Question and Answer Session

Dr. Kupfer: *A number of questions have been submitted by audience members. The first is: Given the information already available on the cost-effectiveness of programs for diagnosis, treatment, and referral in the primary care setting and integration of mental health specialists into primary care, what now needs to be done to turn such an effort into health care policy? Do we need another 10 studies, another 20 studies? Do we need to write our representatives in Congress?*

Dr. Wells: The most persuasive evidence for policy makers is likely to be proof that social costs of depression are reduced by such programs. We have not yet conducted studies examining effects on these costs. I do not know that the increased cost-effectiveness of such programs as shown in the data presented by Dr. Katon would necessarily convince a health care plan to adopt such measures. However, I am pretty sure that the differences in social costs implied by the differences in cost-effectiveness would convince policy makers. So, I think the next step is to include measures of social costs in our studies.

Dr. Katon: Although we included measures of work and social disability in our trial, they were not very accurate measures, and our focus was primarily on symptom outcomes.

I want to point out that the Group Health Cooperative in Seattle actually is integrating mental health professionals into primary care and is using a lot of our data in doing this. So, this is an example of research helping to change an actual system of care, and we have been working closely with both the primary care and mental health leaders of this particular effort. Of course, there are many other systems of care in the United States and there are many other models of integration that can be and are being tried.

Dr. Kupfer: *It is not that difficult to see how primary care models with increased psychiatric input can be instituted in large HMOs. How can this be accomplished in smaller primary care practices?*

Dr. Katon: I agree that it is easier to integrate mental health specialists into large clinic systems. But, in our area of the country, we are seeing mental health professionals integrated into many small practices. Practices of four or five family doctors and internists frequently have a social worker coming in one day a week and a psychologist coming in one day a week as part of their practice. This is not currently being done as much by psychiatrists, but there certainly is room for psychiatrists to approach internists and family doctors in this regard. What has been done in Seattle is that psychiatrists have essentially rented office space in primary care clinics. This has proved to be a great way of improving referrals to their practice. What you find is that if you are there a half day a week, you are educating the doctor all the time. They are talking to you about difficult cases, and your rapport is constantly improving.

Dr. Wells: I have seen this occurring in slightly different ways. Some of the largest psychiatric group practices have worked out arrangements to serve a variety of primary care sites. They have done this by having a social worker or nurse clinician and sometimes a psychiatrist on a regularly scheduled basis actually work in the office of the primary care doctor to create a large service and referral network for themselves.

In cases in which this kind of integration is impossible or unavailable, the tools for improving recognition and treatment of depression by primary care physicians that were discussed in the meeting would be of particularly great value in improving quality of care.

Dr. Kupfer: *A question for Dr. Horn. How do you respond to the information Dr. Katon presented from randomized controlled trials in light of what you have said about the Clinical Practice Improvement (CPI) process?*

Dr. Horn: Well, I certainly agree that randomized controlled trials, if you can do them and they do not influence other aspects of care, are an appropriate way to go. However, in many situations, their findings cannot be applied to the general practice of medicine. To try to determine what works best in the general practice of medicine, the techniques I described—measuring in detail what has been done, how the patients differed, and what factors are associated with better outcome—are an important way of gathering information regarding what needs to be changed in the process of care.

Dr. Kupfer: *Are there any studies similar to the ones described by Dr. Katon for depression that have looked at collaborative programs between primary care physicians and other medical specialties? Is this kind of collaborative work being done with other specialties?*

Dr. Wells: It is being done with other specialties, as well. For example, in diabetes there are a number of trials of programs designed to improve education and care by having specialty nurses work very closely with physicians and provide patient education. There are also intervention studies going on in arthritis, hypertension, and asthma. So, these types of disease management modules are being tested in a variety of very common illnesses.

Dr. Kupfer: *Given what is happening with respect to at least psychiatric managed care carve-outs, how can we expect managed care to be really concerned about cost-effectiveness? Or, what is the best way to get to Congress about issues around parity and laws that are currently pending? While this is not necessarily a political forum, I would like to hear anybody's comments about this.*

Dr. Katon: On the issues of cost-effectiveness and value of care, I think that this is something that managed care companies understand. It may not yet be what the marketplace is demanding, but I think the companies are very much oriented in that direction. If we are able to get more standardized measures of quality of care into play, then I think the marketplace will demand attention to it as well, because it also makes sense from a business perspective.

Dr. Wells: The issue of parity is really complex; it would require a separate symposium. But, briefly, it might be useful to distinguish between trying to make sure that there is not a major discrepancy and determining whether parity is exactly the right solution. I think that the work done by Dr. Katon's group and my group suggests that adding greater barriers to care for depression is not going to help the situation and is not going to be socially useful for this country. Certainly, excluding mental health from health care coverage arguments is not going to help us make progress in treatment of depression.

Dr. Docherty: I also think the issue of integrated care, or carve-in versus carve-out, is a complicated one that has something to do with the current period of evolution or development of the field we are in. The issues involved differ according to whether one views the type of system as dictated by policy rather than as an ideal to be reached for or as something that could be achieved in certain specific sites. The main threat to psychiatry, and to mental health care in general, from not having a carve-out position has to do with dwindling resources getting assigned to mental health care. The National Institute of Mental Health (NIMH) just reviewed what happens when plans shift from a carve-out to an integrated system and found that there is a strong decrement in the amount of the health care dollar allocated to mental health care overall—from approximately 9% to 11% down to 3% to 5%. So, what we have become is basically a small entity in a system that by reason of its history has its values oriented in another direction. We face all the problems of stigma; so, there is some protection to be gained in the carve-out system. Vis-à-vis the issue of cost-effectiveness in carve-outs, there are various contractual arrangements that can be made that would build those cost-effectiveness issues into the contracts, so that the gains that could be made on the medical-surgical side can be made a part of the activities of the carve-out group.

Dr. Wells: One interesting trend we are seeing in our state is that more and more insurance companies are covering unlimited numbers of medication visits but drastically limiting the number of psychotherapy visits. So, they are sort of buying the medical model of depression, but putting stringent controls on the amount of psychotherapy people can get.

Dr. Kupfer: *Another question: is there any free psychiatric care available in the United States, and does the lack of access to such care have an impact on the lack of treatment for depression?*

Dr. Wells: The models of insurance in this country almost never include "free anything." Even in the case of capitation or prepayment, there is a premium being paid. The closest thing we have to a social health care system is Medicare—and there we have virtually universal coverage for the elderly. Medicare is not something that people have over the long term; they usually have it for a year or two. We do know from the health insurance study, which included randomization to free care versus more traditional prepaid and fee-for-service plans, that level of coverage definitely affects access to care.

Dr. Kupfer: *Are there any effective psychological approaches available in primary care settings to manage minor anxiety in depressive disorders?*

Dr. Katon: We have a study in progress at four sites cofunded by the MacArthur Foundation and the Hartford Foundation looking at people with minor depression: patients who have two to four depressive symptoms for a month or more get randomly assigned to a problem focus group versus SSRI treatment versus placebo. But, there are very few data specifically about patients with minor anxiety and depression.

Dr. Docherty: I know of only one trial in minor anxiety and depression that has been completed. It is a study at the University of California, San Francisco, that examined the impact of cognitive-behavioral therapy and demonstrated effectiveness of the therapy in that population.

Dr. Kupfer: *We have several questions to the effect that even in this era of managed care, psychiatrists are going to have to do—and perhaps are already doing—brief and even super-brief exams. What instruments would you recommend that psychiatrists use to increase their chance of making accurate diagnoses, especially those that may not be the most obvious primary diagnoses?*

Dr. Katon: We have had experience with Prime-MD, which you can certainly use as a screening instrument for the psychiatrist. It screens for six diagnoses; then, you can in your clinical exam or with the structured interview from Prime-MD go over the specific diagnoses. It is a way of being more complete: do your usual exam, do the screener, and then compare them to make sure you did not miss

something that came out positive on the screener. A psychiatrist could certainly use that.

Dr. Wells: Another approach is to use one of the brief screeners for psychological distress. The Mental Health Inventory, Five Item Version (MHI-5) or the Zung Self-Rating Depression Scale or the others discussed by Dr. Docherty are good examples. You can use these initially, then use the clinical exam, the Prime-MD, or whatever tool you are using on the subset of patients you find positive on this first step.

Dr. Kupfer: *What is the most cost-effective method we would recommend for mental health practitioners collaborating with primary care physicians at the present time?*

Dr. Katon: It depends on whether you are talking about someone who is just trying to set up a practice with primary care doctors versus someone who is trying to, say, lower the prevalence of depression in primary care. Lowering the prevalence of untreated depression in primary care, for example, really requires you to develop and use a whole range of disease management modules, and I think the average person in private practice is not going to want to do this. But, I think that one of the things we found by exploring our own model is that a perhaps more cost-effective way than our model might be to require primary care doctors you are working with to monitor 6-week outcomes of patients they diagnose with depression; this could certainly be done with the Hopkins Symptom Checklist (SCL) or with the Hamilton Rating Scale for Depression (HAM-D) or with almost any acceptable scale. Patients not getting better at 6 weeks ought to get a mental health referral.

So, if I were running a primary care system and wanted to use the most cost-effective system for the most common mental illnesses, I would probably want to give the doctors 4 to 8 weeks to see if they could improve the illness. If they could not, then, as with hypertension or other illnesses, a specialist should become involved. And the key thing that is not happening now is that the primary care doctors are not really monitoring the quality of improvement; so, I think that patients really are not getting referrals based on how they are doing over time, and only a minority of them are getting referrals.

Dr. Docherty: I do not think we know yet what the most cost-effective means of collaborating is. We are at a very interesting phase of this process in that we are generating and testing models. The computerized methodology that I mentioned earlier is also a very interesting approach. It attempts to address each of those key processes of care where we have identified problems in primary care and it seeks to provide guidance and advice to the primary care doctor at each of those points. First, it addresses the issue of whether or not there is a depression. Then, if a depression is present, the first thing that the system does is to determine whether the depression is complicated in some way—whether the patient is bipolar or psychotic or has a comorbid substance abuse problem or is suicidal, for example. Patients who have evidence of complications are referred immediately to specialty care; so, the complicated, difficult patients are taken out of the pool before the process proceeds. Then, the system helps the doctor through the pattern of treatment, stating precisely which medications make sense in the patient on the basis of past history and status, and how to implement such treatment. And, addressing one of the issues Dr. Horn raised regarding the lack of specificity of treatment guidelines, it goes into great detail in arriving at an actual decision and in showing how that decision can be implemented. I think use of this methodology is going to be an interesting experiment. If it works, it would be highly cost-effective. But, we do not know that yet; we are still in the validation and testing phases.

Dr. Wells: A brief response to the question on cost-effective strategies. Generally, the most cost-effective strategy is to first remove treatments that are doing harm or doing no good. In the area of depression, the candidate for that is minor tranquilizer use. So, one thing a psychiatrist can do is to advise his or her colleagues to reduce the use of regular ongoing minor tranquilizers in seriously depressed patients. The second principle of cost-effective care is to then institute appropriate treatments that will improve outcomes and that are a good value for that outcome improvement. There the issue is: is antidepressant medication or counseling or psychotherapy a better value? The answer to that is not fully in yet, frankly, even though we are acting as if we think medication is a better value in terms of the policies that are being enacted now. That actually is an issue that we are trying to address in the PORT study: the relative cost-effectiveness of improving practice through medication or through psychotherapy.

Dr. Horn: I just want to reiterate the idea that, in addition to the trials that are running and the other studies we have heard about, in general medical practice the CPI model I discussed is a model that can help define in other patient populations—that is, beyond those that qualify for randomized controlled trials—what appears to work best when. One of the advantages of using the model is that you do not have to start doing things to certain patients and stop doing things to certain patients on the basis of the clinical trial criteria for enrollment or evaluability. Instead, you are measuring what is currently going on in actual practice and determining what works best under which patient circumstances.

In all of the experiences we have had in conducting such studies—including the areas of bone marrow transplantation, colorectal cancer, dysfunctional intrauterine bleeding, heart conditions, and surgical conditions—we have always been surprised by our findings when we have examined patient differences, treatment differences, and

the relationship of these differences to outcomes. Things we never expected to be factors in outcome are ultimately found to be influencing outcomes of care. So, this type of analysis, which can include examination of a great number of variables, can allow us to construct models for improvement of care that are based on the factors found to actually influence outcomes; and this method consequently poses certain advantages over trying to guess at whether a particular patient/physician interaction or education model or a specific drug is the thing we should test.

Dr. Docherty: I think that the presentations today, taken together, have really emphasized the importance of depression in general health care. The work presented by Dr. Horn was particularly illustrative of that in that it demonstrated the relationship of the comorbid depression to the worsening state of the patient's "primary" condition; this is a really critical finding, bringing to a fine point some of the work that Dr. Wells and Dr. Katon have been doing. It shows that the patient's general health status, aside from the morbidity that the depression itself brings, is greatly worsened by the presence of a depression and that in light of all this, the role of the primary care doctor in the recognition and treatment of depression becomes absolutely critical.