Consensus Statement on the Primary Care Management of Depression From the International Consensus Group on Depression and Anxiety

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Depressive syndromes can occur with various degrees of severity and duration, ranging from major depression to subthreshold depressive disorders such as minor depression or brief recurrent depression. Most clinical evidence on the prevalence, burden, and management of depressive disorders has been gained in studies of major depression. In formulating our views on primary care management of depressive disorders, we have focused on major depression. We recognize that more extensive clinical evidence in minor depression will emerge in the next few years, as current therapeutic trials are completed and reported.

PREVALENCE OF DEPRESSION

Depression is a common condition and one that is frequently comorbid with anxiety, some other form of psychopathology, or with physical complaints or illnesses.

In the Community

There is general agreement in European community studies that the current (6-month) prevalence rate of major depressive disorder is approximately 7%.[1] Similar current prevalence rates were reported in the U.S. National Comorbidity Survey.[2]

In Primary Care Attendees

With the exception of hypertension, depression is more common in primary care than any other condition. The World Health Organization (WHO) study of consecutive presenters in primary care reported an average prevalence rate of 10.4% for current depressive episode (ICD-10).[3]

WHERE TO LOOK FOR DEPRESSION

In primary care, patients rarely present with depressive disorders in their pure prototypical form. Most often, psychiatric or somatic symptoms of a comorbid condition complicate the clinical presentation of major depression, making it more difficult to diagnose. The primary care physician needs the skills to detect depression masked by these other conditions, to avoid focusing too readily on the first symptoms mentioned by the patient and moving to a rapid clinical decision.

When there is an index of suspicion of depression, simple screening questions may be adequate to reveal the presence of depressive syndromes. Simply asking the patient "Have you lost interest and pleasure in most things you usually enjoy?" "Have you lost energy or do you suffer from unexplained fatigue?" or "Are you feeling sad, blue, or depressed?" might be helpful. This should be followed by a set of questions to assess the severity of any depressive illness present.

Physicians should be especially alert to the possibility of depressive symptoms in patients who present with substance abuse, anxiety, unexplained pain, as well as physical symptoms that are difficult to explain.

Anxiety Symptoms

Two of the most commonly associated clusters of psychiatric symptoms are anxiety and depressive symptoms. Approximately half the cases of anxiety and depressive syndromes in primary care occur in the same patient at the same time.[3]

Anxiety is often the presenting symptom for depressed patients with concomitant anxiety, and it is necessary that the physician identifies the breadth of symptoms and detects the coexistence of depression. Conversely, symptoms

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Table 1. Rates of Depression Associated With Physical Illness[a]

Physical Illness	Rate of Depression (%)
Cancer	20–45
Cerebrovascular accident	26–34
Chronic pain	33–35
Myocardial infarction	15–33
Parkinson's disease	40

[a]Adapted from Katon and Sullivan.[6]

of anxiety should be identified in the patient with major depression, since outcome is worse for depression comorbid with anxiety than for pure depression and both depressive and anxiety symptoms must be treated effectively.

Alcohol or Substance Abuse

One of the most important conditions comorbid with major depression is alcoholism or other substance abuse. An estimated 23% of subjects with substance use disorder also have a current major depressive disorder (see Wittchen et al.,[4] this supplement). This justifies a high index of suspicion for the presence of depressive symptoms in patients who present with either alcohol or substance abuse.

Physical Illness

When a depressed patient presents with physical illness, such as cardiovascular disease, depression may well be overlooked as the physician focuses on somatic symptoms, such as chest pain. Major depression affects more than 25% of patients with cardiovascular disease and is reported in some 20% of those who survive a myocardial infarction. If left untreated, major depression affects prognosis.[5]

Major depression is also commonly associated with cancer, cerebrovascular accident, chronic pain, and Parkinson's disease. The prevalence rates for depression in each of these conditions are presented in Table 1.

Whenever major depression and physical illness occur together, the patient experiences more severe symptoms and has a poorer outcome. Physicians should be careful to diagnose major depression in the presence of physical illness: it is a treatable condition and effective treatment can affect prognosis.

Research Need: Does the presence of depression affect the level of treatment patients need or receive when they also have a physical illness?

WHY IS IT IMPORTANT TO IDENTIFY DEPRESSION?

Disability

A consistent finding across countries and cultures is that depression interferes substantially with the ability to carry out normal daily activities.[7] The level of functional disability is in part related to the number of depressive symptoms and the chronicity of the depressive disorder. With the sole exception of advanced coronary artery disease and current angina, which cause greater functional disability, depression is more disabling than the other common chronic physical illnesses in primary care.[8] And when depression is comorbid with anxiety, other psychiatric symptoms, or physical illness, the effects on functional ability are additive.[3,9,10]

In considering the health care problem posed by depression, we are tempted to draw a parallel with hypertension. Recognition of the consequences of hypertension gave rise to routine blood pressure checks. By analogy, there may be a case for promoting mental health checks, especially for depressive and anxiety symptoms, as routine clinical practice.[11] Like hypertension, these conditions are also chronic, and routine follow-up is essential.

Suicide

Not only is suicidality a core feature of depressive disorders, but the risk of suicide attempts and suicidal ideation more than doubles in a depressed patient with comorbid anxiety disorders or physical illness.[12] This finding is consistent across epidemiologic studies in the community and is being confirmed in primary care samples. The rate of suicide attempts in pure depression is around 15% and is highest (around 40%) when panic disorder is the anxiety disorder comorbid with major depression.[13]

Health Care Utilization

Depressed patients are high utilizers of health care in terms of the number of visits they make to primary care physicians. Also, the presence of somatic or anxiety symptoms increases 3-fold the likelihood of consulting several types of physicians and undergoing more tests. Around 25% of distressed high utilizers of medical care meet diagnostic criteria for current major depression, while two thirds have a lifetime history of major depression.[6] Identification and treatment of depression in subjects with a history of high medical expenditure not only improve depressive symptoms, but also reduce the use of medical services.[14]

Indirect Economic Cost

The indirect economic cost of depression can be assessed from the loss of productivity, usually measured as the number of days of work lost or days of reduced work capacity (disability days) as a result of depressive illness. In the WHO study in primary care, pure depression was associated with 6.1 disability days per month, whereas depression comorbid with one or more disorders was associated with 7.7 disability days per month.[7] The Medical Outcomes Study highlighted that primary care patients suffering from depression spend more "bed days" per month than patients with other common chronic medical conditions with the exception of advanced coronary artery disease.[8]

HOW WELL IS DEPRESSION RECOGNIZED AND TREATED?

Depression is currently underrecognized and undertreated. Only around one half of the subjects suffering from depression are diagnosed as having psychological symptoms or difficulties. Again, only one half of these subjects are specifically identified as depressed. Among those diagnosed as suffering from depression, around 90% will receive inadequate treatment, in terms of dosing and duration, and only approximately 10% will receive adequate antidepressant therapy.[10]

Underrecognition and undertreatment of depression are particular problems in young adults.[15] The rate of depression is increasing in subjects aged less than 25 years (particularly young males), with an attendant high frequency of suicides and suicide attempts. As there is a low index of suspicion for depression in young adults, there is a low level of recognition and diagnosis. Without prompt and effective treatment, depression in this age group can become chronic, with recurrent episodes and often residual symptoms between these episodes.

While physicians tend to overlook depression in young adults,[12] they are more likely to identify depression in the elderly but be reluctant to treat it because they perceive depression as a normal and acceptable feature of aging. Also, they are often reluctant to complicate an already complex drug regimen because of inexperience with drug interactions and dosing in the elderly. For the older patient, who is likely to have a concomitant physical illness, late-life depression is treatable, and effective antidepressant therapy can improve outcome.

WHY DEPRESSION SHOULD BE BETTER RECOGNIZED AND TREATED

Major depression is predicted to become the second most disabling condition worldwide by the year 2020; it will be second only to ischemic heart disease in the level of disability and cost to society.[16]

Depressed patients are high utilizers of nonpsychiatric services. However, paradoxically, the rate of treatment of depression in primary care remains low. Increasing the rate of recognition and effective treatment of depression has the potential of reducing the burden on health care resources and increasing work productivity levels. It is particularly important to detect depression in young adults, because early treatment of depression at this age can reduce the likelihood of recurrence with its added burden of disability and loss of productivity. The rates of depression and suicide are increasing in young people, which underlines the importance of paying attention to this target group. There is evidence to indicate that antidepressant therapy can reduce the rate of suicide attempts.[17,18]

MANAGEMENT OF DEPRESSION

Symptom severity, patient preference, and availability of treatment options are all issues for physicians to consider when managing their depressed patients. The starting point is the time and skills needed by the physician to recognize and diagnose depression. Consultation times available to primary care physicians are decreasing. In the United States, for example, no more than 6 to 7 minutes on average is now devoted to each patient in a primary care setting. The rate of change in the pattern of consultation means that most of the data we have reviewed in reaching our consensus views were gathered in health care systems that in some ways no longer exist.

The physician also needs time to educate patients about depressive illness, explain how their symptoms can be managed, explore background problems, define treatment goals, and dispel negative perceptions, for example, that antidepressant therapy is addictive. This form of psychosocial education and support is an essential component of the management strategy for depression. Disease management programs have been developed for chronic conditions such as asthma and diabetes and a similar approach must be adopted for depression. It has major implications for compliance with antidepressant therapy and treatment outcome.

Drug Therapy

The decision to prescribe antidepressant therapy should be based on the number of symptoms, the level of dysfunction, and prior episodes of depression. It should not be influenced by whether there is an understandable explanation for the depressive episode, such as a stressful life event. Full-dose drug therapy is indicated for depressed patients with moderate-to-severe depression, for example, with symptoms like sleep disturbance that disrupt their normal daily activities, or for those patients whose functional disability prevents them from working.

All classes of antidepressant therapy have similar efficacy in resolving acute episodes of depression, but they differ in their side effect profiles. Side effects are an important determinant of choice of medication because they affect compliance with treatment. The selective serotonin reuptake inhibitors (SSRIs) have become first-line treatment for depression in psychiatric patients primarily because of their improved side effect profiles. This is somewhat less true in primary care where the tricyclic antidepressants are still commonly utilized. Recently, they have also been shown to be effective in treating conditions frequently comorbid with depression, such as panic disorder, social anxiety disorder, obsessive-compulsive disorder (OCD), alcoholism,[19] and depression with concomitant anxiety symptoms. (For a discussion of the appropriate management of panic disorder, see an earlier consensus statement in *J Clin Psychiatry* 1998; 59 [suppl 8].[20])

Antidepressant therapy needs to be maintained in an adequate dosage for an appropriate duration, if it is to be effective. Based on studies of depressed psychiatric patients, the current recommendation to prevent a rapid relapse is that patients be continued on antidepressants for 4 to 5 months after clinical recovery, which itself usually takes 3.6 months. This is not generally the practice in primary care in many countries at this time.

In a similar fashion, studies in depressed psychiatric patients indicate that depression is highly recurrent in a majority of patients. In patients who have 3 or more episodes of major depression, the risk of more episodes occurring approaches 90%. This has led to the recommendation that these patients be maintained on antidepressants for extended periods, indefinitely in some patients. Maintenance treatment is not yet routine practice in primary care, and research is needed to determine how these patients should be managed.

Research Need: Research is needed to establish whether depressed primary care patients need maintenance therapy to prevent relapse and prophylactic therapy after the third episode of depression, as do depressed psychiatric patients.

Nondrug Treatments

Cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are effective forms of psychotherapy for depression. These are sophisticated psychological techniques rather than interventions that a general physician can apply. Health care systems vary in their ability to provide effective psychological treatments as a component of the management strategy for depression, but we recognize that trained personnel to provide these therapies are not widely and equally available in all countries in primary care.

Problem-solving skills and other behavioral techniques, most of which can be provided as simple self-help materials, are part of the psychosocial support that general physicians could generally provide in a disease management program for depressive illness. It is a promising therapeutic approach, shown to be feasible and effective for primary care management of depression.[21] Physicians should explore whether their depressed patients have problems that are likely to be soluble and, if so, help develop solutions. If their problems are insoluble, however, physicians should consider appropriate coping mechanisms or the need to add cognitive therapy to counter automatic negative thinking. The process of negotiation between physicians and patients about the appropriate management of depression has been summarized succinctly in one public education program as "pills for symptoms and talk for problems."

Where resources are available, problem solving can be undertaken by nurses and counselors, rather than by busy physicians. In the United Kingdom, an estimated 53% of primary care practices have access to counselors. In the United States, only the larger health maintenance organizations (HMOs) are likely to have a behavioral component to treatment, although there is a trend for an increasing use of counseling.

Research Need: Research is needed on (1) appropriate drug and nondrug therapies and (2) identification of the most effective psychological component suitable for use by primary care physicians.

Table 2. Complicated Cases of Depression

Depression with psychotic features
Depression associated with substance abuse
Depression comorbid with panic disorder
Atypical depression (agitated depression)
Severe depression
Bipolar depression
Depression with active suicidality
Chronic relapsing depression needing long-term treatment
Double depression and chronic dysthymic depression

Referral to Specialist Care

Variations in the systems of health care provision from one country to another make it difficult for us as an International Consensus Group to propose strict rules for referral to specialist care. Additionally, in the United States, there is the added complication that access to specialists varies with both the location and the fiscal arrangement for payment.

We have set out to define minimum standards of care, recognizing that how these are accomplished will depend on the health care system. For example, in Germany, prophylaxis for relapse prevention is carried out in close consultation with psychiatrists, whereas there is no widely accepted practice in the United States to ensure this.

Most depressed patients are seen only in primary care. However, we can identify complicated cases of depression, typically involving patients who are resistant to treatment or have complicating comorbid conditions, for which the most appropriate form of management will involve referral to a specialist or consultation with one (Table 2). We recognize, however, that in managed care systems in the United States, there is a financial disincentive to referring a patient from the practice of the general practitioner (GP), and a similar situation may develop in the United Kingdom with GP purchasing of health care services.

We should single out suicidality for particular mention, as it is the one circumstance that will prompt most primary care physicians to refer patients to specialist care.[22]

Microskills

There are manuals describing how patients should be managed on a session-by-session basis.[23] With the current

standard for consultation times in the United States, it is inconceivable that primary care physicians will bring patients in for 6 consecutive visits to focus on problem-solving and psychosocial support. However simple the techniques, generalist physicians do not have the time to practice them. As it is unrealistic to expect generalist physicians to spend 20-minute sessions on 6 consecutive visits, they, or someone in their practice, e.g., a nurse, should be taught microskills that they can learn and integrate into their working practice.

IMPROVING THE RECOGNITION AND TREATMENT OF DEPRESSION

How can we improve the recognition and treatment of depression? We considered this question from different perspectives, identifying issues particular to the patient, physician, health care system, and society and making recommendations for tackling them. Since the majority of depressed individuals in many countries either never seek treatment or see their primary care physician and fail to mention their depressive symptoms, we reached consensus that attention to the issues underlying these problems was critical.

Patient Issues

1. *Stigma.* We recommend public awareness campaigns using testimony from prominent people who have suffered from depressive disorders and emphasizing the benefit of effective antidepressant therapy. In the United States, for example, Kay Jamison's best selling book, *An Unquiet Mind*, provides a moving account of manic depressive illness that can influence negative perceptions about depression and its treatment.[24] Advocacy groups, such as the Depression Alliance in the United Kingdom, can build on the achievements of public awareness campaigns run by medical bodies. Educational initiatives to counter stigma are important in the workplace to influence employers, and education about depressive disorders should start at an early age in schools.

Individuals with depression experience difficulty in obtaining medical insurance, which underlines the need for public policy changes to destigmatize the condition.

2. *Ignorance of depression.* We recognize that national programs to teach the public about depressive symptoms and their treatment, such as the D/ART (Depression Awareness, Recognition, and Treatment) program in the United States, are necessary and effective, as are information campaigns targeted at primary care, such as notices and on-line information in physicians' waiting rooms. A key message in educational programs is that anyone can get depressed, particularly someone suffering from a physical illness, and that it is important to seek medical help because depression is an eminently treatable condition.

Patient education materials must stress that antidepressant therapy is not addictive and that treatment of concurrent depression can improve the quality of life of patients with physical illness. We recommend that package insert leaflets for medication for physical illnesses such as cancer, heart disease, Parkinson's disease, and cerebrovascular disease refer to the psychological consequences of chronic illness and the benefit of treating any concurrent depression.

In the United States, the National Depression Screening Day has widespread television and radio coverage about depressive symptoms and where to seek medical help, which has proved very effective in identifying new cases of depression: some 70% of those who come forward are found to meet diagnostic criteria for depressive illness. Screening programs targeted at the workplace detect a high level (15% to 30%) of depression in workers coming forward.

There is no screening day for depression in the United Kingdom, but, in Germany, there is a nationwide awareness and depression screening day, including wide television and newspaper coverage, in which psychoeducative materials and information about recognition and treatment are provided.

In many countries, it is the pharmacists who advise patients about prescriptions, which makes them an important group to assist in the education of patients; self-help leaflets and illness information books can be made available in pharmacies.

3. *Self-blame.* Depression changes the way people think about themselves, and this cognitive distortion results in a lack of positive thinking, a sense of futility, and self-blame that can prevent them from seeking help. Even if they do recognize that they need medical help, they can be easily discouraged by any delay in getting a doctor's appointment. Receptionists can be unsympathetic about psychological problems. For example, anecdotally, receptionists give the patient with chest pain ready access to a GP whereas a patient with a relapse of depression may have to wait 2 weeks for an appointment. This highlights the importance of a whole team approach to training members of the practice.

The depressed patient often needs someone to take him/her to see a doctor, which is why it is important to involve the family in treatment.

4. *Failure to complete a course of adequate treatment.* Physicians play the major role in helping patients to accept the benefit of completing their course of treatment. They should elicit patients' views before they prescribe medication, countering ignorance about depressive symptoms and their treatment and stressing that antidepressant therapy is nonaddictive.

Treatment selection is an important determinant of compliance. Physicians can encourage patients to continue treatment by selecting antidepressant therapy with simple

once-daily regimens and minimal adverse effects. It is important that they inform patients adequately about what adverse effects to expect and provide them with telephone access to discuss any treatment issues. Other ways that physicians can encourage compliance are to make a definite appointment for a follow-up visit, rather than telling patients to come back in 3 weeks' time, involve the practice nurse by getting him/her to telephone patients, and gain the support of patients' families, because some may fail to be adequately supportive or even discourage patients from continuing treatment.

5. Presentation. When consulting a physician, many depressed patients focus on somatic symptoms, pain, or discomfort. If questioned, they tend to admit to depression, but they do not consider themselves to be depressed. Clearly, the patient with chest pain will want to discuss this first with the physician, but patients should consider their psychological state and, if they are depressed, mention this early in the consultation process. This is a critical issue because it has implications for the underdiagnosis of depression: the rate of recognition of depression falls if it is not included in the first 4 complaints mentioned by the patient.

Educating patients to be straightforward and honest about depression falls to physicians in primary care or physicians treating physical illness. Liaison psychiatrists can also play an important role because they have contact with physicians treating medical conditions in a hospital setting. Another educational route is to inform physical illness support groups about the frequency of concurrent depression and how effective antidepressant therapy can improve outcome.

Physician Issues

1. *Knowledge about depression.* Currently, most physicians can avoid significant mental health training throughout their professional careers. In the United States, it is not included in most training programs for primary care physicians, with the exception of those funded by a U.S. federal grant, in which the faculty must include a behavioral scientist, but even these do not focus significantly on the diagnosis and treatment of mental disorders. In the United Kingdom, a survey of the training needs of GPs showed that some 40% judged their 6-month psychiatric placements to have no relevance to their work as generalists.

2. *Skills development.* In our view, psychiatry should be a compulsory section in postgraduate examinations, and we advocate the increased use of skills development workshops, and less emphasis on lectures on mental health, at undergraduate, postgraduate, and continuing medical education (CME) levels. Psychiatric training of primary care physicians must be relevant to their needs. It must focus on the skills needed to diagnose and manage depression, anxiety, and substance abuse, because these are so common in primary care. For the recognition of depression, physicians need effective interviewing skills to elicit relevant information about depression when the patient emphasizes somatic complaints. This includes the skill to assess the severity of depression.

For better management of depression, physicians need both (1) clear guidelines on the adequate dose and duration of treatment and (2) more effective skills training to increase their abilities to accurately diagnose and treat depression. They also need to be aware, for example, that they can improve the quality of life of sufferers from chronic medical conditions such as rheumatoid arthritis and multiple sclerosis by treating their concurrent depression. The fact that depression is explicable because of chronic illness is not a reason for withholding treatment. We need to address the misconception that giving small doses of antidepressant medication for a short period of time constitutes appropriate treatment. Similarly, many primary care physicians fail to accept that benzodiazepines are not the treatment of choice for depression and are inappropriate as sole therapy, even for patients with depression and concomitant anxiety.

3. *Lack of time.* We wish to emphasize the need to open the debate with managed care and other health care providers about consultation times for depressed patients. This is a health economic issue to increase their awareness about the burden of depressive disorder and the complexity of managing the condition. The current approach to tackling the issue of competing demands on primary care physicians is to use screening instruments that make most efficient use of their time, to use new diagnostic systems specifically developed for primary care such as ICD-10 Primary Health Care (PHC)[25] and DSM-IV, Primary Care (PC),[26] and to make more use of extender resources.

We advocate a team approach to the management of depression, involving all members of the practice, including the receptionist, and applying appropriate training to ensure there are no front-line attitudes discouraging depressed patients who are seeking medical help. Physicians lack the time to follow up patients. In programs directed at increasing the time patients continue to take medication, getting a nurse to telephone after the first weeks of treatment is found to improve compliance substantially. However, the average duration of taking antidepressant therapy is around 10 to 12 weeks, which is still disappointing.

Research Need: Would an increased primary care consultation time lead to an improved outcome? If 20 minutes rather than 10 minutes were available for a consultation, would this lead to an improvement in the quality of care and reduce the number of future visits?

Health System Issues

1. *Nonbiased funding.* There is a need to establish parity for insurance coverage between psychiatric disorders and other medical conditions. In the United States, mental disorders are often not reimbursable in primary care.

2. *Structure.* We have identified a number of structural changes that would be potentially helpful in the management of depression in primary care but that are not in widespread use, for example, (1) the use of simple depression screening scales, like the Defense Style Questionnaire (DSQ),[27] Center for Epidemiologic Studies–Depressed Mood Scale (CES-D),[28] or Symptom-Driven Diagnostic System for Primary Care (SDDS-PC)[29]; (2) using physician extenders, nurses, and depression specialists to collaborate with primary care physicians in the management of depression; (3) setting up depression management clinics within practices to improve scheduling of follow-up visits and encourage collaboration within the health care team; (4) exploring computerized systems for diagnosis and management or for raising an index of suspicion of depression, for example, by identifying patients in the practice who are chronic users of benzodiazepines; (5) setting up telephone follow-up of patients to encourage them to comply with treatment regimens and linking this with regular appointments to review their treatment; and (6) involving the pharmacist system in the detection and management of depression; for example, since medical conditions associated with chronic pain have a high incidence of depression, a feedback mechanism when a patient has 3 consecutive prescriptions for chronic analgesia would alert the primary care physician to possible concurrent depression in need of treatment.

3. *Links between mental health and primary care.* The central issue is the need for an information network for primary care physicians, so that they are aware of the methods for referral of patients and which mental health specialists they can consult. In the United States, study data suggest that telephone contact, on-site work, teaching, and the development of protocols are effective means of improving the working relationship between mental health and primary care physicians. We note that some managed care companies have tried to implement disease protocols, but that these are often directed at restricting treatment rather than facilitating or enhancing it. In the United Kingdom, national standards and performance indicators are being developed within the framework of the new national health service and, for example, primary care groups will have to develop mental health strategies consistent with these standards.

4. *Training skills.* We have identified the need for practice-based, skills-based training, which will clearly cost more than didactic lectures in postgraduate centers. The implications for training budgets are significant, but as the requisite skills to implement changes in the health system are not widely distributed, we maintain that appropriate mental health training is a priority that must be met.

Societal Issues

1. *Attitudes.* There is an overwhelming need for educational programs targeted at policy makers, employers, and the general public to change attitudes about depressive disorders. There is a prevailing view that depression is a normal human reaction (simply not feeling well) and, with the exception of very severe depression, no intervention is needed. In terms of their influence, policy makers within governments and health care systems are the most important target group. They need to be convinced, through educational initiatives and direct lobbying by advocacy groups (such as the Depression Alliance in the United Kingdom), that depression is a diagnosable disorder for which treatment is both cost-effective and humane. The core of our educational message for all these target groups is that depression is common and costly in terms of disability, morbidity, and health care costs; it is treatable, yet it is underrecognized and undertreated.

Employers present 2 educational challenges: (1) at a policy level, to convince companies paying the health bills that they should ensure adequate reimbursement for treating mental disorders and that their employees have adequate access to appropriate treatment, because the return should be fewer days of work lost to illness and potentially overall savings; (2) at a managerial level, to ensure that individuals with depression are not discriminated against by their immediate supervisors.

We are aware of an educational initiative in the workplace in Europe, funded by large industrial companies in Austria, Switzerland, and Germany. It is driven by a panel of psychiatric opinion leaders and provides consultants who advise on coping with mental disorders in the workforce, annual courses and awareness days on depression, and information targeted at employees and physicians.

We advocate educational programs in schools as well as the workplace. Substance abuse and drug addiction are health issues tackled in the school systems in the United States and Europe. We would like to see a school program like that in Norway, where depression and other mental disorders are included in the 10-hour curriculum on health issues.

Research Need: The medical costs of treating psychiatric problems in an industrial setting have been calculated, but there are relatively limited data on the return in terms of productivity.

2. *Cost to society.* An important aspect of any public education program on depression is to provide an appreciation of the economic burden of the disorder, in terms of the days of work lost to illness or days in which the capacity to work is impaired, and the economic benefit of effective treatment.

3. *Model of depression.* There is a confused perception in society about the nature of depression, with debate about whether it should be redefined as a biological disease. We believe it is more helpful to the public to maintain the integrated view that depression is both biological and psycho-

logical. What we would want to emphasize is that without intervention, depression can be chronic and relapsing. A model of an episodic disorder is one that is readily understandable to both physicians and the public. Typically, at the end of psychotherapeutic intervention, we teach patients to be aware of the symptoms that brought on the index episode, so that the onset of any new episode is recognized. Prodromal symptoms, such as sleep disturbance and fatigue, can appear weeks or even months before a subsequent episode. The earlier treatment is started, the easier the episode of depression is to treat. The simple message to patients is to seek help sooner, rather than later, and insist on effective treatment.

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