Follow-ups prove powerful tool for treating depression in primary care

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In the 15 minutes a primary care doctor typically has with a patient, she's expected to diagnose the current ailment, help manage ongoing health issues and provide preventive care. In this setting, confronting all but the most obvious and immediate mental health needs of patients is an ongoing challenge.

A new study by researchers at the University of Michigan Health System, however, points to an encouraging strategy for improving and sustaining mental health results in chronically depressed patients by providing small amounts of flexible, targeted follow-up care – without overburdening busy doctors' offices.

The study, published in the September/October issue of *Annals of Family Medicine*, shows that patients who received interventions that included self-monitoring tools and follow-up phone calls from a care manager were more likely a year and a half later to have symptoms that were in remission and to have fewer reduced-function days than those receiving usual primary care treatment.

"They key is to keep patients engaged in treatment," says Michael Klinkman, M.D., M.S., a professor of family medicine at the University of Michigan Medical School and lead author of the study. "What it's not is telephone therapy. Patients have a human contact, somebody who can help them become more actively involved in their own care. It's hard to do that if you're just spoon feeding information to 'educate' a patient or telling them to go to a website."

With a more traditional approach that depends on a follow-up office visit, it might be months before a primary care doctor learns that his patient's depression is getting worse. And in many cases patients simply don't follow up.

For the study, a care manager worked in collaboration with doctors' practices, rather than on the side or independently, Klinkman says. That helps the family practice office to act as a home base for all of a patient's medical needs. The approach can also serve as a model for treating other types of chronic conditions, he adds.

Many patients have depression alongside other mental health and medical problems, Klinkman notes.

"There are people with chronic issues who have had multiple depressive episodes in the past," he says. "No one wants to study them because it's hard to make them better. But we didn't cherry pick, we took everyone – and the rate of remission we saw was about double what it has been with usual care. The other thing that is really noteworthy: the results persisted over time."

While some patients did become less engaged when their symptoms started getting better, many got back in touch with their care manager when things started to slip again.

"We helped get people back into care who otherwise might not have returned to treatment," Klinkman says.

Meanwhile, the U-M Depression Center has recently launched a new web-based toolkit for patients and their families, which is also intended to be a resource for primary care physicians.

The site, depressiontoolkit.org, has a wealth of resources and

downloadable tools that can help individuals assess whether they might be suffering from depression, and tips for how to talk with others about depression. Several of the tools developed for the study were integrated into the Depression Center Toolkit.

More information: "Long-Term Clinical Outcomes of Care Management for Chronically Depressed Primary Care Patients: A Report From the Depression in Primary Care Project." *Annals of Family Medicine*, September/October 2010.

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