment methods that achieve the same high-quality outcomes achieved with the collaborative care model or similar programs for depression management.

REFERENCES

1. **Pignone MP, Gaynes BN, Rushton JL, et al.** Screening for depression in adults. A summary of the evidence for the US Preventive Services Task Force. Ann Intern Med 2002; 136:765–776.
2. **Simon GE, VonKorff M.** Recognition, management, and outcomes of depression in primary care. Arch Fam Med 1995; 4:99–105.
3. **Magruder KM, Norquist GS.** Structural issues and policy in the primary care management of depression. J Clin Psychiatry 1999; 60 (suppl 7):45–51.
4. **Valenstein M, Vijan S, Zeber JE, Boehm K, Buttar A.** The cost-utility of screening for depression in primary care. Ann Intern Med 2001; 134:345–360.
5. **Depression Guideline Panel.** Depression in Primary Care, Volume 1. Detection and Diagnosis. Clinical Practice Guideline, Number 5. Rockville, Md: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication 93-0550. April 1993.
6. **Kroenke K.** Depression screening is not enough (editorial). Ann Intern Med 2001; 134:418–420.
7. **Spitzer RL, Williams JBW, Kroenke K, et al.** Utility of a new procedure for diagnosing mental disorders in primary care: the PRIME-MD 1000 study. JAMA 1994; 272:1749–1756.
8. **Spitzer RL, Kroenke K, Williams JBW, et al.** Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. JAMA 1999; 282:1737–1744.
9. **Shedler J, Beck A, Bensen S.** Practical mental health assessment in primary care: validity and utility of the Quick PsychoDiagnostics (QPD) panel. J Fam Pract 2000; 49:614–621.
10. **Kobak KA, Taylor LvH, Dottl SL, et al.** A computer-administered telephone interview to identify mental disorders. JAMA 1997; 278:905–910.
11. **Musselman DL, Evans DL, Nemeroff CB.** The relationship of depression to cardiovascular disease. Arch Gen Psychiatry 1998; 55:580–592.
12. **Lustman PJ, Freedland KE, Griffith LS, Clouse RE.** Fluoxetine for depression in diabetes: a randomized double-blind placebo-controlled trial. Diabetes Care 2000; 23:618–623.
13. **Simon GE, Willard MG, Katzelnick DJ, et al.** Cost-effectiveness of systematic depression treatment for high utilizers of general medical care. Arch Gen Psychiatry 2001; 58:181–187.
14. **Katon W, Von Korff M, Lin E, et al.** Collaborative management to achieve treatment guidelines: impact on depression in primary care. JAMA 1995; 273:1026–1031.
15. **Von Korff M, Katon W, Bush T, et al.** Treatment costs, cost offset, and cost-effectiveness of collaborative management of depression. Psychosom Med 1998; 60:143–149.

ADDRESS: *George E. Tesar, MD, Department of Psychiatry and Psychology, P57, The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, OH 44195.*