Standardised pharmacotherapy and psychotherapy were more effective than usual care for major depression in primary care.


Objective
To compare a multifaceted intervention with usual care (UC) for the treatment of depression in adults in a primary care setting.

Setting
Primary care (health maintenance organisation) clinic in the United States.

Patients
155 patients between 18 and 90 years old (mean age 46 ± 74% women) who had definite or probable major depression as measured by a structured interview. Exclusion criteria were alcohol alcohol dependence or abuse, schizophrenia, bipolar disorder, or suicidal tendencies, dementia, pregnancy, terminal illness, poor English, or intent to withdraw from the Group Health Insurance plan within 12 months.

Main outcome measures
1. Improvement in severity of depressive symptoms and proportion of patients who recovered by 8 months.
2. Analysed was by intention to treat. At 8 months, patients who received either NT or IPT had lower Hamilton Depression Rating Scale scores than did patients who received UC (P < 0.005).
3. In the NT and IPT groups did not differ for depressive severity scores at any time. More patients who received NT recovered after 8 months than did those who received UC (51% vs 28%. P = 0.001). This absolute risk improvement (ARI) of 33% means that 4 patients would need to be treated (NNT) with NT (rather than UC) to prevent a complication (a patient report outcome, 95% CI 2 to 5; the relative risk improvement (RR) was 170%, CI 33% to 329%).

Conclusion
Standardised pharmacotherapy and psychotherapy were more effective than usual care for the treatment of depression in adults with major depression. Source of funding: National Institute of Mental Health.

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Multifaceted intervention improved the treatment of depression in adults in a primary care setting


Katon and colleagues may consume more resources than are needed for maximal effectiveness and offers nothing to the patient whose depression is not recognised by the doctor. We need studies to delineate the minimal intervention for maximal effectiveness and further research to determine the benefits (if any) of enhancing the detection and subsequent management of depression by patients who present with somatic or other nonpsychological symptoms. In the meantime, those of us who work in primary care must be willing to bear and acknowledge our patients’ distress, apply standard criteria for the diagnosis of depression, assess the risk of self-harm and identify comorbidities, prescribe antidepressant medication with adequate support, and in adequate doses, and for at least 6 months, offer psychotherapeutic interventions of proven effectiveness, and be ready to refer when necessary.

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Author’s response
The consequence of collaborative care by a general health specialist and primary care doctor could be improved by targeting patients with major depression because patients with minor depression have high recovery rates with usual primary care. Recent studies have shown that primary care physicians accurately recognise patients with severe depression who are more disabled.

Wayne Katon, MD

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