The Telephone as a New Weapon in the Battle against Depression

EDITORIAL

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We've known about the efficacy of certain drugs and psychotherapies in the treatment of major depressive disorder for almost a decade,[1] but the application of that knowledge outside of research settings has presented a major challenge. The science of application—that is, knowledge of the processes of care that produce the desired outcomes—has not kept pace with the science of best treatments.

Outside of the research setting, the obstacles to community application of proven therapies loom large. Many patients with major depression present with somatic complaints that distract their clinicians from recognizing depression. Patients who are recognized as being depressed may resist the diagnosis. Those who are treated may be prescribed an inadequate dose of antidepressants (or may not fill their prescriptions) and may have no access to psychotherapy. Even those who receive ideal treatment may become discouraged and discontinue care because of the time required to achieve a response.

Recently, the science of application has advanced substantially. The year 2000 has already produced important reports relevant to the primary care of depression. Four new studies,[2–5] all randomized, controlled trials, have shown that certain enhancements to the care process—what goes on between the clinician and the patient—can improve patient outcomes in primary care settings. The studies, briefly described in **Table 1**, deserve careful scrutiny for their similarities as well as their differences.

Each of the four recently published studies involved other professionals in addition to the patient's continuity clinician. In one intervention,[2] that person was a psychologist skilled in cognitive–behavioral therapy. The three other trials involved staff members with backgrounds that would be hard to distinguish from those of many nurses and medical assistants working in typical practices, albeit with a few hours of extra training, as well as modest ongoing supervision. All of the interventions involved some degree of monitoring of patients' responses to therapy. This study element, commonly known as the case manager function, is often combined with patient education and helps to address barriers to care. The number of contacts received by patients varied from as few as two[3, 4] to more than a dozen,[2, 5] and the average duration of each contact varied from 10 to 50 minutes.

The report by Tutty and colleagues in this issue[6] contributes to the science of application for the primary care of depression. In this pilot study, a modest enhancement to routine care—six sessions of telephone counseling by a master's level therapist who gave regular feedback to the primary care provider—led to improved patient outcomes among those who had begun receiving antidepressants. Patient acceptance was good, and the costs were modest (an additional $150 per patient).

How does a study in which only 28 patients received the intervention add to our knowledge? A recent report by Keller[7] on patients with chronic depression sets the stage. This study provides suggestive evidence that using a combination of antidepressant therapy with cognitive behavioral therapy yields superior patient outcomes over time than either used alone. Tutty and colleagues' work thus builds on the Hunckler study[5] in which patients were provided behavioral support but were not given formal psychotherapy by telephone. Through the use of communication by

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TABLE 1

Recent Randomized Trials of Management Strategies for the Primary Care of Depression

INTERVENTION AND REFERENCE	PATIENTS	SETTING	FINDINGS	
			PROCESS	SYMPTOMS
Monthly nurse contact for medication management or 12 to 16 sessions with a psychotherapist for cognitive–behavioral therapy[2]	1356 patients who tested positive during screening for current depression	46 primary care clinics (Staff- and network-model group practices and public health clinics)	Patients who received the intervention were more likely to receive appropriate antidepressant dose or counseling (59% vs. 50%)	Patients who received the intervention were less likely to meet criteria for depression at 1 year (42% vs. 51%)
Systematic telephone follow-up by care managers at 8 and 16 weeks; feedback report prepared for physicians with recommendations; care managers available to assist in implementation[3]	613 patients who had new antidepressant prescriptions	5 primary care clinics within Group Health Cooperative of Puget Sound	Patients who received the intervention were more likely to receive at least moderate antidepressant dose (30% vs. 18%)	Patients who received the intervention were less likely to have major depression at 6 months (7% vs. 14%)
Physician education, treatment protocol, and telephone-based treatment coordination by nonphysicians[4]	407 patients who were "high utilizers" and tested positive during screening for current depression	3 staff-model HMOs	Patients who received the intervention were more likely to fill an antidepressant prescription (82% vs. 32%)	Patients who received the intervention were less likely to be depressed at 1 year (55% vs. 72%)
Emotional support and focused behavioral interventions in 10 telephone calls by primary care nurses[5]	303 patients who had new antidepressant prescriptions	2 primary care clinics within Kaiser Permanente Northern California	No difference in antidepressant use (80% vs. 73%)	Patients who received the intervention were more likely to improve substantially at 6 months (57% vs. 38%)

telephone and the flexibility it provides, Tutty and colleagues address a key obstacle—patient access to efficacious psychotherapy as an adjunct to medication.

The limitations of the Tutty report should not go unrecognized, and the authors do not oversell their results. The number of patients receiving enhanced care was small. The setting was one clinic in a staff-model HMO that is renowned for its ability to field and test innovative treatment for depression in primary care settings. Patients were predominately white and lived in the suburbs. Controls were neither contemporary nor randomly assigned. The strengths of this study relate to the modesty and transportability of the intervention and its apparent acceptance by patients. The $150 added cost per patient stacks up well against the cost of antidepressant prescriptions, providing only a very modest increase in total costs of care. Few patients refused it. The telephone counselors could be available centrally and were available for evening and weekend hours; the counselors were thus accessible to patients whose work constraints, fears of stigmatization, or access issues would otherwise have interfered with mental heath referral.

What do these five recent studies tell us about efficacious processes of depression care? A systematic approach to care including monitoring and active team management makes a difference. These elements and the integrated process of care of which they are a part are common to other chronic disease case management approaches. What is new is that we know that these elements can apply to the care of major depression.

Is it a coincidence that four of these five recent primary care intervention studies on depression rely heavily on the telephone? Wasson and colleagues led the way on telephone care with their landmark study.[8] On the strength of these and other studies, it's time for payers and policymakers to follow this method. Health Plan Employer Data Information Set standards need to recognize telephone follow-up as a legitimate means of pro-

viding follow-up care with patients who have depression. Payers need to allow direct payment for telephone support and counseling in recognition of the increased workload required to properly manage chronic care conditions. The science of application is catching up with the science of depression treatment. Policymakers and payers need to catch up with that science.

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