EDITORIAL

Better Management of Depression in Primary Care

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Primary care physicians, especially family physicians, contribute substantially to the care of patients with depression.[1] They are the health care providers of choice for the full biopsychosocial spectrum of care. In the spirit of the American Academy of Family Physicians' 2000 Annual Clinical Focus on mental health, family physicians should take this time to enhance their skills of recognition and management of depression in family practice.

Several studies in this issue of the *Journal* address aspects of depression in primary care. Three of these articles contribute new knowledge about current practice patterns,[2-4] one addresses the use of antidepressants in common syndromes of uncertain etiology,[5] and one reports the results of a randomized controlled trial assessing a novel approach to strengthening depression management skills.[6] All were sponsored by the John D. and Catherine T. MacArthur Foundation through its Initiative on Depression and Primary Care.

THE SIGNIFICANCE OF THE RESEARCH

These articles are significant for 3 reasons. First, they represent a new phase in developing the research base through the use of innovative research methodologies (standardized patients, meta-analysis, and focus groups). Second, the studies were conducted by investigators who sought to understand the unique aspects of primary care. Third, although some of the work is preliminary, these articles provide new insights into current practice patterns, therapies, and strategies that will enable physicians to reach their full potential in providing clinical services.

Solberg and colleagues[2] describe the barriers to providing mental health care perceived by primary care physicians in Maine. It is no surprise that lack of time, patient reluctance to accept mental health referrals, and lack of access to mental health providers stand out. What may surprise primary care critics is that among almost 1000 consecutive adult patients who were seen in these community practices, the majority who scored high on a depression survey had been asked at the clinical visit if they were depressed. The patient survey was administered independently, and the clinicians did not know the results.

Using actors as standardized patients portraying 2 depression scenarios, Carney and coworkers[3] found that primary care physicians recognized all patients who had major depression and also recognized many with subthreshold depression. For the most part, patients with major depression received care concordant with Agency for Health Care Policy and Research guidelines. In the subthreshold scenario where the chief complaint was headaches, Carney and colleagues[4] found that primary care physicians differ greatly in their use of psychosocial questions. Typically, the proportion of psychosocial questions asked by the physician increased in the period immediately before recognition that depression was a factor in the case. Primary care physicians who ask about mood early in the interview may be able to recognize depression more quickly.

Antidepressants have revolutionized care for major depression. What about their use in other common conditions? O'Malley and colleagues[5] reviewed the literature from English-language journals on the use of antidepressants for syndromes of unclear etiology that are common in primary care. Antidepressants were a successful treatment method for most of the conditions, even if formal depression was excluded. This study offers encouraging news about therapies for treating these challenging conditions.

Finally, Gerrity and coworkers[6] tested an innovative educational intervention directed at improving depression recognition and management skills, with a strong focus on physician-patient communication. One month after the program, physicians who participated performed significantly better in managing depression than those who did not. The physician participants in this study were well-motivated volunteers. Thus, this study shows that physicians interested in mental health and willing to participate in an evaluation study can do even better with this training. In an ongoing study, investigators are examining the impact of this program on the skills of an unselected sample of physicians.

What lessons can be learned from these results? First, you can teach old dogs — even high performers — new tricks through interactive education programs.[6] Second, primary care physicians do not, cannot, and should not act like mental health specialists. For a typical depressed patient presenting with a somatic complaint, psychosocial issues are only part of the agenda. As Carney and coworkers[4] show, primary care physicians explore both psychosocial and somatic concerns. Those primary care physicians who ask more psychosocial questions perform better in recognizing depression than physicians who ask fewer of these questions. Solberg and colleagues[2] pinpoint some barriers to the recognition of depression that are unique to primary care and offer solutions. In an insightful discussion, these authors

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urge development of better office systems to help physicians overcome these barriers.

These articles are among the first products of the MacArthur Foundation Initiative on Depression and Primary Care. Additional information about the MacArthur Foundation's program is available on the Initiative's Web site (www.depression-primarycare.org), including the teaching materials from the Depression Education Program evaluated by Gerrity and colleagues[6] and other tools that can support depression management office systems.

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