



Parents' Role in Adolescent Depression Care: Primary Care Provider Perspectives

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Objective To understand how primary care providers (PCPs) perceive barriers to adolescent depression care to inform strategies to increase treatment engagement.

Study design We conducted semistructured interviews with 15 PCPs recruited from community pediatric offices with access to integrated behavioral health services (ie, low system-level barriers to care) who participated in a larger study on treating adolescent depression. Interviews addressed PCP perceptions of barriers to adolescents' uptake of care for depression. Interviews were audiorecorded, transcribed, and coded for key themes.

Results Although PCPs mentioned several adolescent barriers to care, they thought parents played a critical role in assisting adolescents in accessing mental health services. Important aspects of the parental role in accessing treatment included transportation, financial support, and social support. PCPs perceived that parental unwillingness to accept the depression diagnosis, family dysfunction, and trauma were common barriers. PCPs contrasted this with examples of good family support they believed would enable adolescents to attend follow-up appointments and have a "life coach" at home to help monitor for side effects and watch for increased suicidality when starting antidepressants.

Conclusions In this PCP population, which had enhanced access to mental health specialists, PCPs primarily reported attitudinal barriers to adolescent depression treatment, focusing mainly on perceived parent barriers. The results of these qualitative interviews provide a framework for understanding PCP perceptions of parental barriers to care, identifying that addressing complex parental barriers to care may be important for future interventions. (*J Pediatr* 2015;167:911-8).

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Adolescent depression is an undertreated mental health problem contributing to poor functioning, risky behaviors, and medical comorbidities as an adolescent and adult.¹⁻⁴ Almost 12% of adolescents are diagnosed with major depression or dysthymia⁵; only one-third of those receive mental health care.² National organizations call on pediatric primary care settings to fill this gap of mental health care need⁶ partly through depression screening and referral.⁷ A recent primary care study shows that although one-half of adolescents with a positive mental health screen are referred for mental health services, one-third will refuse the referral, and less than 20% of those screening positive will be seen by a mental health professional.⁸ Primary care interventions addressing barriers to care with the goal of increasing adolescent engagement with mental health services are urgently needed.

Studies among parents have identified that when they do not recognize and acknowledge depression, adolescents are less likely to access mental health care.^{9,10} Parents may not seek care for their adolescent child because of difficulty in identifying depressive symptoms that are present,¹¹ negative treatment attitudes,¹² structural barriers (eg, access, transportation, financial),¹³ and poor parent-adolescent communication.¹¹ Primary care providers (PCPs) experience more difficulty with making a diagnosis and are less likely to refer to therapy and prescribe antidepressants when a parent does not agree with treatment.^{14,15} Many PCPs feel parental involvement is needed for adolescents to follow through with referrals.¹⁶

PCPs are particularly well positioned to assess both adolescent and parent barriers to mental health care because they have an established relationship with families. In fact, primary care is a setting where adolescents frequently present with emotional problems,¹⁷ and several interventions supporting PCPs in providing mental health services have been helpful to increase access.^{18,19} Ideally, PCP-initiated conversations about a potential need for mental health care

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PCP Primary care provider

triggers shared decision making about depression treatment, incorporating perspectives of the adolescent, parent, and PCP.²⁰ Our prior work demonstrated that PCPs perceive that there are both parent and adolescent barriers to participating in depression treatment and they are often different from each other.²¹ To inform strategies to increase treatment engagement, we conducted follow-up interviews with PCPs to inquire how they perceived and attempted to address parent and adolescent barriers.

Methods

Participants (n = 15) were drawn from a larger cohort of PCPs (pediatricians, pediatric nurse practitioners, and physician assistants; N = 58) who had completed a survey about treating adolescent depression in primary care and who expressed interest in providing further comments on the survey findings.²² Qualitative methods can describe experiences, concerns, and beliefs of participants with great fidelity, while allowing for clarifying discussions about existing quantitative results. Richer and more detailed perspectives can be elicited compared with standard quantitative surveys.

PCPs were part of a large regional pediatric practice network serving approximately 46 000 adolescents. The network has an integrated behavioral health model in place with routine depression screening of all 15- to 17-year-olds and colocated mental health therapists. Protocols based on diagnosis and severity are used by mental health therapists to facilitate access to colocated or affiliated child psychiatrists or to connect patients with community mental health resources. An integrated electronic health record is used to facilitate communication between PCPs and mental health specialists. PCPs also had an opportunity to attend a network-hosted series of 4 presentations in the year prior to the survey on the evaluation and management of common child and adolescent mental health conditions, including depression. As a result, patients in this practice network face fewer structural barriers to treatment than may be typical.¹² Thus, the current study was able to focus attention on pediatric PCPs' perceived nonstructural barriers to depression care (eg, negative attitudes and beliefs). Individual demographic statistics for the sample of 15 PCPs were not collected to preserve confidentiality. The larger PCP survey sample was 67% female, 95% White, and 5% Asian/Pacific Islander, with a mean age of 46 years (SD 11). Interviews were conducted from October 2012 to December of 2012.

PCPs self-selected into this study by identifying interest in the survey phase of the larger project. Each interview was conducted by telephone by the first author and digitally recorded, with consent obtained verbally. At the time, she was an adolescent medicine fellow physician who had completed a pediatrics residency, and identified herself this way. Interview data were not linked to prior survey results. Interviewees were asked to refrain from using patient or participant identifiers but, if used, these were removed

from transcripts along with clinic location to preserve confidentiality and patient privacy. Semistructured interview scripts first asked the PCPs to describe their roles in treating adolescent depression and then about 3 main topic areas: antidepressant prescribing, influential factors on treatment decisions, and barriers to depression treatment. In this manuscript, findings from the barriers to depression treatment section are emphasized. Specifically, interviewees were asked about their views on barriers to care in general, whether they think there are differences between adolescent and parent barriers, and how they can identify and address barriers that apply to a patient and family. These questions were constructed as a qualitative follow-up study²³ to our survey study,²¹ where we found that PCPs perceive the continued presence of and differences between adolescent and parental barriers in an integrated behavioral health model. Interviewees were encouraged to provide case examples. Interviews lasted approximately 30 minutes. Each interviewee received a \$50 debit card upon interview completion. This study was approved by the institutional review board at the University of Pittsburgh and the University of Pittsburgh Clinical and Translational Science Institute pediatric practice-based research network, Pediatric PittNet.

Statistical Analyses

The interviews were audiotaped, transcribed verbatim, and coded using ATLAS.ti version 7 (Scientific Software Development GmbH, Berlin, Germany). The approach of qualitative description as described by Sandelowski—a comprehensive summary of phenomena while staying close to the data—was used to describe PCP opinions and beliefs about barriers to depression care.²⁴ Using a content analysis approach,^{22,25} the first 3 interviews were reviewed by 2 investigators (A.R. and H.M.) and an initial list of codes focusing on key areas of interest was generated with additional review by a supervising investigator (E.M.): access, antidepressants, barriers, case studies, clinician characteristics, collaborative care, communication styles, depression characteristics, facilitators, identifying depression, influential factors, PCP responsibility, screening, substance use, and treatment. All interviews were coded by 2 investigators (A.R. and H.M.), compared for agreement, and finalized. Additions of new codes or changes in code definitions were determined via consensus among the research team. No new sets of codes emerged after approximately 6 interviews were completed, suggesting content saturation was achieved. Final sample size was determined by content saturation as well as achieving a sample of PCPs from various clinic locations. Patterns and concepts were retrieved related to factors influencing initiation of mental health care. The current analysis focuses specifically on PCP perspectives and experiences with barriers to depression care.

Results

In line with our assumptions that the integrated behavioral healthcare model in which providers were situated would

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