Barriers to Initiating Depression Treatment in Primary Care Practice

Paul A. Nutting, MD, MSPH, Kathryn Rost, PhD, Miriam Dickinson, PhD, James J. Werner, MS, Perry Dickinson, MD, Jeffrey L. Smith, BS, Beth Gallovic, MA

OBJECTIVE AND DESIGN: This study used qualitative and quantitative methods to examine the reasons primary care physicians and nurses offered for their inability to initiate guideline-concordant acute-phase care for patients with current major depression.

PARTICIPANTS AND SETTING: Two hundred thirty-nine patients with 5 or more symptoms of depression seeing 12 physicians in 6 primary care practices were randomized to the intervention arm of a trial of the effectiveness of depression treatment. Sixty-six (27.6%) patients identified as failing to meet criteria for guideline-concordant treatment 8 weeks following the index visit were the focus of this analysis.

METHODS: The research team interviewed the 12 physicians and 6 nurse care managers to explore the major reasons depressed patients fail to receive guideline-concordant acute-phase care. This information was used to develop a checklist of barriers to depression care. The 12 physicians then completed the checklist for each of the 64 patients for whom he or she was the primary care provider. Physicians chose which barriers they felt applied to each patient and weighted the importance of the barrier by assigning a total of 100 points for each patient. Cluster analysis of barrier scores identified naturally occurring groups of patients with common barrier profiles.

RESULTS: The cluster analysis produced a 5-cluster solution with profiles characterized by patient resistance (19 patients, 30.6%), patient noncompliance with visits (15 patients, 24.2%), physician judgment overruled the guideline (12 patients, 19.3%), patient psychosocial burden (8 patients, 12.9%), and health care system problems (8 patients, 12.9%). The physicians assigned 4,707 (75.9%) of the 6,200 weighting points to patient-centered barriers. Physician-centered barriers accounted for 927 (15.0%) and system barriers accounted for 566 (9.1%) of weighting points. Twenty-eight percent of the patients not initiating guideline-concordant acute-stage care went on to receive additional care and met criteria for remission at 6 months, with no statistical difference across the 5 patient clusters.

CONCLUSIONS: Current interventions fail to address barriers to initiating guideline-concordant acute-stage care faced by more than a quarter of depressed primary care patients. Physicians feel that barriers arise most frequently from factors centered with the patients, their psychosocial circumstances, and their attitudes and beliefs about depression and its care. Physicians less frequently make judgments that overrule the guidelines, but do so when patients have complex illness patterns. Further descriptive and experimental studies are needed to confirm and further examine barriers to depression care. Because few untreated patients improve without acute-stage care, additional work is also needed to develop new intervention components that address these barriers.

KEY WORDS: primary health care; depression; guidelines; family physicians.


Recent research evidence has established considerable potential to improve outcomes for primary care patients with major depression using a variety of interventions.1–11 A recent report from our research group describes significantly improved outcomes from an intervention that uses primary care office nurses trained as care managers to identify and work through barriers to guideline-concordant depression care.11,12 Guideline-concordant treatment in the acute phase includes 1) the initiation of a treatment strategy (watchful waiting with weekly follow-up, antidepressant medication, or referral to a mental health professional for counseling) and 2) modification of the treatment at 8 weeks if patients did not improve. The purpose of this article is to describe the reasons primary care physicians and nurse care managers offered for their inability to initiate guideline-concordant acute-phase care for patients with current major depression.

METHODS

Study Setting and Participants

Twelve primary care practices from 3 practice-based research networks (Ambulatory Sentinel Practice Network, Wisconsin Research Network, and the Minnesota Academy of Family Physicians Research Network) participated in the study. Eligibility criteria included 1) two primary care physicians willing to participate in the study; 2) a nurse willing to deliver the nursing intervention if randomized to the enhanced care condition; and 3) administrative staff willing to screen primary care patients for major depression as part of routine care. Practices in which primary care physicians would routinely refer depressed study patients to onsite mental health specialists for treatment were excluded. Participating practices included 8 located in...
metropolitan areas and 4 located in rural areas. The 12 practices were located in Colorado, Michigan, Minnesota, New Jersey, North Carolina (n = 2), North Dakota, Oklahoma, Oregon, Virginia, and Wisconsin (n = 2).

The 12 practices were randomized to usual care and intervention groups, and enrolled 240 and 239 patients, respectively, who met criteria for current major depression. Two hundred thirty-nine patients enrolled in the 6 intervention practices and the subset of 66 patients failing to initiate guideline-concordant care were the subjects of this analysis.

Defining Acute-stage Guideline Nonadherence

We operationalized acute-stage adherence to the Agency for Health Care Policy and Research (AHCPR) depression guidelines,13,14 as requiring evidence in the nurse care managers’ logs that 2 criteria were met. The first criterion required that patients were placed on depression treatment (antidepressant medication, psychotherapy, or a period of watchful waiting with weekly visits or telephone follow-up) during the first 8 weeks after enrollment in the study. The second criterion required that 9 depressive symptoms were monitored after a treatment plan was initiated and treatment was modified if more than 3 depressive symptoms were reported. Modifications could include starting an antidepressant (when psychotherapy alone was initially selected), starting a second antidepressant in another class or increasing the dose of initial antidepressant (when medication alone was initially selected), and starting either psychotherapy or medication when watchful waiting was initially selected.

Logs for each patient were maintained by the nurse care manager during the first 8 weeks after enrollment. The logs were reviewed for criteria for initiating acute-stage treatment as detailed above. Patients currently receiving care from a mental health specialist were asked to review their medication history during their next regularly scheduled contact with the nurse care manager. When the logs were inconclusive, the nurse care manager was contacted for clarification. This process identified 68 patients who failed to meet criteria for initiating guideline concordant treatment within 8 weeks of enrollment. Physicians clarified that 2 of these 68 patients actually met criteria, which left 66 patients for barrier analysis.

Role of the Nurse Care Manager

The intervention described in detail elsewhere12 consisted of 2 components, 4 sessions of academic detailing for participating physicians and 8 hours of depression care manager education for office nurses to train them to work with patients to overcome barriers to guideline-concordant depression care and monitor their response to treatment. The training and accompanying manual (available from the authors on request) prepared the nurse care manager to identify 27 specific barriers to depression care, of which 15 were barriers to initiating treatment. For each barrier, the nurses were trained to consider what the patient might say to suggest presence of the barrier, explore the patient’s concern, work with the patient to address the barrier, and discuss next steps with the patient.

The nurses followed patients with telephone or face-to-face discussion once a week for the 6 weeks after enrollment, with the option of extending the protocol for 2 additional weeks. At each subsequent contact, nurses completed a checklist of 9 symptoms of major depression and recorded treatment recommendations and adherence in a treatment log. The nurses were able to provide at least 1 session to 92.5% of the depressed patients, and contacted patients they saw at least once an average of 5.2 times over the 8-week period.

The nurses were uniformly enthusiastic about this role and several reported that this was one of the few times they felt they were adding value to the physician’s care and directly affecting patient outcome. Without exception, the physicians supported the nurse’s expanded role, noting that they observed the nurse developing an independent relationship with the patient that increased opportunities for meaningful therapeutic contact. Patients also responded positively to the nurses’ expanded role as evidenced by the number of contacts they completed.

Instrument Development

Structured telephone interviews were conducted with each of the 12 physicians and 6 nurse care managers in the intervention practices in order to identify major barriers they perceived in the care of depressed patients. Physicians were asked first to comment on selected aspects of the AHCPR depression guidelines. Then, while referring to the medical record, physicians and nurses were asked to discuss the care of specific patients selected from among the 66 patients failing criteria for initiating acute-stage treatment.

All interviews were audiotaped and transcribed. Transcripts were coded with the aid of the text analysis program Atlas.ti (Sage Publication Software, Thousand Oaks, Calif). After each interview took place, the 2 interviewers (JJW, BG) discussed the important major themes that were emerging, and a formal analysis of the complete data set involved the larger research team. The results of the analysis, combined with the literature about barriers to treatment of depression15-22 resulted in the development of a structured checklist of 45 specific barriers to the initiation of acute-stage treatment. Physicians were asked to indicate all barriers on this checklist that were a factor in the patient’s care and to spread 100 points across the relevant barriers, weighting them according to their importance for each patient.

Data Collection

Physicians. Physicians were asked to complete checklists for the 66 patients who failed 1 or both criteria for initiating acute-stage treatment during the first 8 weeks following the index visit. The physicians were encouraged to have the patient’s medical record for reference while completing the