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Disparities in Depression Care: Implications for Population-Based Surveys

To the Editor: I applaud the work of Alegría and colleagues described in their article, "Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States," in the November 2008 issue (1). In examining whether individuals who could benefit from depression treatment received no treatment or inadequate treatment, these investigators touched on an important policy issue that warrants further discussion. Namely, given the lack of population-based studies that take an expanded look at issues related to depression, what are some of the lessons that health professionals in the policy and research arena can learn from their findings? In terms of population health, one lesson is that we may need to broaden the focus from using a single indicator to using multiple indicators to improve the detection of the need for mental health care and the assessment of the quality of mental health care.

The Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Centers for Disease Control and Prevention, is arguably the largest annual telephone health survey in the world. The BRFSS contains one general item related to the number of days

in which the respondents rated their mental health as not good. In addition, eight items related to the severity of depressive symptoms are included in a list of optional questions, which means that states can elect not to include these items in their surveys. Although the eight optional questions measure some of the aspects of global functioning that are addressed in most depression scales, none of the BRFSS questions specifically ask for information related to the number of days in which respondents felt totally unable to carry out daily activities. In the study by Alegría and colleagues this variable was associated with the strongest likelihood of receipt of depression treatment and of receipt of adequate depression treatment. The strength of this association was second only to that of insurance type. In addition, none of the BRFSS questions attempt to look at the frequency or quality of depression treatment.

Our awareness of mental health care disparities is not new. The continued call by the Healthy People 2010 initiative to reduce racial and ethnic disparities in mental health care requires us to seriously reevaluate how we approach the identification of mental health care need in a racially and ethnically diverse society and how we measure the quality of that care as a way to engage and retain people in treatment. In a society that is increasingly more diverse, health policy makers and researchers must recognize the need to be sensitive and flexible in the use of language that is understandable to patients (2) and that recognizes how the expression of depression and depressive symptoms may be culturally shaped (3).

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Mr. Lee is an independent researcher who is also affiliated with the California Department of Public Health, Sacramento. The views expressed are those of the author and may not necessarily represent the policies of the California Department of Public Health.

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In Reply: We appreciate Mr. Lee's positive comments on our study. He highlights the importance of adding questions to the assessment battery of the BRFSS that are specifically related to the number of days in which respondents felt totally unable to carry out daily activities. We could not agree more. Like other BRFSS items, additional items on problems with daily living would allow for greater focus on monitoring mental health at the population level. We can no longer continue to plan resources and evaluate the quality of mental health service delivery only at the individual level. Being able to identify geographic, systemic, and sociocultural barriers to high-quality mental health care is paramount to eradicating persistent ethnic and racial service disparities.

Having a national data source such as the BRFSS could help identify important shortcomings in the U.S. mental health care system. Community estimates of need could be used as outcome measures to monitor the impact of services, as they reflect the overall mental health status of the population (1). Need estimates by region could help policy makers allocate available resources more efficiently and fairly. Narrow definitions of need fail to provide information that is useful from a community prevention perspective (2,3). Although such definitions capture individual-level cases, they may fail to capture cases that are important to measure in community-level need estimates for monitoring and prevention, rather than for acute care. We do hope that Mr. Lee's suggestion is adopted.

Margarita Alegría, Ph.D.

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Increased Antipsychotic Prescribing to Youths in Germany

To the Editor: Recent studies from the United States and some European countries have assessed changes in the prevalence of antipsychotic medication use among children and adolescents over the past ten years (1–3). Concerns have been raised that these medications are prescribed for psychiatric disorders other than those for which they are intended. In Germany we were able to analyze administrative data from a regional health insurance fund that is responsible for insuring approximately one-third of the region's eligible population. The database, known as the Statutory Health Insurance Sample AOK Hesse/KV Hesse, contains information for a random sample of 1.9 million persons, or about 19% of all persons insured by the fund in this region.

We used data for children and adolescents between the ages of 0 and 19 years to compare prescription of antipsychotic drugs in 2000 (N=65,866) and in 2006 (N=56,169). We found that the prevalence of antipsychotic drug use increased from 1.9 per 1,000 to 2.8 per 1,000 over this period, which represents an increase of 50.6%. The increase resulted from a steep rise in prescription of second-generation antipsychotic drugs (mainly risperidone, olanzapine, and quetiapine). For second-generation antipsychotics, the prevalence increased from .4 per 1,000 in 2000 to

1.8 per 1,000 in 2006. Over the same period, first-generation antipsychotic drugs were prescribed less often, from 1.6 per 1,000 in 2000 to 1.4 per 1,000 in 2006—a decrease of 12%.

In the ten- to 14-year age group, a steep increase in second-generation antipsychotic prescribing could be observed, although the prevalence remained very low: from .1 per 1,000 in 2000 to 2.4 per 1,000 in 2006. In the 15- to 19-year age group, second-generation prescribing more than doubled—from 1.3 per 1,000 to 3.1 per 1,000. In both 2000 and 2006 a higher percentage of boys were prescribed second-generation antipsychotic drugs, and the prevalence increased more than fourfold (.6 per 1,000 to 2.7 per 1,000). A similar increase at a lower level was observed among girls (.2 per 1,000 to 1.0 per 1,000).

The database permitted us to determine the *ICD-10* diagnoses that were entered in the quarter of the year in which the prescription was issued. When we restricted the analysis to the diagnosis coded by the physician who prescribed the antipsychotic drug, we found evidence of a shift from a diagnosis of schizophrenia in 2000 to diagnoses indicating behavioral problems in 2006. The *ICD-10* diagnostic codes included F60–69 (disorders of adult personality and behavior), F70–79 (mental retardation), F80–89 (disorders of psychological development), and F90–98 (behavioral and emotional disorders with onset usually occurring in childhood and adolescence). A U.S. study by Domino and Swartz (1) found increased use of antipsychotics to treat affective disorders between 1996 and 2005. According to our data, there were no changes in antipsychotic prescribing for the treatment of affective disorders.

The increase in antipsychotic drug use among youths in Germany is considerably lower than increases in the United States (1) and the Netherlands (2), but it is higher than in the United Kingdom (3). When prevalence rates are compared, we have to keep in mind the methodological differences between studies as well as cultural and regional variations in prescribing habits.

In contrast to the Netherlands study, which examined data for Dutch youths in eastern and northern parts of the country, our study was restricted to a single health insurance fund with a larger proportion of lower-income groups and to a single region—the federal state of Hesse. Differences in antipsychotic prescribing could also be attributable to differences in the socioeconomic status of the insured persons. In a nationwide German sickness fund that insured persons with higher incomes than those in our sample, the prevalence rate of antipsychotic prescribing in 2000 was higher than the rate found in our study (4).

At this time, the prevalence of treatment with antipsychotic drugs among youths is still low; however, the observed trend is similar to the steep increase in prescription of methylphenidate over the past ten years. The results of our study also raise concerns about the rise in off-label prescription of antipsychotics in Germany even though serious adverse drug events have been reported (5).

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