Intervention's Benefits Last in Late-Life Depression

BY DAMIAN McNAMARA
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MARCO ISLAND, FLA. — An intervention significantly increases depression-free days and improves physical functioning in the elderly—even 12 months later, Wayne J. Katon, M.D., reported at the annual meeting of the Academy of Psychosomatic Medicine.

New 2-year data from the Improving Mood—Promoting Access to Collaborative Treatment for Late Life Depression (IMPACT) study show that the clinical benefits of the intervention persist well beyond the initial 1-year treatment period.

"We saw improvements in functioning, pain, and overall quality of life," said Dr. Katon, a psychiatrist at the University of Washington, Seattle. "We were surprised at that the extent of the benefit in year 2, which was equal to the benefit we found in year 1."

In addition, the intervention proved cost effective at most of the sites. (See box.)

An estimated 10%-20% of older primary care patients meet the criteria for depression, and the percentage increases to up to 25% with chronic illness. But few depressed elderly patients receive appropriate care because of the burden of comorbidities, poor physical function, and often "an understanding" that they are depressed because of those comorbidities, said Dr. Katon, professor, vice chair, and director of the division of health services and psychiatric epidemiology at the university.

An initial report on IMPACT—a multicenter study of 1,801 depressed older adults—had shown that 45% of the 906 patients randomized to the intervention group had a 50% or greater improvement in depressive symptoms at 12 months (JAMA 2002;288:2836-45). In contrast, only 19% of the 895 patients randomized to usual care showed the same level of improvement.

The researchers recruited patients from 18 primary care clinics in five states. The participants were 66% female and 24% nonwhite, and all were 60 years or older (mean age 71). Many met criteria for major depression (17%), dysthymia (30%), or both (53%). Participants had a mean of 3.2 chronic illnesses, which included chronic pain, osteoarthritis, incontinence, and diabetes.

"A lot of these people would not be admitted into other depression studies because of the extent of their comorbidities," Dr. Katon said.

Participants randomized to the intervention group had access to a dedicated depression care manager. This manager provided education, behavioral activation, support of antidepressant therapy (prescribed by the patients' primary care physicians), or brief psychotherapy using the Problem Solving Treatment in Primary Care protocol. Depression care managers tracked outcomes using the depression module of the Patient Health Questionnaire (PHQ-9) and adjusted treatment accordingly.

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DR. KATON

"Stepped care allowed us to add an antidepressant if needed or to add psychotherapy as needed," Dr. Katon explained.

Physicians for patients in the usual care group were only told that the patient met criteria for depression or dysthymia. Physicians in the usual care arm could start patients on antidepressants or refer for psychotherapy or medication.

Patients were assessed at baseline and at 3, 6, 12, and 24 months. By 1 year, the intervention group was more likely to get some antidepressant treatment (odds ratio 2.98) and report more satisfaction with depression care (OR 3.38). Intervention patients got better more quickly over the 12-month period, he added.

Dr. Katon, lead investigator Jürgen Unützer, M.D., (professor of psychiatry at the university), and their colleagues followed patients for an additional year after the intervention.

In other studies that included mixed-age patients, the 12-month intervention versus usual care differences tended to come together, Dr. Katon said. But in the elderly population, the usual care patients improved for about 6 months, and then their improvements reached a plateau, whereas the intervention group did gradually better during the entire 24 months.

The intervention group patients had 107 additional depression-free days, compared with the usual care patients. "That is about a one-third-of-a-year difference," Dr. Katon said.

"We're sorry we did not take this study to a third year, since we saw equal benefit in intervention, compared with usual care patients in the second year," he said.

Of the 107 depression-free days gained by the intervention group, 53 were in the first year, and 54 were in the second.

The John A. Hartman Foundation and the California HealthCare Foundation funded the IMPACT study. ■

Visit www.impact.ucla.edu for more information about the IMPACT study.

Intervention Proves Cost Effective

The IMPACT researchers calculated total outpatient costs as $11,083 in the usual care group, compared with $11,378 in the intervention group. Thus, there is an increase of $295 in the intervention group over 24 months. In year 1, there was $383 more in ambulatory costs for intervention patients, compared with usual care—but in year 2, there was an $88 cost savings associated with the intervention.

"For a small bump in cost, you get 53 depression-free days in year 1, and in the second year, you actually save money for the 54 days [gained]," Dr. Katon said.

To ascertain total costs, the researchers considered the cost of usual care as $0 for reference and calculated intervention-specific costs as a mean $591 per patient over the 2 years. Comparing other mean costs for intervention group vs. usual care, antidepressant medication was $416 higher for intervention patients; other medication costs were $126 lower (a net savings); outpatient specialty mental health care was $86 lower; and other outpatient costs were $501 lower for intervention patients.

Intervention-specific costs included psychiatrist and primary care supervision time, nurse time, overhead costs, and educational materials. Other ambulatory medical costs included primary care and specialty visits, emergency department use, urgent care visits, and laboratory and imaging charges. Researchers excluded costs of inpatient care and patient time. The cost of patient time is "difficult to do in the elderly, because most are not working," he said.

Some figures were estimated. For example, 17%-24% of health care data were not available, Dr. Katon said. In addition, some organizations did not have pharmacy data. In cases where data were missing, imputation—which estimates costs by considering demographics, prior health care use, and other factors—was used to estimate costs.

The researchers estimated the incremental cost per quality-adjusted life year (QALY) for the intervention group. The range was $2,521 to $5,000. "It is widely accepted that anything that is under $10,000 per QALY for health care should be implemented immediately," Dr. Katon said.

New interventions typically cost more with increased effectiveness, Dr. Katon said. "The holy grail is that an intervention that costs less with increased effectiveness should be implemented immediately." For three of the eight organizations, the intervention saved money over the 2 years, with greater benefit, he added.

Reimbursement for collaborative care remains an issue. Psychiatrist supervision with the primary care physicians and depression care manager was not reimbursable, nor were the depression care manager's consultations with other providers (nonpatient treatment time). Follow-up telephone calls, likewise, were not reimbursed.

Despite the reimbursement issues, interest in the IMPACT model has been strong. "We're getting called all the time from health care organizations all over the United States with questions about how to implement this," Dr. Katon said.

Few Older Americans Opt for Outpatient Mental Services

BY HEIDI SPLETE
Senior Writer

WASHINGTON — Only 2.5% of adults aged 65 years and older use outpatient mental health services compared with 7.1% of adults aged 18-64 years, Bradley E. Karlin said at the annual meeting of the Gerontological Society of America.

These results, based on data from the 2001 National Survey on Drug Use and Health, show that older Americans continue to underuse mental health services, despite their need for them, said Mr. Karlin, a doctoral candidate in clinical psychology at Texas A&M University, College Station.

"One of the most disconcerting findings in the mental health literature is the underuse of mental health services by the older population," he noted.

Mr. Karlin and his coauthor, Michael Duffy, Ph.D., of Texas A&M University, conducted a logistic regression analysis to identify factors relating to unmet mental health needs and use of outpatient treatment. Older adults identified fewer mental health problems than did younger adults in the survey and had lower rates of serious mental illness. However, only 9% of older adults with serious mental illness and 10% with mental health syndromes used outpatient mental health services.

"Virtually nothing is known about predictors of mental health care in the elderly population. We don't know who the health seekers are," Mr. Karlin said. A greater understanding of the role of mental health in aging in the general population may increase the use of outpatient services, and older adults who hear about a friend's positive experience may be more likely to try outpatient care themselves, he added.

Overall, no differences appeared in the extent to which mental health treatment improves ability to manage daily activities, suggesting that older adults who do use outpatient mental health services derive at least as much benefit as younger adults, Dr. Karlin noted. ■