

## EDITOR'S NOTE

This column reflects our commitment to provide you, the primary care physician, with information that will prove helpful in making informed decisions about the care of your patients who suffer from psychiatric disorders. We will highlight abstracts of high interest to you from our sister publication, *The Journal of Clinical Psychiatry*, and summarize pertinent articles from the general scientific literature. We hope that this section is clinically relevant to your practice and that it will encourage you to expand your horizons.

### Receiving Guideline-Concordant Pharmacotherapy for Major Depression: Impact on Ambulatory and Inpatient Health Service Use

*Sewitch MJ, Blais R, Rahme E, et al.*

Can J Psychiatry 2007;52:191–200

**Objective:** The investigators sought to ascertain the relationships between guideline-concordant pharmacotherapy for depression and the use of health services in the year following diagnosis.

**Method:** Quebec drug plans between 1999 and 2002 were investigated in a population-based, retrospective cohort study. Beneficiaries aged 18 to 64 years who were newly diagnosed with an episode of depression by primary care physicians and psychiatrists between October 1, 2000, and March 31, 2001, and who made at least 1 psychotropic pharmacy claim within 31 days of diagnosis were included. Guideline concordance was defined as the receipt of recommended medication, starting dosage, and treatment duration as defined by the Canadian Network for Mood and Anxiety Treatments guidelines. The use of ambulatory (number of visits to prescribing physician, other physicians, or emergency departments) and inpatient (hospitalization) services were measured outcomes.

**Results:** Study criteria were met by 2742 patients (mean age of 42 years; 64% female). An antidepressant was dispensed to 2047 patients (75%). Of these, 1958 (71%) received a recommended first-line medication, 1297 (63%) received a recommended starting dosage, and 304 (15%) received a recommended duration. Only 8% received appropriate treatment according to the guidelines; 21% received benzodiazepines instead of antidepressants. Two median visits (interquartile range [IQR], 1–3) were made to prescribing physicians, none (IQR, 0–1) to other physicians, and none (IQR, 0–0) to emergency departments; 497 patients (18%) were hospitalized. Recommended first-line medication, dosage, and duration were associated with more prescribing physician visits in separate multivariate models for repeated measures, and the odds of hospitalization were lowered by recommended first-line medication.

**Conclusion:** Guideline concordance was related to more visits to prescribing physicians and lower odds of hospitalization.

### Effect of Depression Treatment on Depressive Symptoms in Older Adulthood: The Moderating Role of Pain

*Mavandadi S, Ten Have TR, Katz IR, et al.*

J Am Geriatr Soc 2007;55:202–211

**Objectives:** The investigators asked whether pain severity and hindrances to regular work activities diminish the effectiveness of depression intervention on changes in depressive symptoms over time in older adults in primary care.

**Method:** This randomized clinical trial was conducted at 3 clinics located in Veterans Affairs Medical Centers. Subjects were adults aged 60 and older (N = 524) who screened positive for depression and participated in the Primary Care Research in Substance Abuse and Mental Health for the Elderly Study. Integrated care was compared with enhanced specialty referral care, and pain severity, the extent to which pain interferes with work inside and outside of the home, and depressive symptoms were assessed at baseline and 3, 6, and 12 months.

**Results:** According to intention-to-treat analyses, both treatment groups demonstrated a reduction in depressive symptoms over time, although self-reported pain diminished reductions in depressive symptoms. At higher levels of pain severity and interference with work activities, improvements in depressive symptoms were blunted. In addition, pain interference seemed to have a greater effect on depressive symptoms than did pain severity; in individuals with major depression, pain interference accounted completely for the moderating effects of pain severity on changes in symptoms of depression over time.

**Conclusion:** Pain and its interference with functioning hinder depression recovery. Findings emphasize the importance of addressing multiple domains of functioning (e.g., physical and social disability) and the extent to which pain and other forms of physical comorbidity may interfere with or minimize treatment-related improvements in symptoms of depression.

## Association Between Parental Depression and Children's Health Care Use

Sills MR, Shetterly S, Xu S, et al.

Pediatrics 2007;119:e829–e836

**Objective:** The investigators sought to ascertain the relationship between parental depression and patterns of pediatric health care use.

**Method:** All children and adolescents who were 0 to 17 years of age, enrolled in Kaiser Permanente of Colorado during the study period July 1997 to December 2002, and linked to at least 1 parent/subscriber who had been enrolled for at least 6 months during that period were selected. Children whose parents did not have a depression diagnosis comprised the pool from which unexposed children were selected. Outcome measures, which included 5 categories of use (well-child visits, sick visits to primary care departments, specialty clinic visits, emergency department visits, and inpatient visits), were derived from the child's payment files and electronic medical charts. The rate of use per enrollment month for these 5 categories between exposed and unexposed children within each of the 5 age strata was compared.

**Results:** Our study population comprised 24,391 exposed and 45,274 age-matched, unexposed children. Teenagers showed decreased rates of well-child visits among exposed children. Exposed children in the 4 oldest age groups had higher rates of specialty department visits. Exposed children across all 5 age categories had higher rates of both emergency department visits and sick visits to primary care departments. Exposed children in 2 of the 5 age groups had a higher rate of inpatient visits.

**Conclusions:** Overall, a greater rate of emergency department and sick visits across all age groups, greater use of inpatient and specialty services in some age groups, and a lower rate of well-child visits among 13- to 17-year-olds were associated with having at least 1 depressed parent. One of the hidden costs of adult depression is represented by this pattern of increased use of expensive resources and decreased use of preventive services.

## Utility of Observer-Rated and Self-Report Instruments for Detecting Major Depression in Women After Cardiac Surgery: A Pilot Study

Doering LV, Cross R, Magsarili MC, et al.

Am J Crit Care 2007;16:260–269

**Background:** Coronary artery bypass graft surgery is frequently followed by major depression, which is related to increased mortality and morbidity. Women, in particular, are at greater risk for depression, and few useful methods for detecting depression are available to clinicians.

**Objectives:** This study sought to determine the practical usefulness of standard instruments available to identify, through self-report or observer rating, major depression in women who have had coronary artery bypass graft surgery.

**Method:** Before discharge, 66 women who had undergone coronary artery bypass graft surgery were evaluated with the Hamilton Rating Scale for Depression, the Beck Depression Inventory, the Beck Depression Inventory Short Form, and the Beck Depression Inventory for Primary Care. Receiver-operating-characteristic curves were assessed and positive and negative predictive values were calculated for cutoff points derived from the curves, for each instrument.

**Results:** At discharge, the curves provided by all 4 instruments were very accurate. The cutoffs identified for screening were higher when the Hamilton Rating Scale for Depression and

the Beck Depression Inventory were used to calculate all types of depressive symptoms (cognitive, affective, behavioral, somatic) but lower when the 2 subscales of the Beck Depression Inventory were used to calculate only cognitive and/or affective symptoms, relative to cutoffs suggested for patients with no medical illness and hospitalized nonsurgical patients.

**Conclusion:** Although additional study is indicated to confirm cutoffs in women who have recently undergone coronary artery bypass graft surgery, the Hamilton Rating Scale for Depression and both subscales of the Beck Depression Inventory appear useful for identifying major depression in these patients.

## Depression and Physical Comorbidity in Primary Care

Aragonès E, Piñol JL, Labad A

J Psychosom Res 2007;63:107–111

**Objective:** We examined how clinical features in depressed patients and the management of their depression are related to the presence of significant physical comorbidity.

**Method:** This 2-phase, cross-sectional study was conducted in 10 primary care centers in Tarragona (Spain). In total, 906 patients were evaluated consecutively for depression with a self-rating questionnaire; a structured interview that assessed the diagnoses of major depression and dysthymia (DSM-IV) and the severity of the physical comorbidity (Duke Severity of Illness Scale: DUSOI) was administered to 306 subjects. The relationship of several clinical variables with the presence of physical comorbidity was assessed.

**Results:** In 31.7% of cases, comorbidity was of moderate to extreme severity (DUSOI score > 50). The physician was consulted more often by patients with comorbidity. The consumption of antidepressants, the reason for seeking a physician (psychological/somatic), and the probability of being detected as depressed were the same in both groups. The severity or disability was also the same between both groups.

**Conclusion:** Depressed patients in primary care frequently exhibit physical comorbidity. As a rule, patients with and without comorbidity have similar characteristics of depression and are handled by the doctor in similar ways

## Sleep Problems in Primary Care: A North Carolina Family Practice Research Network (NC-FP-RN) Study

Alattar M, Harrington JJ, Mitchell CM, et al.

J Am Board Fam Med 2007;20:365–374

**Background:** The frequency and character of sleep disorders in primary care have not been widely examined. We participated in a survey conducted in 5 family practice offices in North Carolina assessing adult patients for sleep syndromes, and we sought to determine the demographic status and health status related to these disorders.

**Method:** Among the 5 study practices, 2963 adults who presented consecutively for office visits were invited to participate. Those who agreed completed a 4-page study questionnaire, in English or Spanish, including items on insomnia, excessive daytime sleepiness, obstructive sleep apnea syndrome, and restless legs syndrome. The association between sleep syndromes and demographic factors, health status, and disability was analyzed.

**Results:** We enrolled 1935 patients (65.3% response rate). More than half reported excessive daytime sleepiness, one third had insomnia, more than 25% had symptoms of restless legs

syndrome, and 13% to 33% reported obstructive sleep apnea syndrome symptoms. Significantly higher rates of all sleep disturbance items were attested by participants characterizing their health as poor. A significantly increased risk for all sleep complaints was found in patients who reported hypertension, pain syndromes, and depression. A significant risk of restless legs syndrome was found in patients with limited activity.

**Conclusion:** In primary care populations, sleep complaints are frequent. Patients with pain, mental illness, limited activity, and overall "poor physical and mental health" are at the highest risk for sleep disturbance. Because sleep disorders are associated with a significant health impact, further diagnostic inquiry is called for when sleep problems are discovered.

### Coming to Terms With ADHD: How Urban African-American Families Come to Seek Care for Their Children

*dosReis S, Mychailyszyn MP, Myers M, et al.*  
Psychiatr Serv 2007;58:636–641

**Objective:** The process by which parents' interpretations of their child's disruptive or inattentive behaviors led them to seek medical care that resulted in a diagnosis of attention-deficit/hyperactivity disorder (ADHD) was the focus of this study.

**Method:** Parents of children who had been recently diagnosed with ADHD (96% of the children were African American) took part in qualitative, semistructured telephone interviews. Participants (N = 26) were recruited from primary care, developmental and behavioral, and specialty mental health pediatric clinics associated with a large, urban teaching hospital. The analysis followed a grounded theory approach.

**Results:** Parents had been through an extensive process to pinpoint their child's problems by the time that they sought treatment for their child's ADHD. As parents described their child's behavior, explained the situation, described how ADHD affected their children, and explained how they sought answers, their conceptualizations materialized. Parents' desire to manage the situation was reflected in their reactions to the behavior and visions they had for their child's future. The process of coming to terms with their child's ADHD and the need for care were described by parents' conceptualization and management of the behaviors. Immediate resolution, pragmatic management, attributional ambivalence, and coerced conformance were the 4 distinct patterns describing this process that emerged from the analysis.

**Conclusions:** Clinicians' awareness of the different routes by which families reach the decision to seek care for their child's ADHD will most likely allow them to provide more responsive care and better tailor interventions to improve therapeutic outcomes for children receiving mental health treatments.

### Implementing Routine Cognitive Screening of Older Adults in Primary Care: Process and Impact on Physician Behavior

*Borson S, Scanlan J, Hummel J, et al.*  
J Gen Intern Med 2007;22:811–817

**Background:** Although early detection of cognitive impairment is a goal of high-quality geriatric medical care, novel strategies are required to lower rates of undiagnosed cases. This study sought to evaluate whether rates of dementia diagnosis,

specialist referral, or prescribing of antidementia medications are increased by adding routine cognitive screening to primary care visits for older adults.

**Method:** Four primary care clinics in a university-affiliated primary care network were the setting for a quality improvement screening project and quasiexperimental comparison of 2 intervention clinics and 2 control clinics. Medical assistants administered the Mini-Cog to intervention clinic patients aged 65 years and older. Computerized administrative data tracked rates of dementia diagnoses, referrals, and medication prescribing over time.

**Results:** Seventy percent (N = 524) of all eligible patients who made at least 1 clinic visit during the intervention period were successfully screened by 26 medical assistants without complaints about workflow interruption; 18% of those screened tested positive. Increased dementia diagnoses, specialist referrals, and prescribing of cognitive enhancing medications were associated with Mini-Cog screening compared with baseline rates and control clinics. A new dementia diagnosis, specialty referral, or cognitive enhancing medication was more likely to be received by patients with no earlier dementia indicators who had a positive Mini-Cog screen. However, physicians took appropriate action in only 17% of patients who screened positive on the Mini-Cog. Responses were most related to the lowest Mini-Cog score level (0/5) and advanced age.

**Conclusion:** Mini-Cog screening by office staff is practicable in primary care practice, and it affects physician behavior in measurable ways. Nonetheless, only severe impairment was likely to prompt new physician action relevant to dementia, and additional strategies are required to help primary care physicians follow up appropriately on data suggesting cognitive impairment in older patients.

### A Randomized Trial of Telemedicine-Based Collaborative Care for Depression

*Fortney JC, Pyne JM, Edlund MJ, et al.*  
J Gen Intern Med 2007;22:1086–1093

**Background:** Evidence-based practices designed for large urban clinics are not necessarily useful in smaller isolated clinics. Because it is often not practical to employ on-site psychiatrists, unique challenges are presented by implementing practice-based collaborative care for depression in smaller primary care clinics.

**Objective:** The Telemedicine Enhanced Antidepressant Management (TEAM) study assessed a telemedicine-based collaborative care model adapted for small clinics without on-site psychiatrists. Matched sites were randomly assigned to the intervention or usual care.

**Method:** Small Veterans Affairs community-based outpatient clinics without on-site psychiatrists but with access to telepsychiatrists participated in the study. In 2003–2004, 395 primary care patients with depression severity scores greater than or equal to 12 as measured by the 9-item depression scale of the Patient Health Questionnaire were enrolled and followed for 12 months. Serious mental illness and current substance dependence were exclusion criteria. Outcome measures were medication adherence, treatment response, remission, health status, health-related quality of life, and treatment satisfaction.

**Results:** The sample consisted of largely elderly, white men with substantial physical and behavioral health comorbidity. At baseline, participants had moderate depression severity (Hopkins Symptom Checklist, SCL-20 = 1.8) and 3.7 prior de-

pression episodes, and 67% had received depression treatment prior to the study. As assessed by multivariate analyses, intervention patients were more likely to be adherent at both 6 (odds ratio [OR] = 2.1,  $p = .04$ ) and 12 months (OR = 2.7,  $p = .01$ ). Patients receiving collaborative care were more likely to respond by 6 months (OR = 2.0,  $p = .02$ ) and remit by 12 months (OR = 2.4,  $p = .02$ ). The same cohort reported larger gains in mental health status and health-related quality of life and reported greater satisfaction.

**Conclusions:** With the use of telemedicine technologies, collaborative care can be successfully adapted to primary care clinics without on-site psychiatrists.

### Treatment of Depression in Primary Care: Socioeconomic Status, Clinical Need, and Receipt of Treatment

Weich S, Nazareth I, Morgan L, et al.

Br J Psychiatry 2007;191:164–169

**Background:** Depression is widespread, costly, and frequently undertreated. This study aimed to test the hypothesis that, after controlling for clinical need, people with low socioeconomic status are least likely to receive and adhere to evidence-based treatments for depression.

**Method:** Individuals with an ICD-10 depressive episode in the past 12 months ( $N = 866$ ) were recruited from 7271 attendees in 36 general practices in England and Wales. The 12-month Composite International Diagnostic Interview was used to identify depressive episodes. A structured interview was used to evaluate treatment receipt and adherence, which were rated using evidence-based criteria.

**Results:** We identified 332 individuals (38.3%) who received and adhered to evidence-based treatment, with few socioeconomic differences in treatment allocation. Those without educational qualifications were least likely to receive psychological treatments (OR = 0.55, 95% CI = 0.34 to 0.89,  $p = .02$ ), but after adjusting for depression severity, this association was not statistically significant.

**Conclusions:** This study revealed no evidence of barriers to care based on socioeconomic status in the treatment of moderate and severe depression in primary care in England and Wales.

### Predictors of Depression in a Sample of 1021 Primary Care Patients With Osteoarthritis

Rosemann T, Backenstrass M, Joest K, et al.

Arthritis Rheum 2007;57:415–422

**Objective:** There is a strong relationship between depression, chronic pain, and physical activity, but there are few data addressing the prevalence and predictors of depression in patients with osteoarthritis (OA). The present study sought to evaluate the prevalence and severity of depression in a large sample of patients with OA and to discover predictors of depression.

**Method:** Patients in 75 general practices were recruited consecutively. Of 1250 distributed questionnaires, 1021 were returned and analyzed. In addition to sociodemographic data, medication, and comorbidities, depression and arthritis were evaluated with the Patient Health Questionnaire (PHQ-9) and the Arthritis Impact Measurement Scale. The PHQ-9 score was

the dependent variable in a stepwise multiple linear regression analysis.

**Results:** Depression of at least a moderately severe level was found in 19.76% of men and 19.16% of women, who achieved a score greater than or equal to 15 on the PHQ-9. No significant sex differences were found. Perceived pain ( $\beta = 0.243$ ,  $p < .001$ ) and few social contacts ( $\beta = 0.218$ ,  $p < .001$ ) were the strongest predictors for depression severity. Physical limitation of the lower body ( $\beta = 0.157$ ,  $p < .001$ ) and upper body ( $\beta = 0.163$ ,  $p < .001$ ), age ( $\beta = -0.168$ ,  $p < .001$ ), and body mass index ( $\beta = 0.080$ ,  $p = .020$ ) were further predictors.

**Conclusion:** An increased prevalence of depression among patients with OA is suggested by these results, which underscore the need for recognition and appropriate treatment. Because most of the revealed predictors can be modified, they should be potential targets in a comprehensive care plan of OA to break the vicious circle of pain, physical limitation, and depression.

### Pediatricians' Attitudes About Discussing Maternal Depression During a Pediatric Primary Care Visit

Heneghan AM, Morton S, Deleone NL

Child Care Health Dev 2007;33:333–339

**Objectives:** To evaluate pediatricians' beliefs about discussing maternal depressive symptoms during a pediatric visit and methods pediatricians use to identify mothers with depressive symptoms.

**Method:** Investigators conducted in-depth telephone interviews with 23 primary care pediatricians from a practice-based research network. A series of previously developed questions was asked concerning the discussion of maternal depressive symptoms during a pediatric visit: strategies used to recognize mothers at risk; obstacles encountered; and possible methods for improving identification and treatment of maternal depression. Interviews were audiotaped and transcribed. Standard qualitative data techniques were used to codify and analyze data.

**Results:** Because a mother's well-being affects her children, the pediatricians agreed unanimously that a well-child visit is an appropriate place to ask mothers about their own health. Pediatricians relied on observational cues, especially mother-child interactions, to recognize a mother with depressive symptoms. Few used direct questions or a checklist. Lack of time was the obstacle to addressing maternal depression encountered most often, according to almost all the pediatricians. Additional obstacles included lack of training, incomplete knowledge of resources, and distractions endemic in the primary care setting. The fear of judgment and stigma that a mother may face when discussing maternal stresses were factors cited by one third of pediatricians. Pediatricians wanted improved ability to refer mothers to social workers for help.

**Conclusions:** Observational cues are preferred over direct questions or screening tools to identify mothers at risk of depression. This preference may under-identify mothers at risk. While pediatricians favor relying on other professionals, social services in particular, to address maternal depression, mothers may still be reluctant or conflicted over such assistance owing to fear of judgment. In fact, pediatricians may be the professional mothers are most eager to talk to. Thus, the ability of pediatricians to help mothers at risk for depression can be improved by appreciation of mothers' points of view, empathetic communication, and knowledge of community resources.