

**TO THE EDITOR:**

In their otherwise very helpful article, Sussman and Castaneda<sup>1</sup> omitted an important point in their discussion of common errors in diagnosing depression. The point concerns the common coexistence of depression and substance use disorders.<sup>2</sup> Substance use disorders can lead to depression or depressive symptomatology.<sup>3</sup> Alternatively, depression can lead to self-medication and secondary substance abuse disorders.<sup>3</sup> Identifying patients with such dual diagnoses is critical, as the first step in treatment, if possible, is obtaining abstinence.<sup>3</sup>

Every depressed patient should at least be screened for substance use disorders. Primary care clinicians can perform such screening. However, since such clinicians often do not attend to substance use disorders,<sup>4</sup> mental health treatment systems should be constructed, and mental health professionals should be trained to recognize and treat patients with dual diagnoses.

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**AUTHORS' REPLY:**

We concur with the main point of the letter. Addictive disorders are frequent among individuals presenting with depressive complaints and greatly complicate diagnostic and treatment efforts.<sup>1</sup> This is especially relevant because managed care companies, as a rule, only allow for the hospitalization of depressed patients whose condition is compounded by suicidality or psychosis. Depressed patients who nonetheless lack adequate support systems to ensure continued medical follow-up are frequently denied

coverage for hospitalization, resulting in poor treatment compliance and outcome. A suboptimal management of coexisting addictive disorders can have disastrous consequences. Depressed suicidal patients represent a most difficult clinical situation. In fact, 15% of depressed patients eventually commit suicide.<sup>2</sup> Addictions greatly increase the risk of suicide.<sup>3</sup> Complicating matters, given that antidepressants require several weeks to affect mood improvement, the few days of hospitalization mandated by managed care only allow providers to address associated problems such as withdrawal from substances, agitation, and insomnia. Brief hospitalizations do not permit evaluation of the efficacy of antidepressants or the likelihood of success of efforts to treat associated addictions. Incidentally, it is a fact that the frequently necessary adjustments in dose and type of antidepressants are delegated to outpatient settings.

In their letter the authors express a concern about the ability of primary care clinicians to address addiction disorders. We have recently investigated this issue.<sup>4</sup> In order to assess the addiction knowledge of non-psychiatric physicians as compared to general psychiatrists, we recently designed and administered a nineteen-item questionnaire. Consisting of boards-type questions, the questionnaire was distributed and completed at a national conference of primary care specialists (n = 30), and at a national conference of psychiatrists (n = 22). There were no significant differences on the overall score when the psychiatrists were compared to the non-psychiatrists. However, the statistically significant differences on individual questions revealed that while the non-psychiatrists were more adept at answering pharmacological and definitional questions, the psychiatrists were more accurate in selecting appropriate integrated treatment strategies. We conclude that psychiatrists in this survey need further education on pharmacologic issues, while the non-psychiatrists need training in treatment selection.

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