For more than twenty years the Depression and Bipolar Support Alliance (DBSA) has provided help, hope and support to patients and families coping with depression and bipolar disorder. “We’ve been there. We can help.” We say this because more than half of us – Board members, volunteers and staff alike – live with a mood disorder. Because of our personal struggles, we viscerally know what needs to be done.

The State of Depression in America initiative reflects the huge unmet need to examine all aspects of this illness and to fully educate the public about depression. Perhaps the greatest challenges are the wide disparities in the quality of care and access to treatment – disparities that cross socio-economic populations, state boundaries and throughout the public and private payor systems.

We have many opportunities to transform mental health care. But to meet the needs of the millions suffering with depression and the millions more touched in other ways by this illness, we need far-reaching partnerships. To that end, DBSA compiled The State Of Depression in America and presents its findings so that together we can make change happen.

Thank you to the patients and their families, policymakers, regulators, insurance companies and other payors, pharmaceutical manufacturers, government agencies and employers for the generous amount of time spent speaking with us. The State of Depression in America would not have been possible without their dedication.

Ellen Frank, Ph.D.
Miriam Johnson-Hoyte, J.D.
Lydia Lewis
Acknowledgements

The Depression and Bipolar Support Alliance (DBSA) is the leading patient-directed national organization focusing on the most prevalent mental illnesses. The organization fosters an environment of understanding about the impact and management of these life-threatening illnesses by providing up-to-date, scientifically-based tools and information written in language the general public can understand. DBSA supports research to promote more timely diagnosis, develop more effective and tolerable treatments and discover a cure. The organization works to ensure that people living with mood orders are treated equitably.

Assisted by a Scientific Advisory Board comprised of the leading researchers and clinicians in the field of mood disorders, DBSA has more than 1,000 peer-run support groups across the country. Over four million people request and receive information and assistance each year. DBSA’s mission is to improve the lives of people living with mood disorders.

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* * *

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* * *

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Executive Summary

In recent years, a number of studies and government reports have underscored mental health care as a critical component of health policy and public health. Often misunderstood, feared and stigmatized, nearly 19 million Americans suffer from depression, which can have high costs for individuals, their families and society. The social and economic consequences of untreated depression are substantial, including disrupted family and social relationships and increased risk of suicide. Depression has a significant impact on well-being and national prosperity, accounting for direct and indirect costs totaling over $80 billion per year. Symptoms for depression can range from mild to severe. In many cases, individuals diagnosed with depression do not have adequate access to quality care, which impedes their ability to lead full and productive lives.

The United States health care delivery system and its stakeholders face a critical challenge: developing and implementing effective strategies that can bridge the various gaps to improve health care for people with depression. Within the past several years, mental health issues have gained increased public awareness leading to President Bush’s creation of the New Freedom Commission on Mental Health, which issued a report in July 2003, Achieving the Promise: Transforming Mental Health Care in America. Mental health research has made promising breakthroughs in developing successful treatments. Despite the sustained activism in recent years, there is still a sense of unease that improvements (e.g., depression prevention, improving recovery methods and improving the quality of life of those living with depression) are not happening quickly enough and are not having an impact on the lives of consumers. A lack of funding, public stigma and an extremely complex, uncoordinated system of care, have all combined to create significant challenges for accessing adequate treatment for depression.

This report aims to create a thorough, comprehensive and actionable body of information to inform legislators, policymakers and other critical stakeholders about the state of depression in the United States and the urgent need for action. In order to present a thorough understanding of depression, primary and secondary research was conducted in preparation of this report, including extensive interviews and literature reviews. Approximately 100 interviews were conducted across a wide range of stakeholders, including policymakers, regulators, payors, providers, employers, consumer advocates, pharmaceutical manufacturers and researchers. The interviews focused on developing a comprehensive understanding of the key issues facing the mental health system, specifically related to depression, as well as identifying the opportunities for stakeholders to address the needs of those suffering from depression. Specifically, the report provides a landscape of the current state of depression, followed by more in-depth discussions related to the economic and social impact of the illness, access issues, quality issues and emerging recovery options.

I. Landscape

Depression is one of the most pressing public health issues in the United States. Depression can have devastating effects on quality of life, relationships and employment or academic achievement. Depression is one of the leading causes of disability worldwide and is associated with increased morbidity and mortality. Despite the high prevalence and tremendous impact of depression, it often remains undiagnosed and/or untreated. Although more consumers are seeking help for depression and rates of antidepressant use are

* For the purposes of this report, the Pharmaceutical Manufacturers stakeholder group includes pharmaceutical manufacturers, as well as manufacturers of other forms of treatment.
Executive Summary

State of Depression in America

Page 2

- Depression is a real illness Depression is a type of mood disorder characterized by severe, persistent depressed mood or diminished interest or pleasure in almost all activities, accompanied by symptoms such as insomnia or hypersomnia, weight loss or gain, fatigue, feelings of worthlessness, diminished ability to think and recurrent thoughts of suicide.

- Depression can be deadly Suicide is the 11th leading cause of death among persons of all ages in the United States. While 30,000 Americans die by suicide each year, a staggering 730,000 people attempt suicide, with suicides outnumbering homicides three to two in the United States. Research has shown that more than 90 percent of people who die by suicide have depression or another diagnosable mental or substance abuse disorder.

- Mental health problems can affect anyone Some subpopulations have an elevated risk of developing problems, being diagnosed with a mental illness or experiencing difficulty accessing appropriate services. Higher rates of depression are found among women, older adults, low-income individuals, individuals with comorbidities and individuals who have experienced trauma. Access to quality mental health treatment may decrease for individuals within some racial and minority ethnic communities, people with chronic illness, children and adolescents and individuals in the criminal justice system.

- Mental health care delivery is evolving and complex Striking changes have occurred in the delivery of mental health care over the past few decades. Treatment has transitioned from primarily inpatient, hospitalized settings, to care in outpatient and community settings. The development of Medicaid and Medicare and other public programs have increased access to mental health services for some populations. Managed behavioral health care has also fostered the emergence of markets providing greater choice to individuals with depression as consumers of health care. However, the development of the health care delivery system has resulted in fragmented care across a patchwork of public and private insurance programs and delivery settings, making it difficult for consumers to navigate the system and receive needed care.

- Tremendous variation exists presently in state mental health services and funding Mental health services have traditionally been provided at the state level. Government programs (e.g., juvenile justice, Medicaid and SCHIP) can differ drastically from state to state due to variations in state agency mental health expenditures, mental health mandates and parity laws.

II. Economic and Social Impact of Depression

Depression is a devastating mental illness that has profound economic and social implications. Depression affects not only the individual suffering from the illness, but also the extended family and community in which that person lives. Depression does not occur in isolation and its affects on cost and personal well-being are often magnified through a direct correlation with other factors. The findings on the economic and social impact of depression include:

- Depression is an expensive illness It is estimated that the cost of depression is over $80 billion annually. Direct and indirect cost factors include prevalence of illness, prescribed treatments, treatment effectiveness, comorbidity, adherence and population characteristics.
• **Depression places an economic burden on all stakeholders**  Major depressive disorder is the leading cause of disability in the United States and results in more days of disability, lost work days and presenteeism (the result of one showing up for work even if one is too sick, stressed or distracted to be productive) than many other medical conditions, placing a large financial burden on employers.6 Payors incur direct cost charges as more consumers receive treatment, including antidepressant medication, psychotherapy and care in a variety of settings, including inpatient hospitalization and outpatient and community-based services. Federal and state governmental programs, including Medicare, Medicaid, criminal justice and state mental health agencies are becoming increasingly burdened by the costs of mental illness. Depending upon the severity of the illness, the quality of care received and one’s insurance status, depression can cause varying levels of financial strain on families.

• **Key economic drivers impact cost**  Key cost drivers of depression include undetected depression and inadequate treatment, comorbidity of depression with other medical conditions and substance abuse disorders and an aging population.

• **Impact of depression on society is tremendous**  Depression affects families, marriages and other relationships, as well as the development of children and adolescents. Depression in a loved one, whether it is a family member or a friend, is a major source of pain, suffering and disruption. Depression has pronounced effects on childhood development, academic achievement and social well-being. Without adequate treatment, depression can lead to suicide, which represents a significant drain on the economic, social and health resources in the United States.

Unless properly diagnosed, depression will increasingly impose unnecessary and severe economic and social costs on American society. All stakeholders must play a role in affecting change. The following opportunities represent actions for stakeholders to contribute toward the improvement of the United States mental health system.

<table>
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<th>OPPORTUNITIES FOR STAKEHOLDERS</th>
<th>Payors</th>
<th>Providers</th>
<th>Employers</th>
<th>Policymakers</th>
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<td>Introduce disease management programs and preventive care in the workplace.</td>
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<td>Promote Employee Assistance Programs (EAP) within the workplace.</td>
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<td>Improve treatment within criminal justice system to address disease management.</td>
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<td>Increase awareness of the prevalence of co-occurring chronic illnesses and depression.</td>
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<td>Implement treatment adherence programs for consumers.</td>
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<td>Promote open communication and therapy for depression within families and communities.</td>
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<td>Educate at-risk populations such as adolescents, elderly and their family members about suicide and its indicators.</td>
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III. Access

Inadequate access to care is a primary constraint to the development of a robust national mental health system. The current system is constrained at multiple levels, which include societal, health system and individual factors. These barriers result in a mental health system that is not adequately accessible and often non-responsive to consumers who need treatment for depression. Access related findings in the report include:

- **Stigma** surrounding mental illness is one of the major barriers to access of mental health services. While recent public awareness and education campaigns have helped to decrease stigma, it is still one of the most prominent access barriers for the American consumer.

- **Inadequate public awareness and education** impedes access to mental health services. The public often does not understand mental illness, where to seek care or the efficacy of available treatments.

- **Inadequate funding and reimbursement** is a key barrier to care. Funding streams for mental health are separate and limited in scope without coordination between private and public payors. The lack of parity in mental health insurance is one of the most troubling barriers to accessing mental health services. Health insurance companies often put limits on per episode reimbursements and charge higher copayments for mental health services.

- **Lack of screening and early intervention** for depression prevents access to mental health services. Additionally, current reimbursement procedures do not give providers incentives for identifying or managing complex cases of chronic depression.

- **Fragmentation of the mental health system** has been cited as a barrier to access for several years. Identified areas of focus include treatment in primary care settings, coordination between different service sectors and care of individuals with comorbidities, such as substance abuse disorders or general medical conditions. Primary Care Physicians (PCPs) offer an important point of access to treatment and have helped more consumers receive care, but fragmentation problems can often occur at this point. PCPs time constraints and lack of expertise with diagnosing and treating depression can impede access to appropriate treatment.

- **Lack of available providers**, particularly psychiatrists and other mental health providers who specialize in children, adolescents and the elderly, is one of the most critical gaps in the mental health care system. The growing number of mental health consumers has far outpaced the number of physicians specializing in psychiatry and other qualified providers. As a result of this shortage, some consumers may wait weeks or even months before receiving mental health treatment.

- **Lack of resources** to seek treatment, such as health insurance, income and transportation are substantial barriers to care. Homelessness, addiction, unemployment and lack of education are also obstacles to getting necessary treatment for depression. Inadequate resources may disproportionately affect racial and ethnic minorities and individuals in rural communities, who often have lower incomes and lower likelihood of having health insurance.

Assuring that all Americans have access to treatment for depression is critical. The following are opportunities for stakeholders to improve access to treatment for depression. Improving access will provide necessary and critical treatment to more consumers and significantly lessen the impact of depression.
### OPPORTUNITIES FOR STAKEHOLDERS

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<th>ACCESS</th>
<th>Payors</th>
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<td>Provide education about depression to employees and create a stigma-free work environment.</td>
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<td>Improve reimbursement for PCPs to take the time to screen, diagnose and treat depression.</td>
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<td>Provide easy-to-use mechanisms, such as a website or a dedicated toll-free telephone number, for PCPs to easily alert the payor that the consumer needs to be referred to a mental health specialist.</td>
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<td>Offer higher rates of reimbursement or bonuses to providers who agree to practice in designated shortage areas.</td>
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<td>Provide the same coverage for mental health services and treatments as for other medical conditions.</td>
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<td>Provide peer support linkage to payors and providers to offer consumers access to peer support in their communities.</td>
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<td>Develop programs that specifically reach out to minority groups to address their culturally specific issues with accessing treatment.</td>
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<td>Develop programs to ensure prisoners have access to follow-up mental health treatment in the community once released.</td>
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<td>Expand programs to provide loan repayments for students in social work, nursing or medical school who agree to specialize in mental health.</td>
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### IV. Treatment and Emerging Recovery Methods

Depression is a complex and serious medical condition, therefore its treatment is a multifaceted undertaking, with the road to recovery incorporating many elements. Treatment of depression has evolved significantly over the last half of the 20th and the beginning of the 21st Century. A wide spectrum of treatments with documented efficacy have made an impact on individuals suffering from depression. More than 80 percent of people with depressive disorders improve with appropriate treatment. Medical treatment models that focus on the reduction, elimination and control of symptoms based on psychopharmacological care are increasingly used in conjunction with psychosocial treatment models. These psychosocial treatment models incorporate methods such as counseling, psychotherapy, social skills training and peer support – focusing on overall improvement in quality of life and recovery. Findings related to treatment and emerging recovery methods include:

- **Treatment modalities include antidepressants and psychosocial treatments** and recent studies provide evidence that psychotherapy combined with antidepressant therapy is associated with a significantly higher improvement rate than drug treatment alone. In longer term treatment, the addition of psychotherapy has been shown to have a lasting effect on patient wellness. There are several other available treatment options often utilized to treat depression and other mental illnesses.

- **Case management and coordination of care** is needed to combat the fragmentation and disorganization of the current mental health care system. The variety of disciplines involved in mental health treatment
Executive Summary

highlights the need for improved coordination of care for individuals with depression. Case management and coordination of care helps to ensure that depression is managed across all providers, including those treating depression and any other co-occurring illnesses.

- **Early screening and detection of depression**, when combined with adequate treatment, can prevent depression from worsening and in some cases, can prevent long-term disability. It can also save significant expense, both for the individual facing depression, who will be able to undergo shorter and less intensive treatment if their depression is detected at an earlier and less debilitating stage, and for the health care system. Early screening has the potential to reduce costs for employers, who will benefit from the decrease absenteeism and staff turnover and from an increase in motivation and productivity that early detection can facilitate.

- **Peer support programs in depression treatment** are one form of self-help treatment that has proven effective and has been described as a key component of the process of recovery. Peer support programs consist of individuals, in either a group or individual setting, sharing personal knowledge and strategies of living with depression and can be mutually beneficial for all those involved. Participants in peer support programs report improvements in self-esteem, decision-making skills and social functioning, as well as decreased psychiatric symptoms (lower hospitalization rates), lower rates of isolation, larger social networks and increased support seeking.

- **Cultural competency in depression treatment** is necessary to meet the mental health needs of racial and ethnic minority groups. Stigma, language barriers and inability to handle the costs of health care services are also major issues that prevent minority groups from seeking and receiving appropriate treatment. Improving provider awareness of their patients’ cultural orientation and backgrounds and improving provider skills in interacting with specific different cultural groups is critical for improving mental health services for racial and ethnic minorities. Developing ethnic or culturally-specific and responsive services is critical to appropriately engaging minorities in treatment programs for depression.

- **A consumer-driven approach to mental health** should take into account the consumer’s personal preferences, goals and particular circumstances, thus tailoring treatment at the individual level. Consumer groups indicate that being a part of the decision-making process is empowering for individuals with depression and helps to provide a sense of self-worth that can be a powerful force in the road to recovery.

- **Recovery-oriented treatment** defines recovery as the desired outcome or goal of depression treatment. Recovery is a complex multi-dimensional process involving personal growth, healing and development that transforms an individual from an illness-dominated identity to one marked by meaning and well-being. Key facilitators of the recovery process include supportive relationships, engagement in meaningful activities that provide an opportunity for consumers to continue growing and learning about themselves, access to additional treatments and an active role in the decision making about the treatments they are undergoing.

Providing adequate treatment for depression involves many challenges that should be addressed in order to increase the effectiveness of the care provided and improve the chances for individuals with depression to achieve recovery. The following are opportunities for stakeholders to improve treatment for depression.
OPPORTUNITIES FOR STAKEHOLDERS

V. Quality

Providing high quality health care is one of the major challenges currently facing the medical field, especially in the field of mental health. Although a variety of evidence-based treatments for depression exists, the gap between knowledge and practice is still vast. The disparity between the quality of existing clinical treatments for depression and the quality of care that is actually delivered is distressing. Closing this gap in the application and implementation of proven treatment methodology must be a priority in order to improve outcomes for those suffering from depression. Findings related to quality of mental health care include:

- **Lack of prevention and long term care management** due to the crisis-oriented and reactionary structure of the mental health system. The system is often set up for episodic care focusing on crises, such as suicide attempts, rather than on prevention, proactive treatment and long-term wellness.

- **Fragmentation of mental health services** resulting from a lack of coordination across service sectors is a major obstacle to quality mental health treatment. As a result, consumers often face inadequate assessment, treatment, referrals and follow-up.

- **Insufficient funding and reimbursement** for mental health services is also a primary impediment to achieving quality mental health care. Both public funding and private reimbursement are inadequate, which negatively impacts the number of quality providers and available services for individuals with depression. As a result, mental health programs often do not retain the best providers due to low salaries and poor working conditions.

- **Inadequate training of providers**, including PCPs and mental health specialists, influences the quality of care. There is also significant variation in licensing requirements across different types of providers that commonly treat consumers with depression. The treatment approach selected by providers from these different disciplines can vary widely, as can the quality of care they provide. Additional training should focus on optimal treatment approaches, as well a patient’s mental, social and economic situation to ensure positive outcomes.
Executive Summary

• **Lack of standardized outcome measures** negatively impacts consumers and providers. While many evidence-based standards and guidelines have been developed for depression, they are not adequately disseminated, implemented or enforced. The greatest barrier is the establishment of a recognized quality standard. The existence of a broad diversity of disciplines that provide treatment for depression makes it difficult to establish quality measures. Establishment of quality measures would help both providers and consumers make informed decisions on treatment.

• **Inadequate follow-up and treatment adherence** for consumers is a critical issue. Often, consumers cycle in and out of treatment settings, are prescribed antidepressant medications and do not return for follow-up treatment. This lack of follow-up and treatment adherence is especially troublesome in depression, which has a high rate of suicide.

• **Lack of consumer input** in determining treatment options and evaluating care has a negative impact on quality and effectiveness of treatment. Including consumers as part of the decision-making process has shown to improve treatment adherence, satisfaction and success.

While progress has been made in the area of improving the quality of mental health care, barriers still exist to providing optimal treatment for individuals with depression. More investment and attention to quality of care must occur in order to successfully bridge the gap between research and practice. The following are key opportunities for stakeholders related to improving quality and outcomes for depression treatment.

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<td>QUALITY</td>
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- Develop a more comprehensive, coordinated system of care with access and coordination points, so consumers know where to go when they first experience depression.
- Fund mental health services and facilities adequately.
- Improve identification of depression, initial treatment and follow-up.
- Improve education and training of providers.
- Establish quality measures and reward providers for performance.
- Collaborate with mental health advocacy groups to increase their reach and influence.
- Expand biological and genetic research to develop better treatments, identify the subtypes of depression and determine the factors that predict treatment outcomes.
- Expand research needs to include longitudinal studies that are generalizable to different consumer populations.
- Conduct more health services research focusing on treatment outcomes to evaluate and develop evidence based practices.

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VI. Conclusion

Depression is a devastating illness, but one that can be prevented and treated. Access to quality mental health care is fundamental to the health and well-being of Americans. Unfortunately, the current mental health system is not adequately addressing the needs of the millions of Americans with depression. When left untreated, depression can take an enormous toll on an individual’s functioning, productivity and quality of life and is associated with elevated risk of certain medical conditions and suicide. If the current barriers and challenges to treatment and recovery are adequately addressed, however, the majority of people with depression can live productive and satisfying lives.

The goal of this report is to show the need for urgent action and suggest opportunities for change. Overcoming the multiple challenges in meeting the needs of those suffering from depression will require a multifaceted approach involving all stakeholders in the field of mental health. Many possible strategies emerged in the research and development of this report for improving health care delivery related to access, treatment, quality and economic and social impact related to depression. These solutions include promoting education, improving reimbursement structures, appropriate allocation of funds, coordination of care and consumer-driven treatment.

To meet the needs of the millions of Americans suffering with depression and the millions more who are affected in other ways by the illness, stakeholders must work in partnership. Stakeholders across the health care spectrum have opportunities to create a more accessible and comprehensive mental health system that will save lives and potentially reduce costs. If implemented, the opportunities outlined in this report could help transform the state of depression in America and the entire mental health care system.
1.0 Introduction

Depression, a disorder that affects one’s thought processes, moods, feelings, behavior and physical health, is a chronic illness that affects approximately 19 million American adults annually in the United States. Depression can strike anyone regardless of age, ethnic background, socioeconomic status or gender. While depression may occur only once in a person's life, the majority of those affected by this illness experience recurring episodes that can be severely disabling. Research has shown that more than 90 percent of people who die by suicide have depression or another diagnosable mental or substance abuse disorder.

Depression has devastating consequences, both economically and socially. It is in the best interest of all Americans to improve access to care, quality of care and education for depression across the health care delivery system. Such improvements will save lives, jobs, families and communities. The costs, both societal and personal, of undiagnosed, untreated or under-treated depression are enormous. These costs impact the entire health care system in many ways such as increased visits to emergency rooms and in treatment for chronic, co-occurring medical illnesses. These costs impact other segments of our society due to homelessness, crime, substance abuse, disruption of education and unworked days.

The impact of depression is devastating. Worldwide, the leading cause of disability is major depression. Five of the top 10 leading causes of disability in developed countries, including the United States, are mental health disorders. In 2001, more people died by suicide (the 11th leading cause of death) than from homicide and more than twice as many people died from suicide than from HIV/AIDS in the United States.

1.1 Scope & Methodology

The health care landscape is rapidly changing. The population is aging, consumers are becoming more empowered, new technologies are available in the market, new scientific findings are emerging and cost pressures are unrelenting – these are just a few of the many trends affecting the future of health care. Within the past several years, mental health issues have gained much needed public awareness leading to President George W. Bush’s creation of the New Freedom Commission on Mental Health which issued a report, Achieving the Promise: Transforming Mental Health Care in America, in July 2003. Numerous mental health studies have also been published which include staggering statistics related to the personal, social and economic costs of depression. In order to prepare for the future, it will be critical to ensure that improving the gaps within the mental health care space is an integral part of improving the health care delivery system in the United States.

The purpose of this report is to create a thorough, comprehensive and actionable body of information for legislators, policymakers and other critical stakeholders about the state of depression in the United States and the urgent need for action. In order to present a thorough understanding of depression, primary and secondary research was conducted in the preparation of this report, including literature reviews and extensive interviews. The interviews were conducted across a wide range of stakeholders, including policymakers, regulators, payors, providers, employers, consumer advocates, pharmaceutical and other treatment manufacturers and researchers. The interviews focused on developing a comprehensive understanding of the key issues facing the mental health system, specifically related to depression, as well as on the opportunities for stakeholders to address the needs of those suffering from depression.
This report outlines the current landscape of depression and sets out to examine four main areas in need of greater public attention and action:

- The economic and social implications of depression and opportunities for relief.
- The impact of access barriers and opportunities to eliminate barriers.
- Emerging recovery methods and opportunities to more fully integrate peer support services into the health care delivery model.
- Current quality-driven initiatives and opportunities to improve implementation of evidence-based practices for depression.

Approximately 100 interviews were conducted for the report. Exhibit 1 presents all of the stakeholder groups and provides a summation of the key challenges that each group identified in the four main areas described.

### Exhibit 1. Key Challenges Related to Depression Identified by Stakeholder Groups

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Key Challenges</th>
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| **Payors:** Both public and private payors, including government programs, large health plans, managed care companies and behavioral health care organizations | • Current reimbursement system does not give primary care providers incentives to see new patients, address mental health issues or provide evidence based care.  
• Health care delivery system is disorganized and fragmented because mental health is separate and often managed through carve-outs.  
• Lack of appropriate diagnosis, treatment, collaboration and follow-up in treating depression in primary care.  
• Need additional depression disease management programs, chronic care models and collaborative care models which are important for managing depression and reducing costs. |
| **Pharmaceutical and other Treatment Manufacturers:** Representatives from large pharmaceutical companies and other treatment manufactures within the central nervous system (CNS) market | • Pharmaceutical and other treatment manufacturing companies can play a role in educating the public about depression through appropriate educational material, communication and advertising.  
• Quality metrics need to focus on outcomes, reflect what consumers want from treatment and the goal of treatment.  
• Health care systems need to shift from crisis-management to prevention and proactive treatment.  
• Quality of care can be attained by improving efficacy, follow-up and adherence with medications.  
• Collaborative approach of stakeholders (advocacy groups, academic thought leaders and business) is necessary to make a difference. |
| **Providers:** Administrators of hospitals, long-term care facilities, primary care physicians and mental health providers, such as psychiatrists, psychologists, social workers, nurses and counselors | • Lack of connection between providers and consumers leads to a lack of outreach, which can differentially affect subgroups.  
• Mental health needs to be fully integrated into overall health care; communication linkages across professionals must be improved; quality metrics must be developed, standardized and implemented.  
• Existing crisis-orientated mental health system facilitates intensive inpatient care, but lacks early intervention and community-based services focusing on recovery.  
• Funding is a primary issue, causing decreases in compensation, provision of services and quality of care, although the issues vary by types of providers and types of payors. |
| **Employers:** Representatives from companies or coalitions of employers | • Can play a greater role in reducing stigma, educating employees about depression and providing increased mental health benefits and access to services, such as Employee Assistance Programs (EAP).  
• Can drive quality improvement initiatives by using performance measures to rank health plans and profile providers.  
• Economic impact of decreased productivity and absenteeism is significant if not addressed.  
• Recognize their role in addressing depression-related disability. |

*For the purposes of this report, the Pharmaceutical Manufacturers stakeholder group includes pharmaceutical manufacturers, as well as manufacturers of other forms of treatment.*
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<tr>
<th>Stakeholder</th>
<th>Key Challenges</th>
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| **Policymakers and Regulators:** State and Federal government agencies, Members of Congress | • Awareness has increased, but there is a lack of funding and prioritization for mental health issues.  
• Quality measures exist, but they are not uniform, sufficiently utilized or enforced.  
• Under-recognition/diagnosis of depression exists in primary care and there is a lack of connection and coordination between primary care, mental health and other social services.  
• Tremendous variation exists between states in mental health access, parity, benefits and state-delivered government programs.  
• Peer support is an important component of care; more opportunity exists for implementation and large-scale research about its efficacy. |
| **Researchers:** Researchers specializing in depression from universities and academic institutions, hospital systems and governmental agencies | • Research about depression has improved, but requires additional funding.  
• While investment and evidence-based practice in mental health is increasing, treatment is not currently adequate or following recognized standards of care.  
• Outcome measures should be improved and expanded.  
• Studies on the large-scale implementation and benefits of peer support would benefit consumers. |
| **Consumer Advocates:** Groups representing consumer and family mental health issues and the needs of special populations such as children and adolescents, older adults and racial/ethnic minorities | • Multiple barriers to care include lack of: mental health parity, qualified providers, consumer involvement, education, housing and other social supports, geography and transportation  
• Quality of care is poor because of lack of coordination, providers do not have enough time or training to deal with the complexities of depression and the system is crisis-oriented rather than emphasizing recovery.  
• Peer support is critical to therapy by providing hope and understanding, but it is often not funded or supported by health plans or providers.  
• Lack of funding is a critical issue, decreasing preventative care and resulting in more expensive inpatient care and hospitalizations. |

### 1.2 Outline of Report

The report is organized into the following sections:

- Section 2.0 – Landscape
- Section 3.0 – Economic and Social Impact of Depression
- Section 4.0 – Access to Care
- Section 5.0 – Treatment and Emerging Recovery Methods
- Section 6.0 – Quality
- Section 7.0 – Conclusion
- Appendix I – Mental Health System Transformation through the Real Choice Systems Change Grants
- Resources
2.0 Landscape

Depression is one of the most pressing public health issues in the United States. Approximately 10 percent of the adult population experience depression in any given year, while 15 percent of Americans will experience depression sometime during their lifetime. Depression can have a devastating effect on the quality of life, relationships and employment or academic achievement. Depression is one the leading causes of disability worldwide and is associated with increased morbidity and mortality. Each year, 30,000 individuals die by suicide in the United States, the majority of whom have depression or other psychiatric illnesses. Despite its high prevalence and tremendous impact, depression is often remains undiagnosed and undertreated for extended periods. Although more consumers are seeking help for depression and rates of antidepressant use are rising, less than 22 percent of consumers diagnosed with depression receive adequate treatment for their illness.\(^{17}\)

Unmet mental health needs have been gaining national attention and are beginning to become an issue of national priority. \textit{Mental Health: A Report of the Surgeon General} (1999) increased public awareness of mental disorders and highlighted the need for improved mental health care.\(^{18}\) The President’s New Freedom Commission’s \textit{Achieving the Promise: Transforming Mental Health Care in America} (2003),\(^{19}\) promotes six broad goals, including (i) recognizing mental health as an essential part of overall health, (ii) making mental health care consumer and family driven, (iii) eliminating disparities in mental health services, (iv) increasing early mental health screening and treatment, (v) accelerating research in mental health and (vi) using technology to access mental health care information. The Institute of Medicine recently published a report, \textit{Improving the Quality of Health Care for Mental and Substance-Use Conditions},\(^{20}\) which examines deficiencies within the mental health care practice and constructs a strategy aimed at closing the quality gap for mental and substance-abuse conditions.

The following sections include a brief medical overview of depression and its implications among United States subpopulations and provides a summary of policy and legislation influencing the treatment of depression in the United States and a description of the current mental health delivery system, including characteristics of public programs and private services. Variation in mental health services among states is also discussed.

2.1 Medical Overview

\textbf{Depression is a real illness.} Depression is a type of mood disorder characterized by severe, persistent depressed mood or diminished interest or pleasure in almost all activities, accompanied by symptoms such as insomnia or hypersomnia (extensive sleep), weight loss or gain, fatigue, feelings of worthlessness, diminished ability to think and recurrent thoughts of suicide.\(^{21}\) The average age of onset of symptoms peaks between the ages of 15-24, but diagnosis is often not made until some years later. Depression is often chronic and recurrent, as 55-70 percent of individuals with a single episode can be expected to have a second episode and over 70 percent of individuals who experience a second episode will have a third within three years without treatment.\(^{22}\)

The physiological nature of depression is depicted in Exhibit 2, which shows PET (position emission tomography) scans a patient’s brain during depression and after recovery from depression.
There are many different subtypes of depression, including Major Depressive Disorder (MDD), Dysthymic Disorder, Bipolar Disorders (Bipolar Disorder I and II) and sub-syndromal depression. While this paper presents an overview of depression in general, there are differences in the epidemiology, course, progression, treatment and implications for the various types of depression. Understanding bipolar depression is of particular clinical importance, because it is often misdiagnosed as MDD, which can hinder consumers from receiving appropriate and adequate treatment. Bipolar disorder is characterized by both major depressive episodes and manic episodes, with symptoms such as increased energy, overly good mood, extreme irritability, distractibility and poor judgment.

Depression is associated with genetic, biological, psychosocial and environmental factors. Family, twin and adoption studies support a genetic component to the transmission of depression, as depression is about 1.5 - 3 times more common among first-degree relatives than among the general population. Many studies have reported biological factors associated with depression, such as neurotransmitter levels, including serotonin, norepinephrine and dopamine. There is also evidence of hormonal disturbances in individuals with depression. Functional brain imaging studies show alterations in blood flow and metabolism in the brain in some individuals with depression.

Psychosocial and environmental factors associated with depression include child abuse and neglect, violence, social disadvantage and poverty.

Individuals with certain chronic or severe general medical conditions are at an increased risk to develop depression. Depression is commonly associated with a variety of medical conditions, including diabetes, cardiovascular disease, cancer, HIV/AIDS, stroke and other neurological disorders. There is also emerging evidence that depression has a causal role with other major illnesses, such as cardiovascular disease and stroke. The prognosis of medical conditions is less favorable if depression is present and the prognosis of depression is adversely affected by general medical conditions, resulting in longer episodes or poorer responses to treatment. For example, individuals with an acute cardiac episode (“heart attack”) and depression have a 3.5 times greater chance of dying if there is no depression. Depression also affects medication and treatment adherence and other health behaviors. For example, adults who experienced depression in the past year are about 1.5 times more likely to use cigarettes and twice as likely to use illicit drugs than adults who had not experienced a major depressive episode. A variety of mediating factors also link depression and obesity, another leading public health epidemic.

**Depression can be deadly.** Suicide is the 11th leading cause of death among persons of all ages in the United States. While 30,000 Americans die by suicide each year, a staggering 730,000 people attempt suicide each year in the United States. Research has shown that more than 90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder.
Depression can affect anyone. Depression is common with unique implications for certain subpopulations, as described in Exhibit 3.

"Depression, mental illnesses ... affect all of us, I don’t care what your race is, what your religion is, what your ethnicity is, your national origin, your sexual orientation."
— Senator Gordon Smith (R-OR)

<table>
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<tr>
<th>Subgroup</th>
<th>Implication</th>
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| Women                     | • It is estimated that women are twice as likely to experience depression than men, with a lifetime prevalence in community samples of 10-25 percent for women and 5-12 percent for men.36  
  • As a result of their higher levels of depression, women experience more disability than men, including social impairment in family and marital functioning, physical disability and work-related disability, as measured by unemployment and income loss.  
  • Women may have higher prevalence of trauma, such as physical, sexual or emotional abuse, which can affect depressive symptoms. |
| Men                       | • Depression among men may be masked or expressed differently than women, including more expressions of anger, irritability and substance use.  
  • Men are less likely to admit they have depression or seek help for depression, which could lead to higher rates of untreated depression among men.37  
  • Although fewer men attempt suicide than women, four times as many men die by suicide.38 |
| Children and adolescents  | • About 2.2 million American teenagers or nine percent, experienced major depression last year.  
  • Depression is difficult to diagnose in children because they may express more somatic complaints, irritability and social withdrawal.39  
  • Children with depression have increased risk for dropping out of school and abusing alcohol and drugs.40  
  • While the rate of youth suicide declined from 1992-2001, it remains the third leading cause of death among 10-19 year olds of all races and the second leading cause of death for American Indians.41 |
| Older adults              | • Of the 35 million Americans age 65 and older, an estimated two million have a depressive illness.42  
  • Depression is often undiagnosed in older adults because symptoms of depression, such as fatigue, weight loss and pain, are similar to symptoms of other illnesses common in this population.  
  • Older adults are at risk for increased suicide. In particular, white men age 85 and older have a suicide rate more than five times the national rate.43  
  • Depression is more likely to be comorbid with other chronic conditions in the elderly. |
| Race and ethnic groups    | • Research on differences in depression rates among racial/ethnic populations have shown mixed results. Recent research from the National Comorbidity Survey Replication found non-Hispanic blacks had lower rates of depression than whites.44 The National Epidemiologic Study on Alcoholism reported lower rates for black, Hispanic and Asian American adults compared with whites, while Americans Indians had higher rates of depression compared to whites, after controlling for other confounding variables.45  
  • The experience and expression of depression varies by culture and may be expressed in somatic terms. Latino and Mediterranean cultures may express complaints of "nerves" and headaches and Asian cultures may describe weakness, tiredness or "imbalance" when referring to depression.46  
  • Culture and race play a role in access to services and quality of treatment. As a result, some barriers to treatment are more prominent for certain racial and ethnic minorities.  
  • Many studies do not include the representative samples of racial/ethnic groups needed to make reliable estimates. |
| Rural populations         | • Rates of depression do not vary by rural or urban location or region, after controlling for other factors, such as socioeconomic status.47  
  • People with depression in rural and other geographically remote areas may be underserved due to inadequate access to care, limited availability of skilled providers, lower family incomes and greater stigma for seeking mental health treatment than people living in urban areas.48 |
| Victim of trauma          | • Victims of trauma, such as natural disasters, terrorist acts, crime, rape, violence and war have increased risk for depression. Individuals with Posttraumatic Stress Disorder (PTSD) are at higher risk for depression, substance abuse and suicide attempts.49  
  • While the Department of Veteran's Affairs and the Department of Defense offer mental health services to soldiers and veterans, there is no other system specifically designed to serve the health and mental health needs of victims of national disasters or other trauma.  
  • The already burdened mental health care system needs to better prepare and serve victims of trauma, as illustrated recently with Hurricanes Katrina and Rita and the war in Iraq.  
  • A history of sexual abuse (including rape and molestation) doubles the risk for Major Depressive Disorder.50 |
2.2 Mental Health Delivery System

The passage of key legislation, development of government programs, advances in research and medical practice and new prominent reports have influenced the evolution of the mental health delivery system. Exhibit 4 provides a timeline of some key milestones in health care that have impacted the delivery of mental health services for individuals with depression.

Exhibit 4. Timeline of Key Milestones in the Health Care Impacting Depression

- 1946: National Mental Health Act signed, which called for the establishment of a National Institute of Mental Health.
- 1950: Community Mental Health Centers (CMHCs) Act signed into law to provide comprehensive, community-based mental health services.
- 1963: Medicare & Medicaid, which provide mental health services to individuals who are over 65, have disabilities, or meet income requirements, were signed into law.
- 1963: Community Mental Health Centers (CMHCs) Act signed to provide comprehensive, community-based mental health services.
- 1965: Medicare & Medicaid, which provide mental health services to individuals who are over 65, have disabilities, or meet income requirements, were signed into law.
- 1970: Mental Health Systems Act passed, designed to provide improved services for persons with mental disorders.
- 1977: President's Commission on Mental Health established to review mental health needs of the Nation.
- 1980: Mental Health Parity Law prohibits use of lifetime and annual limits on coverage for mental health and somatic illness, but did not address per-episode limits on length of stay or outpatient visits or discriminatory copayments.
- 1980: Mental Health Parity Act extended.
- 1990: Americans with Disabilities Act prohibits discrimination against people with physical or mental disabilities in employment, transportation, public accommodation, communications, and activities of government.
- 1990: The No Child Left Behind Act allows schools the flexibility to provide or expand counseling and mental health services and support for students, teachers, and families.
- 1992: Alcohol, Drug Abuse, & Mental Health Administration (ADAMHA) Reorganization Act establishes Substance Abuse and Mental Health Services Administration.
- 1995: Landmark Supreme Court Olmstead decision supported the right of people with mental and other disabilities to live in community settings, finding unjustified institutionalization of people with disabilities violates Americans with Disabilities Act.
- 1996: Mental Health Parity Law prohibits use of lifetime and annual limits on coverage for mental health and somatic illness, but did not address per-episode limits on length of stay or outpatient visits or discriminatory copayments.
- 2001: The No Child Left Behind Act allows schools the flexibility to provide or expand counseling and mental health services and support for students, teachers, and families.
- 2004: Mentally Ill Offender Treatment and Crime Reduction Act approved, authorizing a $50 million federal grant program for states and counties to expand access to mental health treatment to adult and juvenile offenders with mental health disorders.
- 2004: Garrett Lee Smith Memorial Act signed into law, providing $82 million in grants for the development of suicide prevention programs.
- 2005: Mental Health Parity Act extended.

“We need a health care system which treats mental illness with the same urgency as physical illness.”

– President George W. Bush
Today, the delivery system for mental health in the United States includes a broad range of services and treatments provided by both public and private payors. The de facto Mental Health system includes a variety of specialty mental health providers, primary care providers, human service agencies and voluntary programs. Types of mental health services include inpatient, outpatient, partial hospitalization, 24-hour crisis, consultation and education, substance abuse treatment and intermediate services, such as group homes. Mental health psychotherapy services are often provided through community-based organizations and other state-funded programs including Medicaid, the education, child welfare, juvenile and criminal justice systems. The need for coordination of care increases with each additional component that is added to the health delivery system.

Treatment of mental illnesses, such as depression, are distinctly different and significantly more complex than traditional health care in several ways. As part of standard clinical practice, physicians do not utilize simple x-ray, blood test or scan of physical symptoms to diagnose the illness. Diagnosis involves a close look at patient history, self-reported information and an understanding of the role social factors such as family and environment have on depression. As such, professional interpretation plays a greater role in diagnosis and there is a greater degree of variability diagnosing individuals with depression than is seen with many traditional medical illnesses.

The mental health arena has a large and diverse cadre of providers and health professionals who are licensed to diagnose and treat depression. Traditional health care providers include physicians, both primary care and specialty (psychiatry), advance practice nurses and physician assistants – all of whom play a role in diagnosis and treatment of patients. There is also a multitude of other health care professionals that make up the specialty mental health work force. They include psychologists, therapists, social workers and counselors, all of whom have a varying expertise specialties and areas of focus. For instance, a therapist may focus on psychosocial rehabilitation or family and marriage counseling. A psychologist may focus on a particular sub-discipline within the field of psychology, such as counseling, social or clinical psychology. Within these disciplines, providers vary greatly in their training and ability to provide care to patients with comorbidities or patients who come from a special needs group such as the elderly or children. Additionally, consumer advocacy groups, mutual support and peer-to-peer support play an important role in the treatment of depression.

The organization and financing of mental health services is also extremely complex. The mental health system includes publicly funded government programs at the Federal, state and local levels and privately funded health plans. The following section describes characteristics of both public and private payors and provides details of some mental health programs and services within each section.

2.3 Characteristics of Public Programs

Several government agencies offer health programs, such as the Centers for Medicare and Medicaid Services (CMS), State Children’s Health Insurance Program (SCHIP), Veterans’ Health Administration (VHA) and the Department of Defense military health care plan (TRICARE). Additional government programs, such as the Departments of Justice, Education, Social Security Administration, Housing and Urban Development and Welfare also provide mental health and other services to individuals with depression and other serious mental illness. A variety of grant programs, such as the Community Mental Health Services Block grants administered through SAMHSA, provide funding to states and territories for mental health services.

2.3.1 Medicare

Medicare and Medicaid programs spend nearly $24 billion each year on beneficiaries’ mental health care. Medicare provides health insurance to older Americans and individuals with certain disabilities, populations
with extremely high rates of depression. Depression commonly occurs with other chronic diseases and approximately 15 percent of Americans over age 65 experience symptoms of depression. However, Medicare provides lower coverage for mental health benefits, such as paying only 50 percent of mental health outpatient services as compared to 80 percent of non-mental health outpatient services. The disparity in reimbursement impacts the commercially insured population as well, as some physician offices presume that Medicare reimbursements apply to all older adults. Given the high prevalence of depression among older adults and the high rate of suicide in this population, it is critical that these barriers to mental health care be addressed. While the implementation of the Part D prescription drug benefit may increase access to antidepressant medications for older adults with depression, it will not facilitate access to psychotherapy or other types of mental health services.

2.3.2 Medicaid

The Medicaid program, which is jointly funded by the state and Federal governments, has become the primary payor of public mental health services at the state level. Within the Medicaid system, states have the broad discretion (within certain Federal guidelines) in determining the services provided, financing structure and reimbursement rate for those services. As a result, states vary considerably in their mental health benefit packages and implementation. Most states have implemented managed care arrangements to provide mental health care. Although Federal Medicaid rules do not require states to cover many services and supports necessary for people with mental illnesses, most states have adopted Medicaid options that permit reimbursement for a broad range of these services.

Typically, Medicaid benefits are more generous than private insurance plans, partly due to the Omnibus Budget Reconciliation Act (1989), which requires a state to cover all necessary services identified by an Early Periodic Screening and Diagnostic Test (EPSDT) screen. An EPSDT is required for all eligible children under 21 years of age and includes a comprehensive health and developmental history, including a developmental assessment of physical and mental health. However, a recent General Accounting Office (GAO) report, Stronger Efforts Needed to Ensure Children’s Access to Health Screening Services, found that comprehensive EPSDT screening rates are extremely low, limiting access to necessary services. Additionally, recent Federal budget cuts to Medicaid will affect critical mental health services, such as case management.

Many states are utilizing their Medicaid funding to implement self-directed care programs for depression and mental illness through the Real Choice Systems Change Grants, which provide $208 million across the 50 states, District of Columbia and two territories. This grant program was developed partly in response to the New Freedom Initiative, a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses, such as depression. One of the underlying objectives of the Real Choice Systems Change Grants is to improve access to and delivery of health care to persons served by Medicaid including the cost of research or demonstration projects. Eleven states have developed Mental Health System Transformation Research Demonstration Projects (see Appendix I for program descriptions).

Dual eligibles, beneficiaries that are eligible for both Medicaid and either Part A or B of Medicare, are a particularly vulnerable population that has received increasing attention since the implementation of the Medicare Part D prescription drug benefit on January 1, 2006. Dual eligibles will transition to receiving their prescription drug benefits under Medicare Part D and will not pay for premiums or deductibles. The Federal government is responsible for transferring dual eligibles from Medicaid drug coverage to the new Medicare prescription drug benefit, which is posing problems. Additionally, automatic enrollment could disrupt beneficiaries’ drug regimen. If CMS does not enroll a dual eligible in a Medicare drug plan, pharmacists are responsible for contacting health plans to obtain coverage, relying on enrollment databases that might not be available at every pharmacy. If coverage is not arranged, dual eligible beneficiaries may have great difficulty
in paying retail price for their medications upfront. Recent reports indicate enrollment problems within Part D have led some states, such as Arkansas, California, Connecticut, Hawaii, Maine, New Jersey, North Dakota, Rhode Island and South Dakota to pay for beneficiaries’ medications.

2.3.3 **State Children’s Health Insurance Program (SCHIP)**

As part of the Balanced Budget Act of 1997, Congress created the SCHIP to extend coverage to uninsured children. Under SCHIP, states can expand Medicaid, establish a new program separate from Medicaid or use some combination of these strategies. Like Medicaid programs, SCHIP programs vary widely in their eligibility criteria, benefit structure and limitations and management by state. Mental health services under SCHIP are subject to the same funding constraints as Medicaid.

2.3.4 **Veterans Health Administration (VHA)**

The VHA aims to meet the mental health needs of the nation’s veterans by offering comprehensive and effective mental health services via its Veterans Integrated Service Networks (VISN). The VHA also has a system of Mental Illness Research, Education and Clinical (MIRECC) Centers that conduct research into causes and treatment of mental illness to improve quality of veteran’s mental health care. The VHA recently created a Comprehensive Strategic Plan for Mental Health Services to implement the initiatives of the President’s New Freedom Commission. Special populations served by the VHA include aging veterans, homeless veterans and veterans dealing with comorbid mental illness, such as Posttraumatic Stress Disorder (PTSD), medical conditions and substance abuse disorders.

2.3.5 **United States Department of Defense**

The Military Health System provides health insurance to active duty, reserve and some retired service members in addition to some family members. With a large number or military personnel serving in Iraq and the fact that exposure to violence or trauma may lead to illnesses such as PTSD, depression and substance abuse, the military health system has a critical role to play in supplying mental health services. Stigma has traditionally played a large role in military culture, impeding awareness of and access to services.

Exhibit 5 provides an overview of these government programs, including eligibility criteria and benefits and services and describes how these programs provide funding for community based mental health services.

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**Exhibit 5. Government Programs Providing Mental Health Funding and Services**

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<tr>
<th>Program Description</th>
<th>Eligibility criteria</th>
<th>Benefits and Services</th>
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<tbody>
<tr>
<td><strong>Program: Medicare</strong></td>
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| Medicare includes hospital insurance (Part A, mandatory), medical insurance (Part B), Medicare Advantage plans (Part C) and the new prescription drug benefit (Part D) | • Age 65 or older  
• Under age 65 with certain disabilities  
• End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant) | • Inpatient care (Limit of 190 days)  
• Outpatient mental health treatment (Limit of 50 percent of the costs, although Medicare covers 80 percent of non-mental health related outpatient services)  
• Outpatient substance abuse services  
• Prescription medication (Part D)  
• No coverage for case management or psychiatric rehabilitation |
<p>| <strong>Coverage:</strong> 41 million Americans | | |</p>
<table>
<thead>
<tr>
<th>Program Description</th>
<th>Eligibility criteria</th>
<th>Benefits and Services</th>
</tr>
</thead>
</table>
| **Program: Medicaid**<sup>64</sup> | • Families who meet states’ Aid to Families with Dependent Children (AFDC) eligibility requirements.  
• Pregnant women and children under age six whose family income is at or below 133 percent of the Federal poverty level (FPL)  
• All children born after September 30, 1983 in families with income at or below the FPL  
• Supplemental Security Income (SSI) recipients  
• Special protected groups  
• Recipients of adoption or foster care assistance under Title IV of the Social Security Act | **Mandated benefits:**  
• Inpatient hospitalization  
• Physician Services (Psychiatrist)  
• Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for all individuals under 21  
**Optional benefits:**  
• Outpatient mental health services  
• Other practitioners’ services (Psychologist or Social Work)  
• Service coordination/case management  
• Psychiatric rehabilitation  
• Prescription medication  
• Medicaid Home and Community-Based Waivers allow states to provide a range of home and community-based services |
| **Program: State Children’s Health Insurance Program (SCHIP)**<sup>65</sup> | • Children 18 years and under whose family income is either below 200 percent FPL (in 16 states), at 200 percent of poverty (in 25 states) and above 200 percent of poverty (10 states) | • Mental health benefits and services vary by state. Some states have benefits equivalent to those offered under Medicaid, while others have benefits similar to Medicaid with some limitations for children with Serious Emotional Disturbance (SED)<sup>66</sup> |
| **Program: Veteran’s Health Administration (VHA)**<sup>67</sup> | • Active military service in the Army, Navy, Air Force, Marines or Coast Guard (or Merchant Marines during WW II) and retired members discharged under other than dishonorable conditions  
• Reservists and National Guard members who were called to active duty by a Federal Executive Order  
• Returning service members, including Reservists and National Guard members who served on active duty in a theater of combat operations have special eligibility for hospital care, medical services and nursing home care for two years followig discharge from active duty | • Inpatient and outpatient mental health and substance abuse treatment  
• Prescription medication  
• Community based outpatient treatment |
| **Program: Department of Defense of Military Health (TRICARE)**<sup>68</sup> | • Active duty and retired service members  
• Spouses and unmarried children of active duty, reserve or retired service members  
• Reserve members on active duty for more than 30 days and reserve reserve service members and their family members  
• Widows/widowers and unmarried children of deceased active duty or retired service members  
• Medal of Honor recipients and their family members | There are several different TRICARE plans available, such as TRICARE Prime, Extra, Standard and For Life, which offer various benefits. For example, services provided by TRICARE For Life include:  
• Inpatient Mental Health in Psychiatric Facility requires preauthorization. Care in excess of 30 days requires a waiver for secondary TRICARE  
• 50 percent of mental health outpatient visits.  
• Prescription medication |

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2.3.6 Additional Key Government Programs

Due to the inadequacy and fragmentation of the current mental health system and the wide-ranging needs of many individuals with mental illness, many other government organizations have played a role in providing essential services for individuals with depression.

Departments of Justice

Many incarcerated adults in jails and state prisons either have a mental disorder or substance abuse disorder. Almost all facilities provide screening for mental illness at intake, assessing psychiatric problems, delivering around-the-clock mental health care, providing therapy or counseling, prescribing psychotropic medications and providing reentry assistance. In addition, mental health courts provide services to individuals with depression and other serious mental illnesses.

An estimated 60-75 percent of youth in the Juvenile Justice system have a diagnosable mental disorder and about 20 percent have a severe mental illness. Many youth remain inappropriately incarcerated only because there are not enough mental health services available. Two thirds of all juvenile justice detention facilities in the United States reported holding youth because they were awaiting community mental health services. This highlights the need for more effective mental health treatment to prevent youth from entering the justice system, continuing services while they are incarcerated and making treatment available when they are released from detention centers.

Department of Education

Schools are an important source of mental health services for children with depression and serious emotional disturbance (SED). Through The Individuals with Disabilities Education Act (IDEA) legislation, schools must provide children with emotional and behavioral disorders a free and appropriate public education. This includes providing special education services, mental health counseling and access to additional mental health services.

Social Security Administration (SSA)

SSA provides financial support to individuals with disabilities caused by serious mental illness. Social Security Disability Insurance (SSDI) is a Federal assistance program that pays benefits to individuals and family members who have worked and have a medical condition. The Social Security's definition of disability is a medical condition that prevents an individual from working and is expected to last for at least one year or to result in death. Supplemental Security Income (SSI) is a Federal income supplement program which provides cash to meet basic needs for food, clothing and shelter to low income individuals who are blind, disabled or age 65 and older. Children are one of the fastest growing populations on SSI and more than 60 percent have an emotional/mental disorder or are mentally retarded. More than 50 percent of adults on SSI either have a mental/emotional disorder or have a mental disability. SSA projects sharply escalating disability costs through the next two decades.
Department of Housing and Urban Development (HUD)

HUD increases homeownership, supports community development and increases access to affordable housing free from discrimination. HUD has a variety of programs for homeless individuals, who have high rates of mental illness, including depression and PTSD and substance abuse disorders.

2.4 Characteristics of Private Payor Services

Private funding of mental health services include employer-based health plans, purchased health insurance and out of pocket payments, including copayments, deductibles and other costs not covered by health insurance. In 1996, private funding accounted for 47 percent of mental health care spending, while public payors accounted for 53 percent. Due to the rising costs of health care, managed behavioral health care (MBHC) has grown dramatically throughout the 1990s as a method of reducing medical expenditures by monitoring utilization of service and improving efficiency and coordination. Approximately 177 million Americans with health insurance were enrolled in managed behavioral health organizations in 1999.

Types of managed care networks include health maintenance organizations (HMO), preferred provider organizations (PPOs) and point-of-service plans (POS). In HMOs, beneficiaries must use providers within their network and obtain a PCP referral before receiving specialty care. PPOs are managed care plans that contract with networks of “preferred” providers to supply services at discounted rates, but enrollees can use non-network providers at higher costs and do not need referrals. POS plans combine aspects of HMO and PPO plans, requiring a PCP to manage a beneficiaries’ care, but allowing enrollees to see providers outside their network at higher costs. Despite the various designs and structures, most managed care programs have provider networks/panels (selected practitioners to provide a specific set of health care services to enrollees), limited choice, gatekeeping, risk sharing, formal programs for ongoing quality assurance, quality improvement, utilization review and financial incentives for members to use practitioners within the network and procedures covered by the plan.

While knowledge about the biological mechanisms of mental illnesses has improved, mental health services continue to be “carved out” of health care plans, having separate reimbursement mechanisms. In addition to carve-out designs, MBHCs use integrated designs and divided-benefit designs. In integrated design structures, the financing and administration of physical and mental health care are fully incorporated, such as in a group-model HMO. In a non-HMO benefit design, the financing and administration of selected mental health services, such as basic level or acute care services, are integrated with physical health services. Additional mental health services are carved out for separate management and financing. One advantage of carve-outs is that they may provide some resources that would be lost in an integrated system. However, the separation of systems can make the coordination of care difficult.

While the effect of managed care on access and quality of mental health care is controversial, the number of consumers receiving services has increased substantially. According to the National Medical Expenditure Survey and the Medical Expenditure Panel Survey, the number of patients receiving outpatient mental health treatment increased by threefold from 1987 to 1997, mostly due to the rise in antidepressant use among individuals treated for depression, which increased from 37 percent to 75 percent. However, private health plans vary tremendously in their mental health service offerings. Despite the passing of the Mental Health Parity Act (1996), which bans the use of discriminatory lifetime and annual limits on coverage, most health insurance companies place restrictions mental health benefits, including per-episode limits on length of stay and outpatient visits and discriminatory copayments.
2.5 Variation in Mental Health Services Across United States

Mental health services have traditionally been provided at the state level. As illustrated in Exhibit 6, there is tremendous variation in state mental health funding, services and governmental programs, such as juvenile justice, Medicaid and SCHIP. State agency mental health expenditures vary drastically, ranging from a high of $398 per capita in the District of Columbia to an average of $26 per capita in West Virginia and $19 per capita in Puerto Rico. While this may be driven in part by variations in prevalence of mental illness and costs of services in geographic regions, it has implications for the access and quality of services and types of treatment individuals receive in different areas of the nation.

States also vary in mental health mandates and parity laws. In addition to the Federal Mental Health Parity Act, most states have enacted legislation for mental health parity that varies from comprehensive to more limited coverage. However, several states only have mental health mandates, not parity laws and two states have not implemented any type of mental health parity or mandate laws. Exhibit 7 shows which states that have enacted mental health parity laws (classified as “Yes”) and which states that have not (coded as “No”).
3.0 Economic and Social Impact of Depression

Depression places an economic and social burden on all facets of society. According to stakeholders, identifying solutions that are both cost effective and improve quality of life are critical to mitigating the impact of this prevalent mental illness. In order to address the topic of depression as it relates to economic and social impact, the following section address the cost of depression, the economic burden among stakeholders, cost drivers and the impact of depression on society.

3.1 Current State

The impact of mental illness on the United States economy is significant and affects all stakeholders in the mental health value chain. In recent years, there has been an increased focus on the economic and social aspects of health care, especially around chronic illnesses. The cost of depression, like heart disease and diabetes, has experienced a rise in costs – both economic and societal, due to increasing diagnosis and costly treatments. Many of the stakeholders interviewed for this report mentioned that the prevalence of depression is rising in this country, with more consumers diagnosed compared with 10 years ago resulting in an increase in direct treatment costs.

3.1.1 The Cost of Depression

Depression is an expensive illness. The economic burden of depression in the United States was estimated to be $83.1 billion annually (in 2000 dollars). As illustrated in Exhibit 8, economic costs associated with the illness are categorized by both direct and indirect costs. Direct costs represent actual costs associated with treating depression, largely driven by diagnosing, treating and rehabilitating patients in both primary and secondary care settings. Indirect costs or workplace costs represent the economic loss to employers attributed to absent or underproductive employees suffering from depression. These costs are driven by prevalence of illness, prescribed treatments, treatment effectiveness, comorbidity, adherence and population characteristics.


<table>
<thead>
<tr>
<th>Type of Cost</th>
<th>1990 (in 2000 dollars)</th>
<th>2000 (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Cost</td>
<td>19,883</td>
<td>26,087</td>
</tr>
<tr>
<td>Inpatient</td>
<td>13,368</td>
<td>8,883</td>
</tr>
<tr>
<td>Outpatient</td>
<td>4,632</td>
<td>6,803</td>
</tr>
<tr>
<td>Pharmaceutical</td>
<td>1,882</td>
<td>10,400</td>
</tr>
<tr>
<td>Suicide-related</td>
<td>5,584</td>
<td>5,450</td>
</tr>
<tr>
<td>Workplace Costs</td>
<td>51,888</td>
<td>51,543</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>39,450</td>
<td>36,248</td>
</tr>
<tr>
<td>Presenteeism</td>
<td>12,439</td>
<td>15,295</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$ 77,355</td>
<td>$ 83,080</td>
</tr>
</tbody>
</table>

The World Health Organization and the World Bank recently ranked depression as the world’s fourth most disabling condition and projects it will become number two, behind only heart disease, by the year 2020.
3.1.2 Economic Burden: Employers

Depression results in a considerable economic burden on employers. In fact, a depressed employee accounts for four times more lost work hours as compared to an employee who is not depressed. Even more critical is the ripple affect on other employees. One depressed employee can affect 20 co-workers.

The cost of depression to employers, particularly in lost work days, is disproportionately greater than the cost of many other common medical illnesses. According to Exhibit 8, absenteeism and presenteeism (when people continue to work despite illnesses that reduce their productivity) represent over 50 percent of all costs associated with depression. These costs can grow at an exponential rate when depression is undiagnosed. Findings from a recent study conducted on individuals who had been diagnosed with major depression indicate that, on average, there is a gap of five years between symptom onset and diagnosis. This is a period in which the individual’s condition may continue to deteriorate, in which there is likely to be a loss of functionality or time on the job and when other significant negative costs to the individual’s social and personal life will occur.

Most self-insured employers see anti-depressants as one of their top pharmaceutical costs, but are often unaware of the full extent of the burden of depression in the workplace. Approximately, 16.5 percent of the working population is affected by major depression. The result is a tremendous financial strain on United States employers. Additionally, from a national economic perspective, sick, unemployed individuals are not contributing to the tax base.

3.1.3 Economic Burden: Private Payors

Private payors for mental health services include employer-based health plans and privately-purchased health insurance. In recent years, health economists, mental health advocates and quality-based organizations, such as NCQA, have made the economic case for improving access and quality of mental health treatment, especially for employers and payors. Claims reimbursement for inpatient and outpatient care as well as for pharmaceutical expenditures comprise the majority of a payors’ responsibility. While the economic burden of depression is evident, employers and payors have been concerned with funding mental health care for two main reasons, 1) cost-effectiveness for adopting mental health care benefits, in which outcomes are unknown, and 2) benefit structure and design.

In a depression management program, cost-effectiveness is based on the length of time it takes health plans and employers to realize the economic benefit of improved mental health among its members and employees. While quality of life may improve dramatically for the consumer, the length of time it takes to translate into an economic benefit is difficult to measure due to employee/member turn-over rates. Chronic illnesses, such as depression, often require daily management over a long period of time before improvement can be appreciated. However, assuming proper adherence and adequate care, the individual’s health improves and medical costs eventually decrease over time. During that time, the individual may have changed employers and/or health plans, in which case the ROI is not realized for the employer and/or payor.

Benefit plan design can also impact whether disease management programs are effective. In most instances, insurance companies outsource mental health products and services to separate entities. In addition, prescription drug plans are often administered by a Pharmacy Benefit Manager (PBM). As a result, health coverage, mental health coverage and drug benefits are managed in silos with varying reimbursement structures and incentives. Such variation among health benefits and services creates a challenging
environment for payors and employers to invest in comprehensive mental health benefits and depression management programs.

In contrast to the impact of indirect costs on employers, payors incur direct cost charges as more individuals receive treatment for depression. Claims reimbursement for inpatient and outpatient care as well as pharmaceutical expenditures comprise the majority of a payor's responsibility. According to primary and secondary research, there are three key trends driving depression-related costs for private and in most cases public payors. First, as illustrated in Exhibit 8, pharmaceuticals account for the highest depression-related expenditures. However, according to stakeholders, if all private payor beneficiaries who needed pharmacological treatment for depression received the right medication, the correct dosage and complied with treatment protocols, expenditures would not be as high.

The second trend is the direct link between the rise in pharmaceutical expenditures and treatment for depression in the primary care setting. According to interviews, PCPs are not adequately trained to diagnose and treat mental illness. As a result, no treatment is offered or the wrong medication or incorrect dosage may be prescribed, resulting in under-filling of prescriptions, multiple prescriptions being unnecessarily filled, as well as some over-prescribing of medication for patients who are not actually depressed.

Thirdly, the prevalence of undiagnosed depression in a patient with a chronic condition directly affects medical costs due to a consumer’s diminished ability to self-manage their condition. The poor health outcomes that result from inappropriate management of a chronic condition can lead to more inpatient stays and the need for added medication.

3.1.4 Economic Burden: Medicare and Medicaid

Medicare and Medicaid programs spend nearly $24 billion each year on beneficiaries’ mental health care, with Medicaid serving as the primary payor of public mental health services at the state level. As described in the landscape section of this report, Medicaid and Medicare benefit designs differ based on the funding sources, services and populations covered. According to stakeholder interviewees, recent changes to both programs, such as the advent of the Medicare prescription drug benefit, will impact the expenditures for the programs and beneficiaries.

The economic impact of depression on Medicaid is driven primarily by the number of enrollees receiving services and the broad range of services offered by the different states. Approximately 16 percent of adult enrollees (ages 21-64) and eight percent of children on Medicaid use mental health or substance abuse services. Additionally, women from low-income groups are nearly twice as likely as those from higher income groups to be depressed. An estimated one-third of the 600,000 homeless people have a severe mental illness. According to research, depression is prevalent among the Medicaid beneficiary population which greatly adds to financial strain for the program and the state which administers the benefits. Adding to that strain is the increase in Medicaid enrollees during an economic downturn when people lose private employer-based coverage and are forced to rely on personal costs or Medicaid as their primary insurance.

The Medicaid program’s benefit structure also affects the economic burden of depression. Under federal law, mandatory mental health services must be offered to all state Medicaid beneficiaries. States can offer optional services for adults and must make them available to children when medically necessary. The mandatory mental health services include inpatient and residential treatment and outpatient physician and other ambulatory services. Optional services for adults include the array of community-based services that are usually offered through the public mental health system. Optional services, however, can vary based on the...
availability of state funds. When services are reduced, consumers’ treatment is often discontinued. Access to adequate treatment enables consumers to manage their depression, allows them to remain with their families, report to work and contribute to society. This is also more cost-effective for Medicaid since the episodes of inpatient care and more costly treatments are often reduced. In most states, preventive or maintenance related care is provided under the community-services programs which are commonly the first mental health programs to experience budget cuts when funding is decreased. When consumers lose access to treatment, the depression symptoms often become more severe which can result in more costly treatments, such as inpatient care.

Medicare, in contrast to Medicaid, places more limitations on covered services. For example, patients are limited to 190 days of inpatient treatment and Medicare places limits on 50 percent of costs for outpatient mental health treatment compared to non-mental health services. However, two changes to the Medicare program will potentially increase the proportion of depression-related expenditures. The first change is the recent implementation of the Part D prescription drug benefit program which may increase access to antidepressant medications and could potentially increase the program’s expenditures. While prescription expenditures may increase, Medicare beneficiaries will likely have more access to pharmacological treatment when needed and perhaps reduce more costly emergency room visits or inpatient hospital stays. The second change is related to the projected increase of beneficiaries receiving Medicare benefits as the baby-boomer generation ages.

Presently, of the 35 million Americans age 65 and older, an estimated two million have a depressive illness. Given this high prevalence of depression among older adults, this illness will contribute to the continued financial strain on the Medicare program.

3.1.5 Economic Burden: Criminal Justice System

There is a considerable burden placed upon the criminal justice system due to inmates suffering from depression. It has been documented that inadequate treatment for depression can lead to substance abuse and other behavioral problems, often times resulting in involvement with the criminal justice system. In the state prison systems, between 13.1 and 18.6 percent of the inmates have major depression.

Once a person enters the justice system, the cost of treatment for any mental illness shifts to the justice system. This not only increases the costs for the justice system but affects the overall economy. Each person that is incarcerated is one less person who can potentially contribute to the work force or their community. In addition, people with mental illness who are left untreated often necessitate increased expenditure in law enforcement and management of prisoners with mental illness, costing the criminal justice system far more than caring for prisoners without mental illness. For example, the Pennsylvania Department of Corrections estimates it costs $140 per day to incarcerate an inmate with a serious mental illness, while it costs $80 per day for an average inmate.

3.1.6 Economic Burden: States

State funding for mental health has traditionally centered on institutional care. In fiscal year 2001, state Mental Health Agencies spent an estimated $23 billion on services, which takes into account inpatient costs, mental health services in jails and prisons, as well as publicly supported housing for the mentally ill. In addition to the State Mental Health Agencies, state agencies that are becoming increasingly burdened by mental illness include: housing agencies, corrections agencies and an assortment of other agencies that arrange for care. According to stakeholders, the pending Medicaid cuts pursuant to the FY06 Budget
Reconciliation bill, would likely increase the burden on states to fund mental health treatment for Medicaid beneficiaries.

The financial relationship between the states and Medicaid as it pertains to coverage for mental illness is a critical component affecting state agency funding. As stated previously, the optional services that states must provide include community-based services. Presently, there are an estimated 50,000 consumers with mental illnesses residing in state and county hospitals but there are millions that move in and out of community-based settings. According to stakeholders, consumer receiving care in both settings will be largely affected by Medicaid cuts as states work to find a balance between the cost of providing care in a community-based setting and the potential for an increase in inpatient care, incarceration and homelessness due to inappropriately managed illnesses.

3.1.7 Economic Burden: Families

Financial stability for families can be tenuous when a member suffers from depression. That family member may not be able to work and therefore unable to contribute to the overall household income. Depression can cause major financial strain on a family depending on the severity of the illness, the quality of care and insurance status.

The situation is often worse when depression occurs in a single-parent family. In this case, when the parent cannot work because they are ill or they must care for a child with depression, it can lead to job loss and the possibility of reliance on public assistance. The inability to access or afford mental health care for children is a major problem for many families already relying on public assistance. With the existing structure of public mental health treatment for children, many poor families are separated in order for a child to receive adequate mental care.

GAO released a report in April 2003, finding that in 2001 parents in 19 states and 30 counties surveyed for the report turned more than 12,700 children over to the juvenile justice system so that children would have access to needed mental health services. Presently, 60 to 75 percent of youth in the juvenile justice system have a diagnosable mental disorder. Parents often have to surrender their children, who are suffering from depression, to the public welfare systems in order to obtain the necessary medical care for them.

3.1.8 Economic Burden: Suicide

Suicide has a significant impact on the economic, social and health resources in the United States. Suicide takes the lives of more than 30,000 Americans every year and accounts for $25 billion each year in direct costs, including lost earnings, health and mental health care services, funeral services, autopsies and investigations and indirect costs like lost productivity. Worldwide, suicide is the leading cause of violent deaths, outnumbering homicide and war-related deaths. According to the CDC, more than 324,000 people were treated in hospital emergency departments for deliberate self harm in 2002. While depression does have a significant economic cost associated with it, there is emotional impact and loss of valuable life that truly makes suicide a drain on society.

3.1.9 Cost Drivers

Depression rarely occurs around an isolated event. There are a number of cost drivers that, when combined with depression, can significantly increase direct and indirect expenditures related to preventing, diagnosing,
treating and managing the illness. The following exhibit defines the key cost drivers identified by the literature and stakeholder interviews that are having a significant affect on economic burden.

**Exhibit 9. Cost Drivers and Economic Implications**

<table>
<thead>
<tr>
<th>Cost Drivers</th>
<th>Economic Implications</th>
</tr>
</thead>
</table>
| Undetected Depression and Inadequate Treatment | - Untreated depression leads to lost productivity and decreased ability to earn wages.  
- Caring for a depressed spouse, parent, child or sibling may take away from employment opportunities.  
- Individuals with untreated depression are more likely to have repeated episodes of depression with increasing severity that may result in more costly treatment, such as hospitalizations. |
| Comorbidity                          | - Consumers suffering from a chronic illness have an increased risk of being diagnosed with a major depressive disorder.  
- Depression can affect self-management of chronic diseases, leading to increased morbidity, slower recovery, increased health care utilization and higher health care costs.  
- Health outcomes are compromised when depression is unrecognized or undertreated. |
| Substance Use Disorders              | - Depression and substance abuse commonly co-occur, often masking disorders or complicating treatment.  
- As many as one in three consumers who have depression also have a co-occurring substance abuse or dependence. Both must be treated for either treatment to be effective.  
- Individuals with depression and co-occurring substance abuse are on average, likely to use more health care and to have higher treatment costs. |
| Aging Population                     | - Longer life spans and demographic trends are leading to an increasing population with a high incidence of depression.  
- Baby boom generation may be more likely to discuss depression with their physician leading to an increase in treatment, which will increase direct costs of care.  
- Older adults often have higher rates of comorbidity with chronic illness, which may lead to more complications and expensive treatment.  
- Financial burden on consumers caused by minimal coverage for mental illness under Medicare. |

**Undetected Depression and Inadequate Treatment**

Access barriers and under-diagnosis of depression leads to many individual with depression receiving inadequate treatment. As discussed, depression is an extremely costly illness, even more so when the quality of care is poor. According to stakeholder interviews and literature sources, while higher rates of treatment would impact direct expenditures, the price for ineffectively treating individuals with depression or not treating them at all is more costly to the United States economy. According to the 2004 *National Survey on Drug Use and Health*, approximately 5 percent of all adults (10.8 million people) in the United States reported they had an unmet need for mental health care resulting from insufficient, interrupted and/or delayed treatment. Only 57 percent of individuals with Major Depressive Disorder reported receiving any treatment in the past year and only 22 percent received adequate treatment in the past year.

For the individual, living with depression is all encompassing. It affects one’s quality of life, ability to contribute to one’s family and ability to be a productive member of society. These effects can linger or worsen depending on the amount of time that passes before the illness is diagnosed and treated appropriately. When the illness is not properly managed, many other stakeholders, especially employers, payors and families suffer a tremendous economic burden. The implications associated with untreated or inadequately treated depression can include increased indirect costs around low productivity, poor health outcomes, rising medical cost and lost household income.

**Comorbidity**

Chronic physical health conditions, including diabetes, heart disease and depression generate the highest percentage of health care expenditures among the United States population. These conditions lead to disability at home and at work. Individuals suffering from a chronic illness such as diabetes or heart disease
have an increased risk of being diagnosed with a major depressive disorder. Results from a health survey of 10,000 New York City resident indicated that patients with depression and diabetes were more likely to live in poverty, report poor health, have no access to health care and have lost a partner. Comorbidity complicates accurate diagnosis of depression and can lead to a dramatic increase in health care costs. Approximately 50 percent of increases in medical costs of chronic illnesses are associated with the occurrence of depression. This increase in costs is attributed to depression’s adverse impact on the self-management of many illnesses, resulting in negative health outcomes.

Unfortunately, when comorbidity is a factor, depression is often not diagnosed because it does not present as the primary illness. In some cases, the providers who treat a medically ill patient are not trained to identify or treat depression, increasing the likelihood that the depression will remain untreated. When this situation occurs, there is most often increased negative health outcomes associated with the medical illness and therefore increased medical costs, as well as the economic costs directly associated with depression such as increased absence and decreased productivity at work.

There is emerging evidence that depression has a causal role with other major illnesses. Additionally, individuals suffering from depression are more likely to engage in unhealthy behaviors such as smoking, over-eating and limiting exercise. All of these health behaviors can lead to poor overall poor health and the potential for developing a chronic illness. The connection between depression and physical well-being is evident and presents considerable economic burden on our society.

**Substance Use Disorders**

One in three consumers who have depression also have co-occurring substance abuse or dependence. According to stakeholder interviews, substance abuse does impact the cost of care related to depression. Health service use for individuals who receive outpatient alcohol treatment is decreased substantially for individuals who are refuse substance abuse treatment. Since, substance abuse is related to serious medical complications, including cirrhosis of the liver and other extensive organ damage, earlier treatment will help reduce medical costs. Unfortunately, the fragmentation within the United States health care system prevents efficient treatment of both conditions simultaneously, which also leads to increased costs.

Depression and substance abuse commonly co-occur; as many as one in three consumers who have depression also have a co-occurring substance abuse or dependence. Both must be treated for either treatment to be effective. Individuals with some type of substance abuse are on average, likely to use more health care and to have higher treatment costs than those without depression complications.

**Aging Population**

According to the United States Bureau of the Census, the proportion of the population aged 65 and over is projected to increase from 12.4 percent in 2000 to 19.6 percent in 2030, bringing the total number to 71 million. Eighty-eight percent of people aged 65 and older have one or more chronic medical illness and one quarter of them will have four or more conditions. As a result of the impending population shift, the growing number of older adults will increase demands on the public health system and on medical and social services. The majority of stakeholders interviewed identified baby boomers and their increased comorbidity as a leading factor in increased economic costs associated with treating depression.
Depression is not only a common problem among older adults, but one that is difficult to diagnose and treat. This difficulty occurs for several reasons. First, older adults often present depression to their physician as a physical ailment. Second, when a physical or medical problem occurs, older patients often prefer to visit their PCP. In the primary care setting, the depression may not be recognized and the patient may be treated only for a physical problem. Additional factors in this population include the increased loss of family and friends, inability to perform the same physical activities, transportation issues and financial strain caused by inadequate medical insurance. Regardless of the reasons, undiagnosed depression is harmful to the individual and especially costly because of the potential for poor health outcomes if comorbidity is present.

Despite these factors, there appears to be an increased acceptance of depression among baby boomers. As many stakeholders pointed out, this generation will be much more likely to openly discuss depression with their physicians than the previous WWII generation. If this is the case, then diagnosis of the illness among the older adult population should increase, leading to improved health outcomes among the population and a decrease in suicide rates.

3.1.10 Social Burden

The social costs of depression, while more difficult to quantify than economic costs, are equally burdensome to the consumer, their families and society as a whole. Divorce, decreased academic achievement among children and adolescents, behavioral problems, criminalization and suicide occur at higher rates when depression is present. Exhibit 10 and subsequent sections discuss the major social problems, identified through stakeholder interviews that are linked with depression.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Social Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>• Depression can lead to communication breakdown between spouses and other family members.</td>
</tr>
<tr>
<td></td>
<td>• Depression, when not properly treated, may lead to strained relationships, discord and even divorce.</td>
</tr>
<tr>
<td>Families</td>
<td>• Depression can cause an individual to withdraw as a cohesive member of the family unit.</td>
</tr>
<tr>
<td></td>
<td>• Family members are often required to provide both physical and emotional support which can cause financial difficulties, negative emotional reactions and stress.</td>
</tr>
<tr>
<td></td>
<td>• Depression causes disruption to normal routines.</td>
</tr>
<tr>
<td>Children and Adolescents</td>
<td>• Children with untreated depression often suffer poor academic achievement.</td>
</tr>
<tr>
<td></td>
<td>• Depressed children are at risk for delinquent and antisocial behavior and for dropping out of school and rapid, repeated adolescent pregnancies.</td>
</tr>
<tr>
<td>Suicide</td>
<td>• Suicide is the third leading cause of death among young people ages 15 to 24.</td>
</tr>
<tr>
<td></td>
<td>• Suicide is the eighth leading cause of death for all United States men.</td>
</tr>
<tr>
<td></td>
<td>• Suicide has a direct economic cost of $5.5 billion per year.</td>
</tr>
</tbody>
</table>

Relationships

Depression and its affects on interpersonal relationships is a serious concern. Depression, if not recognized or treated properly, can cause stress in an individual’s relationships or marriage. When a spouse or significant other is depressed, there often is misunderstanding about why the depressed partner is acting or feeling a certain way. This can cause a communication breakdown, which can reinforce an individual’s isolation and unwillingness to admit that they need help or must recognize that there is a problem. According to the DBSA Survey of Patients, Partners and Health Professionals, about half of patients and partners report that depression has a negative impact on their relationship and more than two thirds of patients and partners report
that depression has caused a feeling of distance or isolation, avoidance or withdrawal, lack of communication, anger or conflict and lack of physical intimacy.126

The relationship strain, misunderstanding and miscommunication resulting when one partner has depression may lead to discord and divorce. The majority of stakeholders interviewed stated that discord and divorce in relationships were devastating factors associated with untreated or undiagnosed depression. Another concern is that if one partner suffers from depression, the other partner may have a subsequent increased likelihood of developing depression.127 An unsatisfying or difficult relationship or marriage can be a stressor that acts to intensify an individual’s depression, creating a downward cycle.

**Families**

It is estimated that one in four families has at least one member currently suffering from a mental or behavioral disorder. Depression in a parent, child or spouse is a major source of pain and suffering among families. Life often becomes increasingly disrupted as the depressed family member withdraws from daily activities and interaction. Feelings of guilt can arise in both spouses and children for causing the illness if it is not addressed in open communication. In addition, family members are often forced to make comprises in their own lives, setting aside major portions of their time to attend to a suffering family member.

Post-partum depression and parental depression, especially among mothers, can not only place stress on any existing family structure, but can cause developmental and behavioral issues with children. Children of untreated depressed mothers have significantly more problems with behavior and school achievement.129

**Children and Adolescents**

Depression among children and adolescents is a trend that needs to be recognized and addressed. One source estimated that an average of two percent of school-aged children, between the ages of 6 and 12, appear to have a major depression at any one time.131 There have also been cases where depression is diagnosable between children aged two to five.132 Depression becomes increasingly prevalent as children reach adolescence. According to the most recent National Survey on Drug Use and Health, the rate of a major depressive episode during a 12-month span among youths aged 12 to 17 was nine percent.133 Prevalence of MDD increases as children and adolescents get older, as shown in Exhibit 11.
Many stakeholders pointed out that higher rates of stigma were attached to adolescent and childhood depression. Behavioral changes or mood swings are often attributed to adolescent hormones and to the fact that children are just “going through a phase.” The fear of labeling children with a mental illness may prevent some providers from giving youth these diagnoses. When a child is properly diagnosed with depression, accessing adequate treatment is difficult for many families who do not have private health insurance or who face challenges in navigating the complexities of the system. There are significant social and economic costs when a child is not properly treated for depression.

Similar to adults, children and adolescents with depression often experience behavioral changes as part of the illness – often they are no longer interested in spending time with family and friends, there is a lack of interest in certain activities and they often criticize themselves and lose self-esteem. If not properly diagnosed and treated during onset, it can lead to poor academic achievement, behavioral problems, substance abuse and even suicide. Optional screening for depression should be available for children with their parents consent. Depression can have long-term effects, as these children grow up and are limited in their ability to become productive members of society.

3.2 Key Opportunities for Reducing the Economic and Social Burden of Depression

Depression affects not only the individual suffering from the illness, but also has economic and social implications for the extended community in which that person lives. Families, employers, public and private payors and providers must all play a role in affecting change. Otherwise, health care costs and the economic burden will continue to rise and families will break down.

Depression is an illness that can be treated successfully, however, if not properly diagnosed, depression will continue to impose unnecessary and severe economic and social costs on American society. The following section represents opportunities for stakeholders to improve the economic and social burden that results from depression.

**Stakeholders:**
- Payors
- Employers

**OPPORTUNITY**

*Introduce disease management programs and preventive care in the workplace.*

Employers and health plans must work together to create a positive, supportive environment for those suffering from depression. Employers should make accommodations for individuals with depression, such as flexibility in scheduling. Depression screening could also be offered at work. Providing disease management programs in the workplace will increase the successful management of depression among employees and help defray some of the indirect costs employers incur when employees remain untreated.
If appropriately integrated with other disease management programs, preventive and proactive care programs can also address concerns and expenditures caused by comorbidity. When employers and their health plans work in unison, delivering a consistent message, the costs associated with medical illness as well as mental illness can be reduced significantly and the quality of care improved. This can limit the financial costs associated with undetected depression in chronically ill patient and minimizing severe episodic cases of depression which often can result in costly inpatient treatment.

**OPPORTUNITY**

**Promote Employee Assistance Programs (EAP) within the workplace.**

Promoting EAPs is a cost-effective opportunity for employers and health plans to manage depression among employees. EAPs are designed to assist employees by providing a service that can help identify and resolve personal concerns or help individuals who have subsyndromal depression and do not require major mental health treatment. EAPs can help decrease direct and indirect costs by providing employees another avenue to access mental health professionals.

Including EAPs in the workplace can lead to an environment free from stigma and focused on self-empowerment for individuals living with depression. These programs can improve productivity and reduce absences and disability associated with depression. According to the United States Department of Labor, for every $1 invested in an EAP there is a $5 to $16 dollar savings in health care costs.¹³⁵

It is incumbent on managers and supervisors to encourage employees to utilize disease management and EAPs if an employee may be depressed or facing a personal burden that is affecting their ability to perform at work. Creating an environment where employees feel comfortable disclosing that they or someone close to them has a mental illness like depression and utilizing resources available to treat that illness will allow for a more productive workplace.

**OPPORTUNITY**

**Improve treatment within the criminal justice system to address disease management.**

Recidivism within the criminal justice system is a major problem, especially among individuals with untreated or mismanaged mental illness. Improved treatment designed to manage depression and work towards recovery instead of focusing solely on the reduction of symptoms can greatly improve outcomes once the individual is released from prison.

These types of improvement will not only reduce incarceration of depressed inmates, it will limit the impact on other types of public health assistance due to inpatient treatment, because of the reduced need for acute care treatment. Providing inmates with adequate diagnosis and treatment and educating them about how to properly
manage their illness will afford them a greater opportunity to return as productive members of society.

**Stakeholders:**

- All Stakeholders

**OPPORTUNITY**

*Increase awareness of the prevalence of co-occurring chronic illnesses and depression.*

Comorbidity is common with depression. Increasing public awareness of the potential for depression for those individuals suffering from other chronic medical conditions, as well as training providers to ask the right questions to detect depression in chronically ill patients, will have positive economic outcomes. Educating primary care physicians, physicians in other specialty areas, family members and individuals is critical in order to minimize the costs associated with co-occurring diseases.

**Stakeholders:**

- Payors
- Providers

**OPPORTUNITY**

*Implement treatment adherence programs for consumers.*

Properly diagnosing depression and commencing therapy is only the first step in the treatment process. Unless consumers and providers actively engage in treatment adherence, outcomes will not improve. A critical step for providers is to regularly follow up after prescribing an antidepressant. According to a recent study, 47 percent of consumers discontinued medication therapy after only 60 days of treatment. Additionally, lack of adherence can lead to other increased costs. Total annual average health care charges were highest in patients who changed antidepressant medication and lowest for consumers that remained on the initial therapy for more than 90 days.

Educating the consumer about the potential side-effects and the length of time it takes for medications to work is one solution to improving adherence. Direct follow-up with patients at different intervals throughout treatment through phone calls, email reminders and through automatic appointment scheduling are opportunities to maintain contact with patients and ensure that they are properly managing their condition. Involving patients in their own care decisions and making recovery the goal of treatment plan can lead to improved adherence.

**Stakeholders:**

- All Stakeholders

**OPPORTUNITY**

*Promote open communication and therapy for depression within families and communities.*

Addressing depression among families and communities is critical in order to create an environment of support and understanding. Ignoring the existence of depression only increases tension and negatively affects treatment outcomes. Open communication about the illness, its causes and treatment programs leads to better overall care.
Suicide is preventable. There are often signs that appear long before an individual attempts to take their own life. Unfortunately, these signs are often missed or not taken seriously and the result can result in the loss of a loved one. This point echoes stakeholder interview results which emphasize the need for early screening and detection of depression, along with effective implementation of early intervention, especially among at-risk populations.

It is critical that as the elderly population increases, providers and family members increase their awareness of the increased risk of suicide among the elderly. The risk for committing and attempting suicide increase with age. White men 85 and older have a suicide rate that is six times that of the overall national rate.\textsuperscript{138} Approximately 75 percent of elderly patients who die by suicide had visited their PCP in the month preceding their suicide.\textsuperscript{139} Physicians can miss the signs, especially when treating a patient for an underlying co-occurring medical condition. Depression-related suicide among adolescents is also rising. Educating parents, friends, siblings, teachers and physicians specializing in adolescent medicine about the warning signs is necessary to reduce adolescent suicide in the United States.
4.0 Access to Care

Inadequate access to care is a major hurdle for patients seeking treatment for depression. Societal, health system and individual constraints all contribute to limited access to care. These barriers result in a mental health system that is not adequately accessible and often non-responsive to consumer needs. This section will examine these issues in more detail and enumerate opportunities to improve access to consumers facing depression.

4.1 Current State

Recovery from depression is difficult to impossible without access to appropriate mental health treatment. However, approximately half of consumers who experience depression do not obtain access to proper treatment. Inadequate access has been a primary constraint to the development of a robust national mental health system. The current system is constrained at multiple levels, which include societal, health system and individual factors. These barriers result in a mental health system that is not adequately accessible and often non-responsive to the needs of those suffering from depression.

Stigma and fear, inadequate public awareness and education, insufficient funding, fragmentation of services and lack of resources are among the most formidable barriers to mental health care access. This section addresses the consequences of these barriers and potential opportunities for improvement to achieve more broadly reaching mental health care. The development of a robust mental health system is only possible if and when these constraints are addressed or eliminated.

4.1.1 Stigma

One of the major barriers to access of mental health services is the stigma surrounding mental illness. While recent public awareness and education campaigns have helped to decrease stigma, it is still one of the most prominent access barriers for the American consumer. Stigma may lead to discriminatory practices in employment and housing and cause others to socially avoid individuals with depression. Stigma is caused by misperceptions, ignorance and fear of individuals with mental illness. Individuals with depression and other mental illness may be looked upon as weak or lazy, as others expect them to “just snap out of it,” since they do not believe depression is a “real” illness. The public often perceives individual with mental illness as violent or responsible for their condition. Individuals with depression often become isolated, staying at home and having difficulty getting out of bed. As a result, the public only associates disruptive social behavior with mental illness, unaware of the quiet, internal struggle of many individuals with depression. These fallacies are a result of lack of education and awareness about mental illness and depression. As a result, individuals may be reluctant to seek care.

Stigma may disproportionately affect individuals in different contexts and in different demographic subgroups. Stigma surrounding depression in the workplace was one area of concern mentioned in stakeholder interviews. Individuals with depression often fear that misperceptions about their illness will affect their employment or how coworkers treat them at work. In one published study, only 41 percent of employees surveyed indicated they could acknowledge that they had depression without jeopardizing...
potential for career advancement and only 37 percent of benefit managers surveyed provided depression education for the employees they support.\textsuperscript{140} Stakeholders indicated that employers could play an important role in educating employees on depression and available services, identifying employees with depression and facilitating adequate treatment of depression. A variety of employer initiatives have been developed to increase access to mental health services, such as framing mental health programs as “behavioral health,” group coaching or positive skills training.

Stigma a significant problem in the primary care provider (PCP) office. Some individuals may only seek mental health care from PCPs because they are unwilling to see mental health specialists due to stigma or because their insurance plans require them to seek the care of a PCP. According to stakeholder interviewers, stigma against individuals with mental illness also translates into discriminatory health insurance reimbursement practices, which can affect treatment practices in the primary care setting. In some cases, physicians report deliberately substituting an alternative diagnosis for depression due to reimbursement concerns.\textsuperscript{142}

Stigma plays a particularly significant role among certain subgroups, including older adults, racial and ethnic minorities and individuals living in rural communities. A common perception is that depression is a normal part of aging, thus providers and family members may dismiss depressive symptoms in older adults.\textsuperscript{143} Older adults may also deny symptoms because of the negative perceptions of mental illness in that population. Among racial and ethnic groups, factors contributing to stigma include mistrust and fear of treatment, different cultural ideas about illnesses and mental health and differences in help-seeking behaviors.\textsuperscript{144} For example, research indicates an expectation of self reliance is deeply embedded in African-American\textsuperscript{145} and Latino-American cultures,\textsuperscript{146} decreasing willingness of individuals to seek mental health treatment. For individuals living in smaller, rural communities, confidentiality and anonymity is more difficult to maintain in health care settings and there may be less awareness and acceptance of mental illness.

4.1.2 Inadequate Public Awareness and Education

Public awareness and education about depression is lacking. The general public often does not understand depression or where to seek care. Many people do not understand depression or its episodic nature. As a result, people may not seek treatment or may stop treatment because they begin feeling better. According to the National Survey on Drug Use and Health, one of the most common reasons individuals in need of mental health care reported that they did not receive treatment is that they did not perceive the need for treatment or believe that they could handle the illness on their own.\textsuperscript{147}

In other cases, individuals may not know where to go to seek treatment for depression, as they do for other medical conditions. In the same survey, approximately 23 percent of individuals who had an unmet mental health need reported they did not know where to go for services.\textsuperscript{148} The complex private and public health insurance systems, which include behavioral health carve-outs, cumbersome outpatient authorization procedures and the complexity of benefit design, can create confusion and frustration for consumers, deterring access to treatment. Peer support and advocacy groups can help consumers feel more comfortable entering and navigating the system. Organizations such as DBSA, the National Alliance on Mental Illness, (NAMI), National Mental Health Association (NMHA) and Freedom from Fear (FFF), offer free or low-cost resources for those seeking treatment, yet are underutilized by providers, consumers and family members.

There are also misperceptions about the efficacy of treatment for depression. Patients may be unwilling to take medication for mental illness, fearing they will become addicted to medications or have to rely on

“Being a man, it was and still is hard not to try to hide all of my emotions, except for anger. I had crying bouts too numerous to list and went to the depths of despair because of my refusal to seek help despite my knowledge that I needed it.”

– Larry, Consumer\textsuperscript{141}
medications for the rest of their life. According to the DBSA General Public Survey, almost three fourths (74 percent) of the general public believed that medications change the patient’s personality and 67 percent thought medications are habit forming. Several stakeholder interviewees indicated that inaccurate perceptions or inadequate information about medication was a top barrier to access. They indicated that recent media coverage on the possible dangerous side effects of antidepressants has also reinforced the negative image of medication. In addition, they noted that the media does not adequately reflect the millions of people who have been treated successfully by medications and other treatment.

Improving education was identified as a key area to increase accessibility to treatment and reduce stigma. Growing awareness about the need for education has prompted the implementation of a variety of education programs such as:

- **Resource Center to Address Discrimination and Stigma (ADS Center):** SAMHSA’s ADS Center provides assistance in designing and implementing anti-stigma and anti-discrimination initiatives by disseminating and maintaining best practice information, policies, research and programs to individuals, states and local communities and public and private organizations.

- **DBSA Support Groups and Peer-to-Peer Resource Center:** DBSA chapters offer more than 1,000 peer-run support groups where consumers find comfort and direction in a confidential and supportive setting.

- **Real Men, Real Depression:** An NIMH initiative that provides educational material specifically targeted to men, with materials that specifically address stigma issues encountered by Latino-American males.

- **Depression Education and Health Promotion Project:** A collaboration of the University of Connecticut Health Center, schools and communities to provide depression education and health resources to 5th graders, their families and schools.

### 4.1.3 Insufficient Funding and Reimbursement

Inadequate funding and reimbursement is one of the most frequently cited barriers to care. Funding streams for mental health are often separate and limited in scope without coordination between private and public payors. Despite increasing Federal attention on mental health issues, Federal and state funding for mental health services has been mixed, with some instances of budget increases and others of significant reduction. Funding for some important grant programs has increased, such as the additional $6 million for Mental Health System Transformation Grants (discussed in Section 2.0, the Landscape). However, funding for other government programs, such as Medicaid, may receive significant budget cuts over the next five years.

Reimbursement systems under managed behavioral care is also insufficient. The lack of parity in mental health insurance is one of the most troubling barriers to accessing mental health services. Health insurance companies often put limits on per episode reimbursements and charge higher copayments for mental health services. In order to reduce the life time cost of undertreated depression, a shift to providing payment for mental health services that are equal to other medical conditions should be implemented in both public sector programs and by private payors.

While the specific issues may vary, reimbursement issues exist for individuals with both private and public health insurance. For many private employer-sponsored health insurance services, provider networks and
medication formularies lack flexibility, which can be a barrier to accessing adequate treatment. Policies that have more restrictive networks often result in longer wait times for consumers to get an initial outpatient appointment. Public health insurance, such as Medicare and Medicaid, often have lower reimbursement rates than private health insurance. As a result, some providers will not accept public insurance, limiting the number of available providers. These issues often result in consumers not seeking help at all or giving up on treatment and becoming more severely depressed – ultimately leading to much more costly intensive care.

Current reimbursement procedures also do not give providers incentives for identifying new cases of depression or managing complex cases of chronic depression. Since reimbursement for many providers is based on the number of patients they see, they are not encouraged to take the time to screen new and existing patients for depression. Providers may be more reluctant to take on new patients if the reimbursement for an initial diagnostic evaluation is lower than performing other standard medical care. Additionally, providers may be unaware of the range of coding options available for the longer encounter times and titration of medications typically necessitated by patients with depression. As a result, there is a lack of screening and early intervention.

Screening has been shown to be effective at identifying depression and improving treatment outcomes with appropriate follow-up care. Since depression can manifest itself in a wide variety of physical signs and symptoms and consumers may be reluctant to discuss their emotions and mood, depression is often misdiagnosed. One study found that 69 percent of consumers who are diagnosed with depression present with physical symptoms as their chief complaint. Systematic screening procedures to identify depression and other mental health problems are critical to help clinicians make a differential diagnosis between physical symptoms and underlying depression. Some payors have begun increasing payments for providers who actively screen and talk with patients to diagnose depression.

4.1.4 Fragmentation of Mental Health Care System

The current mental health care system is fragmented and disorganized. While fragmentation has been cited as a barrier to access for several years, gaps remain. Priority areas include treatment in primary care settings, coordination between different service sectors and care of individuals with comorbidities, such as substance abuse disorders or general medical conditions.

Data indicates that treatment for depression is most often sought with the consumer’s PCP. While PCPs offer an important point of access to mental health treatment and have helped more consumers receive treatment, fragmentation problems often occur. PCPs time constraints and lack of expertise with diagnosing and treating depression can impede access to appropriate treatment through inadequate assessment, treatment and follow-up. Though many PCPs are knowledgeable and adequately trained pharmacologically to treat consumers for depression, PCPs often do not refer consumers to psychotherapy, peer support and other recovery oriented treatment options that are available to the consumer. Only about 28 percent of individuals with self-reported depression received at least one psychotherapy or counseling visit in the past year, despite the fact that there is a multitude of data that suggests that a combination of psychotherapy and antidepressant medication is more effective than treatment with medication alone. Providers, especially PCPs, must improve their knowledge and awareness of depression in order to ensure consumers are able to access appropriate treatment. Their role as a gate keeper to medical services makes it all the more important that they have the appropriate knowledge and tools to diagnose depression and either provide or refer patients to the appropriate services.
Fragmentation is also apparent in the distinct silos and across the different disciplines that provide treatment for depression, including PCPs and mental health specialists, such as psychiatrists, psychologists and clinical social workers. There is often little or no communication or coordination of care between a mental health consumer’s prescribing physician and the consumer’s additional treatment professionals. This leads to problems in follow-up and continuity of care. Efforts to improve coordination and continuity of care could ensure consumers get access to adequate care.

Fragmentation in the mental health system is a significant problem for individuals with both mental illness and substance abuse problems. Depression and substance abuse commonly co-occur; as many as one in three consumers who have depression also have a co-occurring substance abuse or dependence. In a recent survey of 14,923 consumers, 11 percent of the adults and 17 percent of the adolescents with a diagnosis of depression had co-occurring substance abuse problems. Much of the health care infrastructure is designed to address only one condition or the other. This fragmentation involves issues of training, licensing, location of services, treatment modalities and philosophies of providers, as well as competition for funding and other resources. This creates formidable barriers to treatment access for consumers with co-occurring depression and substance abuse conditions – consumers who especially need comprehensive and integrated care.

Fragmentation is also a significant issue for individuals with comorbid medical conditions. Depression commonly co-occurs with other types of somatic illnesses, such as chronic pain, cancer, diabetes, various cardiovascular problems and auto-immune diseases. These co-occurring conditions can affect treatment access because the consumer’s presentation is complicated when depression is accompanied by one or more of these comorbid conditions. Additionally, depression may increase morbidity and mortality rates by affecting self care and treatment adherence. Successfully treating consumers with comorbidities requires addressing both co-occurring conditions and integrating mental health and general medical care.

4.1.5 Lack of Resources

Fragmentation of the mental health care system is compounded by a lack of resources, at the system, provider and consumer levels. At the system level, there is an inadequate supply of mental health providers. Training and education for providers may be inadequate. Consumers often lack the resources necessary to seek care, including health insurance, income, transportation and other social support.

The lack of available providers, particularly psychiatrists and mental health providers who specialize in children, adolescents and the elderly is a critical need within the mental health care system. The growing number of mental health consumers has far outpaced the number of medical students graduating with a specialty in psychiatry and other qualified providers. As a result of this shortage, many consumers have to wait weeks or even months before receiving mental health treatment. There is a severe lack of mental health providers experienced in proven psychotherapies, including cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). Pediatric and geriatric specialists and mental health providers in rural areas are particularly in demand.

Access to appropriate medications is critical to providing adequate treatment for those suffering from depression. A lack of prescription drug coverage or formulary structures for those with prescription drug plans may limit the availability of antidepressants to individuals in need. Individuals with treatment resistant depression or other chronic illnesses who require certain types of antidepressant drugs that may not be on a formulary often face additional barriers and higher out of pocket costs for appropriate psychotropic medication. The Medicare Part D prescription drug benefit may provide an increase in the older adult population’s access to antidepressants and other medically necessary prescription drugs. Under Part D, plan formularies must include at least two drugs within each therapeutic class and one may be generic.
Many consumers lack adequate resources to seek treatment, such as health insurance, income and transportation. Homelessness, addiction, unemployment and lack of education are also obstacles to getting necessary treatment for depression. Lack of resources may disproportionately affect racial and ethnic minorities and individuals in rural communities, who often have lower incomes and lower likelihood of having health insurance. For example, African American and Latino patients are significantly less likely to receive any treatment for depression and less likely to fill an antidepressant prescription than Caucasians. More information on the adequate and appropriate treatment for these groups is provided in the Treatment section.

There are a variety of issues that cause barriers to access of proper mental health care. These barriers have different implications for the consumer. These implications are summarized in Exhibit 12.

### Exhibit 12. Access Issues, Barriers and Implications

<table>
<thead>
<tr>
<th>Access Issue</th>
<th>Barriers</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma and Fear</td>
<td>Many consumers will not access treatment for fear of discrimination by peer group, insurance provider or workplace.</td>
<td>Consumers are less likely to access treatment, even if it is available to them. Even if the PCP diagnoses depression and offers treatment, the consumer will often refuse it.</td>
</tr>
<tr>
<td></td>
<td>For some groups of consumers, there is a strong culture of self-reliance. Their fear manifest itself in the form of more acute stigma against seeking treatment for depression.</td>
<td></td>
</tr>
<tr>
<td>Inadequate Public Awareness and Education</td>
<td>Many Americans lack an understanding of the nature of depression and appropriate treatment available for depression. Consumers may not know where to go to seek treatment or have difficulty navigating the complex mental health system.</td>
<td>Consumers will forgo care and do not receive adequate treatment. Consumers may seek treatment for a physical symptom, such as head aches, not knowing it is related to depression.</td>
</tr>
<tr>
<td>Insufficient Funding and Reimbursement</td>
<td>Public and private funding streams for mental health services are limited and uncoordinated. Both public and private health insurance limits mental health coverage. Medicare only provides 50 percent coverage for mental health treatment. Many Medicare recipients have lower incomes, may be financially dependent on social security and cannot afford a 50 percent co-payment. Consumers seek out their PCP first to access treatment for depression, but PCPs’ reimbursement structure is not set up to allow them to take the time required to properly screen, diagnose and treat depression.</td>
<td>Consumers will often not get properly diagnosed, resulting in treatment for a symptom of depression, not the underlying cause. Without proper treatment, consumers will often suffer more serious medical problems that are more costly to treat than timely intervention for depression.</td>
</tr>
<tr>
<td>Fragmentation of the Mental Health Care Delivery System</td>
<td>Consumers are often unsure of how to access treatment for depression. While PCPs prescribe medication, they often do not refer patients to psychotherapy or other specialty care. PCPs and specialty providers may not communicate or coordinate care effectively. PCPs may not have the appropriate knowledge, training or tools to diagnose depression.</td>
<td>Consumers either have no access to treatment at all or receive “one-time” treatment at the PCP office in the form of a prescription for depression or only prescription for a physical ailment. Both are often inadequate to achieve and sustain recovery from depression.</td>
</tr>
<tr>
<td>Lack of Resources (Service providers, programs and facilities)</td>
<td>Some consumers cannot access treatment for depression because of the lack of providers in their area or the long waiting times to get an appointment. Consumers may not be able to access treatment, because they cannot afford out-of-pocket costs.</td>
<td>The consumer may have to seek treatment in an emergency room or be hospitalized, which is the most costly form of treatment.</td>
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</tbody>
</table>
These access barriers cause many individuals with depression to go undiagnosed and untreated. The financial and emotional consequences of untreated depression are substantial. For example, individuals with depression have more lost work days, higher health care costs, disrupted family and social relationships and increased risk of suicide.

4.2 Key Opportunities for Improving Access to Care

Assuring that all Americans have access to treatment for depression is critical. The vast majority of individuals with depression – 80 percent or more – show improvement in their depression when they receive appropriate treatment. However, only half of consumers who experience depression access treatment. All stakeholders can play a key role in improving access to care, through a variety of mechanisms. For example, both public and private payors should provide the appropriate incentives, reimbursement levels and education to improve access to mental health services. The following section represent opportunities and strategies for stakeholders to improve access to treatment for depression.

<table>
<thead>
<tr>
<th>Stakeholders: Employers</th>
<th>OPPORTUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide education about depression to employees and create a stigma-free work environment.</td>
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</tbody>
</table>

Many employees do not know what their mental health benefits are or how to access them. Many consumers will not access EAPs for help with depression due to fear it will adversely affect their careers. Untreated depression in the workplace results in losses of billions of dollars in lost productivity. Employer sponsored education programs can reduce the access barrier of stigma and misinterpretation.

<table>
<thead>
<tr>
<th>Stakeholders: Payors, Employers, Policymakers</th>
<th>OPPORTUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve reimbursement for PCPs to take the time to screen, diagnose and treat depression.</td>
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</table>

The majority of consumers access treatment from their PCP, who often does not have the necessary time to adequately address depression. Payors can provide incentives for PCPs to screen, diagnose and treat depression through higher reimbursement rates. Payors should educate their physician network on procedures for diagnosing, treating and seeking reimbursement for depression. Some managed care companies are already addressing this opportunity.
OPPORTUNITY

Provide easy-to-use mechanisms, such as a website or a dedicated toll-free telephone number, for PCPs to easily alert the payor when a consumer needs to be referred to a mental health specialist.

Many consumers who seek treatment for depression from their PCP do not always receive adequate follow-up. Consumers are much more likely to show improvement if their PCP is able to link them with specialized services for mental health. They are also more likely to follow up with a mental health specialist when that referral process is established before leaving the PCP's office. Payors should implement tools that will allow PCPs to initiate this process in an easier manner than is available today. Some payors have implemented toll-free numbers or websites for PCPs to use to do this. Widespread adoption of easy to use tools such as these can improve the referral process and help ensure that consumers are linked to the appropriate mental health services in a timely manner.

OPPORTUNITY

Offer higher rates of reimbursement or bonuses to providers who agree to practice in designated shortage areas.

Many consumers, particularly those who live in rural areas, cannot access treatment because there are too few or no providers in their area. This often results in consumers only being able to get treatment in a hospital, after their condition worsens. If consumers could access outpatient treatment in their own geographic area, they are more likely to improve and much less likely to require more intensive treatment, such as hospitalization. Stakeholders interviewed believe that higher reimbursements may incent providers to work in these areas.

OPPORTUNITY

Provide the same coverage for mental health services and treatments as for other medical conditions.

Consumers who receive Medicare only receive 50 percent coverage for mental health treatment and additional limitations are placed on individuals with private health insurance plans. Consumers who cannot afford treatment can suffer significant consequences. Untreated depression can exacerbate other co-occurring medical problems, cause other medical problems to occur and can be life-threatening. Treating depression early can minimize or prevent co-occurring medical problems.
Support is a critical element of depression recovery, which can be provided by support groups and other peer-to-peer support services. However, most consumers are not aware of such groups or services. Consumers may receive their initial encouragement to seek treatment from a peer support group. Peers and advocates also help consumers navigate the complex mental health care system and support adherence to treatment, leading to quicker recovery in some cases.

In some minority groups, the culture of self-reliance is so strong, that consumers in that group are often reluctant to access treatment. Such groups may be more likely to access treatment if they felt depression is a real illness and that it was acceptable to reach out for help within their community. An example of one successful program addressing these types of cultural issues is NIMH’s Real Men, Real Depression campaign which targets Latino-American males and provides Spanish language materials to them.

Many of those incarcerated have mental health problems, including depression. Those who are able to access treatment once released are less likely to be reincarcerated. It is more cost effective to provide mental health treatment as part of the rehabilitation process, than to pay for repeated incarcerations.

The demand for mental health providers is exceeding the supply. The shortage of mental health providers, specifically psychiatrists, is an access barrier to all consumers. More providers would improve access to early intervention and reduce the costly impact of depression.
5.0 Treatment and Emerging Recovery Methods

Despite misconceptions to the contrary, depression is a very treatable illness. A wide spectrum of treatments exists with documented efficacies that have made an impact on individuals suffering from depression.\textsuperscript{160} The National Institutes of Health report that “more than 80 percent of people with depressive disorders improve when they receive appropriate treatment.”\textsuperscript{161} Depression is a complex and serious medical condition that impacts individuals physically, emotionally and mentally. Accordingly, treatment of depression is a multifaceted undertaking, with the road to recovery incorporating many elements. This section describes key issues surrounding treatment of depression along with the emerging recovery methods and philosophies that are gaining momentum and support among both providers and consumers.

5.1 Current State

Treatment of depression has evolved significantly over the last half of the 20\textsuperscript{th} and the beginning of the 21\textsuperscript{st} Century. Medical treatment models which focus on reduction, elimination and control of symptoms are increasingly used in conjunction with psychosocial treatment models. These models incorporate methods such as counseling, psychotherapy, cognitive therapy, social skills training and peer support - focusing on overall improvement in quality of life and recovery.\textsuperscript{162,163} However there are still many issues related to the treatment of depression that must be addressed in order to increase the effectiveness of treatment for consumers. These issues are highlighted in Exhibit 13.

<table>
<thead>
<tr>
<th>Treatment Topic</th>
<th>Issue</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Modalities</td>
<td>• Need to increase knowledge and awareness among providers of the appropriate use of antidepressants, new medical technologies, psychotherapy and other emerging recovery tools such as peer support, wellness action recovery programs (WRAP), pathway to recovery workbooks, among others.</td>
<td>• Treatment selection is one of the most important factors that will impact an individual’s ability to recover from depression. Inappropriate treatment and non-adherence to treatment regimens can be detrimental to progressing towards recovery. The use of recovery tools from the beginning of treatment infuses self-reliance and builds on consumer strengths, leading to recovery.</td>
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<tr>
<td></td>
<td>• Need to increase patient adherence to medication therapies by improving their understanding that time and adjustments to medication selection are required to achieve the full benefit of treatment.</td>
<td>• Medication, when positioned as one part of a holistic recovery plan, is more likely to be seen as important to the consumer. Adherence increases as understanding of one’s own recovery plan increases.</td>
</tr>
<tr>
<td></td>
<td>• Need to increase patient adherence with medication therapies by ensuring they are just one part of a multifaceted plan to help consumers achieve their recovery goals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Need to increase patient adherence to psychotherapy by educating them about the time and personal investment that is needed in order to make progress towards recovery.</td>
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</tr>
</tbody>
</table>

“We have to make sure that everybody understands that this is a recognizable illness and one that can be treated very effectively.”
– United States Surgeon General, January 2006
<table>
<thead>
<tr>
<th>Treatment Topic</th>
<th>Issue</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management/Coordination of Care</td>
<td>• Difficulty in obtaining referrals in a timely manner or to the appropriate type of mental health provider or service.</td>
<td>• Lack of coordination of care across providers and across the different components of the mental health system hinders the ability of providers to effectively manage depression treatment and for consumers to navigate the mental health system.</td>
</tr>
<tr>
<td></td>
<td>• Managing co-occurring illnesses in addition to managing the depression treatment itself.</td>
<td>• Inability to effectively manage treatment for individuals with depression can have an adverse impact on their ability to move towards recovery, especially for those individuals who have co-occurring illnesses.</td>
</tr>
<tr>
<td></td>
<td>• Need to improve coordination across the different components of the mental health system including providers, the education system, the justice system and the welfare system.</td>
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</tr>
<tr>
<td>Detection and Treatment</td>
<td>• Studies indicate there is an average gap of approximately five years between symptom onset and diagnosis and treatment of depression.</td>
<td>• Untreated depression has significant societal and social costs such as lost person hours and productivity in the workplace and deterioration in relationships, underscoring the value of early detection and treatment in order to avoid these costs.</td>
</tr>
<tr>
<td></td>
<td>• Primary care providers and other individuals who serially enter points into the health care system may not be appropriately equipped to diagnose depression, especially in its early and less severe forms.</td>
<td>• Treating depression in its more advanced stages costs significantly more for both the mental health system and the consumer.</td>
</tr>
<tr>
<td>Consumer-Driven Treatment and Consumer Empowerment</td>
<td>• Consumers (and their families) do not often feel like they have a role in their treatment plan, which often reinforces any feelings that they do not have the power to control their lives.</td>
<td>• Consumers (and their families) often feel frustrated with treatment programs that they have not had a role in selecting, leading to decreased adherence to treatment and reduced ability of an individual to recover.</td>
</tr>
<tr>
<td></td>
<td>• Treatment selection does not always take into account non-physiological issues, such as finances or relationships.</td>
<td>• Case management is often done in isolation without the input of the consumer and without being individualized to the consumer, recovery can be hindered.</td>
</tr>
<tr>
<td></td>
<td>• Treatment selection does not always take into account consumers’ personal goals, preferences or circumstances.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tools such as case management are not always based on consumer strengths and personal goals.</td>
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</tr>
<tr>
<td>Peer Support</td>
<td>• There is a critical need for additional services such as peer support programs to fill the gaps in treatment and to address the isolation, reduced social functioning and alienation felt by individuals with depresions.</td>
<td>• Individuals with depression (and their families) often feel isolated, have reduced social functioning and feel that they are not understood by those trying to help them.</td>
</tr>
<tr>
<td></td>
<td>• There is a need to improve provider and payor awareness and implementation of peer support programs.</td>
<td>• Individuals with depression, especially minorities, the homeless and those who have had negative experiences with traditional providers often feel alienated from the mental health system.</td>
</tr>
<tr>
<td></td>
<td>• There is a need for free or inexpensive programs, such as peer support, that are easily accessible and can be used as an additive to traditional care.</td>
<td>• Traditional providers of care have limited time to treat patients and access to these providers can be difficult and expensive.</td>
</tr>
<tr>
<td>Cultural Competency</td>
<td>• Racial and ethnic minorities often face greater financial limitations, transportation barriers, lack insurance and have less access to culturally competent information regarding depression and its treatment.</td>
<td>• Lack of information regarding cultural differences can result in less help-seeking behaviors and underutilization of treatment programs.</td>
</tr>
<tr>
<td></td>
<td>• Consumers may not be able to communicate effectively with providers who cannot speak their language.</td>
<td>• Inability to communicate effectively due to language barriers and a lack of understanding of cultural differences often results in improper diagnosis, miscommunication regarding treatment, non-adherence with treatment and diminished recovery.</td>
</tr>
<tr>
<td></td>
<td>• Providers are not always equipped to understand cultural differences that may impact diagnosis and treatment effectiveness.</td>
<td></td>
</tr>
<tr>
<td>Recovery-Oriented Treatment</td>
<td>• Depression manifests itself in ways beyond physical symptoms and changes in physiological functioning.</td>
<td>• Focus on symptom relief and not on overall recovery can hinder an individual’s ability to recover from depression. This approach focuses on a person’s weakness, whereas recovery focuses on and builds upon strengths in order to achieve wellness.</td>
</tr>
<tr>
<td></td>
<td>• Treatments that focus solely on symptom relief do not address other aspects of depression such as social functioning, inability to find meaning in life or the desire to feel a part of one’s own community.</td>
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</tbody>
</table>
5.1.1 Common Treatment Modalities

Antidepressants

Antidepressants are widely and successfully used to treat depression. Some key indicators of the widespread use of anti-depressants in the treatment of depression can be found in a survey conducted by DBSA in 2000 of 1,001 individuals with depression, 881 primary care physicians and 716 therapists or counselors who treat individuals with a diagnosis of major depression. This study found that 97 percent of primary care physicians said they would normally prescribe antidepressants for (newly diagnosed) individuals diagnosed with major depression as part of their initial course of treatment. This same study also found that psychopharmacological care is seen as effective by the majority of individuals treated for depression by primary care providers.

The most commonly prescribed antidepressant medications are described in the box at right.

While use of antidepressants is extensive in the treatment of depression, providers and patients must consider certain aspects of treatment. Patients react differently to medications and it is difficult to predict an individual’s response to a particular drug regimen with a high degree of certainty. It often takes from several weeks to well over a month before the effectiveness of a drug treatment regimen can be determined and for the full therapeutic effect to be realized, after which adjustments in dosage and combinations of drugs are often made. A recent consumer survey revealed that more than 50 percent of respondents who took antidepressants had to try two or more drugs before finding one that was both effective and had an acceptable side effects profile, while 10 percent had to try five or more drugs before finding a drug regimen that was effective. Patients must be informed that a certain degree of trial and error will be a part of finding the drug regimen that will work for them and that adherence to the drug regimen is essential to finding an effective drug treatment.

“I was diagnosed with depression about three and a half years ago. I had a hard time at first understanding that it wasn’t just something that I could change myself. I needed help. It took many times of trial and error with my medication. On three different occasions I just thought I was fine and stopped taking my medication. On each occasion, after about a month, I would relapse with my depression. Each time it would get deeper and deeper and harder to get out of. I finally realized how much treatment really helped me.”

– Alice, Consumer

There are currently a variety of treatment guidelines and algorithms outlining types of treatment, sequencing of treatment and length of treatment for the different phases of depression. Some of these include guidelines published by the American Psychiatric Association (APA) and the Agency for Health Care Research and Quality (AHRQ). Predicting response to medications is also a very active area of research. A key example of research in this area is the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, the largest medication treatment trial for major depression in the United States conducted to date. This study focuses on determining which treatments work best if the first medication prescribed does not produce an acceptable response. The study attempts to define subsequent treatment strategies along with their associated costs and cost-savings, looking specifically at the effectiveness of different treatment sequences and combinations.
Many individuals treated with antidepressants experience side effects such as impotence or somnambulism that are often debilitating and can severely impact quality of life. Experiencing these side effects, in addition to the symptoms that a person may already experience from the depression itself, can result in non-adherence to the drug regimen. Providers must ensure that patients are aware of this when prescribing a drug regimen for them to follow.

Many individuals with co-occurring illnesses are taking other medication that must be factored in when selecting medications to treat depression. Providers should ensure that they are aware of the potential drug-interactions that may occur given other medications a patient may be taking and only prescribe drugs that can be safely used in conjunction with these other medications.

There are many research findings that questioned the safety of antidepressants in particular demographic groups. Results from recent studies have led the FDA to direct pharmaceutical manufacturers to add a “black box” label to all antidepressant medications warning health care professionals of the increased risk of suicide in adolescents and children. Providers should ensure that they understand and take into account relevant safety considerations when prescribing drugs to patients with depression.

Use of antidepressants as a stand alone treatment may not address the full recovery needs for individuals with depression. Unless personalized attention is provided in the form of psychotherapy or other psychosocial therapies, patients may not be fully invested in the use of antidepressants as their main treatment and may not adhere to the drug regimen prescribed. Pharmacologic therapy should be just one aspect of a multifaceted plan to help consumers achieve their recovery goals.

**Psychosocial and Psychotherapeutic Treatment**

Psychosocial treatments focus on both the psychological and social elements of depression and utilize treatment approaches that are based on communication, sharing and, increasingly, community and/or family involvement. Psychotherapy, the most common form of psychosocial treatment, focuses on the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal of changing behavior, which can lead to improved social and vocational functioning, relief of symptoms and personality growth. Psychotherapy treatments that are used in treating individuals diagnosed with depression include (but are not limited to) cognitive therapy, behavioral therapy, cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), family therapies, couples therapies and psychoanalysis. The efficacy of CBT and IPT in treating depression has been the most well-documented. Exhibit 14 provides a brief description of several commonly used psychotherapies used in the treatment of mental illnesses including depression.

**Exhibit 14. Commonly Used Psychotherapies**

<table>
<thead>
<tr>
<th>Psychotherapy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Therapy</td>
<td>Cognitive therapy seeks to identify and correct thinking patterns that can lead to troublesome feelings and behaviors. Beliefs and expectations are explored to identify how they shape a person’s experiences. If a thought or belief is too rigid and causes problems, the therapist helps the client to modify his or her belief so that it is less extreme.</td>
</tr>
<tr>
<td>Behavioral Therapy</td>
<td>Behavior therapy, also called behavior modification or behaviorism, sets up rewards and punishments to change thinking patterns and shape behavior. Behavioral therapy can involve relaxation training, stress management, biofeedback and desensitization of phobias. Behavioral therapists help patients learn how to get more satisfaction and rewards through their own actions and how to unlearn the behavioral patterns that contribute to or result from, their problems.</td>
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</tbody>
</table>
### Treatment and Emerging Recovery Methods

#### Psychotherapy

<table>
<thead>
<tr>
<th>Psychotherapy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive-Behavioral Therapy</td>
<td>- Cognitive-behavioral therapy (CBT) helps a person to recognize his or her own negative thought patterns and behaviors and to replace them with positive ones. Used both with and without medication, cognitive-behavioral therapy is the most popular and commonly used therapy for the treatment of depression. A major aim of CBT is to reduce anxiety and depression by eliminating beliefs or behaviors that help to maintain problematic emotions. (^{175})</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
<td>- Interpersonal therapy (IPT) focuses on the patient's immediate social context, instead of the past, with a goal of improving current interpersonal relationships and social functioning. This type of therapy is usually conducted one on one with a trained therapist. (^{176})</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>- In group therapy, carefully selected patients meet in a group guided by a trained therapist and help one another with a goal of effecting personality change and improving interpersonal relations. A variety of techniques are used to direct the group's interaction and bring about changes. (^{177})</td>
</tr>
<tr>
<td>Family and Marriage Therapy</td>
<td>- A type of group therapy that focuses on altering the interactions among family members and attempts to improve the functioning of the overall family unit. Marriage or couples therapy focuses specifically on the interaction of two people in conflict with one another and attempts to improve communication, change negative patterns of behavior and encourage growth and development. (^{178})</td>
</tr>
<tr>
<td>Psychoanalysis / Psychodynamic Therapy</td>
<td>- Also called psychodynamic or psychoanalytic therapy, this type of treatment helps a person look inside himself or herself to discover and understand emotional conflicts that may be contributing to emotional problems. The therapist (psychoanalyst) helps the client &quot;uncover&quot; unconscious motivations, unresolved problems from childhood and early patterns to resolve issues and to become aware of how those motivations influence present actions and feelings. (^{179})</td>
</tr>
</tbody>
</table>

Recent studies provide evidence that psychotherapy combined with antidepressant therapy is associated with a significantly higher improvement rate than drug treatment alone. \(^{180}\) In longer term treatment, the addition of psychotherapy has been shown to have a lasting effect on patient wellness. \(^{181}\) Stakeholder interview findings indicate that the increasing recognition of the effectiveness of psychotherapy, combined with the increased scrutiny and awareness of the side-effects of antidepressants, is contributing to increased utilization of psychotherapeutic care in conjunction with pharmacologic therapy, instead of using one or the other as a stand alone treatment.

Additional psychosocial treatment options that empower the consumer and focus on wellness, healthy social functioning and recovery are slowly gaining increased momentum and support. Furthermore, their importance in achieving recovery is becoming more widely accepted. They include treatment options such as peer support, wellness action recovery programs, pathway to recovery workbooks, vocational training, social-skills training and other community-based and self-help oriented treatment options. There is growing evidence that the use of recovery tools such as previously described can improve an individual’s ability to recover from depression. Peer support, in particular, is gaining considerable acceptance. The most prominent and distinguishing feature of peer support is its emphasis on interaction with other consumers or “peers” as a method to foster feelings of acceptance and normality among consumers. More information on peer support is provided in Section 5.1.5.

**Other Treatment Options**

There are several other treatment options often utilized to treat depression and other mental illnesses. Some of these treatment options are used in conjunction with other therapies, for severe cases of depression or when other treatments fail to help. Demonstrating the efficacy of some emerging treatments will require additional testing, but those mentioned here are currently used in the treatment of depression, either as FDA approved therapies or as experimental therapies. Existing and emerging treatments for depression include:

- **Electroconvulsive Therapy (ECT).** In the 1930s, researchers discovered that applying a small amount of electrical current to the brain caused small mild seizures that changed brain chemistry. Over the years, much has been done to make this form of treatment, milder and easier for patients to tolerate. ECT is
used to treat approximately 100,000 patients with depression each year and it is generally used in patients who are unresponsive or unable to tolerate other commonly used treatments or medications. While severe cases of depression have responded favorably to ECT, there can be side effects such as confusion and memory loss. The procedure must be performed at inpatient facilities under general anesthesia.

- **Vagus Nerve Stimulation (VNS).** VNS involves implanting a pacemaker-like device which sends electric pulses into the vagus nerve, which is a critical conduit for relaying information to and from the central nervous system. In July 2005, the United States FDA granted final Premarket Application approval for VNS for “adjunctive long-term treatment of chronic or recurrent depression for patients 18 years of age or older who are experiencing a major depressive episode and have not had an adequate response to 4 or more adequate antidepressant treatments.” Results of the VNS pilot study showed that 40 percent of the patients treated displayed at least a 50 percent or greater improvement in their condition. The most common side effects reported by people who use VNS therapy are hoarseness, sore throat and shortness of breath. People with the VNS device are advised to follow the same precautions as someone who has a pacemaker for heart problems.

- **Transcranial Magnetic Stimulation (TMS).** TMS is also referred to as repetitive transcranial magnetic stimulation (rTMS). This experimental technique was developed in 1985 and has been studied as a treatment for mental illness since 1995. In TMS therapy, a special electromagnet delivers short bursts of energy to stimulate nerve cells in the brain. Preliminary studies have shown TMS is effective compared with placebo in relieving severe depression that has not responded to traditional therapies. Though these results are promising, more studies are needed to determine any long-term side effects and benefits.

- **Herbal and Natural Treatments.** There are several dietary supplements currently on the market that are advertised as having a positive impact on depression. They include (among others) Omega-3 essential fatty acids, St. John’s Wort, SAM-e, Ginkgo Biloba and Ginseng. While herbal and natural treatments are easily accessible, few studies have demonstrated their efficacy in treating depression. Different brands of supplements may contain unique concentrations of the active substance when processed in different ways, possibly resulting in various side effects. Consumers should be urged to consult their physician or pharmacist prior to using these as treatments.

5.1.2 **Case Management and Coordination of Care**

One of the President’s New Freedom Commission on Mental Health main messages is that the mental health services delivery system is fragmented and in need of transformation. There are several issues that contribute to this fragmentation. The managed care system is structured such that mental health care is managed and financed separately from traditional health care. Additionally, because of the large public sector component of mental health services, coordination across different institutions and organizations is especially critical. There are many different providers within the mental health arena that may be treating an individual for depression. Obtaining referrals to specialized providers can be difficult and time consuming, making it challenging to provide continuous and appropriate care. In addition, depending on the training, background or availability of a given provider, referrals to appropriate care may not be made at all. In fact, a recent poll of mental health consumers found that only 40 percent had been offered access to non-pharmacologic treatments, such as counseling and psychotherapy, despite the strong evidence that a combination of drugs and psychological treatments benefit people with mental health problems such as depression. Another challenge facing individuals who suffer from depression is the common co-occurrence of other illnesses that must be managed in parallel. This is particularly relevant in older adults who often have multiple chronic illnesses. Individuals with disabilities, minorities and low-income consumers face specific challenges in navigating the health delivery system due to physical, language or economic constraints.
The combination of all of these issues underscores the need for improved coordination of care for individuals with depression. Coordination of care helps to ensure that the depression is managed across all providers, including those treating depression and for any other co-occurring illnesses. Several different models have been implemented and evaluated for integrating treatment within the primary care setting, including the following:

- **Stepped care model**: Combines various interventions, including education of PCPs about evidence-based depression care, education of patients about adherence to treatment regimens and implementation of measures designed to encourage collaboration between PCPs and mental health specialists.

- **Collaborative care model**: Includes non-physician depression care managers in a consulting role, often located offsite. Studies have shown that this model is effective at decreasing the patients’ depression symptoms and adherence to treatment.\(^\text{188}\)

- **Integrated care model**: Similar to collaborative care models, integrated care models include non-physician care managers or mental health specialists. However, the mental health specialists are usually located with the primary care setting to provide services.

- **Chronic care model**: Emphasizes collaboration among various physician and non-physician health care professionals and expands upon earlier models through the inclusion of potential strategies such as: increase physician leadership endorsement, redesign of the delivery system, improvement of the clinical information system to facilitate patient follow-up, patient self-management support and patient linkage with community resources. Wagner’s Chronic Care Model is one of the best recognized models for treatment of chronic conditions used today.\(^\text{189}\) It promotes clinical change through six elements which are depicted in the schematic summary of this model in Exhibit 15. This model has been applied across a range of chronic illnesses and holds promise in its application to depression.

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**Exhibit 15. The Wagner Chronic Care Model\(^\text{190}\)**

<table>
<thead>
<tr>
<th>Community Resources and Policies</th>
<th>Health System Organization of Health Care</th>
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</thead>
</table>

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Functional and Clinical Outcomes
Coordination of care also enables the consumer to navigate an otherwise complex health care system. Exhibit 16 identifies examples of successful coordinated care programs implemented in the primary care setting.

### Exhibit 16. Primary Care Treatment Models Utilizing Coordination of Care

<table>
<thead>
<tr>
<th>Primary Care Models</th>
<th>Program Description</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)</td>
<td>Randomized controlled trial using depression care management and increased physician knowledge of clinical treatment guidelines versus usual care in primary care patients with geriatric depression.</td>
<td>Degree and rate of symptom reduction was improved with intervention compared to usual care. Rates of suicidal ideation decreased faster among consumers receiving care management.</td>
</tr>
<tr>
<td>Improving Mood-Promoting Access to Collaborative Care (IMPACT)</td>
<td>Funded by the Hartford Foundation, California Health Care Foundation, RWJ Foundation and the Hogg Foundation, a multisite randomized clinical trial of 1,801 older adults comparing collaborative care for depression with usual care.</td>
<td>Collaborative care improved rates and outcomes of depression care in older, minority consumers, who showed: higher response rates for both antidepressant medication and psychotherapy, lower depression severity and less health-related functional impairment than usual care.</td>
</tr>
<tr>
<td>Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E)</td>
<td>Multisite effectiveness trial to compare effectiveness of mental health and substance abuse specialists located in primary care practices (integrated care model) and use of direct referrals to specialty care (enhanced referral model).</td>
<td>PCPs preferred an integrated care model, citing that it improved communication, reduced stigma for patients and increased coordination of physical and mental health care. The majority of PCPs (64%) reported that integrated care led to better management of depression and alcohol abuse (65.6%) and quicker mental health appointments (85.7%).</td>
</tr>
<tr>
<td>The Robert Wood Johnson (RWJ) Depression in Primary Care: Linking Clinical and Systems Strategies</td>
<td>Depression in primary care consists of demonstration programs on 1) incentives for realigning services, structure and/or payments to improve treatment, 2) the value of improved care for depression in primary care settings and 3) grants for physician leadership development in the adoption of chronic care management for depression.</td>
<td>Because of the large number of grantees who have received funds to support each of the three project areas, there are a correspondingly large number of quality and outcomes oriented evaluations currently underway. Each of these has findings specific to the interventions or initiatives of which the grants were focused</td>
</tr>
<tr>
<td>Translating Initiatives for Depression into Effective Solutions (TIDES/WAVES)</td>
<td>Veteran Affairs collaborative care model intervention consists of PCP and nurse care management, patient self-management support, provider education and active collaboration between primary care and mental health specialists at seven outpatient clinics in three participating Veteran centers.</td>
<td>Nurse care manager averaged five telephone contacts per patient per six month period. The first cohort of patients showed high adherence to both medication (75 percent) and follow-up clinic visits (92 percent). 78 percent of patients (43 out of 55) achieved resolution of depressive symptoms.</td>
</tr>
</tbody>
</table>

Case management is increasingly utilized as a strategy to improve mental health care and support across both the public and private sectors, with evidence supporting that cost savings and improved mental health outcomes result. New York state implemented an intensive case management system in the early 1990s which has demonstrated proven outcomes. State inpatient mental health care utilization was reduced and consumer’s unmet needs, psychiatric status and quality of life improved. A recent University of Washington study found that one model of case management, the “team care model,” which includes a case manager, PCP and consulting psychiatrist, resulted in improved outcomes as well as considerable cost savings when treating clinical depression.

In the private sector, a prominent example of a shift to decrease fragmentation and improve integration of care comes from Aetna Managed Care. Aetna recently implemented a depression management program that attempts to integrate traditional and behavioral health care at the primary care level, a key feature of which will be providing primary care providers with on-call access to case managers and behavioral health specialists. Stakeholder interview findings indicate that other state, private and public-sector organizations that are part of the mental health delivery system are working to improve coordination of care for individuals.
with depression by implementing similar case management programs. There is increasing recognition that coordination must be improved not only within the mental health delivery system, but also with other non-clinical supportive services that are equally critical to helping individuals with depression recover and move to fully-functional and meaningful living. Some of these supportive services include housing, education and job training programs.\(^{199}\) In addition, case management must be personalized to individual consumers and individual. When case management is done in collaboration with the consumer and is individualized to the consumer, outcomes and overall recovery will be optimized. The message is clear that case management and coordination of care are critical components of mental health and depression treatment and efforts should continue to be made to increase these programs in an effort to better integrate care for consumers facing depression.

5.1.3 Early Detection and Treatment of Depression

The President’s Freedom Commission Report outlines early mental health screening, assessment and referrals as one of its key goals for the transformation of our mental health system.\(^{200}\) Providing early screening and interventions can prevent depression from worsening and, in some cases, can prevent long-term disability. Early detection can also save significant expense, both for the individual facing depression, who will be able to undergo shorter and less intensive treatment if their depression is detected at an earlier and less debilitating stage and for the health care system. Early detection will also reduce costs for employers, who will benefit from decreased absenteeism and staff turnover and increased motivation and productivity.

Studies indicate that most individuals with depression are first diagnosed and treated by their PCPs.\(^{201}\) PCPs prescribe the majority of psychotropic drugs for both adults and children. While two thirds of patients indicate that they are satisfied with the treatment they are receiving from their PCP,\(^{202}\) mental disorders including depression often go undiagnosed, misdiagnosed and are not always adequately treated. This is particularly true for uninsured, low-income, minority, elderly and child/adolescent patients.\(^{203}\) Improving the ability of PCPs to recognize depression in even its mild forms is critical to ensuring early treatment.

One example of implementation of screening is with Aetna Managed Care, as previously referenced. The “Aetna Depression Management” program was recently implemented, with the goal to improve the ability of PCPs to diagnose depression and help consumers reach appropriate treatment more quickly. This program is an example of a recent nation-wide effort to integrate traditional and behavioral health care at the PCP level. Key features of this program include training of office staff, provision of clinical tools for PCPs, access to nurse case managers, on-call support from Aetna’s network of behavioral health specialists and increases in reimbursement for physicians who actively screen for depression.\(^{204}\) Aetna implemented this program in an effort to more effectively manage care for individuals with depression, with a goal to diagnose depression before it becomes a more severe and debilitating problem.

Stakeholder interview results and research data indicate that in order to effectively screen and detect depression, health care providers across the mental health system (both public and private sector), including the primary care setting, should incorporate routine screening and assessment into their regular practice.

5.1.4 A Consumer-Driven Approach to Mental Health

Accompanying the shifting paradigm in the modalities used to treat depression in the last 10 to 20 years has been a corresponding shift in the way both providers and consumers think about the goals of treatment. Traditional medicine tests the effectiveness of interventions through clinical trials focused on testing for clearly definable physiological outcomes. In the mental health arena, while clinical trials and scientific studies provide evidence for successful treatment modalities, there is a growing consensus that desired impact or outcomes are highly specific to the individual consumer. In addition to taking into account the symptoms
and co-occurring illnesses that the consumer may be facing, treatment should also take into account the consumer’s personal preferences, goals and particular circumstances, thus tailoring treatment at the individual level.205

A recent report by SAMHSA’s Consumer Direction Initiative Summit indicated that the rising cost of both insurance and health care services, as well as the inconsistent quality of health care, has led to the rise of consumer-driven health care and its adoption by both consumers and providers.206 Consumer groups indicate that being a part of the decision-making process is empowering for individuals with depression and helps to provide a sense of self-worth that can be a powerful force in the road to recovery. Consumers often feel that they have been rejected by society and do not have the power to control their lives.207 This feeling often extends to their treatment programs. A recent study208 indicated that while 71 percent of physicians report presenting all treatment options to patients in a collaborative decision-making process, only 54 percent of patients felt they were part of the process, indicating that there is a clear disconnect between what providers and consumers perceive regarding consumer involvement in treatment selection. This disconnect unfortunately often results in patient non-adherence with treatment programs, pointing to the need for provider training to improve patient involvement in the treatment decision-making process.

While providing better training to providers is one method to help ensure increased consumer involvement, consumers and their families must also be able to be their own advocates and increase their involvement in planning their treatment. In a paper for the Consumer Direction Initiative Summit, CMS summarized four elements critical for successful self-directed care:

- Person-centered planning that focuses on comprehensive strategies to help consumers achieve their recovery goals.
- Individual consumer input and control over how funds are spent for their care.
- Financial management services that help consumers manage their budget, billing and the documentation related to their care.
- Support brokerage which includes education and operational support for helping consumers design and manage their treatment.

Consumer-driven mental health and depression programs are on the rise. In the private sector, medical savings accounts and flexible spending accounts are increasingly being used to provide consumers with more choice, flexibility and control over their treatment selection. In the public sector, SAMHSA currently has several programs that incorporate elements of consumer-driven mental health and substance abuse care. The President’s New Freedom Commission Report also emphasizes the need to shift towards a consumer-oriented treatment model, with one of its key goals for the mental health system being that mental health become consumer and family driven.209 At a state and community level, programs are also evolving to incorporate consumer-centered philosophies. For example, the state of Florida implemented a Self-Directed Care program aimed at providing completely operational self-direction for

"Studies show that consumer-run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services and serve as a resource in the recovery of people with a psychiatric diagnosis."

"Consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training and service delivery."
- Achieving the Promise: Transforming Mental Health Care in America, President’s New Freedom Commission Report, 2003
adults with mental illness. Its initial successes helped the program receive authorization for expansion by the Florida Legislature in 2004. The Georgia Peer Supports program, discussed in Section 5.1.5, is part of an overall shift in the way the state of Georgia offers mental health services – one that includes a much greater emphasis and focus on self-directed recovery.

5.1.5 Peer Support Programs in Depression Treatment

Since the 1970s, many consumer advocacy groups have emphasized the role of self-help in the treatment of mental illnesses such as depression. In 2003, the National Mental Health Association (NMHA) instituted a policy “urging Mental Health Associations, mental health service provider organizations and other advocates to make peer support an integral part of mental health service delivery and to ensure that consumers are involved at multiple levels of planning and implementation of peer support services, including senior management positions in service programs.”

Peer support is one form of self-help treatment that has proven effective and has been described as a key component of the process of recovery. Peer support is a form of social network therapy in which stigmatized people interact with each other, feel self-acceptance and strive to be valued members of a community. There are several formats that peer support can take and while the vision, mission and individual structure of peer support programs vary greatly and depend on individual program goals, most programs can be grouped into the following broad categories:

- Mutual support groups that are voluntary, informal and led by peers.
- Consumer-run groups where peers are paid employees of a program designed to encourage regular and consistent interaction with peers.
- Employment of consumers within clinical and rehabilitation settings to work with their peers.

There is an emerging body of evidence regarding the efficacy of peer support programs for individuals with depression and other mental health-related illnesses. Studies indicate that giving an individual the feeling of support from people outside of the family network, such as peer support groups, can facilitate recovery. Individuals who are depressed often have difficulty forming and maintaining friendships and social skills development can be critical to helping those individuals. Participants in peer support programs report improvements in self-esteem, decision-making skills and social functioning, as well as decreased psychiatric symptoms (lower hospitalization rates), lower rates of isolation, larger social networks and increased support seeking. Peer support is valued by consumers for multiple reasons, including:

- Peer support consists of individuals sharing personal knowledge and strategies of living with depression.
- Peer support is considered mutually beneficial and empowering for both those participating as consumers and those participating as peer leaders.
- Peer support takes the form of a natural social support.
- Peer support provides consumers with a sense of empowerment because they feel a greater level of control over their own decisions.
- Unlike standard care, peer support is not paternalistic or hierarchical, as consumers are on the same level as their peers.
Additionally, many stakeholders indicate that consumers may feel that peers, because of their shared experiences with depression, may be more well-equipped to listen and support their treatment goals, perspectives and objectives than traditional providers.

From a mental health system perspective, peer support programs fill a gap in the mental health service delivery system, providing service to individuals who may otherwise be alienated from the traditional mental health system such as the homeless, minorities or individuals who have had a negative experience with the system. There is evidence that adding peers onto provider teams and/or coupling peer support with traditional mental health services, contributes to improved outcomes. Additionally, there are consistent findings that indicate that the use of peer support helps decrease hospitalizations, shorten length of hospitalization stays and contribute to reduced utilization of the mental health system. In addition, peer support programs are inexpensive to implement, indicating that these programs are mutually beneficial for both the mental health system and its consumers.

Stakeholder interviewees voiced that peer support programs are a welcome and much needed addition to the services offered to individuals facing depression, and that peer support should be provided in conjunction with more traditional psychotherapy and psychopharmacologic treatment programs. Many voiced that increasing peer support program use and incorporating it earlier on into a treatment program (if not at the beginning) would be beneficial for consumers and help with the road to recovery. Despite the overwhelmingly positive perspective on the role of peer support in the treatment of depression, many interviewees indicated that they did not have in-depth knowledge regarding the effectiveness of peer support programs or the availability of such services and felt that additional research and investment in large-scale studies was needed.

Peer support programs are often offered through stand-alone community-based programs, through programs sponsored or funded by state or local governments or through a combined service offering where community organizations work in conjunction with state or local governments. Some states are utilizing their Medicaid funding and seeking supplementary funding to implement peer support and other self-directed care programs for depression and mental illness. One example of this is through the Real Choice Systems Change Grants that are offered through CMS. One of the underlying objectives of the Real Choice Systems Change Grants is to improve access to and delivery of health care to persons served by Medicaid including the cost of research or demonstration projects.

Through this program, the state of Georgia has developed the Georgia Peer Support program, with the goal to provide an opportunity for consumers to teach and support each other in the acquisition and exercise of skills needed for the management of symptoms and utilization of natural resources within the community. This program was the first of its type to receive Medicaid funding to implement a peer support program and the first peer support program coordinated at a state-wide level. The state of Georgia has made peer support a billable service under Medicaid, helping to cement its status as a Medicaid service offering. Since its
Treatment and Emerging Recovery Methods

inception and demonstrated success, other states, including Iowa and South Carolina, are adopting the program design and have been able to obtain funding to implement similar programs.225

The Georgia Peer Support program trains and certifies peer specialists to provide ongoing peer support services through the Georgia Mental Health Service with a goal of promoting self-determination, personal responsibility and empowerment inherent in self-directed recovery. Assessments of the program have demonstrated positive outcomes for consumers involved in the program, both those who were recruited, certified and trained as peer specialists, as well as those who have been recipients of the peer specialist services. Consumers showed improvement in their current symptoms and behaviors, addressed skills deficits and indicated that resources were more available and their needs more adequately met. Additionally, the state of Georgia was able to demonstrate cost savings from the implementation of this program.226 The success of this program prompted SAMHSA’s Center for Mental Health Services to work with the state of Georgia to develop a Federal toolkit on peer support to be disseminated as a best practice to all state Medicaid authorities and mental health departments as well as other programs as appropriate.227

Some interviewees voiced that individuals facilitating peer support programs should receive more extensive training to ensure that programs are managed and provided in an appropriate manner. The dissemination of best practices from established programs, such as the Georgia Peer Support program, through government vehicles such as SAMHSA and through partners such as DBSA, can help ensure that this happens. Broad implementation of peer support services will require funding, research and a continued shift towards consumer-driven mental health care.

5.1.6 Cultural Competency in Depression Treatment

The United States Surgeon General Report on Mental Health explicitly states that the mental health system in the United States is not well equipped to meet the need of racial and ethnic minority groups.228 Research indicates that racial and ethnic minority groups underutilize treatment, have less access to treatment, mistrust the health care system, have a greater degree of non-adherence with treatment programs, demonstrate less-help seeking behavior and are often diagnosed inappropriately.229 These issues are interrelated; for example, mistrust of the health care system may result in less help-seeking behavior. Inappropriate diagnosis may result in non-adherence with a treatment program. Other issues such as stigma, language barriers and inability to handle the costs of health care services are also major issues that prevent minority groups from seeking and receiving appropriate treatment. Different ethnic and racial minorities have various coping styles for dealing with illnesses such as depression. For example, in some ethnic groups, individuals may be less likely to seek formal treatment and may be more inclined to turn to religion or family to cope. Additionally, minority groups are more likely than whites to be in the lowest socioeconomic brackets. Research has shown that individuals in these socioeconomic groups experience higher rates of mental illness including depression. They also have a greater degree of difficulty in navigating the health care system due to financial limitations, transportation barriers and lack of insurance.230

Education and outreach efforts aimed at minority consumers can help improve their understanding of different treatment options and the importance of treatment adherence. Research indicates that minority patients may have difficulty understanding the course of treatment being selected by their providers, may not volunteer necessary information and/or fully participate as partners in treatment decisions.231 Language also often serves as a barrier in making appropriate diagnoses and providing appropriate treatment.

Providers also contribute to inadequate treatment of depression in racial and ethnic minority groups. For example, lack of sensitivity to cultural differences is a common problem in health care. Additionally, research indicates that there are demonstrable biases both in diagnosis and in treatment selection for certain minority groups versus whites. Improving providers’ awareness of their own cultural orientation, knowledge
of their patients’ ethnic and/or racial background and skills with different cultural groups is critical for improving mental health services for racial and ethnic minorities.

Developing culturally responsive and ethnic or culturally-specific services is critical to appropriately engage minorities in treatment programs. Involving minority consumers, families and communities in developing these services is one method through which this can be accomplished. Ensuring providers can communicate in languages other than English or have language services to facilitate communication in primary care offices and other service settings is another method. Brochures and other materials can be translated into different languages. Religious institutions can be used for outreach and education for groups that rely heavily on these institutions as a critical part of their social networks. Recruiting minorities into the mental health workforce is another method that can help eliminate disparities in the provision of mental health treatment services, including those for depression. Involving minorities in research studies can help improve the body of knowledge of how treatment affects different consumer groups, taking into account issues such as age, gender, race and location. All of these activities can help minority groups better understand treatment options and feel more comfortable with receiving services. They will also help ensure that providers have the necessary tools and knowledge to better serve this population.

5.1.7 Recovery-Oriented Treatment

Over the last 25 years, the concept of recovery has increasingly been used to define the desired outcome or goal of depression treatment. There are many definitions for the term recovery and what it means to an individual suffering from depression. However, most definitions concur that recovery is a complex multidimensional process involving personal growth, healing and development that transforms an individual from an illness-dominated identity to one marked by meaning and well-being. Katherine Powers, Director for the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration defined recovery as “the process by which people are able to live, work, learn and participate fully in their communities.” Other definitions of recovery from pioneers in the field of recovery and consumer-oriented treatment are included in Exhibit 17.

**Exhibit 17. Definitions of Recovery from Consumer Writings**

<table>
<thead>
<tr>
<th>Having some hope is absolutely critical in recovery. It is the part that allows us to keep going and keep striving, even when things are not their best . . . . recovery means feeling like I can make choices that allow my life to have meaning. Learning skills and methods to achieve the best possible wellness for me as an individual, so that I can be a part of my family and community, is what recovery means to me. (Paul, 2006)</th>
<th>A recovery paradigm is each person’s unique experience of their road to recovery. . . . My recovery paradigm included my reconnection which included the following four key ingredients: connection, safety, hope and acknowledgment of my spiritual self (Long, 1994)</th>
</tr>
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<tbody>
<tr>
<td>. . . a person with mental illness can recover even though the illness is not “cured” . . . . [Recovery] is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993)</td>
<td>I am confident with the skills of coping with depression, medication, and therapy, I will be OK. I take it a day at a time. I look for small accomplishments in my everyday life and pat myself on the back for them. (Jeanne, 2005)</td>
</tr>
<tr>
<td>One of the elements that makes recovery possible is the regaining of one’s belief in oneself (Chamberlin, 1997)</td>
<td>To return renewed with an enriched perspective of the human condition is the major benefit of recovery. To return at peace, with yourself, your experience, your world and your God, is the major joy of recovery (Granger, 1994)</td>
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</table>
The role of recovery in the treatment of depression is a subtle but crucial one. It shifts the focus of treatment from symptom relief to the recovery of identity, normalcy and a meaningful role in the community. It is a concept that has been embraced by consumers and their families as it provides a sense of hope and self-determination for individuals facing depression. Both of these factors were cited by many stakeholder interviewees as critical components of successful treatment – components which are imparted through consumer-directed care and peer support programs – two initiatives that are gaining increasing popularity and support in mental health and depression treatment.

Key facilitators of the recovery process include: (i) supportive relationships in the form of family, friends, peers and health care professionals that are characterized by trust and respect rather than coercion and paternalistic “do as you’re told” attitude, (ii) engagement in meaningful activities that provide an opportunity for consumers to continue growing and learning about themselves; and (iii) access to alternative treatments and an active role in the decision-making about their treatments, services plans and futures. All of these elements create a supportive environment that helps individuals suffering with depression heal from the effects of the depression itself, the pain and stigma associated with it and the feeling of being directed by those who are trying to help. For providers this means a shift from focusing primarily on the symptoms of depression to looking at their patients in a holistic manner, the physical, mental and emotional components and as individuals with a past, a present and viable, healthy, hopeful future. It means combining the psychopharmacologic, psychotherapeutic and the emerging psychosocial care options such as peer support into a single holistic model focused on recovery. Exhibit 18 describes the integration of care models that must occur in order to move towards effective recovery-oriented treatment.

Exhibit 18. Effective Recovery Oriented Treatment Incorporates Several Critical Models of Care
5.2 Key Opportunities for Improving Treatment and Recovery Programs

Treatment for depression faces many challenges that should be addressed in order to increase the effectiveness of the care provided and improve the chances for individuals with depression to achieve recovery. The following section identifies opportunities for stakeholders to address improving treatment for depression.

- **Opportunity:** Shift focus from treating symptoms to achieving and maintaining recovery.
  
  Mental health treatment, including treatment for depression, is shifting from a symptom-relief model to one oriented towards consumer recovery and a return to a life full of meaning and well-being. Continuing to educate consumers, providers and payors on recovery-oriented treatment models and encouraging their adoption is essential to help individuals with depression achieve meaningful lives.

- **Opportunity:** Promote consumer self-empowerment and decision making in treatment and services.
  
  Having an active role in the decision-making process can be a powerful force in the road to recovery. There is a growing recognition that outcomes for mental health patients, including those being treated for depression, are highly specific and unique to the individual consumer and that incorporating an element of self-empowerment can help improve outcomes. All consumers should be strongly encouraged to pursue educational programs and learn as much as possible about their disorders and the available treatments, side effects and importance of adherence. Consumer-driven models for care should be adopted across the mental health services arena to help ensure that caregivers consider an individual’s personal preferences, beliefs, culture and financial circumstances.

- **Opportunity:** Increase consumer access to peer support programs.
  
  Peer support programs are a critical component of recovery treatment for depression and should be a pillar of our mental health services. There is a growing body of evidence regarding the efficacy of peer support programs. Additional large-scale research should be conducted to further establish the efficacy of peer support. This, in turn, will help increase the likelihood of widespread adoption of these promising programs in both the public and private sector and also help to establish peer support as a standard for mental health and depression treatment programs. For this to happen, both public programs and private payors should work together and obtain the information they need in order to justify investment in peer support programs.
addition, incorporating proper payment mechanisms to ensure that peers are paid adequately to serve as peer support providers should occur as well.

**OPPORTUNITY**

**Improve coordination of care and increase case management.**

Coordination of care and case management are critical to depression treatment given that patients often have to deal with multiple providers, both for their depression and for any co-occurring illnesses. While some states and private-sector organizations have taken steps to improve coordination of care, a much greater degree of reform must occur to ensure that all components of the mental health system, both private and public, are integrated. This will be particularly challenging given the role that disparate public programs such as welfare, education and the prison system play in the field of mental health.

Some managed care companies have begun to address this issue and are asking their medical providers, including specialists, to screen for depression and coordinate care with other providers. If depression is suspected, that individual is provided access to a mental health specialist, who will work in conjunction with the medical provider, to treat the patient. Enrolling consumers in case management programs can lead to improved health outcomes and ultimately lower medical costs.

**OPPORTUNITY**

**Provide grants or other funding to States for the development of depression screening and treatment services.**

Significant reductions in long-term health care costs could be realized by investing in less-expensive preventive health care, reducing hospital stays for episodic events. Early screening and detection of depression are critical to reducing costs for mental health care and, more importantly, ensuring that individuals facing depression have a greater chance to recover and go back to leading meaningful and full lives. To help accomplish this, access points to the mental health system must be targeted. This includes PCPs, as well as other access points such as the welfare, education and prison systems. Managed care and government both have key roles in this process given their position and ability to implement procedures and policies that will make early screening standard within the mental health system.

**OPPORTUNITY**

**Improve cultural competency in the delivery of mental health services.**

Provider training in cultural competency must improve in order to remove biases in treatment, ensure treatment adherence, improve provider-patient communications and generally improve the treatment provided to racial and ethnic minorities. Increasing the numbers of minority providers in the field of mental health would contribute
significantly to the effort of improving treatment for minority groups. Managed care and government agencies both have the ability and responsibility to implement procedures and policies to improve cultural competency of treatment.

**OPPORTUNITY**

*Educate consumers and providers about different treatment options.*

While treatment programs are continually evolving to include a combination of both psychotherapy and pharmacologic care, increased education for both consumers and providers needs to occur to ensure that treatment programs consistently integrate both of these critical aspects of care as appropriate. Proven non-pharmacologic therapies, such as ECT and VNS are also available to more severely depressed individuals. Continued research on the efficacy of existing and emerging treatment regimens should occur in order to increase the body of knowledge on appropriate and effective treatment. Managed care and public programs, such as Medicaid, must continue to offer treatment options that offer the best chances for recovery while managing the fiscal realities of managing care for large segments of the United States population.
6.0 Quality

Providing high quality health care is one of the major challenges currently facing the medical field, especially in the field of mental health. Although a variety of evidence-based treatments for depression exist, the gap between knowledge and practice is still vast. The disparity between the quality of existing clinical treatments for depression and the quality of care that is actually delivered is distressing. Closing this gap in the application and implementation of proven treatment methodology must be a priority in order to improve outcomes for those suffering from depression. This section provides an overview of the current state of mental health care quality, including barriers to delivery of quality mental health care and current quality initiatives. Finally, key opportunities for overcoming barriers are identified and specific recommendations for stakeholders are discussed.

6.1 Current State

The IOM has defined quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”\textsuperscript{240} Quality health care should be safe, effective, patient-centered, timely, efficient and equitable.\textsuperscript{241} Quality is often measured on the three dimensions of structure, process and outcomes.\textsuperscript{242} Structure of the health care system includes the resources available to provide health care, such as system characteristics and the credentials and training of providers. Process of health care delivery includes the methodology and implementation of accepted standards. Outcomes are measurable changes in a patient’s condition following treatment, including clinical improvement, patient satisfaction, functional status and wellbeing. Stakeholder interviews identified the following barriers to quality care for depression relating to structure, process and outcomes that need to be addressed:

- **Structure**: Lack of prevention and long term care management, fragmentation of mental health services, insufficient reimbursement and funding and inadequate training of providers.

- **Process**: Lack of dissemination and adoption of uniform quality standards and practices, inadequate follow-up and treatment adherence and lack of consumer input into treatment.

- **Outcomes**: Lack of standardized monitoring and outcome measures.

These barriers and their implications for quality of treatment are described in the following exhibit.
## Exhibit 19. Barriers to Quality Mental Health Care and their Implications

<table>
<thead>
<tr>
<th>Access Issue</th>
<th>Barriers</th>
<th>Implications</th>
</tr>
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<tbody>
<tr>
<td><strong>Structure</strong></td>
<td></td>
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<tr>
<td>Lack of prevention and long term care management</td>
<td>- Currently the system is crisis-oriented and focuses on the most recent</td>
<td>- Inadequate screening and diagnosis of depression.</td>
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<td></td>
<td>episode, rather than providing early intervention or long term</td>
<td>- Lack of follow-up care and ongoing, comprehensive disease management.</td>
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<td></td>
<td>depression management and care.</td>
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<td>- Time, resources and organizational constraints inhibit preventive</td>
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<td>treatment, early intervention or longer-term care.</td>
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<td>Fragmentation of mental health services</td>
<td>- Integration of mental health services across systems, including</td>
<td>- Ineffective, uncoordinated care.</td>
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<td></td>
<td>primary care and social services, is critical for individuals with dual</td>
<td>- Lack of interactions among different health care providers, systems and</td>
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<td>diagnoses and other health or social service needs.</td>
<td>disciplines.</td>
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<td>- Individuals often seek care from PCPs, who may lack the time and</td>
<td>- Some effective treatments such as psychotherapy are underutilized,</td>
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<td>expertise necessary to diagnose and treat depression.</td>
<td>diminishing the quality of available care to consumers.</td>
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<tr>
<td>Insufficient funding and reimbursement</td>
<td>- Current reimbursement systems, cutbacks to services and diminishing</td>
<td>- Inadequate frequency and duration of treatments.</td>
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<td>compensation have caused a decrease in the quality of care.</td>
<td>- Qualified providers do not have an incentive to enter the mental health</td>
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<td>field, leading to provider shortages.</td>
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<tr>
<td>Inadequate training of providers</td>
<td>- There is a lack of standardization and consistency in the training of</td>
<td>- Quality of care is variable and may not be effective.</td>
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<td>mental health providers, who come from a variety of disciplines.</td>
<td>- Effective treatments are not utilized and patients continue to needlessly</td>
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<td>- Mental health providers often lack training in treatments proven to</td>
<td>suffer.</td>
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<td></td>
<td>be effective for depression, such as cognitive behavioral therapy</td>
<td>- Treatment does not meet the needs of the patient or lead to recovery.</td>
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<td></td>
<td>and interpersonal therapy.</td>
<td>- Patients do not adhere to treatment plans because they are not included</td>
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<td>- Providers are not trained to work as partners with consumers or in a</td>
<td>in the creation of the plan.</td>
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<td>recovery oriented manner.</td>
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<td><strong>Process</strong></td>
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<tr>
<td>Lack of dissemination and adoption of quality</td>
<td>- Quality standards are not adequately defined, disseminated, implemented</td>
<td>- Evidence-based treatments are not utilized.</td>
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<td>standards and practices</td>
<td>or enforced. While some guidelines exist, they are not standardized</td>
<td>- Disproportionate focus on medication rather than psychotherapy and other</td>
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<td>across disciplines, providers or health plans.</td>
<td>treatment options.</td>
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<td>- Quality of care is variable and may not be effective.</td>
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<tr>
<td>Inadequate follow-up and treatment adherence</td>
<td>- Follow-up treatment and consumer retention are inadequate.</td>
<td>- Patients fall out of the treatment, symptoms worsen and crisis situations</td>
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<td>- Only 50 percent of medications first prescribed are effective and</td>
<td>are more likely to occur.</td>
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<td>relapse is common, thus patients often remain ill or frustrated with</td>
<td>- Patients give up on treatment.</td>
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<td></td>
<td>their treatment.</td>
<td>- Negative impact on family, employer and community.</td>
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<tr>
<td>Lack of consumer input into their treatment</td>
<td>- Providers often do not engage or educate consumers, ask for consumer</td>
<td>- Treatments that are not targeted towards the unique recovery needs and</td>
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<td></td>
<td>preferences or provide treatment options to consumers.</td>
<td>goals of each consumer.</td>
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<td>- Lack of consumer buy-in to treatment, reducing treatment adherence.</td>
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<tr>
<td><strong>Outcomes</strong></td>
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<tr>
<td>Lack of standardized monitoring and outcome</td>
<td>- Outcome and performance measures are not widely utilized.</td>
<td>- With unclear performance expectations and measurable outcomes for</td>
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<td>measures</td>
<td>- Since performance is not linked to reimbursement, providers do not</td>
<td>treatment, providers and consumers settle for minor improvements rather</td>
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<td>have financial incentives to provide high quality care.</td>
<td>than aiming for full recovery.</td>
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<td>- Inability to demonstrate positive effects of treatment and services</td>
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<td></td>
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<td>limits payors’ willingness to provide funding for mental health programs.</td>
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</table>
6.1.1 Structure

**Lack of prevention and long term care management.** The structure of the mental health system is disproportionately crisis-oriented and reactionary. The system is set up for episodic care focusing on crises, such as suicide attempts, rather than on prevention, proactive treatment and long-term wellness. According to stakeholder interviewees, the system is spending resources on costly, episodic inpatient care treatment, rather than providing much needed preventative services.

**Fragmentation of mental health services.** The current mental health system is disorganized and fragmented. A lack of coordination across service sectors was cited by stakeholders as a major obstacle to quality mental health treatment. As highlighted in Section 4.0, Access, fragmentation of care is especially evident in the treatment of depression, since the majority of consumers, between 40 and 60 percent, seek mental health care from a PCP. Due to organizational and reimbursement constraints, PCPs often lack the time to adequately assess and diagnose an individual with depression, as they have often have to see at least four patients per hour. As a result, consumers often face inadequate assessment, treatment, referrals and follow-up within the primary care setting. Additionally, a PCP will often treat somatic complaints rather than underlying depression.

In many cases, PCPs can treat an individual for depression if it only requires one type of antidepressant. Individuals often need additional treatment in order to fully recover. If consumers are not responding to one type of medication, they need to switch to different types of medication, which may be more difficult for PCPs to manage. While PCPs commonly prescribe antidepressant medication, they are less likely to provide or refer consumers for psychotherapy, despite the fact that combination therapy has been shown to be effective at reducing symptoms of depression.

**Insufficient funding and reimbursement.** In addition to limiting access to care, insufficient funding and reimbursement for mental health services is also a primary concern for quality of mental health care. Both public funding and private reimbursement are inadequate, which negatively impacts the number of quality providers and available services for individuals with depression. When state mental health organizations or community-based services experience tightened budgets, they often cut back on staffing, provider compensation or leave positions unfilled. As a result, mental health programs may not retain the best providers due to low salaries and poor working conditions. Many qualified providers leave clinical practice to go into research or other fields which are more financially rewarding.

Managed care organizations have placed restrictions on provider reimbursement and inpatient care, which affects quality of treatment in both inpatient and outpatient settings. Due to managed care utilization reviews, there has been a significant decline in the number of inpatient hospital days, which may lead to discharging patients from the hospital too quickly. While managed care provides for treatment in an outpatient setting, there are few services to replace inpatient care. Additional intermediate, transitional and community-based services must be made available. According to stakeholder interviews, managed care reimbursement practices have caused a decrease in the use of psychotherapy. The use of certified peer specialists can provide a cost effective way to fill in this service gap.

Alternatives to the current reimbursement system include pay-for-performance (P4P) models that directly link payment with adherence to processes and specific health outcomes. For example, the National Quality Forum has endorsed quality performance measures for physicians in ambulatory settings in the treatment of various conditions, including depression. These measures may be used by Medicare for developing P4P indicators.

“Physicians and therapists came and went. I also tried many medications off and on throughout the years. Day after day, night after night, time just kept passing. Somewhere along the way, I lost weeks, months and years.”

– Stephanie, Consumer
Stakeholder interviewees revealed mixed perspectives about using P4P as an incentive program tied to depression treatment. Some payors and pharmaceutical companies embrace the idea in order to divert funds towards mental health, motivate providers to ensure quality and help consumers make more educated choices when selecting providers. Other stakeholders noted that P4P could have unintended consequences, including dissuading PCPs from wanting to treat consumers with depression. One of the main reasons cited for this potential consequence is that individuals with depression are extremely diverse – for example, some have treatment-resistant depression or complicated comorbidities, which can impact outcomes regardless of the quality of care provided.

**Inadequate training of providers.** Advocates and government stakeholders raised concerns over the consistency of training of mental health professionals. Various professional associations and academic institutions are involved in setting standards for training and education. As a result, training programs across disciplines are not consistent for masters and doctoral programs in medicine, nursing, social work, psychology and counseling. There is also significant variation in licensing requirements at the state level for different types of mental health professionals who commonly treat depression. The treatment approach selected by providers from these different disciplines can vary significantly as can the quality of care they provide. Additionally, clinicians from different disciplines frequently misunderstand or fail to grasp the importance of clinical services being provided by other disciplines. More mental health specialists and other providers need more training in therapies that are proven to be effective in the treatment of depression, such as CBT and IPT.

Provider education often is not consumer-focused, thus providers are not taught that consumers and family members should be equal partners with clinicians in the development of treatment plans and goals. Most providers are not trained to see recovery as the goal of treatment, which is necessary to improve quality of care. Providers are also often not informed of the role that peer support can play in the treatment of depression.

Stakeholder interviewees had concerns over the adequacy of training for PCPs, who provide most of the care for consumers with depression. Recent studies indicate that more than three quarters of PCPs make an initial diagnosis of depression at least once a week and provide treatment to these patients. However, interview findings indicate that most PCPs do not receive specialized training in the field of mental health or depression. PCPs need continuing education and training in order to incorporate evidence-based practices and standardized protocols into daily care. Students and PCPs should receive training in the primary care setting, rather than the psychiatric setting. Additional training needs to focus on optimal treatment approaches, as well how to incorporate a consumer’s mental, social and economic situation into the best course of action for the patient.

6.1.2 **Process**

**Lack of dissemination and adoption of uniform quality standards and practices.** Developing and standardizing treatment protocols for depression is a critical first step in improving quality of care. While many evidence-based standards and guidelines exist for major depression, they are not implemented or utilized consistently across providers and health plans. Barriers to implementation of clinical guidelines include physician knowledge, attitudes (including beliefs about self-efficacy and agreement with guidelines) and behaviors due to external barriers and environmental factors, such as time, resource and organizational constraints. Data from stakeholder interviews suggested that incentives or enforcement of guidelines should be instituted.
Inadequate follow-up and treatment adherence. The majority of stakeholders interviewed pointed out that many consumers are treated for episodic cases rather than with preventative and proactive treatment. In many cases, consumers cycle in and out of treatment settings, are prescribed antidepressant medications and are unable to come back for follow-up treatment. According to NCQA Health Plan Employer Data Information Set (HEDIS) measures, only about half of consumers remain on antidepressant medication during the acute phase (first 12 weeks after diagnosis) and about 44 percent remain on antidepressant medication after 6 months. The percentage of patients who receive at least three follow-up office visits with a PCP or mental health provider in the acute phase is only about 20 percent in commercial and Medicaid settings and approximately 12 percent in Medicare. This lack of follow-up and treatment adherence is especially troublesome in depression, which has a high rate of suicide.

Lack of consumer input into their treatment. Consumer input, consumer choice and education in treatment were cited as additional issues affecting quality of care. Consumers play a meaningful role in the decision-making process has shown to improve treatment adherence, satisfaction and success. Section 5.0, Treatments and Emerging Recovery Methods, provides a more detailed discussion of the consumer-driven approach to mental health.

6.1.3 Outcomes

Lack of standardized monitoring and outcome measures. While outcome measures have been developed and validated, they are not adequately disseminated, implemented or enforced. According to some stakeholders, the greatest barrier is the establishment of a recognized quality standard. The existence of a broad diversity of disciplines that provide treatment for depression makes it difficult to decide on a single measure of quality. In addition to measuring quality outcomes, public reporting and community reports of clinic performance increases transparency and helps to inform consumers of their treatment choices.

Members of racial and ethnic minority groups tend to receive poorer care for depression, as they are less likely to seek treatment or receive an adequate level of treatment and experience more inadequate health outcomes than white patients. For example, African Americans are much less likely to receive treatment overall and less likely to receive guideline-concordant care. Relatively simple steps can increase availability of appropriate care to narrow the gap in treatment and improve outcomes for minority patients. Future quality initiatives must include considerations of populations particularly vulnerable to undertreatment, including racial and ethnic minorities. The Access and Treatment sections of this report outline barriers and suggest opportunities for improving access to culturally competent services.

6.1.4 Current Quality Initiatives

Despite concerns, it is important to recognize that significant progress has been made in the area of improving the quality of mental health services. Implementing evidence-based practices (EBP) is one of the main areas of quality improvement in mental health care and has become a national goal, as outlined in the New Freedom Commission Report. The IOM Committee calls for “better dissemination and adoption of evidence through the use of evidence-based approaches to knowledge dissemination and uptake.” For example, over 25 different mental health associations and standard-setting entities have released types of treatment guidelines, which are critical to
improving the level of care provided to depressed consumers. Merging these various guidelines into recognized standards is essential to setting clear expectations for quality in mental health care.

Efforts to promote evidence-based practices in health care include:

- Accreditation practices
- Clinical and systems-level practice guidelines
- Outcome measures
- System-level report cards

A summary of these measures specific to mental health and depression are included in Exhibit 20.

### Exhibit 20. Examples of Current Quality Measures by Structure, Process and Outcomes

<table>
<thead>
<tr>
<th>Quality Measurement</th>
<th>Examples</th>
<th>Program Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
<td></td>
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</tr>
<tr>
<td>Accreditation</td>
<td>Joint Commission on Accreditation of Health care Organizations (JCAHO).</td>
<td>An independent, not-for-profit organization, JCAHO evaluates and accredits more than 15,000 health care organizations, including psychiatric hospitals, behavioral health care organizations and rehabilitation centers, in the United States based on standards that focus on improving the quality and safety of care.</td>
</tr>
<tr>
<td></td>
<td>National Committee for Quality Assurance (NCQA).</td>
<td>NCQA is a not-for-profit organization dedicated to improving health care by accrediting managed care organizations to evaluate the health plan’s clinical and administrative systems in the areas of patient safety, confidentiality, consumer protection, access, service and continuous improvement.</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Guideline Clearinghouse (NGC) sponsored by AHRQ in partnership with the American Medical Association and the American Association of Health Plans.</td>
<td>Clearinghouse of evidence-based clinical practice guidelines from various agencies that internet users can assess and compare online.</td>
</tr>
<tr>
<td></td>
<td>Veterans Health Administration, Department of Defense Major Depressive Disorder (MDD) Clinical Practice Guideline (CPG) in the Military Health System Version 2.0 (2000).</td>
<td>The MDD guideline is organized into three modules including MDD in the Primary Care Setting, MDD in the Outpatient Mental Health Specialty Setting and MDD in the Inpatient Setting. Contains screening instruments and more detailed information about treatment options.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
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<tr>
<td>Outcome measures</td>
<td>Patient symptoms, measured by scales such as the Patient Health Questionnaire-9 questions (PHQ-9), the Hamilton Rating Scale for Depression (HAM-D) and the Beck Depression Inventory (BDI).</td>
<td>These self-report questionnaires measure the frequency of depressive symptoms. Reductions in depression symptoms would signify improvement.</td>
</tr>
<tr>
<td></td>
<td>Quality of life and functioning, such as the Short Form Health Questionnaire.</td>
<td>Measures include improvements in functioning, such as returning to work and improvements on quality of life and functioning scales.</td>
</tr>
<tr>
<td>Systems-level report cards</td>
<td>Mental Health Statistics Improvement Program (MHSIP) Quality Report (MQR) and MHSIP Consumer-Oriented Report Card.</td>
<td>SAMHSA’s MHSIP has developed consumer-oriented report cards that include consumer perceptions of care, including accessibility, quality and outcomes. These performance measurement system designed to assess and report on the quality of mental health services for children and adults, including consumer-focused and recovery-oriented outcomes.</td>
</tr>
</tbody>
</table>
SAMHSA is developing the National Registry of Evidence-based Programs and Practices (NREPP), which will rate and classify mental health programs as model, effective or promising. Other groups, such as the Cochrane Collaboration, conduct systematic reviews to evaluate research and evidence and disseminate best practices in depression treatment. Recently, EBP has been used to enhance depression treatment in primary care settings. Research performed by the Agency for Health Care Research and Quality (AHRQ) Depression Consumer Outcome Research Team (PORT) has shown that primary care practices that use evidence-based guidelines have improved treatment rates for depression and improved outcomes. Section 5.1.2., Case Management and Coordination of Care, outlines several different treatment models that have been implemented and evaluated in primary care.

While EBP helps improve quality and reduce variability in care, there are concerns and limitations to using EBP. While randomized controlled trials are considered the gold standard and highest level of evidence, they cannot be used to test all types of treatment and services. A concern raised by stakeholders is the dependence of evidence for funding of programs. As a result, promising practices should also be included and incorporated into provider training. For many consumers, their own recovery is the best evidence for the success of the program. Consumer preferences must also be included in the evidence base used to assess and evaluate programs. Evidence-based practice should not prevent innovative programs and services or promote a “one size fits all” approach to treatment. Treatment must be individualized and take into account biopsychosocial factors unique to each consumer.

Increased awareness about the relationship between quality care and improved outcomes has spurred the development of a variety of quality initiatives focused on improving treatment performance. While the question of who should be responsible for ensuring quality has been debated, quality initiatives for treatment of depression have been developed at all levels, including employer, provider, health plan, community, state and national levels. A sample of current evidence-based programs is provided in Exhibit 21. This does not represent a comprehensive list of all the of quality improvement programs recently implemented.

### Exhibit 21. Examples of Quality Improvement Initiatives

<table>
<thead>
<tr>
<th>Quality Initiatives</th>
<th>Program Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Employer-based initiatives</strong></td>
<td></td>
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<tr>
<td>The National Business Coalition on Health (NBCH)</td>
<td>NBCH is a national organization made up of employers such as General Motors, FedEx and Marriott International. The coalition developed a tool to measure the quality of mental health benefits provided by health plans, called “eValue8.” Health plans respond to a Request for Information (RFI) with a module on services for depression and alcohol use, receiving a ranking score. In addition to helping an employer choose which health plan is best, eValue8 provides health plans with an incentive to improve their services.</td>
</tr>
<tr>
<td>The Atlanta Business Coalition Initiative (ABCI)</td>
<td>ABCI works with Atlanta employers to encourage assessment of current mental health benefit plans to determine whether these investments are achieving optimal business and clinical results. ABCI links employers with resources that enhance the development of a mentally healthy and competitive workforce.</td>
</tr>
<tr>
<td>Mid-America Coalition on Health Care</td>
<td>The Mid-America Coalition on Health Care, led by a group of employers, launched the five-year Community Initiative on Depression to focus all stakeholders on collaboratively improving depression care. The project included an educational component, reducing stigma surrounding depression, identification of the direct and indirect costs of depression and creation of a community infrastructure to support appropriate and timely diagnosis and treatment.</td>
</tr>
<tr>
<td><strong>Provider Initiatives</strong></td>
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<tr>
<td>Sequenced Treatment Alternatives to Relieve Depression (STAR*D)</td>
<td>STAR*D was designed to assess effectiveness of treatments in representative samples of patients with nonpsychotic major depressive disorder in 23 psychiatric and 18 primary care settings. The study aimed to define outcomes for patients treated with an SSRI, to determine best “next-step” treatments for depressed patients who do not respond to earlier treatment attempts and compare different types of treatment in terms of relative efficacy, patient’s acceptance, side effects and economic costs.</td>
</tr>
<tr>
<td>American Psychological Association (APA)</td>
<td>APA is working on a joint project of American Academy of Family Physicians and American College of Physicians using the PHQ9 as means of screening in PCP and psychiatric care. This large demonstration project will look at barriers to adopting quantitative approach into routine care.</td>
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### Health Plan Initiatives

<table>
<thead>
<tr>
<th>Quality Initiatives</th>
<th>Program Description</th>
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<tbody>
<tr>
<td>The National Committee for Quality Assurance (NCQA)</td>
<td>NCQA has been successful in getting health plans to implement quality standards using HEDIS. HEDIS scores have two measures of depression treatment quality: 1) Antidepressant medication management (for effective acute phase treatment during first 12 weeks, effective continuation phase treatment during first six months and optimal practitioner contacts for medication management); 2) Follow-up after hospitalization for mental illness (7 days and 30 days).</td>
</tr>
<tr>
<td>Aetna</td>
<td>Aetna recently announced that they will pay primary care physicians to use the PHQ9 to screen for depression and provide follow-up consultations for patients who are either prescribed antidepressants or referred to psychiatrists or psychologists.</td>
</tr>
<tr>
<td>Pacificare Behavioral Health</td>
<td>Pacific Mental Health, which covers about 4.1 million individuals, uses assertive care management, outcomes management through quality practitioner identification and intensive clinical monitoring to improve quality of care. As an example, ALERT, a multi-dimensional outcomes management system, improved practitioner detection of suicide risk by 35 percent and detection of substance abuse risk by 17 percent.</td>
</tr>
<tr>
<td>American Healthways</td>
<td>American Healthways is now marketing a depression disease management program, integrating depression with other chronic illness, such as cancer, heart disease and diabetes. As part of the depression program, America Healthways nurses will screen using PHQ9 and regularly call members with depression to educate and support them regarding medications, side effects, warning signs or relapse and identification of treatment barriers.</td>
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### State Quality Initiatives

<table>
<thead>
<tr>
<th>State Quality Initiatives</th>
<th>Program Description</th>
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</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>The Institute for Clinical Systems Improvement (ICSI) in Minnesota is a collaboration of health care organizations sponsored by six Minnesota health plans. Members of the organization must do four or more quality improvement projects per year and one of the 2006 organization-wide improvement initiatives is primary care for depression. They have an excellence-recognition program based on HEDIS measures and are also working on common quality measures statewide.</td>
</tr>
<tr>
<td>Ohio</td>
<td>The Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, mental health boards, providers and clients developed Solution’s for Ohio’s Quality Improvement and Compliance (SOQIC), which was designed to implement a standardized consumer-centered cost-effective mental health delivery system. Ohio’s SOQIC Standardized Documentation Initiative forms include some measures of consumer outcomes, such as overall quality of life, problem severity and functioning.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Oregon recently passed Senate Bill 267, mandating that an increasing percentage of mental health funding for evidence-based programs. State behavioral health agencies will be required to show that 25 percent of program funding supports evidence-based programs, increasing to 75 percent by July 2009 and beyond.</td>
</tr>
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### Federal Government Initiatives

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<thead>
<tr>
<th>Federal Government Initiatives</th>
<th>Program Description</th>
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<tbody>
<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
<td>In addition to the MHSIP project, SAMHSA has developed national outcomes measures (NOMS) for domains such as employment/education, crime and criminal justice, social connectedness and stability of housing. SAMHSA provides standards for treatment, including evidence-based practice toolkits on illness management and recovery, assertive community treatment, family psychoeducation, supported employment and co-occurring disorders.</td>
</tr>
<tr>
<td>Administration of Veteran's Affairs (VA)</td>
<td>VA’s Quality Enhancement Research Initiative (QUERI) is designed to translate research discoveries into better patient care and systems improvements. QUERI focuses on ten high-risk and/or highly prevalent diseases or conditions among veterans including Mental Health.</td>
</tr>
<tr>
<td>Department of Justice (DOJ)</td>
<td>The DOJ Office of Juvenile Justice and Delinquency Prevention has put together a blueprint of model service programs with best practices for providing services to children regardless of what point they enter the justice system. They have a compendium of screening and assessment instruments specific to reading level, age and certain languages to aid in the identification and assessment of children with mental health problems. There are also a set of health and mental health performance standards for detention and correction facilities.</td>
</tr>
<tr>
<td>Centers for Medicaid and Medicare Services (CMS)</td>
<td>CMS developed quality toolkits and promising practices available on their Website based on their work with the New Freedom Initiative, which includes measures for mental health. Medicaid will support evidence-based practices identified by SAMHSA shown to be effective for individuals with mental illness.</td>
</tr>
</tbody>
</table>

These quality improvement programs provide models for other stakeholders in the field of mental health. While progress has been made in the area of quality mental health care, barriers still exist to providing optimal treatment for individuals with depression. More investment and attention to quality of care must occur in order to successfully bridge the gap between research and practice.
6.2 Key Opportunities for Improving Quality Care

The following section identifies opportunities for stakeholders to improve the quality and outcomes of treatment for depression.

**OPPORTUNITY**

**Develop a more comprehensive, coordinated and transparent system of care with access and coordination points so consumers know how and where to go for help when they first experience depression.**

Improve coordination between providers and form interdisciplinary teams of physicians, psychologists and social workers. Integrated care for mental health and substance abuse is essential to properly treating cases of dual diagnoses. Symptoms and problems of each disorder can overlap or exacerbate one another. Treating depression along with comorbid somatic illness requires integration of services. In primary care settings, improved collaboration between mental health specialists and PCPs is essential. Utilizing existing integrated and collaborative models, such as including depression care managers or mental health specialists in a primary care setting, has been successful in improving coordination of care. Integration of mental health care with other social services agencies, such as education, Department of Justice and welfare would also help improve quality of care. Federal agencies and other funding bodies could include coordination as a requirement for grant programs and funding.

**Stakeholders:**
- Payors
- Providers
- Employers
- Policymakers
- Regulators

**OPPORTUNITY**

**Fund mental health services and facilities adequately.**

Public and private payors should provide sufficient funding to mental health programs and services in order to provide appropriate and high quality care. Payment of providers should be adequate so that qualified providers have an incentive to stay in the clinical field and students have incentives to pursue careers in mental health care. Reimbursement systems must be more flexible and must cover services for treating the whole person, including social services and housing, which are essential for full recovery.

**Stakeholders:**
- Payors
- Policymakers
- Regulators

**OPPORTUNITY**

**Improve identification of depression, initial treatment and follow-up care.**

Screening and mood charts should be a standard component of every primary care visit, allowing providers to monitor depression like blood pressure. Depression care managers could follow up by phone throughout the course of treatment. Online or in-person questionnaires or automatic phone responses could help in tracking whether a patient’s symptoms are improving. Telephone psychotherapy and telephone care
management have been shown to significantly improve consumer satisfaction and clinical outcomes.  

**OPPORTUNITY**

**Improve education and training of providers.**

Providers should receive comprehensive training about the symptoms and warning signs of depression and suicide. Medical school training and continuing medical education (CME) programs for PCPs and other providers could improve the identification and treatment of depression. Providers should learn a recovery orientation and learn how to involve consumers and families in treatment decisions. Whenever possible, providers should be trained in treatment (both medication and psychotherapy) based on evidence-based practices. Data suggest that training can provide professionals with the necessary skills to effectively identify people with depression and treat them appropriately, reducing the potential for suicide.

**OPPORTUNITY**

**Establish quality measures and reward providers for performance.**

Pay-for-Performance (P4P) models could include incentives for reimbursing providers for treating the most difficult cases of depression, rather than the current system in which less ill consumers are the most cost-effective to treat. Ongoing screening should also be incorporated in P4P programs. Additionally, providers could be encouraged to spend more time with a consumer and establishing rapport, which is critical for improving outcomes.

**OPPORTUNITY**

**Collaborate with mental health advocacy groups to increase their reach and influence.**

By collaborating and working together, consumer advocacy groups can partner in order to speak with a unified voice, increase their influence and more effectively leverage resources. Funding mechanisms and government practices should encourage organizations to work together rather than in competition with each other.

**OPPORTUNITY**

**Expand biological and genetic research to develop better treatments, identify the subtypes of depression and determine the factors that predict treatment outcomes.**

Improving the response rate of depression treatments by matching treatments with the patient’s unique medical aspects (such as genetics, brain scans or blood tests) will...
require significant funding. Few areas of research promise greater increase in outcomes, however and this should be a prioritization in funding. Research must increasingly focus on genetic and brain imaging studies to show areas affected by depression and the role of neurogenesis generated by medications. Interactions among genetic, neuroimaging and treatment outcome measures may reveal unique “fingerprints” of response. MRI spectroscopy studies can help show where different medications are working, possibly leading to new therapies. Medication side effects and safety concerns should also be addressed. Medication coupled with psychotherapy has been shown to be effective and treatment and research should focus on improving psychotherapy methodology in addition to continually improving pharmacologic therapy. Depression includes many different types of conditions and differing levels of severity; identifying and learning to discern the subtypes will allow for the development of more targeted treatments. Examples of subtypes of depression that need further research include bipolar depression, treatment-resistant depression and late life depression. Emerging medical technologies will play an increasing role and also need to be integrated into treatment options.

**OPPORTUNITY**

Expand research needs to include longitudinal studies that are generalizable to different consumer populations.

Current epidemiological research is lacking longitudinal cohort studies that are representative of populations with depression. Older adults and individuals with comorbidities are often excluded from clinical studies, despite the fact that these populations have high rates of depression. Some racial and ethnic minorities are also less likely to participate in research. More research should focus on comorbid presentation with mood disorders and safe and effective treatments for this population.

**OPPORTUNITY**

Conduct more health services research focusing on treatment outcomes to evaluate and develop evidence-based practices.

Standardized quality outcomes should be measured consistently across providers and service systems to improve transparency of services. The focus should continue to shift to outcomes rather than process measures to assess patient improvement and promote recovery. More treatment models and programs need to be rigorously evaluated to increase quality of care in multiple settings across different population segments. Increased monitoring will enable patients to become more informed and empowered to decide on treatment and providers.
7.0 Conclusion

Depression is a preventable and treatable illness. Access to quality mental health care is fundamental to the health of individuals and the economic and social welfare of the United States. Depression can take an enormous toll on functional status, productivity and quality of life. With appropriate treatment, however, the majority of people with depression can live productive and satisfying lives.

Many individuals with depression suffer unnecessarily. Over the past 20 years, considerable progress has been made in developing new treatments, including new medications and psychosocial therapies, to help people who live with depression. However, America’s current system of public and private services and insurance coverage creates barriers to accessing mental health treatment. Numerous barriers and challenges, including lack of early detection and screening, fragmentation of services and inadequate reimbursement and funding have an impact on access to care, the types of treatment delivered, quality of services and the economic and social impact of depression.

Overcoming the multiple challenges in meeting the needs of those suffering from depression will require a multifaceted approach involving all stakeholders in the field of mental health. Many possible strategies emerged in the research and development of this report for improving health care delivery related to access, treatment, quality and economic and social impact related to depression. These solutions include promoting education, improving reimbursement structures, appropriate allocation of funds, coordination of care and consumer-driven treatment.

To meet the needs of the millions of Americans suffering with depression and the millions more who are affected in other ways by the illness, stakeholders must work in partnership. Stakeholders across the health care spectrum have opportunities to create a more accessible and comprehensive mental health system that will save lives and potentially reduce costs. If implemented, the opportunities outlined in Exhibit 22 could help transform the state of depression in America and the entire mental health care system.

Exhibit 22. Summary of Opportunities Grouped By Stakeholder

<table>
<thead>
<tr>
<th>OPPORTUNITIES FOR STAKEHOLDERS</th>
<th>PAYORS</th>
</tr>
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<tbody>
<tr>
<td>Introduce disease management programs and preventive care in the workplace.</td>
<td>●</td>
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<tr>
<td>Increase awareness of the prevalence of co-occurring chronic illnesses and depression.</td>
<td>●</td>
</tr>
<tr>
<td>Implement treatment adherence programs for consumers.</td>
<td>●</td>
</tr>
<tr>
<td>Promote open communication and therapy for depression within families and communities</td>
<td>●</td>
</tr>
<tr>
<td>Educate at-risk populations such as adolescents, elderly and their family members about suicide and its indicators.</td>
<td>●</td>
</tr>
<tr>
<td>Improve reimbursement for PCPs to take the time to screen, diagnose and treat depression.</td>
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</tr>
<tr>
<td>Provide easy-to-use mechanisms, such as a website or a dedicated toll-free telephone number, for PCPs to easily alert the payor that the consumer needs to be referred to a mental health specialist.</td>
<td>●</td>
</tr>
<tr>
<td>Offer higher rates of reimbursement or bonuses to providers who agree to practice in designated shortage areas.</td>
<td>●</td>
</tr>
<tr>
<td>Provide the same coverage for mental health services and treatments as for other medical conditions.</td>
<td>●</td>
</tr>
<tr>
<td>Provide peer support linkage to payors and providers to offer consumers access to peer support in their communities.</td>
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</table>
### OPPORTUNITIES FOR STAKEHOLDERS

<table>
<thead>
<tr>
<th>Access</th>
<th>Treatment</th>
<th>Quality</th>
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<tbody>
<tr>
<td>Develop programs that specifically reach out to minority groups to address their culturally specific issues with accessing treatment.</td>
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<tr>
<td>Shift focus from treating symptoms to achieving and maintaining recovery.</td>
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<tr>
<td>Promote consumer self-empowerment and decision making in treatment and services.</td>
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<tr>
<td>Increase consumer access to peer support programs.</td>
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<tr>
<td>Improve coordination of care and increase case management.</td>
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<tr>
<td>Improve cultural competency in the delivery of mental health services.</td>
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<tr>
<td>Educate consumers and providers about different treatment options.</td>
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<tr>
<td>Develop a more comprehensive, coordinated system of care with access and coordination points, so consumers know where to go when they first experience depression.</td>
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<tr>
<td>Fund mental health services and facilities adequately.</td>
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<tr>
<td>Improve identification of depression, initial treatment and follow-up.</td>
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<tr>
<td>Improve education and training of providers.</td>
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<tr>
<td>Establish quality measures and reward providers for performance.</td>
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</table>

### PROVIDERS

<table>
<thead>
<tr>
<th>Access</th>
<th>Treatment</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase awareness of the prevalence of co-occurring chronic illnesses and depression.</td>
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<td>Educate at-risk populations such as adolescents, elderly and their family members about suicide and its indicators.</td>
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<td>Provide easy-to-use mechanisms, such as a website or a dedicated toll-free telephone number, for PCPs to easily alert the payor that the consumer needs to be referred to a mental health specialist.</td>
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<tr>
<td>Offer higher rates of reimbursement or bonuses to providers who agree to practice in designated shortage areas.</td>
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<td>Provide peer support linkage to payors and providers to offer consumers access to peer support in their communities.</td>
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<td>Shift focus from treating symptoms to achieving and maintaining recovery.</td>
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<td>Promote consumer self-empowerment and decision making in treatment and services.</td>
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## OPPORTUNITIES FOR STAKEHOLDERS

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<tr>
<td><strong>EMPLOYERS</strong></td>
<td>Introduce disease management programs and preventive care in the workplace.</td>
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<td>Provide education about depression to employees and create a stigma-free work environment.</td>
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### OPPORTUNITIES FOR STAKEHOLDERS

Conduct more health services research focusing on treatment outcomes to evaluate and develop evidence based practices.

#### CONSUMERS

- Promote open communication and therapy for depression within families and communities.
- Educate at-risk populations such as adolescents, elderly and their family members about suicide and its indicators.
- Provide peer support linkage to payors and providers to offer consumers access to peer support in their communities.
- Develop programs that specifically reach out to minority groups to address their culturally specific issues with accessing treatment.
- Shift focus from treating symptoms to achieving and maintaining recovery.
- Promote consumer self-empowerment and decision making in treatment and services.
- Educate consumers and providers about different treatment options.
- Improve identification of depression, initial treatment and follow-up.
- Improve education and training of providers.
- Collaborate with mental health advocacy groups to increase their reach and influence.

#### PHARMACEUTICAL MANUFACTURERS

- Increase awareness of the prevalence of co-occurring chronic illnesses and depression.
- Promote open communication and therapy for depression within families and communities.
- Educate at-risk populations such as adolescents, elderly and their family members about suicide and its indicators.
- Develop programs that specifically reach out to minority groups to address their culturally specific issues with accessing treatment.
- Shift focus from treating symptoms to achieving and maintaining recovery.
- Provide grants or other funding to States for the development of depression screening and treatment services.
- Educate consumers and providers about different treatment options.
- Improve identification of depression, initial treatment and follow-up.
- Improve education and training of providers.
- Expand biological and genetic research to develop better treatments, identify the subtypes of depression and determine the factors that predict treatment outcomes.
- Expand research needs to include longitudinal studies that are generalizable to different consumer populations.
- Conduct more health services research focusing on treatment outcomes to evaluate and develop evidence based practices.
## Appendix I – Mental Health System Transformation through the Real Choice Systems Change Grants

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<th>State</th>
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<td>Delaware</td>
<td>&quot;Develop, pilot and disseminate for State and system-wide use a manualized, consumer driven family psycho-education program related to children's mental illnesses and severe emotional and behavioral disturbances.&quot;</td>
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| Maine       | "Build capacity for quality peer supports, self-directed services and other consumer-driven services and natural supports by developing a peer support Recovery Specialist Certification Program.  
              "Strengthen the consumer role in system and community agency governance, decision-making, planning and service delivery."                                                                                           |
| Massachusetts | Establish a formal network among all recovery-oriented activities that are also consumer-directed (ROCD) across the State.  
                     Assess the gaps in recovery-oriented and consumer-directed services throughout the State.  
                     Establish a State-level consumer-directed Recovery Center of Excellence (RCOE) that provides training and technical assistance to consumer-directed programs and traditional mental health providers and that impacts State policy regarding mental health services. |
| Minnesota   | Expand and update scientific information available to providers and families for guiding decisions about children's mental health care.  
                     Improve service quality of children's mental health systems of care through the development of an evidence-based practices database.  
                     Establish a fully operational system that improves outcomes for children and families.                                                                                                           |
| New Hampshire | Implement Illness Management and Recovery (IMR) as an evidenced-based practice in a comprehensive manner throughout the Bureau of Behavioral Health (services structures to support consumers in their recovery process.  
                     Involve consumers and peer support programs formally in the provision of IMR services by incorporating consumer-peers as IMR trainers alongside clinicians.  
                     Develop an organizational structure that specifies IMR clinician-peer specialist teams in each community health region to be responsible for delivering the services, as well as an IMR supervisor at each center and an IMR coordinator at the Bureau of Behavioral Health.  
                     Develop a credentialing process for IMR providers, including staff at community mental health centers, peer support agencies and State psychiatric facilities. |
| North Carolina | Achieve greater incorporation of evidence-based practices into the mental health system by assisting Local Management Entities to develop infrastructure necessary to support the implementation of evidence-based practices within their local communities.  
                     Review potential models for infrastructure development and develop or revise models for testing in local communities.  
                     Conduct field testing, review results and design an evaluation.  
                     Disseminate models by conducting training and technical assistance activities.                                                                                                                  |
| Ohio        | Integrate the use of peer support specialists into the evidence-based Assertive Community Treatment (ACT) services for individuals receiving mental health services from a Medicaid-funded community health center.  
                     Provide technical assistance to county boards and providers of ACT services in order to facilitate the incorporation of peer support specialists into Ohio's ACT teams.  
                     Disseminate lessons learned and learn from others about peer support and ACT.                                                                                                                   |
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| Oklahoma | • Develop policy and program framework for evidence-based practice.  
          • Develop policy and program framework for Recovery Support Networks.  
          • Create Recovery Support Networks.  
          • Develop a collaborative relationship with the behavioral health provider community that supports the continuing implementation of recovery-oriented and evidence-based practices. |
| Oregon   | • Develop and expand peer-operated programs and services from five to eight programs.  
          • Facilitate the incorporation of peer-operated programs and services as evidence-based practices.  
          • Identify collaboration strategies, funding mechanisms and policy improvements necessary to sustain peer operated programs.  
          • Increase consumer-participation and collaboration at all levels of service and policy design, implementation and oversight.  
          • Document and evaluate the impact of incorporating peer-operated services on mental health systems transformation. |
| Pennsylvania | • Select, engage and prepare counties in the northeast, central and western regions of Pennsylvania to implement a Certified Peer Specialist (CPS) program.  
              • Conduct CPS training in selected counties.  
              • Support and expand CPS activities.  
              • Develop a State Plan Amendment for Medicaid reimbursement of psychiatric and peer specialist services to provide ongoing program support. |
| Virginia | • Increase stakeholder knowledge to assure the State’s mental health system transformation and restructuring are based on principles of self-determination, recovery and empowerment.  
          • Align the State’s existing Medicaid Rehabilitation Option mental health services with the evidence-based practices of Assertive Community Treatment, Illness Management and Recovery and Supported Employment to the maximum extent possible.  
          • Maximize opportunities for peer specialists and consumer-operated programs to provide Medicaid reimbursable services and evidence-based practices, including a potential new adult peer support Medicaid service. |
Resources


23 Graphic provided by George, M., Ketter, T., & Post, R. Biological Psychiatry Branch, NIMH, Bethesda, MD. Courtesy of F.K. Goodwin, & Fawcett, J.
26 APA. (2000).
36 APA. (2000).


46 APA. (2000).


54 IOM. (2006).


62 Federal Medicaid and SCHIP mandates require minimum eligibility requirements, but states have discretion about extending services to additional groups.


84. Both $44 billion (1990) and $83 billion (2000) are frequently cited as the total cost of the illness in the United States. For the purpose of this paper, the $83 billion estimate is used, because it is the most recent. Both estimates are based on two cost-of-illness framework studies using the same methodologies, conducted by Paul E. Greenburg et al.
89. NDMDA. (2000).


110 CDC. (2002).


123 CDC. (2005).
126 NDMDA. (2000).
132 NAMI. (1997)


149 DBSA. (2002). General public survey findings.


Pampallona et al. (2004).

Pampallona et al. (2004).


235 Lewis, L. & Hoofnagle, L. (n.d.). *Patient perspectives on provider competence; A view from the Depression and Bipolar Support Alliance*. DBSA.


245 NDMDA. (2000).


248 NDMDA. (2000).


Resources

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