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## Home Care Nursing and Detection of Depression

**To the Editor:** It is indeed problematic that depression among elderly persons often goes unrecognized and untreated, particularly among those with chronic illnesses. However, the conclusion drawn by Brown and her colleagues in their article in the February issue (1) that home health care nurses have difficulty making accurate assessments of depression must be interpreted with caution, for several reasons.

We accept that the Structured Clinical Interview for Axis I DSM-IV Disorders (SCID) and the best-estimate procedures used by Brown and her colleagues reflect the state of the art in current diagnostics. However, the conclusions reached by the authors may not have taken into account several factors. First, several weeks went by between the administration of the SCID and the nurses' assessments, and patients' symptoms may have changed. In particular, the diagnostic status of patients who just met or failed to meet threshold diagnostic criteria may have changed dur-

ing that time. Indeed, test-retest reliability of the SCID even among the most well-trained psychiatrists is conspicuously poor ( $\kappa=.37$  for current diagnoses and  $.51$  for lifetime), which is due not only to the lack of reliability of the instrument but also to the typical ebb and flow of illness symptoms and differences in patients' recollection and disclosure (2). In clinical practice a continuous measure of illness severity may be preferable to a dichotomized diagnostic procedure.

Second, the setting is important. Formal administration of a diagnostic interview may elicit different responses than a less formal intake interview in the home. Third, Brown and colleagues did not report whether the nurses were better able to detect depression among patients with more pronounced symptoms. Coyne and associates (3) noted that in a sample of more than 1,500 patients, primary care physicians detected major depression among only 35 percent of patients who were independently given this diagnosis; for patients with any depressive disorder, the detection rate was 28 percent. However, rates of detection and treatment were higher for patients with more severe symptoms. Therefore, it is reasonable to expect that nurses would be better able to detect depression in more severe cases and that patients with the greatest need for treatment may well be getting it. In other words, the situation may be less dire than it would appear from the findings of Brown and colleagues.

Finally, what seems most important to us is that the study lacked a comparison group of other professionals with which to compare the accuracy of the assessments by home health nurses. If primary care physicians, psychiatrists, psychologists, or any other type of health care professional used the assessment procedures that were used by the home health nurses, would their diagnostic assessments be any more accurate? Indeed, it has been suggested that family members and significant others are often more sensitive to subtle changes in patients'

mental health status than are any health professionals (4). Brown and colleagues' conclusion that there is a need for improvement in the education of nurses may be correct; however, the implication that home health nurses are more deficient in their ability to care for depressed elderly patients than are other health care providers is unwarranted in the absence of an actual test of that hypothesis. Given the increasing need for competent elder care, studies in this area require more careful conceptualization, more rigorous research designs, and more cautious interpretation of results.

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**In Reply:** We agree with Drs. Blank and Kane that many factors complicate screening for depression among elderly patients. In particular, the difficulty of recognizing depression in the context of medical illness is a topic that has received a great deal of attention. We are deeply concerned, however, about the low rates of adequate treatment for depression among home care recipients. As we

previously reported, in a sample of 539 elderly home care patients, only 12 percent of the 73 patients with a diagnosis of *DSM-IV* major depression received adequate treatment (1).

The question of who should be responsible for diagnosing and treating depression among home health care patients is complex and without obvious answers. The referring physician has formal responsibility for the patient, yet many patients are referred to home health care agencies by surgeons or medical specialists rather than by primary care physicians. The patients generally suffer complex and multiple medical burdens, complicating the assessment of depression and competing for notice. Many agencies do not have mental health experts on their staff.

In all cases, however, accurate recognition of depression is a necessary first step toward improving care for depression in home health care. We believe that home health care nurses are uniquely positioned to identify depression and to initiate the process that can reduce unnecessary suffering by their patients. First, nurses are the primary health care contact of most home care patients. Second, nurses can observe patients in their home environment. Third, unlike primary care providers, home health nurses are required to screen for symptoms of depression as part of the Outcome and Assessment Information Set (OASIS) and the Plan of Care (Form-CMS-485). Fourth, home care nurses conceptualize their work as part of an interdisciplinary team.

Our study's purpose was not to pit home care nurses against other health professionals by comparing their ability to identify depression. Rather, we hoped to investigate the extent to which problems in identification of clinically significant depression are a barrier to reducing unmet need among elderly persons. We found that home care nurses often miss cases of depression as diagnosed by *DSM-IV* criteria. Further, and contrary to the expectations of Drs. Blank and Kane, the nurses' ability to recognize depression did not improve with the

severity of depression—the sensitivity rates for major and minor depression were 43.7 and 48.5, respectively.

The home care agencies that partner with our institution have committed themselves to the challenge of improving care for depression among their older medically ill patients. This first step—arguably necessary although clearly not sufficient—is to enhance nurses' ability to recognize clinically significant depression in the context of medical burden, functional disability, and the psychosocial challenges of home health care. We are currently collaborating with these agencies to develop and evaluate a nurse training curriculum targeting depression assessment.

We thank our colleagues for their thoughts and look forward to working toward the common goal of improving mental health delivery for this population.

**Ellen L. Brown, Ed.D., R.N.C.**

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### Clinical Care of Veterans Seeking Compensation

**To the Editor:** We read with interest the study by Freuh and his colleagues in the January issue (1), which found overreporting of symptoms among compensation-seeking veterans who were being evaluated for combat-related posttraumatic stress disorder (PTSD). We would like to draw further attention to the impact that overreporting of symptoms and the compensation-seeking process may have on delivery of clinical care to veterans with combat-related PTSD.

After a claim for a service-connected disability is filed, the Department of Veterans Affairs (VA) gives claimants a detailed list of the psychiatric symptoms that correspond to each level of monetary compensation. A patient who is subsequently denied disability payments or who is given a

rating of less than 100 percent (full disability)—and who initially may have reported partial response to a first-line-antidepressant trial—may on a return visit to the clinic report psychotic symptoms, suicidal ideation, or frequent panic attacks that were not present during clinical encounters before the disability ruling was made. Our experience is that VA clinicians are not infrequently treating overreported symptoms or the distress of the compensation-seeking process, which has contributed to the negative perception of clinicians treating this population (2).

An example of this phenomenon is a 58-year-old Vietnam veteran who participated in both outpatient and domiciliary PTSD programs for approximately two years while his service-connected disability claim was being appealed and adjudicated. During this time he had trials of sertraline, nefazadone, bupropion, venlafaxine with buspirone augmentation, nortriptyline, imipramine, and mirtazapine, with trazodone or zolpidem used as a hypnotic agent. At the time that electroconvulsive therapy (ECT) was being recommended for his refractory depression, the level of his disability compensation was increased. Abruptly he reported much less distress. ECT was not scheduled, and he has reported symptom stability since that time.

Although aggressive treatment of psychosis and comorbid severe depression is certainly warranted in this patient population, the side-effect burden of polypharmacy regimens needs to be considered. Clinicians should ensure that prescribed medications target specific symptoms. However, such targeting may be difficult, because these patients frequently have comorbid somatic illnesses (3), have complicated pharmacotherapy regimens prescribed, and may be exaggerating certain symptoms to increase their disability compensation. We recently reviewed the pharmacotherapy regimens of 409 patients referred to our domiciliary-based PTSD program between 1997 and 2000. On average, patients were taking 7.4 medications; be-

tween 1999 and 2000, about 20 percent of patients received antipsychotic medications.

We recommend frank discussion of the level of PTSD symptoms and the effect of the compensation-seeking process on symptom reporting at the initial visit, at follow-up visits, and during periods of crisis management. This problem is not limited to the VA system; a recent surge has been noted in claims for Social Security Disability Income for psychiatric disorders (4,5). We look forward to the results of studies that are currently under way at the VA to examine the relationship between the compensation process and service use.

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## Working With People Who Have Mental Retardation

**To the Editor:** In a letter to the editor in the March issue, Dr. Chaplin (1) pointed out that a literature review published in *Psychiatric Services* (2) failed to uncover two additional articles among the few on mental retarda-

tion that have appeared in the journal in the past five decades. Although Dr. Chaplin's news is cheering, it remains true that there is pathetically little interest in serving this special population, particularly among our "leaders"—the chairs of departments of psychiatry and psychiatric residency directors in medical schools.

As I have said in several other publications, working with patients who have mental retardation may be of interest to colleagues, especially those who are currently seeking to enlarge their patient base in light of the depredations of for-profit managed care. In my long experience—I started in the field as an extern at the Columbus State School in 1955 and later attended the Menningers' elective at Letchworth Village in New York in 1966—I find that many psychiatrists believe that working with this population would be ungratifying and frustrating because of their perception that these individuals are nonverbal, have severe behavioral problems, or are "hopeless."

Actually, this perception is far from accurate. For family psychiatrists, the field can become gratifying and alive when they remember the concept of "fair shares" and use Caplan's classic and dynamic principles of mental health consultation (3) as well as their knowledge of group and family dynamics. I also find that familiarity with the late Virginia Satir's methods of assessment is extremely helpful, as is knowledge of the "*Rashomon* phenomenon," or the multiple interpretations of an event that exist among a group of people who experience that event.

So what comes next? I suggest that academics who read *Psychiatric Services* follow the example of some members of the American Psychiatric Association's mental retardation interest group and work with mentally retarded and developmentally disabled patients and their families and caregivers for a half day a week for several months. Among the books that psychiatrists who are unfamiliar with this population might benefit from is Cohen and Volkmar's *Handbook of Autism and Pervasive Developmental Disorders* (4). In addition, for \$125 a year they can join the American Association on Mental Retardation. After they have increased their knowledge and skills—and changed their attitudes—they might start requiring psychiatric residents to spend some time with us. They won't be disappointed!

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