

# The Education of Depressed Primary Care Patients: What Do Patients Think of Interactive Booklets and a Video?

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**BACKGROUND.** Clinicians, policy makers, and health care administrators are attempting to improve depression outcomes in the primary care setting. Despite positive evidence about the efficacy of self-help materials and psychoeducational interventions, use of educational materials designed for the primary care patient are receiving little attention in present depression initiatives. The present study describes the use and evaluation of three educational materials by depressed primary care patients.

**METHODS.** As a part of a randomized control trial, depressed primary care patients were identified by primary care physicians and randomized to a clinical trial exploring a new method of treating depression. Patients assigned to the new method of treatment received a package of educational materials at the time of the baseline interview. These materials included two brief interactive booklets (medication booklet, behavioral health booklet) and a short video. The present analysis concerns data obtained from 108 intervention patients in a telephone survey conducted 1 week after they received the package of educational materials.

**RESULTS.** Approximately three quarters of the subjects reported that they read or viewed all of the educational products. The majority rated the products as somewhat to significantly helpful: medication booklet 81%; behavioral health booklet 82%; and video 69%. Previously reported results include findings of significantly better medication adherence and improved clinical outcomes by patients with major depression who received a primary care intervention that included the educational products discussed in this paper.

**CONCLUSIONS.** Educational materials may play a significant role in improving depression treatment outcomes in the primary care setting.

**KEY WORDS.** Depression; primary health care; physicians, family; patient education; psychology, medical. (*J Fam Pract* 1997; 44:562-571)

Depression is a frequent problem in the primary care setting,<sup>1,2</sup> and common approaches to treatment include prescription of antidepressant medications and supportive counseling.<sup>3,6</sup> While antidepressant medications are prescribed for most primary care patients with depression, prescribed

dosages tend to be significantly lower than recommended guidelines, and patients frequently fail to adhere to antidepressant medications.<sup>7,9</sup> In the context of the initial antidepressant prescription visit, depressed primary care patients often perceive their physicians as employing behavioral techniques to help with mood improvement.<sup>10</sup> Physician use of a behavioral strategy (eg, helping the patient plan pleasant activities) has been found to help patients adhere successfully to antidepressant regimens during the first month of treatment.<sup>11</sup> Behavioral health treatment by the primary care physician, without adjunctive pharmacological treatment, may also be an effective treatment for depression.<sup>12</sup> Self-help materials<sup>13,14</sup> and psychoedu-

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cational interventions<sup>15</sup> may play important roles in effective treatment of depression. Written materials may help providers improve behavioral and pharmacological treatment outcomes in the primary care setting by enhancing visit time management, thoroughness of planning, and consistency among providers.

The present study presents data concerning the use and evaluation of educational materials by depressed primary care patients. These materials were used in a recent randomized control study in which patients were given an educational materials package.<sup>16</sup> Besides the educational materials, the intervention included physician training and onsite liaison psychiatry services to patients and physicians. Results from the larger study were analyzed separately for patients with major and minor depression. In comparison to "usual care" controls, intervention patients with major depression demonstrated better adherence to an adequate dosage of antidepressant medication for 90 days or more and were more likely to rate (1) the quality of care they received for depression as good to excellent and (2) antidepressant medications as helping somewhat to helping a great deal. Seventy-four percent of intervention patients with major depression showed a 50% improvement on the Symptoms Checklist-90 Depressive Symptoms Scale compared with 43.8% of usual care controls. In patients with minor depression, the intervention group demonstrated significantly better medication adherence than controls. No significant differences were found, however, among patients with minor depression in the intervention and control groups in the percentage who were satisfied with the care they received for depression, in the percentage who experienced a 50% or more decrease in depressive symptoms, or in the decrease of depressive symptoms over time.

Programs that address multiple levels of care are most likely to be successful in improving depression treatment outcomes in the primary care setting. In clinical settings, quality improvements often occur in an incremental fashion, and educational materials may support change within a variety of health care systems. Educational materials employed in the present study attempted to strengthen the primary care response to the depressed patient by (1) educating the patient concerning medications and behavioral strategies, (2) requiring the patient to be active in treatment planning, (3) providing structure for inter-

actions in visits between the depressed patient and the physician, (4) facilitating written medication and behavioral treatment plans, and (5) increasing physician and psychiatrist interactions about pharmacological treatment of depression. Findings from an earlier investigation concerning primary care patient educational materials suggested that educational materials that are not supported by health care staff may not have a significant impact on patient behavior.<sup>17</sup> We worked closely with primary care physicians in designing our materials and developed the materials to link with *and* structure patient and physician interactions.

This article describes the educational materials and the protocol developed to help improve outcomes by increasing both the skillfulness of the patient and the rate of interactions between patients and physicians about the most effective strategies for addressing depressive symptoms. Additionally, patient evaluation data concerning these educational materials are summarized and guidelines for provider use of educational materials are proposed.

## METHODS

### LARGER STUDY SUBJECTS AND PROCEDURE

The present study utilizes a subsample (intervention subjects) from a large randomized control trial<sup>16</sup> designed to evaluate a new model for treating depression in an HMO primary care center. Participants were primary care patients at the Northgate Clinic of Group Health Cooperative of Puget Sound in Seattle, Washington. At the time of the study, the clinic employed 22 primary care physicians who provided health care to approximately 22,000 patients. All physicians agreed to participate.

During a 15-month recruitment period, physicians identified all consecutive patients with probable or definite major depression and invited them to participate in a study designed to investigate a new method of care for depression. Before the study, physicians received training concerning specific symptoms of a major depressive episode. The training encouraged them to use an acronym to aid recall of symptoms of depression in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (DSM-III-R).

After diagnosis by the primary care physician, patients were screened by a research assistant working in the clinic. Eligibility criteria included patient

willingness to take antidepressant medications, being between 18 and 80 years of age, and obtaining a minimal severity cutoff score on a 20-item depression screening questionnaire. Exclusion criteria included current alcohol abuse, psychotic symptoms or serious suicidal ideation or plan, dementia, pregnancy, terminal illness, limited command of English, or plan to disenroll. Patients were randomly assigned to either intervention or usual care after completing a baseline interview.

The research assistant referred usual care patients back to their primary care physician for standard treatment. In the HMO setting, usual care patients (as well as intervention patients) could self-refer or be referred by their physician at any time during the study to the staff model mental health service located 7 miles from the primary care clinic. At the mental health clinic, patients had access to services from social workers, psychologists, and psychiatrists. These included cognitive behavioral therapy in group and individual formats and psychiatric medication consultation services. In the 1-year period following primary care referral to the study, 27% of intervention patients and 31% of usual care patients were seen by an HMO mental health specialist outside the primary care clinic.

After randomization, the research assistant gave intervention patients a package of educational materials (two interactive booklets and a videotape), and telephone interview staff called these patients 1 week later to conduct a brief interview concerning their response to the educational materials. The research assistant also scheduled return appointments for intervention patients, including two with their primary care physician (one 30-minute visit where educational materials were discussed and one 15-minute treatment follow-up visit) and two with the study liaison psychiatrist. All patients completed follow-up telephone interviews to assess intervention effects 1, 4, and 7 months after the baseline.

Physicians referred 281 patients to the study over a 15-month period, and 217 (77.2%) were randomly assigned to intervention or usual care. Ninety-one (42%) of the randomized patients met DSM III-R criteria for major depression at the baseline interview. The remaining patients identified as depressed by the primary care physician reported fewer than 5 symptoms of a major depressive episode. This group with fewer symptoms was referred to as the minor depression group. It included patients with dys-

thymia, patients in partial remission from an episode of major depression, and patients with an adjustment disorder with depressed mood. Our intention was to determine the presence or absence of symptoms of a major depressive episode and to evaluate treatment effects relative to diagnosis of a major depressive episode. We used this diagnostic grouping in the original analyses and again in this paper. Further information is available concerning the formation of these groups.<sup>2</sup>

### PRESENT STUDY SAMPLE AND PROCEDURE

The sample for the present study included the 108 intervention patients from the larger study. Telephone survey staff phoned these subjects 1 week after they received their educational materials package. Contact was made with 104 patients. The telephone survey was designed to obtain evaluative information concerning the two educational booklets and the video.

### EDUCATIONAL FEATURES OF THE INTERVENTION

Educational features included the three products evaluated in the present study, along with a physician training program, and a questionnaire and treatment record form designed to support the occurrence of patient-physician interactions consistent with messages in the educational products.

**The Questionnaire.** The Patient-Doctor Questionnaire was 2 pages and contained 13 questions. It was designed as a pre-visit questionnaire. The patient completed the questionnaire and brought it to the visit, along with the educational materials. The questionnaire included questions that helped the physician understand the patient's individual perspective on her or his difficulties, the patient's experience with previous treatment for depression, and the patient's present questions about the educational materials. Figure 1 presents page 2 of the Patient-Doctor Questionnaire, which helps to elicit the patient's questions about the educational materials, pertinent information about behavioral planning, and patient confidence level in following planned treatments.

**Treatment Record Form.** A treatment record form, which we called the Personal Plan, provided a format for the physician to simultaneously create a medical record and written treatment instructions for the patient concerning medication use and

**FIGURE 1**

**Page 2 of the Patient-Doctor Questionnaire**

6. What questions do you have about the booklets "Planning to Feel Better" or "How Medications Can Help?"

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7. If you have ever had a period of depression before, what helped you start to feel better then?

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8. List the activities or thoughts that have helped you feel even a little better in the last two weeks, no matter how brief the time that you felt better (for example, visiting a friend or going for a walk).

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9. List the activities you'd be doing or the thoughts you'd be having if you started to feel even a little bit better in the coming weeks.

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10. Who can help you start doing some things that may help you feel better?

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11. On the scale below, mark how confident you are that you will take your antidepressant medication(s) as prescribed over the next several months.

Not At All										Completely
1	2	3	4	5	6	7	8	9	10	

12. On the scale below, mark how confident you are that you will carry out lifestyle adjustments and activities that can help you feel a little better over the next several months.

Not At All										Completely
1	2	3	4	5	6	7	8	9	10	

behavioral and lifestyle change plans. Copies of the Personal Plan were given to the patient and placed in the patient's medical chart. Similar materials have been published elsewhere.<sup>22</sup>

**Visits with Provider.** The intervention program included an initial 30-minute appointment and a 15-minute return visit with the primary care physician interspersed with two or more appointments with a liaison psychiatrist working in the primary care clinic. Patients reviewed educational materials in visits with the primary care physician and actively participated in the construction of a plan concerning medication use and behavioral change. In visits with the liaison psychiatrist, patients received additional information about medication. Liaison psychiatrists also evaluated medication selection and gave writ-

ten, and often verbal, feedback to the treating primary care physician regarding needed changes in medication. Liaison psychiatrists also monitored antidepressant prescription refill data on intervention patients and notified the primary care physicians when an intervention patient failed to refill antidepressant prescriptions in accordance with the medication treatment plan.

**Educational Materials on Cognitive-Behavioral Coping Strategies.** We designed a 22-page booklet, "Planning to Feel Better." It was developed to encourage the patient to take an active stance in treatment. The booklet asked patients to respond in writing to questions and exercises presented in the booklet and to share their written responses with the primary care physician in a special 30-minute visit.

The booklet presented instructions on use of specific cognitive and behavioral strategies to improve mood. We selected strategies with demonstrated efficacy in mental health settings. From an earlier investigation, we learned that depressed primary care patients perceived their physicians to use these strategies somewhat often in visits where antidepressant therapy was started.<sup>10</sup> These strategies included: planning activities to improve mood (planning pleasurable, confidence-boosting, relaxation-promoting, and social activities); applying problem solving methods to difficult life problems, and employing techniques to challenge negative thoughts and promote positive thoughts. Figure 2 provides an example of an exercise from the pamphlet on coping strategies. A similar booklet is avail-

able for clinical practice.<sup>22</sup>

**Educational Materials on Using Antidepressant Medications.** We developed a 13-page booklet and titled it, "How Medications Can Help." The booklet explained the usefulness of medications in treating the syndrome of depression and listed and answered questions commonly asked by patients starting antidepressant therapy. Also, the booklet identified problems patients sometimes experience in adhering to prescribed medications and solutions that have worked well for other patients. Both booklets described the "depression cycle" and the biopsychosocial model. Figure 3 provides an excerpt from this pamphlet. A similar booklet is available for clinical practice.<sup>22</sup>

**Educational Video on Coping with Depression.** A 20-minute video, "Overcoming Depression," was developed specifically for this study. We invited patients to view the video at the clinic or in the privacy of their own homes, alone or with a significant other. The video used patient-doctor interactions to present the biopsychosocial model and the risks and benefits of pharmacological and behavioral treatment. The video also used dialogues between depressed patients to illustrate application of effective behavioral strategies to (1) cope with troubling medication side effects and (2) help change negative thought patterns characteristic of depression.

**OUTCOME MEASURES**

Measures in the present study included those related to patient evaluation of three educational products associated with the intervention, a measure to determine the severity of depression and the presence of an episode of major depression, and a measure concerning the patient's report of relationship problems as a factor in causing current depression symptoms.

**Evaluation of Education Materials.** Evaluation measures included: (1) did the patient read or view materials, and (2) did the patient evaluate the educational materials as helpful. Patients described their use of the educational materials by indicating that they read and viewed all, part, or none of each of the three materials. Patients described the helpfulness of each of the educational materials on a 1 to 10 scale, where 1 = not helpful and 10 = very helpful. We grouped helpfulness ratings into 3 categories (1 to 3 = less helpful, 4 to 6 = somewhat helpful, 7 to 10 = significantly helpful) in an effort to find conceptually meaningful differences among

**FIGURE 2**

**An Example from the Booklet "Planning to Feel Better"**

page 5: Planning to Feel Better

**Pleasant Activities**

These are the things in your life that you do just for fun. They are simple and quite personal. They help your body recover from both large and small stresses. Examples include listening to music, going for a walk, watching a favorite show, or reading something you enjoy. If you're interested in planning pleasant activities, follow these steps and **use the work sheet below.**

- Identify what you did for pleasure when you were less depressed.
- Ask yourself, what might you enjoy doing tomorrow?
- Identify and plan to do one pleasant activity each day this week. Start with something that is simple for you.
- Identify what or who can help you do these activities.

Past pleasurable activities:

What enjoyable thing could I do tomorrow?

What would be enjoyable right now?

Who can help with these activities?

*Bring this worksheet to your next visit with your physician.*

patients. To define characteristics of patients who might benefit most from educational materials about behavioral coping strategies, we used helpfulness ratings to sort patients into two groups: positive evaluators (helpfulness ratings = 6 to 10) and negative evaluators (helpfulness ratings = 1 to 5).

**Depression Severity.** Depression severity and diagnosis of the presence of a major depressive episode was determined by the Inventory of Depressive Symptoms (IDS).<sup>18</sup> We modified the IDS to probe for a duration of 2 weeks, as required for DSM-III-R diagnosis of major depression. The IDS has 28 items and employs a 0 to 3 severity index (range, 0 to 84). IDS scores at baseline were used to form major and minor depression groups for our analyses. The major depression group had 5 or more symptoms of depression, including sadness or loss of interest, and persistence of symptoms for nearly every day for 2 weeks. The minor depression subsample consisted of patients who did not meet criteria for major depression. Rush reported that an IDS score of 36.5 (SD = 9.7) is a valid cutoff score for major depression and that it performs comparably to other conventional screening instruments for depression.<sup>18</sup> As a reliability check, we interviewed 57 patients with both the IDS and the Structured Clinical Interview (SCID) for DSM-III-R Diagnosis, Depression Module.<sup>19</sup> Analyses yielded a kappa value of .52 for major depression,<sup>20</sup> and, in all cases of disagreement, the IDS scored patients as having one less DSM III-R symptoms of major depression than the SCID. This suggests that the IDS yields a more conservative measure of major depression than the SCID.

**Relationship Problems.** In that patients often reveal relationship problems to their primary care physician, we used a relationship question from the IDS to evaluate the usefulness of this information for physicians who are faced with treatment decisions, including use of an educational booklet on behavioral health strategies. The item from the IDS baseline administra-

**FIGURE 3**

**How Medications Can Help**

page 1: How Medications Can Help

**Antidepressant Medications Are Often Used for Problems Such As:**

- depression, sadness, or irritability
- pain
- sleeping or eating problems
- fatigue or decreased energy
- difficulty concentrating or remembering
- loss of interest in activities that used to bring pleasure
- nervousness or tension
- anxiety attacks

This booklet describes how using this type of medication can help you feel better and ready to make small changes that may improve the quality of your life.

page 2: How Medications Can Help

**Depression Is a Serious but Common Illness**

Although depression can be truly disabling, it is also common. The good news is that it often improves with time and there are treatments that shorten its course.

Depression is often associated with life stresses or changes such as moving, marital problems, difficulties at work, or may be associated with medical problems such as chronic pain, chronic fatigue, or chronic disease.

**How Do Antidepressants Work?**

Both life stresses and medical problems may cause depletion in the amount of adrenaline-like chemicals in the nervous system. This chemical imbalance results in some of the common symptoms of depression such as sleep and appetite problems, loss of energy, loss of concentration, and chronic pain.

Antidepressant medications restore the normal balance of these chemicals, which helps to relieve some of these symptoms.

**The Cycle of Depression**

Depression is often thought of as a cycle involving thoughts, behavior and feelings, plus physical symptoms. Where one starts in this cycle depends on the individual. The encouraging news is that the cycle can be reversed, symptoms can be relieved, and the depression treated.

tion asked patients to indicate whether or not relationship problems had contributed to depression onset.

**STATISTICAL TOOLS**

All analyses were conducted using the SAS system, Version 6.<sup>22</sup> Chi-square tests were used to determine the level of significance of difference concerning categorical variables. To test for differential age effects, a young group (aged 18 to 54 ) was compared with an older group (aged 55 to 79).

**TABLE 1**

**Demographic Characteristics of Patients Asked to Evaluate Materials (n=108)**

Characteristic	Measure
Mean age	48.1
Median age (range)	45.5
% Female	76.9
% With 1+ years of college	74.7
% Married or cohabiting	50.0
% Employed full- or part-time	63.9

**TABLE 2**

**Patients Who Read and Viewed All, Part, or None of the Three Educational Products (n=104\*)**

Educational Product	All n (%)	Part n (%)	None n (%)
Medication booklet	83 (79.8)	13 (12.5)	8 (7.7)
Behavioral booklet	82 (78.9)	15 (14.4)	7 (7.0)
Video	79 (76.0)	6 (5.8)	19 (18.3)

\*Of 108 patients randomized to intervention group, 104 agreed to participate in telephone interviews.

**RESULTS**

**PATIENT CHARACTERISTICS**

Table 1 presents a summary of demographic characteristics of intervention patients (n = 108). They ranged in age from 20 to 79 years of age. Most were female, had attended 1+ years of college, were employed, and one half were married or cohabiting. Seventy-two percent reported two or more previous episodes of depression. Forty-nine (45.4%) met criteria for major depression and 59 (54.6%) were classified as minor depression subjects. Of the 108 patients randomized to the intervention group, 104 agreed to participate in telephone call interviews evaluating educational materials. Patients who indicated that they had not read or viewed the materials were unable to provide information about the helpfulness of materials.

**READ AND VIEWED MATERIALS**

The number and percentage of patients who read and viewed the two booklets and the video are shown in Table 2. Approximately three quarters of

the subjects read or viewed all of the educational products. The proportion of patients who failed to view the video (18.3%) was somewhat larger than the percentage of patients who failed to read the booklets (7.7%; 7.0%). Patients in the major and minor diagnostic groupings were equally likely to have read or viewed the materials. Data were not collected regarding patient completion of the Patient-Doctor Questionnaire.

**HELPFULNESS OF MATERIALS**

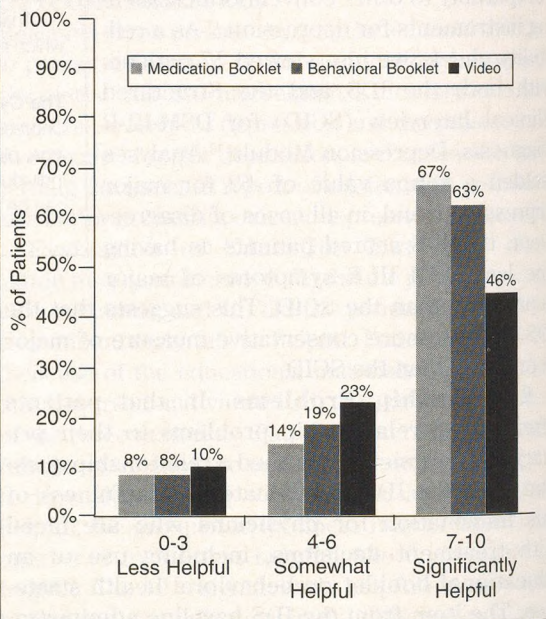
Figure 4 summarizes patient ratings of helpfulness on the two booklets and the video. The majority of patients found the booklets to be significantly helpful (ratings of 7 to 10), while only 45% found the video to be significantly helpful. Ten percent or less gave materials low helpfulness ratings.

**HELPFULNESS OF BEHAVIORAL BOOKLET**

Several additional analyses were completed concerning the booklet on behavioral strategies. The behavioral booklet was read, at least in part, by 93% of the subjects and was rated as somewhat to significantly helpful by 82% of these subjects. In that systematic behavioral health education is newer to the primary care setting than medication education, we

**FIGURE 4**

**Ratings of Helpfulness of Educational Materials by Patients**



attempted to identify characteristics of patients who would benefit most from these materials.

Patients were divided into negative evaluators (ratings of 1 to 5) and positive evaluators (ratings of 6 to 10). Chi-square tests were used to evaluate the significance of difference between positive and negative evaluators of the behavioral booklet. Positive evaluation of the behavioral booklet was not significantly related to patient education level, patient satisfaction with primary care physician, or number of previous episodes of depression.

Table 3 is a summary of the findings concerning the relationship between two patient characteristics at the time of diagnosis (age and report of a relationship problem) and patient evaluation of the behavioral booklet. We grouped patients into major and minor diagnostic groups for these analyses. Our sample sizes were small and findings were not significant. Several suggested trends, however, are worthy of further exploration. Patients with minor depression may find a behavioral health booklet particularly helpful if they report that relationship problems are a factor in depression onset. Age may be a factor in patient benefit from a behavioral booklet when the patient is experiencing more severe symptoms of depression. Older patients may find this type of edu-

cational product less helpful than younger (aged 18 to 54 years) patients.

## CONCLUSIONS

The majority of depressed primary care patients in the present study read booklets and viewed the video on use of medications and behavioral coping strategies. Further, most evaluated these products as helpful. Severity of depression did not appear to be a significant factor in patient use of educational materials. Patients with major depression were as likely as patients with more minor symptoms to read and view the educational products.

Patients were slightly less likely to view the video than to read the booklets. They were also less likely to evaluate the video as significantly helpful. This discrepancy between the actual use and helpfulness ratings of written and filmed educational materials is worthy of further exploration. Some patients may anticipate that "a film about depression will be depressing," and choose not to view it. Level of patient involvement may also be a factor in the patient experience of benefit from use of educational materials. The booklets required the patient to provide written responses and to take these to the primary care visit. Materials that move the patient into an active role may have more impact than a video format, which allows the patient to remain more passive and absorbed in the negative stream-of-thought characteristic of depression.

Systematic behavioral health education is a relatively new depression intervention for the primary care setting. Our results suggest that patients will welcome written materials in this area. Utilization rates and helpfulness ratings were high. Providers may consider use of behavioral health education as a first-response to patients who have more minor symptoms, particularly if they report relationship

TABLE 3

Patient Characteristics Associated with Evaluation of Behavioral Booklet

Characteristic	Positive Evaluation* n (%)	Negative Evaluation* n (%)	P†
<b>Minor depression group (n=59)</b>			
Age			.60
18-54	26 (67)	7 (58)	
≥55	13 (33)	5 (42)	
Relationship problem			.07
yes	27 (75)	5 (45)	
no	9 (25)	6 (54)	
<b>Major depression group (n=49)</b>			
Age			.15
18-54	28 (78)	3 (50)	
≥55	8 (22)	3 (50)	
Relationship problem			.07
yes	26 (72)	4 (67)	
no	10 (28)	2 (33)	

\*Patients rated the helpfulness of product on a scale of 1 to 10. A positive evaluation had ratings between 6 and 10; a negative evaluation received scores between 1 and 5.

†Chi-square tests were conducted to determine the significance level of difference between positive and negative evaluators.



problems. In that physician suggestion of behavioral strategies has been associated with improved medication adherence among primary care patients,<sup>11</sup> physicians are wise to use behavioral health education materials with patients with more severe symptoms who elect to start antidepressant therapy.

Older adults (aged  $\geq 55$  years) who have more severe symptoms may warrant more provider attention in delivery of behavioral health education services. In the present study, older adults with moderate to severe depression tended to rate the behavioral booklet as less helpful than the younger patients. While this finding only approached significance, we have concerns about the behavioral health needs of older patients, as they may not always be good candidates for antidepressant therapy. Older adults are often facing difficult life circumstance problems that are not easily remedied (eg, loss of loved ones, long-term caregiving roles, declining health). Older adults may find an adapted version of patient education materials that maintains a focus on the challenges of aging to be more useful than the generic format used in the present study. Additionally, providers may consider supplementing behavioral education materials with older adults by providing (1) lengthier clinic visits or telephone-call visits to develop and support behavioral health plans and (2) referral for onsite behavioral health services provided by mental health professionals working in primary care clinics when these are available.

While researchers continue to add to the young science of educating depressed primary care patients, we encourage providers to begin use of written educational materials on a routine basis with all depressed patients. Educational booklets help providers address the patient's information needs concerning behavioral health, and, for the patient using medication, information needs concerning strategies for successful adherence to medication regimens. Educational materials may also provide structure for physician-patient interactions so that the most pertinent aspects of both pharmacological and behavioral treatments are reviewed consistently and efficiently in visits. Materials used in the present study have been further refined for routine clinical practice.<sup>22</sup> These, along with lengthier materials,<sup>24-26</sup> may be easily incorporated into routine primary care.

The following guidelines are intended to help providers structure their use of educational materi-

als with depressed patients.

1. Offer written information on behavioral health for all depressed patients.

2. Adjust written information on behavioral health to meet the unique needs of the older patient with moderate to severe symptoms and consider use of clinical management strategies to supplement behavioral health education with this subgroup (eg, longer visit time or ancillary phone contacts).

3. Provide written information on medications and adherence strategies when starting a patient on antidepressant therapy.

4. Use booklets that are brief, interactive, and designed to involve the patient as a partner in treatment planning.

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