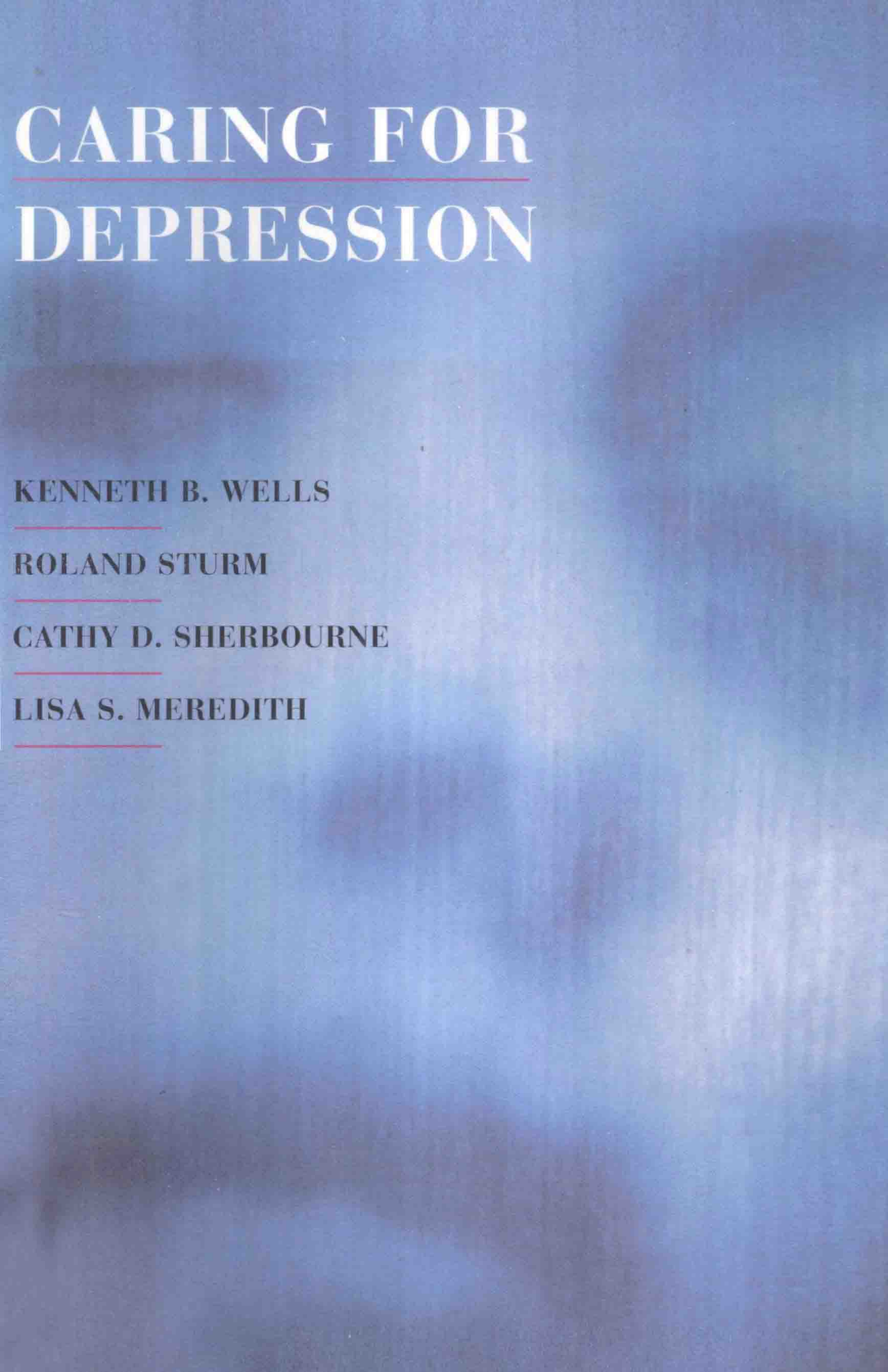

CARING FOR DEPRESSION

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A RAND Study

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Caring for Depression

Preface

The private health care delivery system in the United States is rapidly changing, but little is known about the consequences for patients. This lack of data is particularly pronounced for patients with psychiatric disorders, and a cause of concern in a time when many insurers and employers limit mental health benefits and regulate the use of services.

As trends within the health care delivery system began to evolve, several private foundations and federal agencies funded the Medical Outcomes Study (MOS), a health care study involving more than twenty thousand patients and five hundred clinicians. Its purpose was to provide insight into differences in quality and outcomes of care in typical practices and to develop the tools to monitor outcomes. The Medical Outcomes Study was the first to include a psychiatric condition (depression) on equal footing with chronic medical conditions. No other study of depression thus far has been able to integrate clinical and health policies perspectives to a similar extent.

This book documents what we have learned about depression from the Medical Outcomes Study. Because it covers topics in epidemiology, clinical care, health services research, and cost-effectiveness analysis, we often refer the reader to journal articles for more details. Occasionally we expand on some methodological issues that we perceive to be particularly important or that are often misunderstood.

This book will be useful for a wide range of readers who may focus on selected chapters. Clinicians and educators will be interested in the information about the impact of depression on individuals and about key strengths and weaknesses of quality of care in the private sector, which may be helpful for clinician training, as well as to target quality improvement. These readers should focus on the introductory chapters (1–3) and the chapters providing clinical results (6–8). For health services researchers or managers in practices, insurance plans, or industry, our evaluation methods and measures of quality and outcomes should be of most interest. These readers should focus on Chapters 4 and 5 and the appendixes. Finally, readers interested in health care policy and policy research will find our cost-effectiveness work (Chapter 9) and discussion of policy implications (Chapter 10) to be most relevant, although this book is not a public policy book.

The Medical Outcomes Study and this book would not have been possible without support from the Robert Wood Johnson Foundation, the Henry J. Kaiser Family Foundation, the Pew Charitable Trusts, the Agency for Health Care Policy and Research, the National Institute of Mental Health, RAND, and the cooperation of participating health plans. The most important contributors, however, are the clinicians and patients who shared their experiences with us.

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Chapter One

The Despair beyond Despair

Depression is more prevalent, causes more suffering, and has a more devastating impact on individual functioning and societal welfare than the public, policymakers, and even many health professionals realize. Patients with depression often withdraw socially, perform their usual tasks at work and home poorly—sometimes even stopping these activities completely and spending whole days in bed—and often think about suicide, the second most frequent cause of death among young adults.

The depth of suffering and the benefits of treatment have been powerfully described by the writer William Styron in *Darkness Visible:* "For those who have dwelt in depression's dark wood and known its inexplicable agony, their return from the abyss is not unlike the mythic ascent from Hell described by the poet Dante—a trudging upward and upward out of Hell's black depths and at last emerging into what he saw as 'the shining world.' There, whoever has been restored to health has almost always been restored to the capacity for serenity and joy, and this may be indemnity enough for having endured the despair beyond despair" (Styron, 1992). Yet many seriously depressed individuals receive no appropriate treatment for depression—even though depression can be treated successfully. Why is there such a discrepancy? Where does it occur and how can this situation be improved?

One reason for this discrepancy clearly is the continuing perception that depression is not a real illness. As a result, many people are hesitant to reveal their suffering to friends, family members, employers, and even their doctors, and are unlikely to receive appropriate care. There is little chance that this perception will change as long as there are no comparisons of depression with common medical conditions showing how serious depression really is. Such a comparison is one of the main goals of this book.

Because the quality of care for depression differs across delivery systems, we need to understand where problems are most likely to arise in order to remedy them. The quickly changing U.S. health care system offers a unique opportunity to make health care more efficient, but without information on health consequences, we will learn nothing about quality of care, and changes will be driven by cost-containment alone. An exclusive cost analysis misses half the picture—the half that patients care about the most. The integration of health outcomes and economic impacts in evaluating health care delivery is crucial to making policy decisions that benefit society.

The main changes in the delivery of health care in the United States are in financing strategies and managed care. Prepaid financing—which in the past meant health maintenance organizations (HMOs) but now includes many other organizational forms—alters patient and provider incentives to seek and deliver care. Managed-care strategies—such as gatekeeper policies—attempt to integrate management of a patient's overall health care, including mental health care. Although we do not know yet what these national trends mean for quality of care and health outcomes for all health conditions, this book provides a first detailed analysis for depression.

Such integrated health care evaluations will become more important in a competitive environment that requires information on costs and quality. Monitoring outcomes or quality of care for depression is not a trivial task, and using outcomes data to target quality improvement efforts or to anticipate the consequences of these efforts is even more difficult. We made much progress on these problems in our research over the past ten years. It is our hope that this book, by documenting our approach and measures of quality and outcomes of care for depression, will enable others to perform similar evaluations.

This book examines care for depression from a clinical view that depression is a major illness, in contrast with common usage, in which depression is an amorphous term loosely associated with "feeling blue" or being "down in the dumps." Clinical depression is a period of intense and often continuous feelings of sadness and hopelessness, accompanied by cognitive and somatic symptoms, that merits treatment. For those who have suffered from depression clinically defined, literature and medical experience testify that Styron's characterization of depression as "inexplicable agony" and "despair beyond despair" is not extreme.

Although there is disagreement among clinicians over what types of depression merit treatment, diagnostic systems distinguish several types. We focus on two: *major depressive disorder,* a severe episode of daily depressed mood accompanied by multiple symptoms such as suicidal thoughts or changes in weight and sleep patterns and lasting at least two weeks; and chronic depression, called *dysthymic disorder.* Dysthymic disorder has fewer symptoms but persists at least two years with only brief periods of respite. We also study patients with depressive symptoms that do not meet formal criteria for a depressive disorder because such *subthreshold depression* is very common in primary care settings. There are also bipolar mood disorders associated with periods of elation or excitement, called mania, but we do not study them here because they are rare and have different treatment implications than do depressive disorders without mania.

These different forms of depression raise different clinical treatment issues. Major depressive disorder is perhaps the best understood specific psychiatric condition, supported by many studies of treatment efficacy. Dysthymic disorder is a newer classification category and has fewer treatment efficacy studies. Subthreshold depression is little studied, and there is uncertainty about treatment.

Why Depression Is a Clinical Concern

Diagnosing depression is difficult because there is no obvious marker, like a spot on the skin or a blood pressure reading, and because depression can mimic symptoms of medical illnesses. Treatment for depression can be complicated in the presence of comorbid medical conditions, or if the patient already uses medications for other conditions. In general medicine, many clinicians cannot detect or treat depression in short visits of five to ten minutes that preclude attending to more than one or two of a patient's problems.

Patients who are otherwise similar often receive very different treatments depending on their type of provider. Clinical psychologists provide specialist assessment and psychotherapy, but they are not licensed to prescribe medications, whereas general medical clinicians rarely have the option to provide psychotherapy—even if they have the training and interest to provide it—owing to the constraints of scheduling practices in general medical settings. Only psychiatrists can easily provide both psychotropic medication and counseling, but this situation is changing under managed care, as the more expensive psychiatrists are reserved for medication management and consultation. These very different styles of care by specialty sector are likely to affect patient health outcomes and costs, which are central issues from both a patient and a health care policy perspective.

Why Depression Is a Policy Concern

Depression causes large economic losses because of increased mortality, morbidity, and treatment costs. In some ways, depression is worse than chronic medical conditions like arthritis and heart disease: those conditions usually strike later in life, but depression often begins in youth or middle age, when people are at their productive peak and thus are at risk of permanently damaging their careers. Depression also differs from many medical conditions because its indirect social costs (for example, losses from reduced productivity) are likely to be far higher than direct treatment costs. As a result, low rates of appropriate treatment for depression may be *socially* inefficient if increased treatment costs could be offset by reductions in indirect costs through better treatment.

Policy decisions about financing arrangements and the regulation of insurance systems can affect this tradeoff between direct treatment costs and indirect costs. Current debates often focus on the relative merits of different organizational and financial arrangements and how "generous" mental health care coverage should be. More generous mental health care coverage (low costs for patients, high reimbursement rates for providers) increases the probability that sick patients will receive appropriate services, but also the probability that other patients will receive services of little benefit. Because it is widely thought that the second type of error is more common for mental health than for physical problems, mental health coverage is typically lower than medical care coverage. Many employers offer special mental health and substance abuse plans that include intensive management and cost-control strategies. Mental health care has equal coverage with physical health conditions in some states with mandated mental health coverage, but then only for mental disorders that have a biological basis; this generally includes major depressive disorder, but not dysthymic disorder or subthreshold depression.

Most current trends in financing and organization of health care delivery result in reduced intensity of services. Many hope that this leads to more cost-effective treatment because the link between intensity and quality of care is weak. But these strategies could have stronger adverse effects on a condition like depression than on other medical conditions. Shifts toward primary care, for example, could result in fewer depressed patients being appropriately diagnosed and treated because primary care providers are less familiar with mental health conditions. Depressed patients could also be less capable of dealing with bureaucratic hurdles than other patients. Thus depression is an important test case for how general trends in health care delivery affect vulnerable patient populations.

How We Studied Care for Depression

Health care delivery systems are complex, and the multitudes of clinical conditions and treatments make it impossible to evaluate directly a health care system in its totality. One research and evaluation strategy to understand patient care is the tracer approach, which selects patients with specific health conditions. This approach allows us to go beyond typical policy in that we can study clinical details of quality of care.

Our empirical results are based on the Medical Outcomes Study (MOS), a four-year longitudinal study that involved more than twenty thousand patients with chronic conditions in different practice settings in Los Angeles, Boston, and Chicago. The MOS was one of the first large-scale studies to include a psychiatric tracer (depression) condition on equal footing with chronic medical tracer conditions (recent myocardial infarction, current congestive heart failure, hypertension, diabetes mellitus), and thus permitted a direct comparison of prevalence and societal impact across these conditions.

The Organization of This Book

This book is at the intersection of clinical, policy, health services, and economic research. We therefore first review the clinical aspects of depression and its impact on individuals (Chapter 2) and the policy context of studying care for depression (Chapter 3). We then discuss general design and analytic issues for evaluating health care systems (Chapter 4) and describe our measures of quality and outcomes of care for depression (Chapter 5).

The central findings of the MOS depression component are presented in Chapters 6–9. Chapter 6 documents the impact of depression on an individual's functioning and well-being; Chapter 7 discusses differences in quality of care and use of services by type of payment and provider specialty. Chapter 8 focuses on outcome differences, and Chapter 9 integrates these dimensions in a cost-effectiveness study of quality improvement and shifts to primary care. Chapter 10 concludes the main text of the book with a discussion of the implications of all our findings for clinical practice and health policy.

Because there has been much interest in measures of quality and outcomes of care for depression, and in the MOS measures in particular, we have included a technical appendix with key measures and scoring rules. Several tables with descriptive statistics provide a benchmark for other evaluations to compare their results with the MOS depressed patient sample.

Chapter Two

Depression and Its Treatment

Depression affects both individuals, by limiting their functioning, and society, by draining wealth from the economy. These are two complementary views of depression. The individual perspective is typical among clinicians and clinical research, whereas the societal is adopted in epidemiology and policy research. In this chapter we review the literature from the individual / clinical perspective: What is depression? How does it affect individuals? What causes depression and how can it be treated? How does this differ from actual treatment? In Chapter 3 we address the societal perspective: How common is depression? What are its social costs? How do policies on coverage, financing, and provider specialty affect treatment and social costs?

What Is Depression?

In the general and nontechnical sense of the word, depression consists of feelings of sadness or apathy accompanied by symptoms such as irritability, poor concentration, diminished or increased appetite, or loss of interest in activities usually enjoyed. Many people view depression and its symptoms as a continuum, from mild symptoms as part of normal daily life, for example, in response to an upsetting situation, to severe symptoms that can be persistent and disabling and require clinical intervention.

Prior to 1980, clinical formulations of depression distinguished between neurotic and psychotic and nonendogenous (response to an environmental stress) and endogenous (internally induced or biological) depression. These categories were not always defined operationally, and the validity of distinctions was not consistently supported empirically. In 1980, the American Psychiatric Association's Diagnostic and Statistical Manual, Third Edition (DSM-III), offered a new approach that represented a shift from classification based on etiology to a descriptive one based on identifying homogeneous conditions in terms of symptoms, course, and treatment response. Most subsequent disorder classification schemes followed this approach, which was based on empirical research and expert consensus. Such classification schemes are helpful for service delivery and research (Klerman, 1989b), but may best be viewed as a heuristic that identifies similar types of sickness. If the variation in terms of sickness and treatment response within a classification category is relatively large compared with the variation between categories, a classification scheme becomes less useful. Some argue that this has indeed happened, as psychological distress is a continuum and disorder schemes force arbitrary distinctions (Mirowsky and Ross, 1989).[1]

The two most commonly used psychiatric disorder classification schemes are the Diagnostic and Statistical Manual of Mental Disorders (DSM), now in its fourth edition (Task Force on DSM-IV, 1994), and the International Classification of Diseases, now in its tenth edition (ICD-10, World Health Organization, 1990). The ICD includes medical, surgical, and mental conditions and is used worldwide, including in the United States. Its codes and terms for psychiatric conditions are similar to those in DSM-IV.

Depression falls within the large category of mood disorders. We focus on the most common mood disorders, which in DSM-III (but not DSM-IV) were called unipolar affective disorders. Unipolar disorders involve periods of depression, but not mania. Mood disorders involving mania can be serious, but are much less common and are not discussed further in this book.

The most common mood disorder is major depressive disorder, which used to be called major depression. There is a small difference in the definition between DSM-III and DSM-IV, but seemingly minor differences in definitions can lead to different prevalence estimates (Philipp, Maier, and Delmo, 1991a, b). DSM-III, under which the MOS was designed, defines major depression as a period of at least two weeks during which an individual experiences daily disturbance in mood (intense feelings of sadness or loss of interest in activities that