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Primary care providers' beliefs about teen and parent barriers to depression care

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Abstract

Objective—Only one-third of U.S. adolescents with depression obtain treatment for depression. Teen and parent barriers differ, but both contribute to low treatment rates. Primary care providers (PCPs) may be able to elicit and address such barriers, but little is known about their perceptions of teen and parent barriers, and whether they recognize these differences.

Methods—We administered a survey to 58 PCPs assessing their perceptions of the importance of specific barriers to depression care for teens and parents using McNemar's test to examine differences.

Results—Most PCPs believed barriers for parents included difficulty making appointments, worry about what others would think, and cost. PCPs believed barriers for teens included not wanting treatment and worry about what others would think. PCPs believed parents and teens differed in the extent to which they would perceive cost, difficulty making appointments, and not wanting care as a barrier ($p < .001$).

Conclusions—PCPs recognize teens and parents have different barriers to care, but may have discordant perceptions of the importance of certain barriers for teens and their parents. PCPs may need to probe parents and teens individually about barriers which impede depression care to enhance shared decision making and treatment uptake.

Keywords

primary health care; depressive disorder; adolescent

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Conflict of Interest

There are no known conflicts of interest for any author.

Adolescent depression is an under-recognized public health problem in the United States with serious consequences.^{1, 2} While almost 12% of all adolescents are diagnosed with major depression or dysthymia,³ only one-third of depressed adolescents receive mental health care.⁴ Although screening in primary care settings provides one route to identify and offer treatment for adolescents with depression,^{2, 5} other barriers may intervene to prevent successful treatment initiation, sufficient treatment engagement, and improved outcomes.^{6, 7} For primary care providers (PCPs) to effectively address adolescent depression and increase the likelihood for treatment initiation and engagement, strategies to better identify and address barriers to care are needed.

Teens and parents in primary care settings identify a wide range of both external (e.g. transportation or access) and internal barriers (e.g. negative beliefs and attitudes) to depression care.^{8, 9} Depressed teens endorse internal barriers including fear of being identified as abnormal or a belief that they do not have a problem.^{8, 10} Parents may also face internal barriers such as not acknowledging that depression is a problem for the teen^{7, 9} or feeling guilty that the diagnosis is a result of poor parenting.

Barriers most salient for parents differ from barriers identified by teens.⁹ A study on barriers to depression care among adolescents in primary care found that the top three barriers for parents of depressed teens were trouble making an appointment, high costs, and not wanting care.⁹ The top three barriers for depressed teens were personal responsibilities at school, home, or work, worry about family's perceptions, and trouble making an appointment. Both parent and teen barriers predict poor uptake of depression care.^{7, 9} This study concluded that for PCPs to increase treatment uptake, they should identify and address teen and parent barriers to care.

While several studies have investigated barriers to depression care for teens and parents,^{9–11} we are unaware of studies examining PCPs' perceptions of these teen and parent barriers. Better understanding PCPs' perceptions will assist in designing primary care interventions directed toward assisting PCPs in considering teen and parent needs, values, and preferences, thereby increasing initiation of and engagement with mental health care for adolescent depression. This exploratory study examined how PCPs perceive adolescents' and parents' beliefs about barriers to care, which may be important to improving the quality of shared decision-making in adolescent depression treatment decisions.

METHODS

Study participants and setting

This survey assessing PCPs' beliefs about teen and parent barriers to depression care was part of a larger study on adolescent depression and treatment decision making in the primary care setting,¹² conducted with PCPs (including pediatricians, pediatric nurse practitioners and physician assistants) in a large regional pediatric practice network serving approximately 46,000 adolescents. This integrated behavioral model is described in detail in a prior paper.¹² This study was approved by the institutional review board at the University of Pittsburgh as well as the University of Pittsburgh CTSI pediatric practice-based research network, Pediatric PittNet.

Data Collection

Paper surveys were distributed to 143 PCPs: 56 were distributed in person at a practice network meeting, and 87 were mailed to network PCPs who had not attended the meeting. The 93-item survey was completed anonymously, took approximately 15 minutes to complete, including items assessing practice characteristics and perceived barriers to care. Fifty-eight surveys were returned for a survey response rate of 41%, comparable to the response rate for other PCP surveys on depression treatment (13–63%).^{13, 14}

Measures

Modified Barriers to Care Scale (BCS)—The BCS⁹ assesses teens' and parents' barriers to depression care and was modified to assess PCPs' perceptions of the same teen and parent barrier items. PCPs were cued to imagine that an adolescent patient of theirs is diagnosed with depression, and then asked to rate the extent to which they agreed that a given teen or parent barrier might prevent the teen from receiving care (worded exactly as on the original scale with additions 'the teen might not care because' or 'the parent might not encourage the teen to get care because' – see Table 2). Response options were on a 5-point Likert scale ranging from 1 'disagree' to 5 'strongly agree'. We calculated two aggregate barriers scores by summing 6 PCP-rated teen barriers and the 6 PCP-rated parent barriers. We dropped the barrier "wouldn't want family to find out," because this was only asked for teens, from the aggregate score. The aggregate barriers scores ranged from 6 to 30, with higher numbers indicating perception of greater barriers (original BCS aggregate scale for teens Cronbach's α 0.75 and for parents Cronbach's α 0.83).

Analysis

The primary study outcome was PCPs' perceptions of teen and parent barriers to depression care. Descriptive statistics were used to calculate the percentage of PCPs who 'somewhat agreed' or 'strongly agreed' that an individual item would be a barrier for a teen or a parent. McNemar's test was used to evaluate paired differences in the proportion of PCPs who rated a given item as a barrier for the teen versus the parent. A general linear model (GLM) approach was used to assess whether there were differences in PCPs' aggregate total barriers scores for teens relative to parents. All analyses were conducted using SPSS Version 19.

RESULTS

Primary care provider and practice characteristics

The 58 PCPs were 46 years old on average, predominantly female and White (Table 1). Most reported having an on-site mental health provider within their practice ($n=38$, 66%) and practicing in a suburban setting. Approximately one-half belonged to a medium-sized practice (5 to 9 PCPs; $n=28$, 48%). Most PCPs ($n=52$, 91%) reported that 50% or less of their patients are on Medicaid. Half of PCPs ($n=28$; 48%) reported that they frequently (over 75% of well visits) speak to teens alone, but most PCPs ($n=48$; 83%) infrequently (less than 25% of well visits) speak to a parent alone at well child visits when both teens and parents are present.

Primary care provider beliefs on teen and parent barriers

Most PCPs strongly or somewhat agreed that barriers to care for parents would include difficulty finding or making an appointment with a doctor or therapist (91%), worry about what others might think (79%), and cost (75%). For teens, PCPs thought the most common barriers would be not wanting to get care (91%), worry about what others might think (90%), and problems due to personal responsibilities at school, home, or work (64%). Sixty percent of PCPs believed that teens would not get care because they would not want their family to find out. Less than half of PCPs (42%) thought good care not being available would be a barrier for parents and 29% thought it would be a barrier for teens. Few PCPs (14%) thought cost would be a barrier for teens.

Comparing PCP perceptions of barriers for teens versus parents, there were statistically significant differences between PCPs' beliefs about teen and parent barriers with regards to cost (McNemar $\chi^2(1) = 32.4, p < .001$), difficulty making an appointment (McNemar $\chi^2(1) = 20.6, p < .001$), and just not wanting to receive care (McNemar $\chi^2(1) = 31.0, p < .001$; see Table 2). PCPs perceived cost and difficulty making an appointment to be more likely a barrier for parents than for teens. PCPs perceived just not wanting to get care would be more likely to be a barrier for teens than for parents. The GLM showed that PCPs' aggregate barriers scale scores for parents ($M = 21.5, SD = 3.2$) were significantly greater than for teens ($M = 20.3, SD = 3.6, F(1,54) = 9.26, p = .004, \eta^2 = 0.15$).

DISCUSSION

We found that pediatric primary care providers working in a setting with access to mental health care do recognize that parents and teens experience barriers to obtaining treatment for depression even when these services are readily available. PCPs also perceived that barriers most important to teens differ from barriers important for parents. PCPs believed that difficulty making an appointment would be the most important barrier for parents and that not wanting to receive care would be the most important teen barrier. Worrying what others would think (perhaps due to stigma) was identified as the barrier most likely to be important to both teens and parents.

A study using the same Barriers to Care scale found that teen and parent reported barriers are discordant. The most common parent barrier was difficulty making an appointment, consistent with the perception PCPs have about parent barriers in our study.⁹ However, in contrast, teens in this prior study reported that their most important barrier was having other personal responsibilities and not wanting their family to find out, whereas PCPs in our study assumed that the most salient teen barrier would be not wanting to receive care.⁹ In prior research, parents and depressed teens listed worrying about what others would think as the least frequent barrier to care,⁹ but PCPs in our study thought stigma was a substantial barrier for both parents and teens.

While PCPs in our study recognize that differences in barriers between teens and parents exist, their rating of how important specific barriers may be do not align with what parents and teens have reported in the research literature as their most salient barriers.⁹ One explanation is that PCPs may not be eliciting teen and parent barriers during clinical

encounters, particularly from parents, to whom PCPs reported speaking alone infrequently during clinic visits. In particular for stigma, PCPs may be misjudging the importance of attitudinal or internal barriers by overestimating the importance of patient attitudes over situational factors like personal responsibilities as an explanation for poor uptake of care.¹⁵

On the other hand, PCPs may be identifying the importance of barriers which influence parent and teen depression treatment decisions but are not readily recognized by parents and teens as barriers to care. For example, some PCPs may have rated stigma as important because of its known association with poor uptake of mental health care including depression treatment initiation and adherence in adults¹⁶ and teens.⁹ PCPs practicing in an environment with enhanced access, as in this study, may also be more attuned to the importance of stigma and related internal barriers than PCPs in environments with fewer behavioral health resources who may be more likely to report structural barriers (i.e., lack of access to mental health care) than internal barriers.¹³ Internal barriers, such as negative beliefs and attitudes about depression, negative past treatment experiences, feeling judged or worried they are not normal (teens)^{8, 10} and guilt about the diagnosis (parents) are all likely to contribute to decreased initiation of depression treatment. The persistence of and failure to address these internal barriers for parents and teens during the encounter between the PCP and family may be one reason why prior collaborative interventions resulted in low engagement in mental health care,¹⁷ and suggest that PCPs may have an important role in eliciting, normalizing, and directly addressing these internal barriers which teens and parents may not spontaneously identify as barriers at the time of a diagnosis.

PCPs ranked barriers for teens differently than barriers for parents, reflecting PCPs' understanding that depressed teens' and parents' perceptions of barriers may be discordant.⁹ Treatment decisions for teens are often more complex than those for adults with depression, as engagement in care involves both the teen and their parent(s) together with the PCP. Each individual's perceptions of barriers may influence the other's perceptions, requiring PCPs to consider both teen and parent views. Parents and teens identified in primary care may be at different stages of readiness for treatment, and whether a parent acknowledges their teen's depression and need for treatment has a strong influence on the teen's readiness for treatment.⁷ Parents and teens often disagree on the level of depressive symptoms experienced by the teen, more so when symptoms are primarily internalizing, less severe, or when parents have a mental illness.^{18, 19} A shared decision making process, involving the teen and parent as well as the PCP, is one established approach that could identify more of the barriers to care, increase consensus about the teen's depression treatment,²⁰ and improve uptake of and adherence to care.²¹

Further research is needed to understand which interventions may be helpful for PCPs to help reduce barriers to care for adolescents and parents. It is important for PCPs to individually interview parents and adolescents to elicit barriers as they are likely to be different from one another. Parents and adolescents may not mention negative attitudes toward depression diagnosis or treatment – so the PCP may act to reassure families that negative attitudes toward care are common and counsel about common concerns about treatment (e.g. that antidepressants are addictive). The PCP may question the adolescents' and/or parents' understanding of depression diagnosis and mental health treatment if barriers

are difficult to elicit. If the patient is not in need of a crisis intervention, the PCP can often reassure the adolescent and parent that sometimes it takes time to consider the best treatment option and schedule a follow-up appointment to reassess options and symptoms.

Limitations

Our findings must be considered within the context of our study's limitations. The sample size and response rate were modest, and we do not know to what extent selection bias and the low response rate among our respondents may have influenced our results or generalizability. Respondents were embedded in a health care delivery system with robust behavioral health resources and may not be representative of other pediatric primary care sites. Although this limits the generalizability of this study's findings to sites with fewer mental health resources, this unique setting offered an opportunity to examine the role of other barriers to care when access is less of a problem. The variability of diagnostic presentations in adolescent depression, other mental health and substance use comorbidities and its influence on barriers are likely to influence PCPs' decision making, but for purposes of this exploratory study we did not add that component to the survey design. We used studies of parent and teen self-reported barriers from different clinical settings that also used the Barriers to Care Scale,⁹ and we do not know if parent and teen responses regarding barriers would have been the same in our PCPs' clinics. It is also possible that the observed differences found when we compared PCP perceptions of barriers for teens versus parents were influenced by the within-subjects design in which PCPs were asked to rate both teen and parent barriers separately. However, in follow-up discussion to review and confirm these findings with a subset of the survey sample, PCPs reiterated that many barriers are different for teens than for their parents creating challenges for both initiating and continuing depression care.

CONCLUSIONS

PCPs should make a specific effort to determine both teen and parent beliefs, attitudes, and concerns prior to making treatment decisions and address potential barriers which may impede initiating depression care. Understanding PCPs' perceptions of teen and parent barriers offers further insight into the range of barriers which impede the uptake of depression care. Shared decision making interventions designed to improve the uptake of depression care may assist PCPs with normalizing and addressing these complex teen and parent barriers. Future studies should replicate these results in a larger and more diverse sample and include qualitative research to elaborate on PCPs' perceptions of barriers to care. Also helpful would be longitudinal studies that simultaneously examine teen, parent, and PCP perceptions of barriers to care and subsequent uptake of care.

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Table 1

Primary Care Provider Demographics and Practice Characteristics (N = 58)

	<i>n</i> (%)	<i>M</i> (SD)
<u>Respondent Characteristics</u>		
Gender, female	39 (67)	
Age		46.5 (11.1)
Race		
White	55 (95)	
Asian/Pacific Islander	3 (5)	
Years since graduating medical/nursing school ^a		19.1 (11.4)
<u>Adolescent caseload</u>		
1–25%	34 (60)	
26–50%	20 (35)	
51–75%	3 (5)	
<u>Practice Characteristics</u>		
<u>Total PCPs in Office</u>		
0–4	15 (26)	
5–9	28 (48)	
10–14	15 (26)	
<u>Setting</u>		
Urban	10 (17)	
Suburban	35 (60)	
Rural	13 (22)	

^a2 missing responses.

Table 2

Differences in PCP perceptions about barriers for parents versus barriers for teens to obtaining depression care (N = 57)^a

Barrier	PCP Perceives This is a Barrier for... (%)			P value
	Both Teens and Parents	Neither Teens nor Parents	Only Parents	
Cost	8.8	21.1	3.5	66.7
Worry about what others might think	73.7	5.3	15.8	5.3
Difficulties finding/making an appointment with a doctor/therapist	45.6	5.3	3.5	45.6
Problems due to teen's personal responsibilities at school, home, or work	47.4	14.0	15.8	22.8
Good care isn't available to the teen	17.5	47.4	10.5	24.6
Just doesn't want to	36.8	8.8	54.4	0

^a 1 PCP did not complete items.

Barriers included are from Barriers to Care Scale. Percent for each category reflects PCPs who reported that they 'somewhat agreed' or 'strongly agreed' that an item was a barrier. P value reported is for differences between PCPs' beliefs about teen versus parent barriers to care using McNemar's test.