

IMPACTING LATE LIFE DEPRESSION: INTEGRATING A DEPRESSION INTERVENTION INTO PRIMARY CARE

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Care for depression in late life is often less successful in primary care than in carefully controlled clinical trials. Collaborative care models attempt to integrate mental health services into primary care. The authors conducted two focus

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groups and semi-structured individual interviews with all Depression Clinical Specialists (DCSs) working with Project IMPACT (Improving Mood: Promoting Access to Collaborative Treatment), a study testing a collaborative care intervention for late life depression, to examine integration of the intervention model into primary care. DCSs described key intervention components, including supervision from a psychiatrist and a liaison primary care provider, weekly team meetings, computerized patient tracking, and outcomes assessment tools as effective in supporting patient care. DCSs discussed details of protocols, training, environmental set-up, and interpersonal factors that seemed to facilitate integration. DCSs also identified research-related factors that may need to be preserved in the real world. Basic elements of the IMPACT model seem to support integration of late life depression care into primary care. Research-related components may need modification for dissemination.

KEY WORDS: aging; depression; primary care; integration.

INTRODUCTION

Depression is a risk factor for, and complication of, many common late life illnesses (1), and patients often prefer treatment in primary care over specialty mental health settings (2,3). However, care for depression in late life is often less successful in primary care than in carefully controlled clinical trials (4–6). Researchers have identified barriers on the parts of patients, providers and systems of care that can interfere with initiation and maintenance of adequate treatment (4), yet strategies addressing individual barriers have not been successful in isolation (6). Researchers have begun to look toward comprehensive, multistrategy approaches to delivering depression treatment in primary care.

Reviewing recent studies, Simon (7) suggests a number of key components of a comprehensive population-based depression treatment approach in primary care. These include: integration of mental health services and specialists with primary care that goes beyond colocation, emphasizing communication and shared responsibility for the same patient population; systematic monitoring of follow-up care and treatment adherence; routine assessment of clinical outcomes; and systematic identification of indications for consultation and referral to specialty care. Interventions incorporating these elements in various ways have been successful in mixed age populations (8,9) and are currently being tested among older adults (10–13).

Effective interventions integrate elements that support the patient, the provider and the system interactively, so that the impact of the

package is more powerful than the sum of its parts. As Coyne and Katz (14) point out, multifaceted interventions “must be viewed as integrated packages, not as simple aggregations of efficacious elements of care.”

These principles were incorporated into an intervention tested in a multisite, randomized controlled trial of a collaborative stepped care model for late life depression in primary care, Project IMPACT (**I**mproving **M**ood: **P**romoting **A**ccess to **C**ollaborative **T**reatment) (12). Preliminary findings suggest that this model is significantly more effective than usual care in improving outcomes over 3 and 6 months, and is robust across varying systems of care with diverse patient populations (15). IMPACT attempts to integrate effective components of mental health treatments for depression into primary care. This paper explores how such “integration” was achieved, and suggests factors to consider in disseminating the model from a research paradigm into the real world.

METHODS

Main Study Design

The research design of Project IMPACT and the intervention model tested have been described in detail elsewhere (12,16,17). The IMPACT intervention model emphasizes the elements of population-based depression treatment:

Incorporation of Mental Health Services into Primary Care. IMPACT approaches coordination of medical and mental health services through a collaborative care model. A depression care team is built around a Depression Clinical Specialist (DCS) in primary care. The DCS works with a team of providers including the patient’s own primary care provider (PCP), a consulting psychiatrist, and a liaison PCP. The DCS manages individual care using strategies tailored to primary care. These strategies include depression education, support of antidepressant medication management, delivery of Problem Solving Treatment in Primary Care (PST-PC) (a brief psychotherapy for depression) (18–20), behavioral activation, and referrals to medical, psychological and/or social services as indicated.

During the initial visit the DCS provides psychoeducation by reviewing an educational brochure and videotape (21,22) with the patient and conducts a clinical assessment focusing on the patient’s experience of depression. The biological and psychological aspects of depression, as

well as the rationale behind medication management and PST-PC, are described. The patient is also engaged in a process of behavioral activation in which plans for structuring pleasurable activities are made.

The DCS, team psychiatrist, and liaison PCP meet weekly to review treatment plans and patients' progress. The DCS then works collaboratively with the patient's personal PCP to discuss IMPACT team recommendations and to facilitate implementation of the care plan.

Systematic Monitoring of Follow-up Care and Treatment Adherence. DCSs follow a manualized stepped care treatment protocol (23). The care manual specifies which treatments may be tried at each step and for how long. If an initial treatment trial is not effective ($\geq 50\%$ reduction in depressive symptoms was not achieved), alternative treatments are outlined (16,23). Throughout the treatment trial, DCSs are prompted by a web-based computer system (12,23,24) if overdue for a regular patient contact to monitor treatment effectiveness and side effects.

Routine Assessment of Clinical Outcomes. At each visit the DCS assesses treatment outcomes using a patient self-administered PHQ-9, a nine-item depression subscale derived from the PRIME-MD Patient Health Questionnaire (25) and completes a DSM-IV (Diagnostic and Statistical Manual of Mental Disorders–IV) symptom checklist for major depression and/or dysthymia.

Proactive Approach to Specialty Care. Specialty care is built directly into the intervention via the team meeting. Psychiatrist input is provided in person during the meeting and as needed by telephone. In addition, a psychiatric consultation visit in primary care is recommended for patients who have not responded to two initial courses of treatment.

Settings for the Study

The IMPACT intervention is being tested in a randomized trial with 1,801 older adults with major depression or dysthymia at 18 primary care practices around the United States (12). Participating practices are affiliated with two staff model HMOs, two regions of a large group model HMO, the Department of Veteran's Affairs, two university-affiliated primary care systems, and one private practice physician group. They range in size from 7 to 64 primary care providers.

Methods for the Qualitative Substudy

The authors used qualitative research methods to explore integration of the IMPACT model into varied primary care “cultures.” Two 90-minute focus groups with all DCSs currently participating in the project were conducted in addition to one 60–90 minute individual semi-structured interview with each DCS. Eleven DCSs were interviewed; six others had left the project and could not be contacted. Of the 11 DCSs interviewed, nine were RNs, some with advanced degrees (MS, MSN, CS, or ANP degrees) and many, but not all, had mental health backgrounds. Two DCSs were psychologists.

The first focus group was held prior to the individual interviews and covered topics relevant to understanding the role of the DCS in primary care. The individual interviews were performed subsequently by telephone. The interviews elaborated on the focus group questions. All telephone interviews were transcribed verbatim and reviewed for identification of important and recurring themes. The second focus group followed the individual interviews and focused on those themes identified as pertaining to implementation and integration of the IMPACT model. Themes culled from the interviews were presented to DCSs for verification, correction and comment. Comments were hand-recorded during the meeting and used in combination with interview transcripts to further develop model-related themes. A draft paper summarizing the results was circulated to DCSs for confirmation of the investigators’ interpretation of findings.

RESULTS

For this analysis we define “integration” as the creation of a primary care based environment in which patients, providers and the health care system successfully interact for the improvement of depression outcomes. Themes raised by DCSs in focus groups and interviews speak to integration of aspects of the model with each other, as well as integration of the whole model into primary care.

The Patient

Care Strategies. DCSs pointed to the simple educational and behavioral elements of the IMPACT process of care as valuable tools for engaging patients as collaborators in their treatment. DCSs were able to incorporate these nontraditional elements into brief primary care

visits both in-person and over the telephone. DCSs also commented that empowering patients to recognize symptoms and side effects and to feel competent using the health care system was important in motivating patients to manage their care. They spoke of teaching patients to recognize warning signs that signal a depression recurrence, for example, and to seek follow-up care promptly.

Language. DCSs noted that language can be a barrier to effective communication about depression. Many described patients who did not really understand why they had been referred to the study, as they did not consider themselves “depressed.” Many patients, especially men, identified more with their somatic symptoms, or found that their dominant mood factor was irritability or apathy rather than “the blues.” Engagement in a therapeutic partnership was sometimes more attainable when patients were allowed to approach their depression with words such as “stress,” or “grief,” or with innovative descriptors offered by the patient, such as “metabolic fatigue syndrome.” Some could accept “a little guidance,” even if they rejected the diagnostic label of depression.

Simplicity. DCSs emphasized the importance of simplicity in working with patients in primary care. While some had the skills to deliver more elaborate mental health treatments, they emphasized the importance of using primary care friendly strategies, rather than bringing secondary and tertiary care strategies into the primary care setting. While treatments such as behavioral activation and PST-PC are comfortably used in a brief primary care-based visit, longer term cognitive and insight-oriented therapies can be accessed through referral to off-site mental health providers. Though patients may be initially wary of seeking mental health services, education by the DCS and initial improvements in symptoms may dispel stigma, making it more acceptable to seek further help.

The Health Care Team

Role Definition. DCSs spoke of the importance of a clear role within the health care team. The model envisions the DCS as a care manager who works in partnership with the patient and the PCP. DCSs pointed to the importance of not being perceived as taking over the patient’s depression care. Instead, the DCS reports to the PCP whether a patient is experiencing side effects, for example, and discusses alternate treatment options, but it is the PCP who decides when to change dosage or medication type. DCSs noted the need to be flexible in working with

different physician and system styles. Some described communication via formal notes or by e-mail. Others could stop a doctor in a hallway for a brief chat. With time, many DCSs found that PCPs were contacting them for consultations.

DCSs also described their role as facilitating linkages between patients, the care team and PCP, as well as other components of the health care system. For example, a DCS might assist a patient in accessing a pain management clinic if chronic pain turned out to be a significant component of depression.

Relationships and Supervision. Relationships with other IMPACT team members were repeatedly cited as invaluable for making connections to provide care. Many DCSs spoke of the weekly team meeting as a powerful aspect of the model. This multispecialty forum for treatment planning was well suited to viewing the “whole” patient, examining the interactions of various comorbidities beyond that which a PCP can integrate in a short office visit. For example, older patients often need both their congestive heart failure and their depression treated fully before fatigue is substantially alleviated. With both a psychiatrist and a primary care physician in the room at the same time, an optimal treatment plan could often be efficiently devised.

The presence of the psychiatrist at the team meetings was raised by many DCSs as an extremely successful aspect of the model, and an efficient use of specialist time. During the meeting the psychiatrist could consult on the care of many patients in a short period of time, providing expertise that was not in the arsenal of the DCS, PCP or PCP liaison. While it was more difficult for psychiatrists to make time for individual patient sessions, the commitment to the once-a-week meeting was usually manageable. In addition, DCSs found it helpful to page the psychiatrist whenever immediate consultation was needed.

Though in-person psychiatric consultations were utilized to some degree, these were not always as well integrated into primary care as the model intended. The stepped care protocol specified when a patient visit with a psychiatrist should be recommended, but DCSs said it could be difficult logistically to bring the psychiatrist into the clinic more often than once a week. Time constraints, distances, traffic, etc. interfered with implementation of this intervention component. At times the team felt that the psychiatrist had been so involved in prior treatment planning that a personal visit was unlikely to further enhance the treatment process.

The liaison PCP was described as an important troubleshooter for continuity of care issues. In settings where care can be quite fragmented,

with patients seeing different providers at different visits, the liaison PCP can provide the necessary linkages. In addition, he or she can facilitate communication with providers when the team has medical, rather than depression treatment recommendations. In some clinics the DCS was eventually able to acquire enough familiarity and acceptance to do some of this troubleshooting personally. DCSs pointed to availability of expedient psychiatric and medical input as extremely helpful in fulfilling their responsibilities and in diffusing job stress. Access to team members outside the team meeting was occasionally cited as a problem. Some DCSs looked to other psychiatrists or physicians if the appropriate team member could not be reached.

Knowledge. Primary care content knowledge was raised as being important to the role of the DCS in managing the interrelationships between physical and mental illness. Many DCSs said a thorough understanding of antidepressant medication management and medical comorbidities was invaluable. The project provided specific training in depression treatment for DCSs before recruitment of patients began. Training included project goals, specific aspects of collaborative care including the roles of each team member and how to work with primary care providers. A detailed stepped care algorithm with specific guidance in antidepressant choices, intervention flowchart and timeline, documentation and clinical tracking procedures, use of the web-based clinical information system and a thorough training course in PST-PC were also provided. Many DCSs commented that the training was extremely helpful and that they frequently referred to the intervention manual after training. The value of clearly defined procedures and goals was repeatedly stated. A number of DCSs recommended the addition of content on the treatment of anxiety, cognitive impairment, and chronic pain as common co-occurring conditions with depression. Many DCSs had prior formal mental health training. For those who did not, additional general mental health content would have been valuable.

Many DCSs commented that the rigorous PST-PC training was important. DCSs were convened in person for two two-day training meetings. They then worked with five training cases for six sessions each at their local sites before being certified as PST-PC therapists. They audiotaped each training session for review by a PST-PC expert. DCSs commented that the audiotaping was somewhat stressful, but the individualized feedback was very helpful. It was noted that a fast turnaround time for this feedback was necessary so that the DCS could remember the session well enough to benefit. The DCSs and trainers were geographically separated and could not review the tapes together.

DCSs who joined the project later as replacements or back-ups were given videotapes of the original training sessions along with the intervention manual and access to PST trainers by phone. Some received one-on-one training by another DCS at their site. Still, some of those who did not have the benefit of the full in-person training indicated that they felt less comfortable in their roles.

Boundaries. Clear interpersonal “boundaries” were mentioned as important in maintaining the integrity of the desired DCS role, both with patients and with providers. A clear sense of what was and was not appropriate for a DCS to do helped DCSs focus on facilitating the process of depression care within the system, rather than directly doing tasks that were more appropriately handled by the patient or another provider. DCSs spoke of tolerating the patient’s discomfort and teaching him/her the process of solving problems rather than jumping in to “make it better.” They also spoke of needing to help other clinic providers understand the limitations of the model. In Project IMPACT, DCSs are not responsible for managing all types of mental illness. Based on team discussion, referrals are made for appropriate specialty mental health care.

The Health Care System

Practice Environment. DCSs said it was important to build relationships with front office and nursing staff, and to become known to physicians. DCSs whose offices were located in the practice area where patients were seen said this visibility was very helpful in establishing a presence. Chance meetings and casual hallway conversations supported the process of fitting in and working together. Those whose offices were not in practice locations or in practice locations where they did not encounter PCPs in their day-to-day work said they found it more difficult to acculturate. In these situations, staff members and physicians were less likely to know the DCS, and communication tended to require more formal effort and time. Persistent communication efforts with staff and physicians eventually led to most DCSs considering themselves a well-established presence in their practices.

Having designated office space and easy computer access were mentioned as aspects of feeling comfortable and integrated into the practice. Often DCSs were not permanently located in a personal space (partly due to the temporary nature of the study) and some described this as unsettling. A source of frustration for some DCSs was lack of access to administrative staff for appointment scheduling and administrative

tasks such as copying of paperwork. While some DCSs preferred to do their own appointment scheduling, many said they would ideally want more support. Other signs of feeling integrated that occurred for some but not all DCSs included being invited to office staff meetings or parties.

Patient Monitoring and Outcomes Assessment. The web based clinical information system (CIS) (24) was cited as an invaluable tool for staying on top of patient monitoring so that virtually no one “fell through the cracks.” DCSs accessed the system via the internet on their local computers. The use of the PHQ-9 (25) to monitor outcomes worked well to assist the DCS in determining when additional treatments should be tried within the stepped care framework. DCSs suggested the addition of other assessment tools, such as tools for assessing cognitive decline, alcohol abuse and personality disorders. Patients with significant problems in these areas might not be fully served by the DCS and such tools could help identify them for specialty referrals.

Management. Because IMPACT was introduced into primary care as a research project, some of the administrative and management procedures may not be representative of how things would function under nonresearch conditions. DCSs helped identify components of the research design that may need to be preserved or modified to disseminate the real world.

Case Finding. DCSs pointed out the need to preserve some form of the research recruitment techniques. Study recruiters and project coordinators used screening methods and direct physician referral to identify potential participants (12). They formally interviewed patients to see if they met study criteria for major depression or dysthymia. Ineffective case finding, or referral of patients who do not meet the correct criteria could impede integration of the model. This raises questions about the organization and financing of case finding under nonresearch conditions.

Intervention Length and Caseload

For research purposes, the length of time a patient was to be seen by the DCS was set at 12 months. This was somewhat artificial from a clinical perspective. DCSs commented that though some patients required more time to fully benefit from the intervention, many could have been seen for a shorter period without compromising benefit. The

resources provided by the study, and the time required for study-related documentation allowed the caseloads to be relatively manageable most of the time (a maximum of 85 active patients at a time for a full-time DCS). In the real world, DCSs noted, caseloads might need to be larger for cost-effectiveness, but the heavier caseload could force DCSs to be less thorough in their follow-up efforts.

Documentation

An area where integration was not fully achieved was documentation. Many DCSs spoke of double-documenting, once in the web-based Clinical Information System (CIS) with electronic forms specifically developed for the IMPACT study (24), and once in the clinic's computer or paper-based medical record system. The CIS was seen by DCSs as integral to the IMPACT model, and may need to be maintained in the real world. While the IMPACT forms could be printed and included in the patient medical record, some DCSs still found themselves duplicating work to fit their notes into the clinic's documentation system.

DCS Support

Another "artifact" of the research machinery was the support of the study's coordinating center. DCSs were convened by the coordinating center for monthly conference calls to support standardization of the intervention. Research-related questions, CIS questions and patient issues were discussed with peers and with the coordinating center principal investigator. Many DCSs commented that the conference calls were extremely useful for clarifying how to deal with unusual cases within the model, and for feeling validated and supported by peers. It was mentioned that the DCS role can be isolated and lonely, in that many DCSs had no peers on-site. The project also hosted two meetings where DCSs participated in training updates and interacted with each other in-person.

DISCUSSION

The IMPACT model of depression care was designed to overcome known barriers to care on the parts of patients, providers and systems of primary care delivery. According to impressions gathered from IMPACT DCSs, integration of mental health services into primary care seems to be achievable when 1) a health worker with a clearly defined care manager role is placed at the center of a multidisciplinary team;

2) that central team member is well-versed in biological and psychological depression treatment models especially with regard to antidepressant medication and medical comorbidities of late life; 3) that team member can engage patient cooperation using educational and behavioral strategies, and help patients make their own linkages within the system of care; 4) the team member can maximize efficiency of expert input from a psychiatrist and a primary care expert through case presentations at a regular meeting; 5) expert input can be effectively communicated to the treating provider on a case-by-case basis; 6) follow-up is assisted by simple reliable tracking methods, including computerized reminders to avoid oversights and 7) team members get regular feedback on patient outcomes by means of simple assessment tools.

Features that seemed to facilitate integration of the IMPACT model included clear goals and role definitions in training materials and protocols; ability of DCSs to be flexible in using terms and “labels” that patients can understand and accept; thorough in-person training supported by a “take-home” manual; *both* biological and psychological knowledge and skills training and explicit protocols for care management; ability of psychiatrists to attend weekly team meetings and willingness to be paged as needed for telephone consultations; DCS visibility in the practice setting, and persistence in building relationships with front office and nursing staff and PCPs; clear boundaries in maintaining a care manager role with patients and providers; and sufficient access to information and support for the DCS.

Aspects of integration that will need attention as the model is moved from a research paradigm into the real world include:

Case Finding

Since case finding was carried out by the administrative structure supported by the research operation, cost-effective clinic-based strategies will need to be worked out within systems of care. Existing administrative staff may take on functions such as handing out screening forms in waiting rooms and forwarding positive screens directly to the DCS for further investigation. In large systems of care, screening procedures may be incorporated into regular mailings sent to program members, such as newsletters or health assessments. Physicians may be helped to make appropriate referrals if the PHQ-9 is supplied in the exam room. DCSs or other staff may need to do a brief evaluation to determine whether a referred patient is depressed, or whether other mental health services may be more appropriate.

Intervention Length and Caseload

Varying intervention lengths according to patient need may be more appropriate in the real world than setting a specific time period. DCSs may provide one-time consultations to support physicians in a patient's depression care, if the full range of DCS services is not required. This may make it possible to see more patients while focusing the most intensive services on only those patients who need them. Other methods of maximizing efficiency might include providing broader training for the DCS so that he or she could manage chronic medical conditions (such as diabetes) or other mental health conditions (such as anxiety) in addition to depression.

Documentation

Systems of care would need to investigate efficient and cost effective strategies for combining the CIS into the larger documentation system. While certain confidential information may only be appropriate for the DCS file, much of the data collected by the DCS needs to be accessible to the patient's regular provider and should be entered into the medical record.

DCS Support

Since conference calls and in-person meetings were considered so valuable, systems of care might choose to find ways to offer such support. In large systems of care a medical director might be able to replicate the conference call for DCSs at multiple clinics within the system, and occasional in-service training sessions where DCSs within a system could convene might prove cost-effective. Systems of care should consider the importance of locating the DCS in proximity to clinic staff and PCPs, and of including the DCS in administrative and social events of the practice.

Psychiatric Consultation

Scheduling patients on the same day as the team meeting might make psychiatric consultations easier to coordinate. Other options might be visits to a team psychiatrist's office off-site or telephone follow-up visits once a patient is established.

CONCLUSIONS

While the IMPACT model will certainly evolve after completion of the study, the basic elements of collaborative care, computerized patient monitoring, regular outcomes evaluation, the principles of stepped care, and the availability of expert supervision and consultation should be maintained. As the model is refined and built upon, effective integration of mental health into primary care remains the goal.

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