

# Changing the Landscape: Depression Screening and Management in Primary Care

## FACT SHEET

**Based on a report by:**

**Authors:** Meggan Cristman, Sheina Jean-Marie, Denise Paone, Jorge R. Petit, Sandra Ramos,  
Joshua Rubin & Lloyd L. Sederer

*“There is no health without mental health.”*  
~United States Surgeon General

### BACKGROUND

Depression is a chronic illness much like diabetes, heart disease, and hypertension; it is common, recurrent and costly. More than 35million people are diagnosed and currently living with depression in the United States. Depression is the second leading cause of death and disability (next to heart disease) for all ages and the leading cause for individuals aged 15-40. Certain populations face increased risk, particularly for depression. These groups include the homeless; incarcerated individuals; children in foster care and in the child welfare system; people exposed to violence; persons with chronic diseases. African-Americans are overrepresented among the uninsured in this country. This limited access to health insurance is compounded by the lack of parity for mental health coverage. Many insurance companies make an arbitrary distinction between those with physical health problems; the companies will not pay for needed mental health services. Public programs like Medicaid, on which many people depend, also cap payments for mental treatment payments.

#### **Signs and Symptoms of Depression**

- Depressed or sad mood
- Loss of interest of pleasure
- Loss of appetite and/or weight, or conversely, overeating and/or weight gain
- Fatigue or loss of energy
- Difficulty sleeping or oversleeping
- Difficulty concentrating, making decisions or remembering
- Irritability, restlessness, or feeling slowed down and lethargic
- Feelings of worthlessness or guilt
- Frequent thoughts of death, suicidal ideation, or suicide attempt

#### **What is Depression?**

What is considered major or “clinical” depression is different from the occasional “blues” or grief that people experience from time to time- after the loss of loved one, for example. Clinical depression is a psychiatric illness that includes one or all of the symptoms listed in the above table. The number of symptoms and their severity vary from individual to individual. Depression may become chronic or recurrent, can be associated with anxiety or psychotic symptoms (such as hallucinations or delusions), and

very often lead to substantial impairment in one's ability to work, attend school or take care of oneself and one's family.

### ***Prevalence***

Depression can affect anyone at any age at any time. It affects children, adolescents, and adults (especially older adults). It affects people of all racial, ethnic, religious, and socioeconomic levels as well as both sexes. The most recent data from the federal government's 2005 National Survey on Drug Use and Health (NSDUH) showed an estimated 30.8 million people (14.2 % of the population) ages 18 and older have had at least one major depressive episode in their lifetime. Therefore, chances are that you, someone in your family, a colleague or friend has had or will have an experience with major depression at some point during your lifetime.

### ***High Risk Populations***

Young adults, women of childbearing age (including those who are pregnant or new mothers), people with chronic medical conditions such as diabetes and heart disease, and adults over the age of 55- including seniors living in nursing homes- are at high risk of depression.

## **BARRIERS TO CARE**

Too many people with depression did not get the help that they need. Many are deterred from seeking treatment because they fear stigmatization, lack of available services or insurance or have payment restrictions. Others are deterred by myths and misconceptions about mental illness and are unaware of the effectiveness and availability of treatment.

### ***Health Insurance***

The absence of health insurance parity between mental health disorders and other medical illnesses perpetuates a false dichotomy. It has already been several years since the Surgeon General's *Report on Mental Health* made plain that "there is no health without mental health", but the arbitrary discriminatory, and financially imprudent policies of many insurance companies and corporations continue to be biased against mental health benefits, including coverage for depression treatment. In addition to the lack of private insurance coverage for mental health, the availability of mental health services is further jeopardized by the increasingly dominant role of Medicaid in reimbursing mental health care, especially among people of color who are disproportionately enrolled in Medicaid.

### ***Stigma***

The 2003 report of the President's New Freedom Commission on Mental Health, as well as two reports by the U.S. Surgeon General (*Mental Health: A report of the Surgeon General* in 1999 and *Mental Health: Culture, Race, and Ethnicity*, released in 2001), assert that the stigma and discrimination associated with mental illness and its treatment have a substantial negative impact on the lives of individuals, families and communities.

### ***Unique Difficulties Faced By People of Color***

As difficult as it is for these barriers to be overcome, people of color and non-English speakers have even greater difficulties accessing appropriate depression screening and treatment. Barriers include disparities in insurance coverage access to treatment, and quality of treatment among racial and ethnic groups. They also are more likely to use emergency services or seek treatment from a primary care provider than a mental health specialist. Both African-Americans and Latinos are more likely than whites to be under-diagnosed and under-treated. Furthermore, evidence suggests that in clinical practice settings, minorities are less likely than whites to receive treatment that adheres to accepted guidelines.

## COSTS OF DEPRESSION

In the U.S., the substantial public health and economic impacts of this chronic illness is reflected by the considerable utilization of health services and their tremendous monetary cost. Globally, disruptive disorders are projected to become the leading cause of disability and the second leading contributor to the burden of disease (years of life lost due to disability and premature mortality) by 2020. One of the tragic and preventable costs of undiagnosed, untreated and undertreated depression is suicide. The World Health Organization (WHO) recently reported that suicide causes more deaths around the world every year than homicide or war. Across all age groups nationwide, more than 90% of those who commit suicide have a diagnosable psychiatric illness that the time of death- usually depression, alcohol abuse or both. Finally, depression has a significant economic impact on society. The estimated total annual cost of depression in the U.S. was \$83 billion (in 1990), with the majority of costs in the form of reduced productivity, absenteeism and mortality.

## DEPRESSION SCREENING AND MANAGEMENT IN PRIMARY CARE

Depression is one of the most common conditions in primary care. Primary Care Providers (PCP's) are the initial contact for most people with depression. Studies have shown that 6 to 9 percent of patients in a primary care practice have a treatable depressive disorder.

Depression exacerbates the symptoms of physical illness, and physical illnesses exacerbate the symptoms of depression. Additionally, depressed people are more likely to engage in behaviors that contribute to poor health such as smoking, drug use, overuse of alcohol, limited or no exercise, and poor eating habits.

Depression can be effectively detected in primary care settings with the use of the Patient Health Questionnaire (PHQ), Version 2 and Version 9 (PHQ-2 and PHQ-9). The PHQ is a self-reporting questionnaire designed for use in primary care settings; it is available in multiple languages and has been shown to be equally effective among white, Hispanic, Chinese American, and African American populations. PHQ-2 can be used a simple, low-burden screening tool. It asks two questions, A positive score, resulting from a "yes" response to either question, indicates an approximately 80 percent likelihood of the individual having major depression.

Cultural habits are barriers to effective detection and treatment of depression among Latinos and other minorities, as are language differences, health literacy barriers and depression presenting physical symptoms. Such ethnic and racial differences result in limited access to mental healthcare for millions of Americans.

## ACTION STEPS/RECOMMENDATIONS

**Objective:** Improve Access to Treatment of Depression

**Actions:**

- Engage corporate buyers and the public in improving depression detection and treatment.
- Establish depression screening and care management as a covered benefit for all insurance carriers.
- Combat stigma through media and public education campaigns.
- Educate the public to recognize symptoms and seek help;
- Encourage people to ask their doctors to administer a simple screening test for depression.

**Objective:** Improve Fiscal and Regulatory Climate of Mental Health System

**Actions:**

- Advocate for mental health parity and adequate financing of mental health services.
- Eliminate limitations on Medicaid funding of mental health services (e.g., the Medicaid Neutrality Cap in New York State).

**Objective:** Change the Paradigm in Primary Care Settings to Include Depression Screening in Basic and Regular care.

**Action:**

- Provide education and training and promote depression screening referral and management in public and voluntary hospitals, university health clinics, and other primary care settings.

## CONCLUSION

Depression is an illness that is common, often chronic, and costly. It can be reliably diagnosed and treated, thereby improving the health and quality of life for the individuals and families suffering from it and reducing burden and costs to our society. The effectiveness of treatment is well documented. However, due to stigma as well as fiscal, cultural, and systemic barriers, appropriate care is seldom provided today. People of color and non-English speakers experience great difficulty and disparity in accessing appropriate depression screening and treatment.

Primary care physicians, the point of healthcare access for most Americans, represent the key to screening, treating, and monitoring depression. The PHQ-2 and PHQ-9 are simple, low-burden screening tools that make these three things possible. Public education, physician training, and healthcare system changes, supported by public policy, are necessary to implement depression screening and management in primary care settings.

It is more important than ever to take these steps. Allowing depression to continue undetected and untreated will lead to significant distress for individuals and families- suicide is the most tragic consequence- as well as ongoing losses in productivity of employees and ever-increasing societal costs. Success in achieving these goals will require a change in the primary care landscape; artificial barriers that have been erected between physical and mental care will need to be removed. PCP's and mental health providers will need to systematically collaborate to ensure that patients receive care consistent with guidelines, and parity and fairness in insurance coverage must be achieved. While these are ambitious goals, the cost of not achieving them is a price too great to continue to pay.



