EDITORIALS

Life after Primary Care Depression Quality Improvement Intervention

Policy analysts and researchers were dismayed to learn almost 5 years ago that the impressive impact of acute primary care depression interventions dissolved shortly after interventions ended.¹ While disappointing, these findings made a critical contribution to the recognition that interventions to improve the treatment of chronic diseases like depression not only needed to incorporate chronic disease management principles but also potentially needed to be delivered on an ongoing basis to promote lasting improvements in symptoms and functioning.² The study by Katon et al. suggests that for at least 1 segment of the depressed patient population, ongoing interventions may not be required to ensure sustained symptom improvement.³

Katon et al. demonstrate that an intervention that improves antidepressant medication management over 3 months significantly improves depressive symptoms 2 years later in depressed patients who remain moderately depressed after an 8-week trial of medication. Noting that the intervention does not impact the group's use of antidepressant medication after 6 months, the authors postulate that getting patients on the right antidepressant medication (drug and dose) early in their course of care: (1) increases their rate of complete recovery, which then reduces their susceptibility to relapse; or (2) improves their skills to handle relapse. Importantly, these improvements appear to add little or no financial burden to the health care system, particularly as generic serotonin reuptake inhibitors become more widely used.

This carefully designed and admirably executed study illustrates the compelling logic Katon et al. have articulated for using stepped care intervention (a sequence of clinical guidelines for assigning staged treatment to patients on the basis of observed outcomes) to improve depression outcomes. In step 1, physicians successfully start depressed primary care patients on antidepressant medication. In step 2, consultation-liaison psychiatrists make recommendations for medication adjustment for 20% (perhaps more in some systems) of patients who fail to improve with initially prescribed medication. Because

step 2 intervention results in sustained symptom improvement for moderately depressed patients only, patients who remain severely depressed after step 1 care may need referral to specialty care rather than consultation-liaison intervention. The common sense underlying stepped care intervention is all too uncommon in the allocation resources to provide depression treatment in usual care settings.

As good studies do, that of Katon et al. challenges the field to address issues that remain before primary care depression initiatives can and will be widely adopted. One major challenge is the need to translate onsite consultation-liaison intervention into telephone intervention, because most primary care providers practice in settings that do not employ onsite psychiatrists. A second major challenge is to better understand how primary care depression intervention needs to be tailored to improve long-term functioning. A third challenge is to integrate the results of this study into existing literature to define a more tiered stepped care intervention in which depressed patients who fail to improve in usual care are referred to short-term primary care intervention, and in which short-term intervention patients at risk for poor outcome are referred to ongoing primary care intervention and/or specialty care. As the song instructs us, it is only in turning, turning that we come down right.—**KATHRYN ROST, PhD**, *University of Colorado Health Sciences Center, Denver, Colo.*

REFERENCES

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