In Review

Health Service Patterns Indicate Potential Benefit of Supported Self-Management for Depression in Primary Care

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Objective: To examine health service delivery in a Canadian province (British Columbia) to consider how Canadian health care services might be developed to best address the large number of individuals with mildly to moderately severe depressive illnesses.

Method: We used provincial administrative data to describe patterns of medical services provided to individuals suffering from depression during 3 different time periods (1991–1992, 1995–1996, and 2000–2001) and to determine the frequency with which depression patients receive treatment from primary care physicians and psychiatrists. We then used these findings to consider the feasibility and potential applicability of the various approaches that have been described to decrease the burden of disease related to depression.

Results: In the fiscal year 1991–1992, the "treated prevalence" rate was 7.7%; in 1995–1996, it was 8.7%; and in 2000–2001, it was 9.5%. In each cohort over the 10-year period, the proportion of individuals who received a diagnosis of depression and who were then treated by primary care physicians alone (no psychiatric services were provided) remained constant at 92%.

Conclusions: Supported self-management is identified as a promising intervention that could be integrated into primary health care within the context of the Canadian health care system. It constitutes a feasible and practical approach to enhance the role of family physicians in the delivery of services to individuals with milder forms of depression and promotes the active engagement of individuals in their recovery and in prevention of future episodes.

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Clinical Implications

- Health system support to optimize primary mental health care service delivery for depression could potentially have widespread benefits among the population.
- The addition of a supported self-management component for primary treatment of depression is an effective and feasible strategy, particularly for minor depression.
- Supported self-management is an important component of a CDM approach to depressive disorders and requires the support of psychiatrists and other mental health specialists to be widely adopted.

Limitations

- The present analysis has not captured sessional treatment services delivered by family physicians and psychiatrists.
- The data examine physician services exclusively. Thus services provided by other health care providers are absent from the analysis.
- The findings may not be fully generalizable to other jurisdictions in Canada.

Key Words: *depression, primary care, shared care, self-management, accessibility, mental health services*

It is now well known that depression is a highly prevalent condition responsible for a large burden of disease worldwide.[1] However, solving the question of how health care systems can best respond to the burden of disease created by depression remains a great challenge.

Even in relatively wealthy countries, it is unclear how health care services could most effectively reduce the widespread disability related to depressive illness. In countries with well-developed primary health care services, such as Canada, there is a potential opportunity to use the existing network of family physicians to improve the treatment of depression at a population level. Early recommendations focused on increasing the identification of depression by primary care providers.[2] However, it is now well established that efforts to increase the identification of depression in primary care are relatively ineffective unless they are coupled with other treatment strategies.[3–5] For example, Wagner[6] points to potential benefits in implementing collaborative care, nurse case management, and telephone follow-up, all of which have been shown to increase the effectiveness of treatment for depression.

In this paper, we examine health service delivery in a Canadian province (British Columbia) to consider how Canadian health care services might be developed to best address the vast number of individuals with depressive illnesses, particularly the large proportion with milder forms of depression. We use provincial administrative data to describe patterns of medical services provided to individuals suffering from depression during 3 different time periods and to determine the frequency with which depression patients receive treatment from primary care physicians and psychiatrists. Subsequently, we discuss the implications of the extant service delivery patterns and identify an approach—supported self-management—that we consider to have particular promise for reducing the burden of disease related to depression. A rationale is provided for this approach within the context of the Canadian health care system. Finally, we discuss limitations of the current study and recommend subsequent steps to promote further examination of these issues and strategies.

Abbreviations used in this article

CBT	cognitive-behavioural therapy
CDM	chronic disease management
MSP	Medical Services Plan
NICE	National Institute for Clinical Excellence
SD	standard deviation
SSM	supported self-management

Method

We used provincial administrative medical service use data to create 3 retrospective cohorts of individuals who had been diagnosed with depression in British Columbia at 3 different times over a 10-year period. By combining information obtained through service use data with information provided by British Columbia's Vital Statistics Agency regarding the size of the population in the province during the specified periods, we calculated treatment prevalence rates.

Description of the Administrative Database

In British Columbia, as in most other Canadian provinces and territories, required medical services provided by fee-for-service medical practitioners are paid through a province-wide billing system, known in British Columbia as the MSP. This information, along with information from other sources, has been linked, anonymized, warehoused, and made available to researchers through a university–government partnership.[7] Data related to the MSP claims were abstracted from this dataset and used in this study.

An MSP claim must provide, among other mandatory fields, a unique identifier specifying the individual who received the service, a valid date of service, a valid physician number representing the physician providing the service, and a valid (minimum 3-digit) ICD code or supplemental diagnostic code (certain codes have been added for use specifically within the British Columbia system). The diagnostic code is intended to describe the main diagnosis associated with the specified visit. Although the database does contain unique patient and physician identifiers, these have been encrypted to protect privacy and confidentiality. The specialty of the physician can be obtained from the physician's encrypted number.

Data Abstraction and Analysis

From the information available in the provincial datasets, it is possible to abstract all records wherein the individual was diagnosed with some form of depression by a physician. Previous research with the British Columbia databases has found that most depression episodes are coded with 1 of 2 ICD codes, 296 or 311, and a specific British Columbia code 50B (referred to as anxiety–depression and generally reserved for more minor episodes).

In the current study, we selected a sample of individuals who had been diagnosed with depression (the MSP records contained one or more of the diagnostic codes identified above) within a 10-year time span; we selected samples from each of 3 fiscal years (1991–1992, 1995–1996, and 2000–2001), thus creating 3 retrospective cohorts. Individuals of all ages were included. For each of the fiscal years examined, we calculated

Table 1 Characteristics of 3 retrospective cohorts of individuals diagnosed with minor depression and their service use for the subsequent 1-year period

Characteristic and service use	Cohort 1 1991–1992	Cohort 2 1995–1996	Cohort 3 2000–2001
First diagnosed in last half of fiscal year, *n* (%)	105 526 (40.7)	130 715 (39.6)	144 906 (37.7)
Also identified in earlier cohort, *n* (%)	—	9,527 (7.3)	17,888 (12.3)
Seen by family physician, *n* (%)	101 869 (96.5)	117 218 (96.7)	122 700 (96.6)
Seen by psychiatrist, *n* (%)	6 781 (6.4)	8 691 (7.2)	9 564 (7.5)
Primary care only, *n* (%)	95 088 (92.0)	108 527 (92.0)	113 136 (92.0)
Psychiatric consultation, *n* (%)	2 080 (2.0)	2 726 (2.0)	3 107 (3.0)
Psychiatric treatment, *n* (%)	4 701 (5.0)	5 965 (5.0)	6 457 (5.0)
Number of visits to family physician in subsequent year, mean (SD)	2.1 (2.2)	2.4 (2.6)	2.4 (2.4)
Number of visits to psychiatrist in subsequent year, mean (SD)	5.8 (7.6)	5.9 (8.4)	5.5 (7.7)

— = No data

the 1-year prevalence rates for treated depression by using population statistics for the respective years provided by British Columbia's Vital Statistics Agency.

To favour selection of new episodes of depression (rather than ongoing treatment episodes), we then selected only those records in which depression had been diagnosed on October 1 or later and eliminated all instances in which depression had also been diagnosed during the period March 1 to September 30 of the respective fiscal year. Also, if any of the remaining individuals appeared in 2 or more of the selected fiscal years (for example, if they were identified both in 1991–1992 and 2000–2001), we eliminated the later record. For each cohort, the age distribution was plotted.

Subsequently, we obtained all MSP depression claims for each individual over a 1-year period from the service date associated with their first depression claim in the year in which they were a cohort member. We examined service use characteristics over the 1-year period following the formation of each of the 3 cohorts.

A priori, we defined 3 categories of service delivery as follows:

- Primary care only. The individual had no contact with a psychiatrist over the 1-year period but received primary care physician assessment or treatment.
- Psychiatrist consultation. The individual had one contact with a psychiatrist over the 1-year period in addition to primary care physician assessment or treatment.
- Psychiatrist treatment. The individual had more than one contact with a psychiatrist over the 1-year period, in addition to primary care physician assessment or treatment.

We determined the proportions of individuals who were distributed across the 3 categories of service delivery defined above. We then used the results of our analysis of data concerning the treatment of depression in British Columbia to consider the feasibility and potential applicability of various approaches that have been described to decrease the burden of disease related to depression.

Results

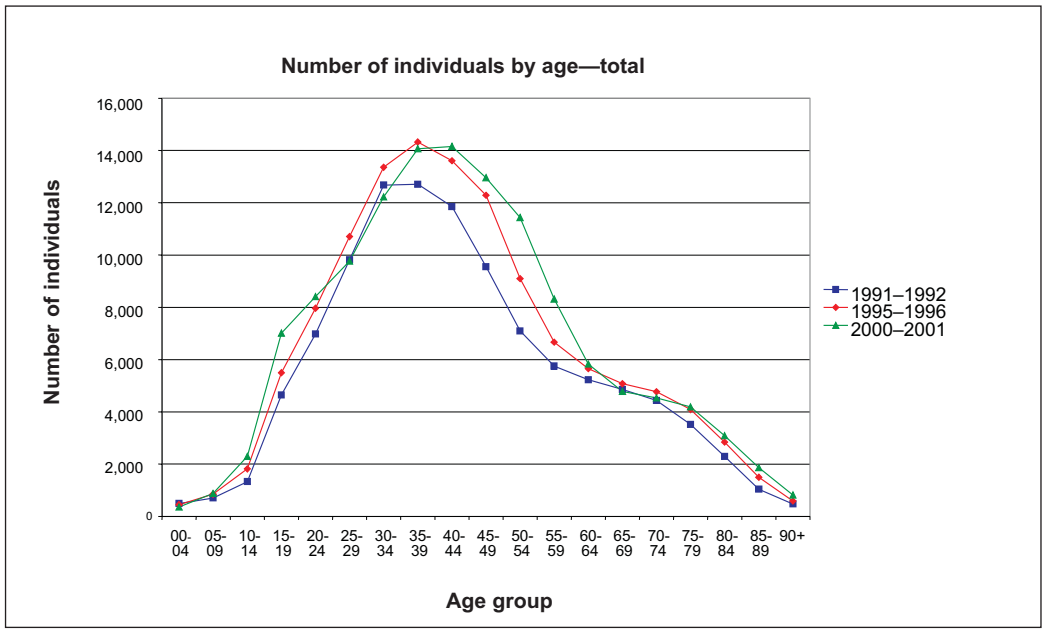
In the fiscal year 1991–1992, British Columbia physicians diagnosed 259 442 individuals of all ages with depression, producing a treated prevalence rate of 7.7%. In 1995–1996, 330 197 individuals received a diagnosis of depression, resulting in a treated prevalence rate of 8.7%. In 2000–2001, 384 484 individuals were diagnosed with depression, resulting in a treated prevalence rate of 9.5%.

Table 1 summarizes the characteristics of the 3 retrospective cohorts, each of which was formed by including only individuals diagnosed with depression in the latter half of each fiscal year examined and by excluding individuals identified in earlier cohorts.

The age distribution within each of the 3 cohorts is plotted in Figure 1. We found the age distributions to be similar across the 3 time periods and did not consider them to show clinically significant differences.

Table 1 also summarizes findings regarding the medical services received by individuals within the 3 cohorts. The proportion of individuals diagnosed with depression and receiving any psychiatric consultation or treatment was found to have increased in each of the subsequent cohorts over the 10-year period, from 6.4% in 1991–1992 to 7.2% in 1995–1996 to 7.5% in 2000–2001. In each cohort over the 10-year period, the proportion of individuals who received a

Figure 1 Age distribution of individuals diagnosed with depression in 3 cohorts (1991–1992, 1995–1996, 2000–2001)



diagnosis of depression and were then treated by primary care physicians alone (that is, no psychiatric services were provided) remained consistent at 92%.

Figure 2 summarizes information regarding Cohort 3 patients' visits to primary care physicians during the year following their diagnosis of depression. During this 1-year period, the mean numbers of visits to primary care physicians for treatment of depression were found to be as follows: for primary care only, mean 2.3 visits, SD 2.2; for psychiatrist consultation, mean 4.4 visits, SD 4.2; and for psychiatrist treatment, mean 5.0 visits, SD 5.0.

Discussion

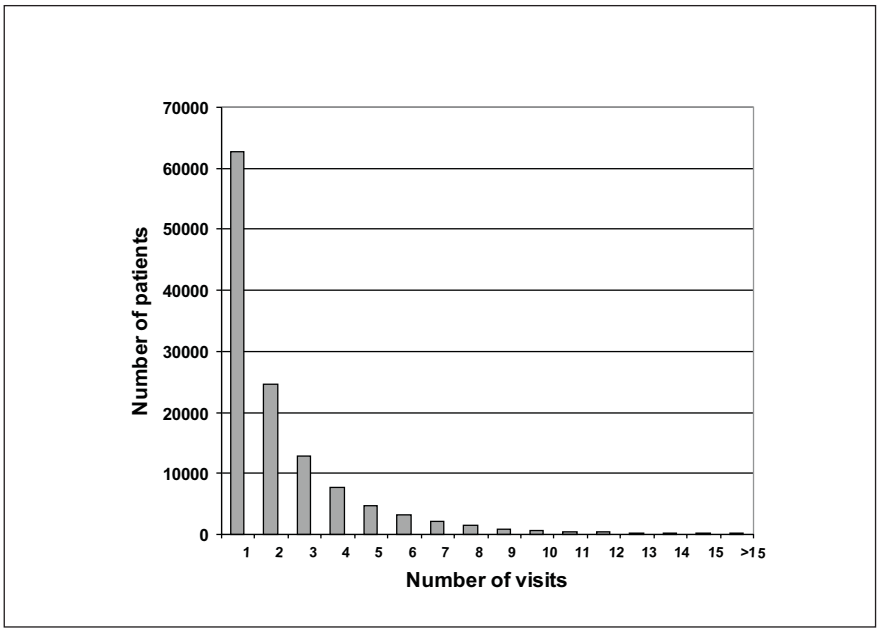
Our results indicate that most individuals who receive publicly funded health care treatment for recent-onset depression fall into the primary care only category, wherein the primary care physician manages the depressive disorder without specialist physician support. This highlights the key role of Canadian primary care physicians in addressing this highly prevalent condition.

Our analysis does not examine services by health care professionals and treatment providers other than physicians, although surveys conducted in Canada have indicated that individuals with mental disorders also receive some treatment from social workers, psychologists, nurses, and others, through publicly funded health care services, employee assistance programs, or private payment arrangements.[8] In British Columbia, some individuals with severe depressive illness receive publicly funded treatment from teams of health professionals, and a proportion of individuals with depression pay privately for counselling, psychotherapy, or other interventions. However, for most individuals with milder depressive illnesses, health care services addressing depression are provided by physicians through the public health care system. In the current paper, we have focused our attention on treatment services for the large group of individuals with milder forms of depression.

Over the 10-year period between 1991–1992 and 2000–2001, the number of individuals diagnosed with depression within a 1-year period increased substantially. The increase in the proportion of individuals being diagnosed with depression by physicians could reflect an increased awareness and sensitivity to depression on the part of primary care physicians as a result of public health efforts, or it may have been associated with continuing education and marketing activities undertaken by the pharmaceutical industry, advocacy groups, professional associations, or governments. Another factor might be an increased level of awareness within the general public and patient populations. Possibly, the findings represent a true increase in the incidence of depression within the British Columbia population over the 10-year period. In any case, the use rates further substantiate the high prevalence of depression that has been the subject of many previous reports and epidemiologic studies.

Another prominent finding is that most patients given a depression diagnosis in primary care are seen for 3 or fewer sessions over a 1-year period. In fact, the largest proportion of patients receive only a single session during the subsequent

Figure 2 Number of visits to family physicians in the year following diagnosis of depression for patients in Cohort 3 (2000–2001)



year and only a very small proportion receive extended follow-up.

Patients receiving psychiatric consultation or treatment experience a greater intensity of service from the primary care physician than do patients who are seen only in primary care. The most likely explanation for this pattern is that primary care physicians refer individuals with more severe depression to psychiatrists[9] but also provide a relatively high level of service themselves to these patients. Thus primary care physicians do not appear to hand over patients with severe depression to psychiatric care but, rather, stay involved in clinical management.

To examine the treatment of depression among recently diagnosed individuals, we created 3 cohorts of individuals who had not received a diagnosis of depression for at least 6 months prior to the identifying diagnosis. We also excluded individuals who had been diagnosed with depression in previous cohorts, although in Cohort 3, about 12% of individuals who received a diagnosis of depression in 2000–2001 had also received at least one diagnosis of depression in one or more of the previous cohorts. This group likely represents individuals who have persistent or frequently recurring problems with depression. However, the service use data indicate that there is a larger group of individuals who may not experience persistent or recurrent illness. It is likely that this large group of individuals has relatively less severe depression, yet they nevertheless suffer painful symptoms such as dysphoria, guilty rumination, and social withdrawal and often experience significant disability at work or at school, with negative consequences for family life and potential physical health problems. Thus we are led back to the challenging question: How may our health care systems best respond to the widespread problem of depression and the large burden of disease among the population?

Various solutions have been proposed, and many would require considerable financial investments, with the addition of substantial human resources. Along these lines have been recommendations for increases in the provision of mental health specialists such as psychiatrists, psychologists, nurse specialists, or counsellors. Another possibility is to train primary care physicians so that they can provide specialized interventions such as CBT. Yet another proposed solution has been to increase the use of antidepressant medications to treat a larger proportion of the population with depression. Several experimental studies and reviews have been published addressing the advantages and disadvantages of these approaches.[9–12]

From our analysis of service use patterns, we believe that an approach exists with particular promise for addressing the large burden of disease associated with depression. The approach has evolved in part through developments initiated within the framework of the CDM model, which represented a revolutionary development in orienting health care systems to respond more effectively to public health problems prevalent among the population. A key aspect of the CDM model is "self-management,"[13] that is, engaging the patient as an active participant in dealing with his or her disorder rather than as someone who merely complies with treatment.[14]

Self-management can be used in a format wherein the health care provider (for example, the primary care physician) supports and guides the patient's self-care efforts. We call this "supported self-management"; elsewhere in the literature, it has been termed "guided self-management" and "guided self-care." SSM is not equivalent to patient education, because SSM addresses self-efficacy and seeks to improve particular skills and behaviours in problem solving and decision making while increasing knowledge about individual health conditions.[15]

SSM for depression has 2 main components. The first is a behavioural intervention by the health care provider, who offers encouragement and guidance in regard to self-management; this role is bound by practical limitations of time and training. The provider is not expected to deliver psychotherapy but, rather, to facilitate the patient's self-management.SSM may be provided as a stand-alone intervention or as an adjunct to psychopharmacological or psychotherapeutic treatment, depending on the severity and complexity of a particular situation.

The second component of SSM is a self-management manual or other tool that is given to the patient. Such a self-management tool provides knowledge of the disorder and teaches skills that are based on research evidence. For depressive disorders, these self-management skills are typically derived from CBT. The information contained within the self-management tool must be clearly expressed, user-friendly, and easily accessed (see the note at the end of this paper). Knowledge and skills related to managing mental health problems are most commonly delivered as bibliotherapy, that is, in a manual or other printed text. Self-management materials may also be delivered via CD ROM or the Web. The latter modes of delivery have more potential for interaction and rich graphic presentations. Several computer-based self-management tools have shown significant benefit for individuals suffering from depression; examples include the Beating the Blues program developed in the United Kingdom[16] and the Overcoming Depression on the Internet program[17] developed at the Kaiser Permanente Center for Health Research in the United States.[17] Another innovative, Web-based self-management tool is the Clinical Management and Treatment Education program developed at the University of New South Wales in Australia.[18]

Inherent to SSM is the setting of realistic, concrete, scheduled, and time-limited goals that enable one to clearly recognize and experience change. SSM helps to direct individuals with depression away from setting goals that are too ambitious, too vaguely stated, not set to a specific time, or not written down. In addition, SSM may contribute to improved outcomes (that is, to relapse prevention) by helping patients maintain recovery achieved through standard treatment modalities.

Although providing support for self-management is relevant to many illnesses, depression seems particularly appropriate for this approach. One of the defining characteristics of depression is its impact on motivation, reducing individuals' perceived ability to plan or initiate self-care activities. Thus depression patients are particularly likely to benefit from their physician's support. Also, note that the role of SSM may be assumed by a friend, family member, or peer counsellor.

With regard to knowledge transfer, it has been shown that providing individuals suffering from depression with self-management material based on cognitive-behavioural principles does increase their knowledge of the cognitive-behavioural model and recommended strategies.[19] Individuals suffering from mildly to moderately severe depression have been found able and willing to apply self-care tools, with demonstrable benefit. Empirical studies of depression self-management have demonstrated that dissemination to such individuals of self-management materials based on cognitive-behavioural principles yields clinical effects similar to those found with antidepressant medication or CBT, that reductions in depressive symptomatology associated with self-care are maintained at 6- to 24-month follow-up, and that similar results are obtained across a wide age range, from adolescents to older adults.[20–25]

These findings have generally been obtained in counselling centres; the incremental benefit of SSM for depression in primary care settings remains to be determined. One study included self-management materials in a multicomponent program to enhance depression treatment in primary care. Although the enhanced program produced better outcomes in patients with major depression and most patients described the self-management materials as helpful, the separate effect of self-management could not be distinguished.[26] In 2 recent studies, self-management materials were delivered by primary care physicians, but the intervention groups did not show improved clinical outcome when compared with groups receiving usual care.[27,28] Note that these studies included only patients with major depression and made no further distinction regarding symptom severity; thus, no conclusion can be drawn regarding the additional benefit of self-management materials for mildly to moderately severe episodes in primary care. In the United Kingdom, the specific utility of SSM for milder forms of depression has been endorsed by the NICE, which produced a depression guideline that states, "For patients with mild depression, health care professionals should consider recommending a guided self-help programme based on cognitive-behavioural therapy (CBT)."[29, p 5]

Notably, the NICE guideline further states, "Antidepressants are not recommended for the initial treatment of mild

depression, because the risk–benefit ratio is poor."[30, p 5] As noted by Katon,

> Evidence also suggests that patients with minor depression and adjustment disorders are frequently treated with antidepressant medications, which represents 'overuse' in the [Institute of Medicine] nosology since there is little evidence of effectiveness of medication in these populations.[30, p 225]

Providing physicians with an alternative approach to managing mild depression supports them in shifting away from relatively ineffective pharmacologic strategies.

In summary, the clinical effectiveness of SSM has been demonstrated for milder forms of depression, although its utility for more severe forms has not been established. It is difficult to mark the point on the depression continuum at which SSM becomes efficacious. The literature concerning prevalence of mild or major depression in primary care indicates that major depression occurs with a 1-year prevalence of about 4%, whereas milder forms of depression have a significantly greater prevalence, with estimates ranging between 5% and 16%.[31–33] An easily administered and well-validated depression measure, the Patient Health Questionnaire, provides score ranges and severity descriptors that can be used to identify appropriate patients.[34]

For patients receiving psychiatric consultation in addition to primary care management, the role of SSM is less clear. These patients are likely to suffer from severe depression and to be less able to focus on self-management. It does not seem probable that a consulting psychiatrist would focus on encouraging self-management for patients with severe depression. Still, the consulting psychiatrist is in a good position to frame the case in biopsychosocial terms and thus promote cognitive and behavioral coping, as taught in SSM.

For patients receiving psychiatric treatment in addition to primary care management, the potential role of SSM is even less apparent: service intensity data suggest that these patients represent the most severely ill group, who are least likely to profit from self-management. Here, SSM would likely be relevant as one component of a relapse prevention program designed to maintain gains after the resolution of a depressive episode.

Self-management for depression has several potential benefits. First, use of effective self-care methods by a patient may contribute directly to improved clinical outcomes. Second, building the patient's capacity for self-management may enhance the individual's sense of agency (that is, self-efficacy), an aspect of psychological function often depleted by the suffering and reduced self-control associated with depression. Third, providing a self-management intervention allows us to deliver partial forms of clinical intervention otherwise unavailable; that is, SSM is a component of a stepped care approach to service delivery.[35] With regard to service delivery for depression, this has mainly involved the use of selfmanagement material to deliver a diluted version of CBT, reflecting the lack of available CBT in public health systems. Fourth, recent Canadian epidemiologic studies indicate that a large proportion of individuals prefer to use self-care for mental health problems.[36] A range of explanations may be provided for this finding (for example, surveyed individuals possibly curtailed their expectations according to their perception of available assistance, or the stigma of receiving mental health treatment possibly dissuaded them from seeking help, or they prefer to cope with mental health difficulties themselves). However, no matter which explanation one accepts, it makes sense to acknowledge this population preference and to support individuals in self-managing their depression.

Limitations and Strengths of the Current Analysis

The results and analysis of service use data presented here should be interpreted with consideration of several limitations. Because information contained in the MSP datasets is not collected according to rigorous research procedures but, rather, as a part of routine clinical practice by physicians, the validity of the diagnostic data can be questioned. Nevertheless, it is likely that physicians who record a diagnosis of depression are, in general, applying considerable clinical skill and experience and, consequently, it is likely that these data provide meaningful information. Data regarding the number and distribution of services are likely to be of high quality, surpassing the reliability and validity of data collected in other studies that use self-report and eliminating errors due to poor recall. A substantial strength of analyses using large administrative datasets in the Canadian public health care system is their ability to examine information about the entire population, diminishing the likelihood of sampling errors and often rendering moot the issue of whether findings are generalizable to the population of interest.

In British Columbia, some physicians are paid for providing mental health services through sessional payments, and in these instances, information about diagnosis and treatment visits is generally unavailable. Consequently, a proportion of treatment services by family physicians and psychiatrists has not been captured in our analysis. However, sessional payment for mental health treatment is devoted primarily to physicians who work in specialist mental health clinics focusing on the treatment of people with psychotic illnesses and to a proportion of physicians working within hospital inpatient services. Consequently, it is unlikely that the lack of information regarding sessional physician services alters our main findings or conclusions.

An important limitation of our analysis of service use is that the data examine physician services exclusively. Thus services provided by other health care providers, such as psychologists, nurses, social workers, and others, are completely absent from the analysis. Clearly, an optimal system of mental health service delivery is multidisciplinary, and improvements in health care service planning must consider the roles of the full and appropriate complement of health care professionals. Nevertheless, an examination of the outpatient treatment options currently available for people with milder forms of depression reveals that virtually no services exist through the Canadian publicly funded health care system other than those provided by primary care physicians and (or) psychiatrists. Generally, individualized outpatient treatment for depression provided by psychologists, social workers, counsellors or other health care workers is not covered by provincial or territorial public insurance. For the most part, any outpatient services for depression provided by someone other than a physician require private out-of-pocket payment. In this paper, we limit our analysis to the public health care system, and consequently, understanding publicly funded physician services is of central importance. However, efforts should be increased to consider how Canadian health care services might respond to the large burden of depressive illness through a strategy that uses the strengths of various health care disciplines and practitioners.

Another limitation concerns the generalizability of our findings to other jurisdictions in Canada. Each Canadian province, territory, and region may have a unique configuration of services and resources. A study by Watson and colleagues[37] used administrative data to examine physician services in Winnipeg, Manitoba, in regard to mental health diagnoses over a similar time period (1992–1993 to 2000–2001), yet they obtained a different picture of service use than was found in the current study. The approaches to cohort identification and procedures for estimating use rates were too dissimilar across the 2 studies to allow meaningful comparison of findings; however, the Winnipeg study appeared to find a much greater proportion of combined services provided by psychiatrists and family physicians.

Conclusion

There seems to be a significant opportunity to enhance existing primary care of depression through the introduction of SSM. This would represent a practice change for primary care physicians—an addition to their existing repertoire of interventions for depression.

However, it is by no means certain that such a practice change can be widely disseminated. Previous attempts to introduce new depression management practices to primary care physicians have been disappointing, to say the least. A range of educational interventions designed to improve depression care have been evaluated, with very limited success. A systematic review of educational interventions to improve depression care concluded, "Simple educational strategies to improve the recognition and management of depression, when given alone, have minimal impact on clinical practice and the outcome of depression."[38, p 153] This review argued that only costly enhancements of the care system itself (for example, funding a telephone-based outreach service for depression patients) would generate significant practice change. Although this conclusion seems overly pessimistic and premature, given that extant studies have demonstrated small but meaningful practice change as a result of educational intervention,[39–41] it does highlight the substantial challenge of disseminating new practices and alerts us to the need for sophisticated dissemination strategies. An emerging literature focused on innovative approaches for disseminating new practices in primary care tells us we must ensure that the planned intervention is practical, persuasively presented, and cognizant of barriers to implementation.[42] Various innovations are being developed to enhance dissemination and uptake of self-management programs (for example, see Frude[43]).

Effective dissemination of SSM into primary care will likely require development of a clinical intervention that fits within the actual constraints of primary care (in terms of available time and skills), requires a small and precisely defined change in physician behaviour, and includes easy access to brief persuasive training. Further, dissemination of SSM is best studied through a series of innovative projects, allowing for gradual improvement of dissemination methodology as more is learned about the resolution of barriers to practice change. A formative evaluation approach seems most appropriate, that is, one that uses outcome data to improve the dissemination method rather than using data to determine whether the endeavour should be discontinued.

Specific research questions deserving investigation include the following:

- What is the relative effectiveness of different strategies for disseminating SSM?
- What is the incremental benefit in primary care SSM for mild depression?
- At which point on the depression severity continuum does SSM become ineffective?
- How effective are different modes of delivering SSM (for example, bibliotherapy, audio recording, CD-ROM, or the Internet)?
- What are the most effective portals for disseminating self-management tools (for example, primary care physician, public health agency, pharmacist, or public library)?

The potential reward of successfully disseminating SSM is so large—meaningful clinical benefit to entire populations at minimal cost—that "failure is not an option."

Note

An example of a self-management manual for depression is the Antidepressant Skills Workbook, downloadable at no cost from http://www.carmha.ca/publications.

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Résumé : Les modèles de services de santé indiquent un avantage potentiel de l'autotraitement assisté de la dépression dans les soins primaires

Objectif : Examiner la prestation des services de santé dans une province canadienne (Colombie-Britannique) pour concevoir comment les services de santé canadiens pourraient être développés afin de mieux servir le grand nombre de personnes souffrant de maladies dépressives dont la gravité va de légère à modérée.

Méthode : Nous avons utilisé des données administratives provinciales pour décrire les modèles des services médicaux fournis aux personnes souffrant de dépression durant 3 périodes différentes (1991–1992, 1995–1996, et 2000–2001), et pour déterminer la fréquence à laquelle les patients souffrant de dépression reçoivent un traitement des médecins et des psychiatres des soins primaires. Nous avons ensuite utilisé ces résultats pour étudier la faisabilité et l'applicabilité éventuelle des diverses approches qui ont été décrites pour alléger le fardeau de la maladie lié à la dépression.

Résultats : Durant l'exercice financier 1991–1992, le taux de « prévalence traitée » était de 7,7 %; en 1995–1996, il était de 8,7 %; et en 2000–2001, de 9,5 %. Dans chaque cohorte, sur la période de 10 ans, la proportion des personnes qui ont reçu un diagnostic de dépression et qui ont ensuite été traitées par des médecins des soins primaires seulement (aucun service psychiatrique n'a été fourni) demeurait constante à 92 %.

Conclusions : L'autotraitement assisté est considéré comme étant une intervention prometteuse qui pourrait être intégrée dans les soins primaires, dans le contexte du système de santé canadien. Il constitue une approche faisable et pratique visant à accroître le rôle prédominant des médecins de famille dans la prestation de services aux personnes souffrant de formes bénignes de la dépression, et à promouvoir l'engagement actif des patients dans leur rétablissement et la prévention de futurs épisodes.