# Conditions That Influence a Primary Care Clinician's Decision to Refer Patients for Depression Care

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**KEY WORDS**

***depression care***
***primary care clinicians***
***referral***

*The objective of this study was to identify conditions that influence primary care clinicians' referral decisions related to depression care. Forty primary care clinicians (15 general internists, 10 nurse practitioners, and 15 family practice physicians) were included in this study. The clinicians participated in semistructured interviews and completed two quantitative instruments (with 33 items on depression treatment decision making and 32 items on provider attitudes toward psychosocial care). Data analysis revealed that several conditions influence a clinician's decision to refer a depressed patient to a mental health specialist: the patient's resources, the clinician's comfort in prescribing antidepressants and counseling patients with depression, and familiarity with a mental health specialist and practice environment. The decision to refer a patient with depression to a mental health specialist is a complex process involving the clinician, patient, and practice-related issues. Understanding these relationships may provide strategies to improve depression care management and lead to the design of depression care quality-improvement interventions that accommodate primary care practice context. The findings from this study suggest a need to increase mental health training opportunities for primary care clinicians to strengthen their skills and comfort level in managing depressed patients and encourage the development of relationships between primary care clinicians and mental health specialists to facilitate timely and accessible mental health care for patients.*

Numerous studies have examined the factors that influence a primary care clinician's decision to refer patients with depression to mental health specialists (Geller, 1999; Harmon, Veazie, & Lyness, 2006). Although influencing factors may vary (Burns, Wagner, Gaynes, Wells, & Schulberg, 2000; Chew-Graham, Mullins, May, Hedley, & Cole, 2002; Knight, 2003; Lin et al., 2000; Wang, Langille, & Patten, 2003; Younes et al., 2005), the most frequently reported factors can be categorized into four groups: patient-related factors, clinician-related issues, practice-environment-related issues, and perceived severity of depression symptoms (Amaddeo, Zambello, Tansella, & Thornicroft, 2001; Krahn et al., 2006; Kravitz et al., 2006; Marwaha & Livingston, 2002; Murphy, James, & Lloyd, 2002; Pierce & Pearee, 2003; Shimizu et al., 2005). Additional research suggests that factors such as patient attitudes and characteristics, clinician experience, and access to mental health services likely influence the referral process (Cooper-Patrick et al., 1999; Miller & McCrone, 2005; Slade et al., 2003; Trude & Stoddard, 2003; Waller et al., 2005).

Depression is a chronic illness that most frequently is first observed in the primary care setting, which places primary care clinicians in a unique position to provide early recognition and management. Primary care clinicians often cite patient concerns about depression's social stigma, histories of noncompliance, and fears about mental/emotional symptoms as barriers to the referral process (Ford, 2006; Kirkcaldy & Tynes, 2006; Klein, Saravay, & Pollack, 1996; McEvoy & Richards, 2007; Tardieu et al., 2006; Vagholkar, Hare, Hasan, Zwar, & Perkins, 2006). Characteristics such as being male, white, single, middle aged, or having poor health status, including chronicity and severity of symptoms (suicidal/homicidal), also are strong predictors of referral to specialized mental health (Bushnell, 2004; Fisher, 2002; Miller & McCrone, 2005).

Several studies have suggested that practice issues such as time constraints, a lack of access to a mental health specialist, and a lack of training and experience significantly increase clinicians' levels of discomfort when working with patients with depression (Bower & Rowland, 2006; Dobscha, Leibowitz, Flores, Doak, & Gerity, 2007; Hull, Jones, Tissier, Eldridge, & Maclaren, 2002; Meredith et al., 1999; Nutting et al., 2002; Onate, 2006; Sigel & Leiper, 2004; Starfield, Forest, Nutting, & von Schrader, 2002; Telford, Hutchinson, Rix, & Howe, 2002).

This article reports on the dimensions and properties of the conditions that influence a primary care clinician's decision to refer patients with depression to a mental health specialist and addresses the associated implications for rehabilitation nurses working with people with depression and their families. Although recent studies have identified several conditions that

influence the referral of patients with depression to mental health specialists (including practice environment and clinician- and patient-related issues), the dimensions of these conditions have not been identified. Using data collected from quantitative and qualitative methods, the researchers were able to identify specific dimensions of conditions associated with the decision to refer or not refer patients for specialized mental health care. An understanding of the dimensions and properties influencing the decision to refer among primary care clinicians may improve depression management and help the design of depression care quality-improvement interventions that complement primary care practice.

## Methods

### *Sampling and the Sample*

Consent to conduct the study was obtained from the University of Cincinnati internal review board before beginning the study. Written informed consent was obtained from each participating clinician at the time of the interview. The goal of the Describing Enigma of Evaluating Depression (DEED) project was to naturally investigate the processes by which primary care clinicians recognize and manage depression in primary care office environments and the conditions (contextual factors) that influence these processes. The grounded-theory theoretical sampling method was used to purposefully recruit participants. This article highlights the conditions that influence primary care clinicians' decisions to refer patients with depression to mental health specialists.

A list of primary care clinicians in the Greater Cincinnati area was obtained from the director of family medicine, University of Cincinnati College of Medicine. Six clinicians (2 general internists, 2 family practice clinicians, and 2 family/adult nurse practitioners) randomly were selected from the list. During interviews with these clinicians, each was asked to nominate one or two primary care clinicians who could be contacted and invited to participate in the study. Nominated sampling guided the recruitment of clinicians throughout the remainder of the study.

Each clinician met once with a trained PhD-prepared DEED research team member who conducted the semistructured interviews. The research project coordinator hand delivered the questionnaire and survey to each participant 2–3 weeks after the in-person interview. Participants completed the questionnaires during their scheduled lunch hours and were compensated with a boxed lunch. The instruments were confidential. By integrating the survey and questionnaire information with the accordant individual interviews (using code numbers), the researchers expected to identify conceptual consistency between clinician instrument responses on attitudes toward mental illness and depression and data from the individual interviews. The instruments were used to determine whether there were commonalities in practice patterns among providers whose beliefs were similar and who were in the same practice discipline or area.

### *Individual Semistructured Interviews*

The semistructured interview questions were followed by unstructured probes to clarify, expand, and compare what was being said by participants (**Figure 1**). The initial interview questions were developed in the primary investigator's previous study (Baik, Bowers, Oakley, & Susman, 2005). The later interview questions were developed based on ongoing analysis to further explore how the participants recognized, diagnosed, and managed depression in their everyday practice without putting them in a defensive mode about what they did and how

**Figure 1. Initial Interview Questions**

1. When do you start to think that you may be seeing mental health issues?
2. How do you know that it is a mental health issue?
3. Are there any clues that you look for?
4. What does it take for you to say to yourself, not the patient, "this may be depression"?
5. What does it take for you to say to your patient that he or she may be depressed?
6. How do you know that this is depression and not just a tough life?
7. Have you had a situation in which you felt that the patient was depressed and the patient said, "I don't think so!" How did you deal with that?
8. I am not a provider, but I would think it would not be easy to sort out whether this is depression or not just a tough life. How do you sort those out?
9. How do you decide which treatment approach is best for a patient?
10. Are there any rules or measures that go through your mind?
11. Is there any difference in deciding what to do for one patient versus another?

they did it. The questions were developed to give conceptual structure to the interviews but were not intended to cover every aspect of practice.

## Data Collection: Instruments

### *The Depression Care Questionnaire*

Based on a review of the literature and the research team's expertise in depression and depression care, the team developed a depression care questionnaire. The depression care questionnaire (DCQ) first was reviewed individually, followed by a discussion among the entire team to determine the appropriateness of the items. Items were included on the questionnaire only after unanimous agreement was reached by the team.

Two to three weeks after the interview, the primary care clinician completed the written quantitative questionnaire along with the survey to be discussed later. The DCQ is a self-report instrument designed to evaluate the likelihood that a primary care clinician will use selected depression treatment options (comparing ideal and actual practice environments). This questionnaire used a 4-point Likert-type (*highly likely, likely, unlikely, highly unlikely*) format. The 4-point scale was used to avoid the neutral inconclusive option. Clinicians first were asked to rate the likelihood of using each of the listed treatment options in an ideal setting (assuming no barriers influenced their decisions). On the second half of the questionnaire, clinicians were asked to rate both the likelihood of making depression care referrals and the specific types of mental health specialists (such as psychiatrists, psychologists, social workers, or psychiatric nurse practitioners) to whom those referrals were made. In making referrals, providers were asked to rate the effectiveness of various depression treatment options based on their own experiences and to rate the importance of specific influencing factors in making referral decisions. Finally, providers were asked whether they knew the health professional to whom they referred their patients (*yes* or *no*) and whether there was a mental health professional practicing in their office (*yes* or *no*).

### *The Provider Belief Survey*

This survey developed by Ashworth and colleagues (1984) has 32 items and is used to measure clinician beliefs about psychosocial aspects of patient care. Each item represents an affirmation or denial of a psychosocial aspect of health care, beliefs concerning the clinician's role, beliefs about what patients want and do not want, and beliefs about the clinician's reactions to patients as people. The respondents were asked to rate their perceptions of personal and environmental factors that they believe influence their decisions related to depression treatment. The original survey questionnaire used a 5-point Likert-type format (*agree, strongly agree, neutral, slightly disagree, strongly disagree*). Because *neutral* often does not give useful information, the team replaced this term with the item *never thought about it.* The scale has a high internal consistency score of rkk = 0.88. The 5-point Likert-type response format has demonstrated satisfactory internal consistency in both initial and validation samples (Ashworth et al.).

The self-administered survey and questionnaire were completed 2–3 weeks after the initial in-person, in-depth qualitative interview to avoid skewing participants' perspectives before the interview.

## Data Organization and Analysis

A mixed data (qualitative and quantitative) method was used to generate a theory. Frequencies and percentiles were used to analyze quantitative data and grounded theory to guide the decision on overall data collection (including theoretical sampling), qualitative interview data analysis, and linking and making sense of quantitative and qualitative data analysis. Grounded theory uses the strategy of constant comparison to develop and refine theoretically relevant categories (Strauss, 1987).

Categories elicited from the data constantly are compared with data obtained earlier in the data-collection process so that commonalities and variations can be determined. As the data collection proceeded, the later data collection and analysis focused on emerging theoretical concerns.

This article reports data from 40 primary care clinicians who participated in semistructured interviews and completed the DCQ and Provider Belief Survey. Each participant met with the researcher one time to complete the interview. The interviews ranged from 30–90 minutes in length and were audiotaped and transcribed verbatim. Each interview first was analyzed independently by each team member and later by the group to validate interpretations and assumptions. Grounded theory's open, axial, and selective codings were used to categorize and analyze the qualitative data from the semistructured interviews.

## Findings

### *Quantitative Results*

The clinicians comprising the first cohort of a multicohort study included 15 general internists, 15 primary care physicians, and 10 adult/family nurse practitioners (13 men, 27 women; among the group, 25 were Caucasian, 10 were African American, and 5 were Asian Americans; **Table 1**). The clinicians practiced in settings with 1–11 providers. The majority of clinicians ($n$ = 39; 97.5%) practiced in urban

settings. Years in practice ranged from 1 to more than 35 years.

Analysis of responses to the DCQ (**Table 2**) showed that each of the clinicians participating in the study estimated that on average 30%–50% of patients in their practices experienced depression. Clinicians were highly likely or likely to use antidepressants as a treatment option for these clients ($n$ = 36; 90%), followed by brief in-office counseling ($n$ = 37; 92.5%), and referral to mental health specialists ($n$ = 34; 85%). Additional findings from the DCQ revealed that 75% ($n$ = 30) of the clinicians were highly likely or likely to have used referrals as a treatment option for patients with depression during the past year. The data show that few clinicians ($n$ = 9; 22.5%) had a mental health specialist practicing in their office; however, 32 (80%) knew a mental health specialist to whom they preferred to refer their patients. Clinicians were highly likely or likely to refer their patients with depression to a psychiatrist ($n$ = 34; 85%), a psychologist ($n$ = 33; 82.5%), or a social worker ($n$ = 30; 75%).

Results from the Provider Belief Survey showed 22 primary care clinicians (55.9%) believed they could treat psychosocial problems and that patients expected them to address their psychosocial problems ($n$ = 27; 67.6%). The majority of the clinicians ($n$ = 37; 94.2%) believed that psychosocial issues and problems must be considered concurrently with organic problems when treating depression. One-third of the clinicians ($n$ = 14; 35.3%) said they do not consider patients' psychosocial problems because of time limitations. Fifty percent of participants agreed with the statement, "There are so many issues to be investigated when seeing a patient that I do not always consider psychosocial factors"; 22 subjects (55.9%) agreed that "investigating psychosocial issues decreased my efficiency"; and 20 subjects (50%) agreed that "investigating psychosocial issues causes me to lose time and money."

### *Qualitative Results from Semistructured Interviews*

Analysis of in-depth interviews showed that the decision to refer a depressed patient to a mental health specialist was a complex one, centering around five major issues: clinicians' perceived severity of depressive symptoms, clinicians' comfort in treating depression, clinicians' perceived complexity of the diagnosis, patient preferences and resources, and practice environment. These issues were found to be influenced by conditions including training and experience, availability of a mental health professional, having a relationship with a mental health professional, patient preferences and resources, and beliefs about depression.

### *Clinician's Perceived Severity of Depressive Symptoms*

An analysis of the interviews showed that the level of severity of depressive symptoms perceived by clinicians was rated as *highly important* by general internists ($n$ = 14; 94%), family practice physicians ($n$ = 14; 94%), and nurse practitioners ($n$ = 9; 90%) when making the decision to refer a patient to a mental health specialist. Most of the participants managed depression by prescribing antidepressants and providing minimal follow-up visits for patients diagnosed with mild or moderate depression. However, 100% of the clinicians stated that a patient's expression of suicidal thoughts

**Table 1. Demographic Characteristics as Percentage of the Sample**

| Demographic Characteristics | *n* | % |
|---|---|---|
| Gender | | |
| Male | 13 | 32.5 |
| Female | 27 | 67.5 |
| Race/Ethnicity | | |
| Caucasian | 25 | 62.5 |
| African American | 10 | 25.0 |
| Asian American | 5 | 12.5 |
| Specialty Area | | |
| Family practice | 15 | 37.5 |
| General internist | 15 | 37.5 |
| Family nurse practitioner | 10 | 25.0 |
| Number of Providers in Office Setting | | |
| 1–3 | 19 | 47.5 |
| 4–6 | 15 | 37.5 |
| 7–10 | 5 | 12.5 |
| More than 10 | 1 | 2.5 |

**Table 2. Results from Depression Care Questionnaire**

| | Highly Likely | Likely | Unlikely | Highly Unlikely |
|---|---|---|---|---|
| **1. Treatment options** | *n* (%) | *n* (%) | *n* (%) | *n* (%) |
| Brief in-office Counseling | 27 (67.5) | 9 (22.5) | 2 (5.0) | 1 (2.5) |
| Antidepressants | 26 (65.0) | 11 (27.5) | 1 (2.5) | 1 (2.5) |
| Psychotherapy | 12 (30.0) | 16 (40.0) | 6 (15.0) | 6 (15.0) |
| Counseling and antidepressants | 21 (52.5) | 15 (37.5) | 2 (5.0) | 1 (2.5) |
| Psychotherapy and antidepressants | 8 (20.0) | 21 (52.5) | 5 (12.5) | 5 (12.5) |
| Referral to mental health specialist | 6 (15.0) | 28 (70.0) | 5 (12.5) | 1 (2.5) |

| **2. In your everyday practice setting over the last year, please rate the likeliness of using the following treatment options for a patient with depression.** | Highly Likely *n* (%) | Likely *n* (%) | Highly Unlikely *n* (%) | Unlikely *n* (%) |
|---|---|---|---|---|
| Brief counseling | 22 (55.0) | 13 (32.5) | (0) | 5 (12.5) |
| Antidepressants | 30 (75.0) | 10 (25.0) | (0) | (0) |
| Other medications | 1 (2.5) | (0) | 3 (7.5) | 21 52.5) |
| Psychotherapy | 5 (12.5) | 14 (35.0) | 6 (15.0) | 14 (35.0) |
| Counseling and antidepressants | 14 (35.0) | 20 (50.0) | 1 (2.5) | 5 (12.5) |
| Psychotherapy and antidepressants | 6 (15.0) | 12 (30.0) | 7 (17.5) | 15 (37.5) |
| Referral/consultation | 12 (30.0) | 18 (45.0) | 1 (2.5) | 9 (22.5) |

**Referral Patterns**

| **3. Please rate the following items in terms of importance in making referral/consultation decisions for patients with depression.** | Highly Important *n* (%) | Important *n* (%) | Highly Unimportant *n* (%) | Unimportant *n* (%) |
|---|---|---|---|---|
| Patient treatment preference | 29 (72.5) | 11 (27.5) | (0) | (0) |
| Patient insurance coverage | 20 (50.0) | 16 (40.0) | 2 (5.0) | 2 (5.0) |
| Office practices/policies | 3 (7.5) | 14 (35.0) | 3 (7.5) | 20 (50.0) |
| Onsite mental health services | 17 (42.5) | 13 (32.5) | 4 (10.0) | 6 (15.0) |
| Family preferences | 1 (2.5) | 22 (55.0) | 1 (2.5) | 15 (37.5) |
| Potential liability for primary care provider (PCP) | 4 (10.0) | 22 (55.0) | 1 (2.5) | 13 (32.5) |
| PCP comfort level | 16 (40.0) | 22 (55.0) | (0) | 2 (5.0) |
| Severity of depression | 38 (95.0) | 2 (5.0) | (0) | (0) |
| Suicidality | 40 (100.0) | (0) | (0) | (0) |

| **4. I know a mental health professional to whom I prefer to refer my patients.** | *n* | % |
|---|---|---|
| Yes | 32 | 80 |
| No | 8 | 20 |

| **5. Is there a mental health professional who practices in your office?** | *n* | % |
|---|---|---|
| Yes | 9 | 22.5 |
| No | 31 | 77.5 |

| **6. Reflecting upon your practice last year, how likely are you to refer to the following:** | Highly Likely *n* (%) | Likely *n* (%) | Unlikely *n* (%) | Highly Unlikely *n* (%) |
|---|---|---|---|---|
| Psychiatrist | 14 (35.0) | 20 (50.0) | 6 (15.0) | (0) |
| Psychologist | 21 (52.5) | 12 (30.0) | 7 (17.5) | (0) |
| Social worker | 11 (27.5) | 19 (47.5) | 9 (22.5) | 1 (2.5) |
| Psychiatric nurse practitioner | 5 (12.5) | 10 (25.0) | 17 (42.5) | 7 (17.5) |
| Family therapist/marriage counselor | 8 (20.0) | 20 (50.0) | 6 (15.0) | 6 (15.0) |

or plans was a criterion for immediate referral to hospital psychiatric services. In cases in which the patient lacked resources or there was no immediate access to a mental health specialist (long waiting lists or unavailability), clinicians would prescribe antidepressants, follow-up with patients (some with daily telephone contact), increase the frequency of office visits, and initiate a no-suicide safety contract until the patient improved or hospitalization had been arranged.

*"Referring the patient on if I feel that there is a problem with the depression that I'm not going to be able to take care of like the acutely suicidal patient…" (Interview 13).*

*"Suicidal patients, patients who hurt themselves are referred immediately." (Interview 18)*

*"If the patient is severely depressed and suicidal, I refer to a psychiatrist." (Interview 15)*

### Clinician Comfort in Treating Depression

Comfort level in treating depression was identified by 86% of clinicians as a very important factor when making the decision to refer a depressed patient to a mental health specialist. Although participants openly talked about their discomfort in treating depression, the majority (55%) tended to treat basic, simple depression in their office. Clinicians described simple, basic depressive symptoms as feelings of overwhelming sadness, frequent crying spells, an increase or decrease in appetite, insomnia or hypersomnia, lack of energy, difficulty concentrating, and anhedonia but able to continue normal activities such as working and taking care of the home and children. Simple, basic depression usually resulted from an acute situation such as the loss of a job, death of a loved one, or serious illness. As depressive symptoms become more severe and patients become more debilitated, clinicians were consistent in their decision to refer to mental health specialists. Not surprising was the fact that training and years of experience were the factors clinicians cited as having the most influence on their level of comfort in working with patients with depression. The clinicians who had trained with a psychologist or psychiatrist or had completed a residency in psychiatry were more comfortable recognizing and managing simple and moderate depression. Three clinicians discussed how their personal experiences with depression or the experiences of a close relative contributed to their comfort in recognizing and managing the condition. Although few clinicians in this study spoke openly about their own depression, their views about the impact of the experience were consistent. They described themselves as more comfortable treating simple depression, spending more time talking to and counseling patients and family members, and trying to find the most effective treatment options.

*"I am by no means a mental health professional. I may identify the problem, which does not mean that I know how to fix the problem." (Interview 19)*

*"If someone has major depression they need more than just me handing out medications. They really need some counseling, some therapy." (Interview 4)*

Some participants expressed discomfort treating depression because the signs and symptoms were subjective and based on patient self-report. The lack of an objective laboratory test to confirm the diagnosis of depression was problematic for some clinicians.

*"Personally, I don't like treating it that much. I would be happy if I never saw another patient who wants an antidepressant for the rest of their life. How do you measure it? They're not going to live longer if I give them Prozac. Whereas, if I lower their blood pressure I know they will live longer. I have no good way to measure outcome or measure response." (Interview 3)*

### Clinician's Perception of Complexity of the Diagnosis

The clinicians were very clear in their categorization of complexity. Complexity was defined in two ways: bipolar disorder or a comorbid diagnosis of depression with another mental disorder, and a lack of patient response after trials with several different antidepressant medications.

*"If I've tried three different meds and a few combinations and don't get any effect, they need to see someone with more training than I have." (Interview 30)*

*"Patients with mixed disorders, bipolar, or who I am not comfortable treating or have treated and they are not stable, I refer…." (Interview 20)*

*"If you see that you're [in] above your head, then send them off to a specialist, somebody who can help them." (Interview 12)*

*"I'm pretty good at it. You know, with the basics. You know generalized anxiety, panic attack, and depression. Once it becomes bipolar and certain schizophrenia I'm usually referring that." (Interview 1)*

The clinicians often said they were unable to adequately treat depression when a patient failed to respond to at least three different antidepressants or when he or she appeared to need extensive therapy (usually patients with chronic depression) or when patients had multiple stressors in their lives.

*"I am willing to try a number of antidepressants... Beyond that, you need to see somebody else—a psychiatrist or therapist." (Interview 4)*

### Patient Preference and Resources

Patient preference was an important consideration when making the decision to refer to a mental health specialist. In a number of cases, the clinician would treat the patient in his or her office because the patient expected it even though he or she had adequate financial and insurance resources to cover visits with a mental health specialist. An underlying factor for patient preference was the presence of a relationship between patient and primary care

clinician. The lack of a relationship generally meant more immediate referral to a mental health specialist. If a patient was willing to see a mental health specialist, he or she generally was referred early in the treatment process.

> *"We do a lot of referrals for additional counseling but the number who goes is very small." (Interview 21)*

> *"Issues [that] I am not competent to handle or [if] the patient needs hospitalization I enroll a psychiatrist." (Interview 15)*

> *"Sometime they will accept a visit to a social worker or psychologist to discuss certain situations they are having. Rarely will they agree to see a psychiatrist because the word* psychiatrist *is in there." (Interview 22)*

> *"Those with good insurance are referred earlier." (Interview 40)*

> *"For someone who has high expectations of me, my being responsible for getting them the right medication and making them feel better right away, I am going to dip into the depression aspect—not dig. Likely a shorter visit. I'm going to refer for psychological evaluation because I feel uncomfortable." (Interview 28)*

> *"Patient preference usually determines whether the referral is to a social worker, psychologist, or employee assistance program." (Interview 39)*

### The Patient's Ability to Pay

The patient's ability to pay significantly limits the referral decision-making process. Insurance companies usually limit the number of visits to mental health professionals and the type of specialty services allowed. In addition, a number of insurance companies require that patients call a specific number to request mental health services. In many instances, patients simply are not able to navigate themselves through this bureaucratic maze and they will return to the primary care clinician or return later in a more deteriorated state.

> *"Insurance companies limit how much mental health you can use." (Interview 5)*

> *"Some insurance plans have restrictions on who the patient can see in terms of counselors and psychiatrists." (Interview 36)*

> *"Many of my patients can't get counseling because of finances or scheduling issues." (Interview 16)*

### Practice Environment

Practice environment was an important condition that influenced referral decision making. Factors that influenced the practice environment and the decision to refer a patient with depression to a mental health specialist included time constraints, limited treatment options, and a lack of access to mental health specialists. The majority of clinicians said that exploring depression takes time, and time constraints in primary care and competing demands limited their ability to explore depression with their patients. With less than 15 minutes to deal with patients' complaints during a visit, clinicians often made the decision to not deal with depression if the patient did not bring it up, even though they knew depression was present. As a strategy to deal with limited time per visit, some clinicians scheduled a second visit so they could address depression. Quantitative data were consistent with the results of qualitative data from the semistructure interviews. The majority of the participants (92.5%) agreed with the statement, "Consideration of psychological problems will require more effort than I have to give," and 50% agreed with the statement, "Investigating psychosocial issues decreases my efficiency." These findings were supported in the interview data demonstrated by the responses, such as

> *"I have time to write for medicine. I don't have time to give counseling." (Interview 22)*

Access to mental health specialists also was cited as a problem. The availability of psychiatrists is limited in the Greater Cincinnati area, and those who practice see patients on a cash-only basis. Specialized mental

## Key Practice Points

1. Although having a working relationship with a mental health professional increases the primary care clinician's level of confidence in treating depressed patients, fewer than 75% have a mental health professional working in their practice environments.
2. Level of comfort was identified by 86% of clinicians as a very important factor in deciding to refer a patient to a mental health professional.
3. The rehabilitation nurse plays a major role in helping the depressed patient to reach and maintain their highest level of wellness by educating him or her about depression, encouraging compliance with medications and physician visits, and promoting a collaborative relationship between patient, family, and provider.
4. Clinicians stated that having a relationship with a mental health professional provided them with immediate access for collaboration and referral, an opportunity to match patient needs with a mental health professional's skills, confidence that patient is receiving quality care, and the opportunity for primary care clinicians to remain in the treatment loop.

health programs have long wait times and patients often fail to follow-up with appointments, landing back in the primary care clinician's office with additional or sometimes more severe symptoms of depression.

*"There aren't many psychiatrists that accept Medicaid. The wait to see a psychiatrist is 3 months." (Interview 20)*

Although few clinicians had a mental health specialist practicing in their office, 86% of family practice physicians, 80% of nurse practitioners, and 67% of general internists knew a mental health specialist to whom they could refer their patients with depression.

*"I'm pretty good at recognizing when I need help and I have a pretty good relationship with the psychiatrist, so I know who to call when I need it." (Interview 1)*

*"I have one or two people I know, mainly from my association with assisted living and nursing homes that I refer to. If I think the problem is psychiatric I refer to a psychiatrist as well." (Interview 15)*

### *Affiliation/Relationship*

Clinicians stated that having a relationship with a mental health specialist provided them with more immediate access to a professional for collaboration or referral purposes, which eliminated long wait times for treatment. In addition, clinicians believed that in many cases they could continue to treat their patient with ongoing collaboration with the specialist. Clinicians said that accessing immediate in-person collaboration or patient referral continues to be a serious problem when caring for patients with depression, however. Findings from the DCQ and Provider Belief Survey showed that the majority of participants (77.5%) did not have a mental health professional practicing in their office setting. The findings also showed that clinicians were most likely to refer to a psychiatrist (85%) or a psychologist (82%) and least likely to refer to a psychiatric nurse practitioner (38.5%).

*"I try to meet and talk with the psychiatrist who has admitted my patient. I read the work-up. If it makes no sense I will not send my patients to him/her. If the work-up is good, I keep the person in mind." (Interview 27)*

*"I would like to have a consulting psychiatrist to collaborate with regarding cases and meds." (Interview 10)*

Having working relationships with a mental health specialist allowed clinicians to match client needs with the skills and techniques of the specialist, which they believed led to better outcomes. Knowing a mental health specialist offered the provider a certain level of confidence that the patient was receiving high-quality care and that he or she could remain in the patient's treatment loop. The clinicians said that keeping informed about a patient is important, and a referral to a mental health specialist often resulted in a loss of involvement with a patient.

*"We never get feedback from mental health." (Interview 3)*

*"I like for my patients to be seen by somebody I know. Somebody I think will be a good match for this particular patient." (Interview 27)*

*"The nice thing about this practice is the proximity to the psychiatry/psychology group." (Interview 13)*

*"I treat depression and anxiety on my own unless they've been tried on a number of medications. Then I refer to a psychiatrist." (Interview 21)*

## Discussion

Thirty to fifty percent of all patients with depression are first seen in a primary care office setting (Ford, 2006; Klein et al., 1996). Structural limitations within the healthcare system and clinician- and patient-related issues hinder the provision of effective referral to mental health specialists and in-office management of patients with depressive symptoms. Findings from this study suggest that the decision to refer a patient with depression to a mental health specialist is a complex one. Although it is well known that practice setting and environment influence primary care clinicians' decisions to refer patients with depression for specialized mental health services, other factors such as clinician comfort in treating depression, perceived complexity and severity of depression, and patient preference and resources may have greater influence (Murphy et al., 2002; Pierce & Pearee, 2003; Schimizu et al., 2005). Clinicians in this study felt that having an ongoing relationship with a mental health specialist and knowing his or her skills and strengths enabled them to better accommodate patient needs.

The ability to effectively meet the care needs for patients with depression either through in-office treatment or referral is greatly influenced by experience and training of primary care clinicians, personal preferences, and limitations of the current healthcare system. Significant changes will need to be made in the training of healthcare professionals. Training options could include a mental health rotation/practicum under the direct preceptorship of a mental health specialist or a longer mental health rotation in both acute and chronic settings. Facilitating partnerships and collaborative relationships between primary care clinicians and mental health specialists could greatly improve recognition and management of depression in primary care settings.

Rehabilitation nurses play a vital role in the rehabilitation and recovery of patients with depression.

Rehabilitation nursing is a philosophy of care that promotes clients' reaching their maximum level of wellness (Issacs & Colby, 2009). Rehabilitation nurses must recognize that patients are individuals and that both patients and family members bring a level of expertise to the caregiving process. Nurses play a major role in helping patients and families focus on the patient's level of social integration and functioning despite their illness and temporary loss of autonomy and independence. Rehabilitation nurses monitor patients with depression for adherence to the treatment program; regularly screen patients for symptoms of depression, worsening of symptoms, and signs of suicidality; and monitor for and teach patients about the side effects of medications (antidepressants) and recognizing stressors that lead to exacerbation of depression symptoms. In addition, nurses teach patients effective coping strategies and reinforce existing strategies.

Rehabilitation nurses can contribute considerably to improving and maintaining good communication among patients, nurses, and other healthcare professionals; ensure that patients keep their visits to the primary care clinician or mental health specialist, and provide patients with timely and relevant information. By encouraging the development of a collaborative relationship between patients, families, and healthcare professionals, nurses help to reduce stress and provide a healthy environment for patients and family members, which is essential to the recovery process. A critical role for rehabilitation nurses is to help patients understand and accept that maintaining their level of functioning is important. In addition, rehabilitation nurses help patients recognize that it is worthwhile to delay any further decline in functioning.

## Limitations

This study had several limitations. First, the small sample of size of 40 clinicians, all from several primary care practice settings, presented referral for patients with depression through a narrow perspective. Second, this study retrospectively explored factors and conditions that influence referral decision making of primary care clinicians for patients with depressive symptoms. Consequently, the reconstructed views about depression care were based on clinicians' memories and perceptions about the ways in which they made referrals in depression care. Third, there was not a way to link the things the clinicians said with their referrals or referral outcomes.

Our findings suggest future research be directed at identifying the ways in which clinicians perceive their role in dealing with depression and the gaps they see in their training and practice environments that inhibit effective work with patients with depression.


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