MAKE DEPRESSION CARE A NATIONAL PRIORITY
Depression’s huge economic burden warrants an equally large response
by Ronald W. Manderscheid, PhD

Depression is one of the most frequently occurring mental disorders, affecting between 7 and 9% of men as well as between 10 and 12% of women. Depression costs more than $80 billion per year in direct care and lost productivity in the United States alone. The World Health Organization predicts that depression will be the number-one cause of disability in the world by 2020.

Untreated depression can lead to serious consequences, including suicide. Less well known, perhaps, is that depression co-occurs with a broad range of persistent health conditions, such as asthma, diabetes, heart disease, and substance use. For each of these conditions, the percentage of people with co-occurring depression ranges from 35% to more than 70%.

Depression not only impairs personal productivity and reduces the global competitiveness of American corporations, but it also harms family and community life. Depression can be difficult to treat effectively, especially because the care system is not well organized. Thus, concern about depression extends from corporate boardrooms to local community health and mental health centers.

A consensus has begun to emerge that closely coordinated mental health, substance use, and primary care is an effective and cost-efficient way to treat depression. As you probably know, last year the Institute of Medicine issued a major report calling for such coordination across all mental health and substance use conditions. Next year, the American College of Mental Health Administration will focus its annual Santa Fe Summit on behavioral healthcare–primary care integration.

To tackle depression, we need to take the following steps, among others:

Create an independent national policy board
This board is likely to be in operation next year, funded jointly by the federal government and key foundations. The board's goal will be to remove impediments to and to promote good, coordinated care. The board's key activities will need to include developing an agenda to remove:

- financial impediments (e.g., the inability to receive payment from Medicaid for a primary care visit and a specialty encounter on the same day);
- systemic impediments (e.g., regulations that prevent the sharing of medical records between primary care and specialty providers); and
- care delivery impediments (e.g., lack of cross-training to promote coordinated care between primary care and specialty staff).

Similarly, the board will need to foster:

- community depression collaboratives (such as those in Atlanta, Kansas City, and Portland, Oregon);
- a new coordination relationship between healthcare and behavioral healthcare plans (e.g., integrated services, such as those offered through Intermountain Healthcare in Utah); and
- early screening and intervention (e.g., using instruments such as the Physician Health Questionnaire [PHQ]).

Test demonstrations of different treatment models
Three coordination models seem to be emerging to treat depression:

- Integration. Mental health providers are part of the primary care service or clinic staff, and services are delivered in a single setting.
- Colocation. Mental health providers are present in the primary care service or clinic, or vice versa; managerial oversight remains separate; and services are delivered in a single setting.
Public-private partnerships will be needed to accomplish these demonstrations. These partnerships should include government, foundations, and the business community.

**Promote treatment of depression in every American community**

The agencies of the U.S. Department of Health and Human Services will have a major role to play in extending the work on depression into every American community. Under the aegis of the President's New Freedom Commission on Mental Health, major collaborative efforts already have been undertaken. For example, SAMHSA and the Health Resources and Services Administration are providing leadership to develop mental health and primary care coordination, in concert with the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services, among others. A major test of this collaboration will be the degree to which these efforts will result in coordinated depression initiatives in all American communities.

**Foster a depression collaborative in your community**

A full collaborative would include a local leadership group and mechanisms to screen for and identify depression, treat it effectively, and assess outcomes in the workplace, family, and community. Key ingredients of such a collaborative encompass public-private partnerships that engage local businesses, local treatment systems that deliver coordinated primary and specialty care, and an electronic capacity to screen, develop and monitor treatment plans, and record outcomes. An effort such as this would be an excellent way to launch a community-wide electronic health record.

This is a loud call for more policy change, community collaboration, and treatment coordination. Ultimately, this work needs to be guided by three fundamental questions: What works clinically? What works financially? And what delivers the best outcomes?

Ronald W. Manderscheid, PhD, currently Director of Mental Health and Substance Use Programs at the consulting firm Constella Group, LLC, worked for more than 30 years in the federal government on behavioral health research and policy. He is a member of Behavioral Healthcare's Editorial Board. To send comments to the author and editors, e-mail manderscheid1106@behavioral.net