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Abstract

Objectives. Low-income and Latinos use the emergency department (ED) as a primary source of care. Also, the depression prevalence in ED patients is high, making the ED a compelling venue for depression screening and intervention. This study examined barriers and facilitators to depression treatment among low-income, predominantly Latino ED patients.

Methods. We conducted telephone interviews with 24 ED patients (18-62 years of age, 79% female) who dropped out of a depression treatment intervention. Using grounded theory, we analyzed perceptions of depression and treatment, and barriers and facilitators to mental health treatment.

Results. Although most patients acknowledged signs of depression, there was a lack of readiness to seek help. Patients reported negative perceptions about anti-depressant medication, even if they had no previous use. Barriers to treatment included transportation concerns, employment/unemployment, patient-provider issues, and immigrant documentation. Identified facilitators included consistent provider advice and "talking." This study introduced new misunderstanding and miscommunication barriers.

Introduction

Depression is associated with significant morbidity, mortality, functional impairment, and costs, and has been identified as the leading cause of disability worldwide (Kessler, Berglund, Demler, et al., 2003; World Health Organization [WHO], 2001; Murray, Lopez, 1997; Wells, Stewart, Hays, et al., 1989). The medically ill are especially likely to suffer co-morbid depressive disorders (Wells, Golding, & Burnam, 1988). Structural factors such as poverty significantly increase the risk of depression (Miranda, Azocar, Komaromy, & Golding, 1998; Walls, Rhodes, & Kennedy, 2002) and the prevalence of related depressive disorders (such as dysthymia) in racial/ethnic minority groups (Walls, Rhodes, & Kennedy, 2002). Low-income, vulnerable populations cared for by the public delivery systems in the United States have higher rates of depressive disorders and lower rates of treatment (Lennon, Blome, English, 2002). Low-income Latinos, in particular, face numerous barriers to accessing mental health care, including higher rates of uninsurance, lack of a reliable source of medical care, limited English proficiency, stigma, and other cultural barriers (Walls, Rhodes, & Kennedy, 2002). Limited English proficiency can be especially challenging for patients with mental health diagnoses because these conditions necessitate communication between the patient and the provider (Sentell, Shumway, & Snowden, 2007). In fact, an analysis of data from the 2001 California Health Interview Survey found that 51% of those speaking English and wanting services received them, while only 8% of non-English speakers received desired services (Sentell, Shumway, & Snowden, 2007).

In 2002 over 110 million visits were made to the emergency department in the United States (WHO, 2001). In a study examining the prevalence of depression among ED visits, it was found that 32% of the patients screened positive for depression, which is greater than the estimated 6.6% prevalence rate of the general community (WHO, 2001) , constituting a significant and increasing burden on the U.S. emergency medical system (Larkin, Claassen, Emond, Pelletier, &Camargo, 2005). Recent prevalence studies have reported rates of significant depressive symptoms among urban medical ED patients to be as high as 32% - 55% (Haughey, Calderon, Torres, Nazario & Bijur, 2005; Boudreaux, Cagande, Kilgannon, Kumar & Camargo, 2006). These figures are higher than reported rates for major depression in both community and primary care settings, which are 2- 4% and 5 - 10%, respectively

(Katon & Schulberg, 1992). Additionally, underdiagnosis in the ED is a problem, especially for racial/ethnic minorities who use the ED as the initial point of contact with the mental health system (Kalogerakis, 1992). Given that racial/ethnic minorities are presenting in EDs with mental health problems, and that the prevalence of depression is high among ED patients in general, research efforts to understand depression in the ED may have an important public health impact (Haughey et al. 2005) on addressing health disparities.

Further, studies on depression and depression treatment have rarely included or focused on Latinos (U.S. Department of Health and Human Services, 2001). Thus, the aims of this study were to examine reasons for dropping out of depression treatment and barriers to depression treatment among predominantly Latino ED patients, and to identify facilitators to depression treatment engagement in this population.

Methods

Study Design

A qualitative sub-study was conducted within the *Robert Wood Johnson Foundation, Finding Answers: Disparities Research for Change* study. The goal of this parent study was to improve access to and sustainability of a quality depression care intervention for low-income patients (n=313) who had screened positive for depression in a large, public ED. Telephone interviews were conducted with a subsample (n=24) between July, 2006 and April, 2009. Interviews were retrospective by four months to three years. Interviews lasted 15 to 25 minutes. This study was approved by the USC Health Sciences Institutional Review Board.

Study Protocol

The parent study was a randomized clinical trial in which patients who screened positive for depression were assigned to one of two treatment groups. The intervention group was given the opportunity to engage in an eight-week Problem Solving Treatment (PST) (Mynors-Wallis et al., 1995) depression counseling intervention with the study social worker, while the control group was waitlisted for a period of four months before meeting with the social worker. The parent study accounted for practical barriers (i.e., bus tokens for transportation) and cultural tailoring (i.e., culture and language matching between study staff and patients; bilingual education material adapted for low literacy patients at the 4th grade reading level), and outreach efforts and logistical support (i.e., study social workers calling patients and/or sending letters to engage them in treatment and reminding them of appointments; telephone therapy; provider flexibility in scheduling treatment appointments, and free childcare at the hospital). If

patients desired depression medication, they were referred to the hospital outpatient psychiatric clinic, and were seen by a psychiatry resident. To be seen in this clinic, they completed a financial screen. Typically, despite a patient's documentation status, the lack of money, or not having insurance, they were still eligible to receive anti-depressant medication free of cost, both under this study and through state insurance screening eligibility guidelines.

Study Setting and Population

Patients for this study were seeking emergency care at Los Angeles County + University of Southern California (LAC + USC) Medical Center, the largest single provider of public care in East Los Angeles, California. The recruitment process took place in the ED of LAC+USC Medical Center. This ED is currently the largest provider of health care in Los Angeles County and serves predominantly minorities, the poor, and the uninsured.

Subject Enrollment/ Eligibility Requirements

Patients presenting themselves in the emergency department at LAC+USC Medical Center for usual care were screened for depression. Exclusion criteria included the following: i) under age 18 of age; ii) not English- or Spanish-speaking; iii) prisoners; iv) patients who had evidence of cognitive impairment based on a six-item screener (Callahan, Unverzagt, Hui, Perkins & Hendrie, 2002); v) patients who are in acute and trauma areas of the ED (as these patients often have more acute medical illnesses and may have difficulty participating in the consent and screening process, as well as with the study if admitted); vi) patients in the psychiatric areas of the ED and those who present to the medical ED, but who are on psychiatric hold (for suicidal or homicidal ideation, or gravely disabled); vii) have documented mental illnesses (more severe – i.e., schizophrenia, bipolar disorder, mania); viii) those who are already receiving psychiatric services; ix) those already enrolled in a study for depression; and x) patients who are acutely intoxicated with alcohol/drugs and/or arrive to the ED with a primary diagnosis of alcohol and/or substance abuse.

Eligible patients were approached by community health promoters and research assistants. Following a verbal informed consent, patients were asked to complete a short study screener. Patients who screened positive in the two-item Patient Health Questionnaire-2 (PHQ-9) continued with the remainder of the PHQ-9 instrument, which assesses the presence of major depressive disorder, as well as a continuous severity score (Kroenke, Spitzer & Williams, 2001). This instrument utilizes a common concept of depression across racial and ethnic groups.

As a conceptual and theoretical starting point for the interview guide development, we used the Transtheoretical Model (TTM) or "stages of change" model, to investigate the stages of awareness, consideration,

decision to participate and remain in depression treatment. Sensitizing concepts (Blumer, 1954) based on the TTM provided a starting point to explore barriers and facilitators, as the trajectory of adherence can follow a temporal pattern from pre-contemplation (being uniformed about depression and depression treatment), to contemplation (where factors that contribute to success or failure in depression treatment participation). Since it was a challenge to get patients to indicate treatment facilitators if they did not even go to treatment, questions focused on the strategies the provider could have used to encourage patients to keep their appointments. Inductive methods of data collection elicited patient perspectives on depression, the utility of depression treatment, barriers to completing a treatment trial, reasons for dropping out or remaining in a treatment trial, and viable strategies for reducing dropout.

Sample Description

There were 165 patients assigned to the parent grant intervention arm, and among these, 130 (79%) had less than 4 visits with the study social worker. All of these 130 individuals were eligible for the qualitative sub-study, and 13 (10%) refused to consider participation in the sub-study. The remaining 117 patients were contacted primarily during working hours, but also after hours, weekends, and at patient request. However, despite repeated attempts, 93 patients (71.5 %) were unreachable due to the transient nature of the population. Transient patients were extremely difficult to contact. Their telephone numbers were often disconnected or there was no voicemail available. Some had no personal telephones and could only provide a family member or friend's telephone number. Other subjects moved out of the area or even out of the country and had no updated information available even in the electronic medical record. Although letters were mailed, these were of limited usefulness with patients who had low literacy levels. This yielded 24 patients who consented to participate. An average of 7.4 calls were made to engage the group of 24 into the intervention treatment with the study social worker. Of the 24 patients, 12 did not attend an initial assessment or first visit with the parent study social worker.

Analysis

This study utilized a grounded theory (Glaser & Strauss, 1967) approach throughout to explore and generate new theory on the phenomenon of depression treatment dropout for patients (Creswell & Maietta, 2002). Analytic methods of "Coding, Consensus, Co-occurrence and Comparison (Willms, Best, Taylor, Gilbert, Wilson, Lindsay & Singer, 1990) were used to analyze telephone interview transcripts. To enhance the overall rigor and credibility of findings, 3 coders separately reviewed all 24 transcripts to achieve consensus in the codes. Following the open coding, codes were assigned to describe connections between categories, and between categories and subcategories

(also known as axial coding [Strauss & Corbin, 1998]). During this process, short descriptive memos were prepared to document all investigators' initial impressions of the topics and themes and their relationships and to define the boundaries of the specific codes (Miles & Huberman, 1994).

Results

Of the 24 patients interviewed in the qualitative study, ages ranged from 18 and 62 years old; 19 were female, 23 were Latino, 16 Spanish-speaking, 19 were uninsured, 16 were married or living with partner, 16 were unemployed, and 21 had an education level under grade 12. Twenty-two patients had never had depression treatment, 18 had never taken depression medication, and 9 patients thought their health was poor. Twelve patients had moderate depression, 8 had moderately severe depression, and 4 patients had severe depression (according to the PHQ-9). Only three of the 24 patients reported being on antidepressants during the course of their time in the study. And none of them took any other psychotrophic medications (other than antidepressants) during the course of the study. All 24 patients' demographic and clinical characteristics were similar to the 130 non-engaged intervention participants (who were predominately Latina, Spanish-speaking, uninsured, married, moderately depressed, etc.).

Perceptions about depression and depression treatment

Most (n=17) were aware they were depressed and "feeling bad." Patients were able to identify psychosomatic symptoms associated with depression: "a really bad headache," "forgetfulness" and "feeling tired." Patients identified a general feeling of "not being myself" and having "no motivation," not feeling like doing anything or "being lazy," isolating self at home, and an inability to problem solve simple daily tasks, "like opening mail or taking a shower." Although most patients acknowledged signs of depression and were encouraged to seek professional depression treatment, there was a general under-readiness to follow through with getting help, along with the lack of motivation to seek treatment.

Although only three patients received anti-depressants, almost half of the patients (n=11) reported that they had negative perceptions related to depression medication. Patients reported reluctance to take medication even if they had never attempted them, and "not liking pills," due to worry over the side effects that they heard about psychiatric or depression medication (n=3), fear of a negative effect of a medication interaction with other prescribed medical medication (n=2) (i.e., being "tired" or "sleepy"), or the possible addictive nature of psychiatric medication (n=2) (i.e., "I don't even like to take pills. I don't like medication. I always feel that I need to be able to

function well, like do my work, read, knit, well you know stuff that I like to do. So I feel like that distracts me"; "I don't like taking medication for depression because it makes you addicted. That is what I have heard and I know by experience"). Patients indicated embarrassment about seeking a mental health provider (i.e., "I guess I was just embarrassed. Sometimes the embarrassment is too much that it prevents you from letting people know how you feel"). Patients were generally more in favor of psychotherapy over medication.

Barriers to Depression Treatment

Patients identified a number of barriers (not mutually exclusive) that contributed to their consent to participate, but discontinuing after less than 4 social work visits: transportation problems, cost concerns, employment/unemployment concerns, patient-provider dissatisfaction and issues, and immigrant documentation worries. Although there was an attempt within the nature of the intervention to improve access by reducing such barriers (i.e., medication costs, transportation, etc.), some patients were unaware of these support efforts.

Although a primary outreach effort of the study was to encourage continued participation in the parent study and to provide transportation assistance with bus tokens, almost half (n=11) of the patients reported having transportation problems due to physical limitations (i.e., "She did not give me any tokens. My toe was cut and I could not walk that much. At that time, the ride to get there was the most important. I would have gone if she picked me up.") and travel distance problems (i.e., another patient reported, " I live very far from there so it was for me the thing of going all the way over there"). Some of the patients did not seem to be aware that transportation was offered as part of the treatment intervention: "I could not go because of transportation – the bus. Tokens were not provided. I think even though I was feeling really bad, I would have shown up if someone would have gone to pick me up at my house."

Cost concerns permeated patient narratives about why patients did not continue treatment. Four patients reported medication cost concerns interfering with their treatment continuation. One of these patients reported, "If I can't get ORSA (Outpatient Reduced Cost Simplified Application), then I would have to pay for everything and I don't have money to pay for it." Social workers attempted to offer flexibility with patients (i.e., rescheduling appointments and arranging after-hours appointments to accommodate patients work schedules), but employment made it difficult to continue with treatment. Another related financial concern involved employment barriers, which included patients having to work early or late in the day, making it difficult to keep appointments. For example, a

patient reported, "because of my job, I was working a lot during that time so I could not go see her. I work really long hours and really late, or else I would have gone."

Patients also reported negative interactions with their clinical non-study related healthcare providers, which interfered with continuing treatment. They reported reluctance to discussing depression with physicians because they were not perceived to listen, care, or give them more time during appointments: "He did not care. He told me that is why I had headaches and gave me this medication. Just to listen to me and give me different medication, not the one he gave me because it was not working." Importantly, patients reported patient-provider miscommunication which may have impacted their treatment satisfaction (i.e., "He really did not help me"; "No, well I did not go to talk to the doctor about it and he did not ask me anything. So I did not tell him anything. I would have liked it if he would have asked me but he didn't"; "I don't think they would listen anyways. They want to see you as fast as they can and then just go on to the next patient. I don't think they care"). Patients also preferred that doctors speak Spanish:

> What I would like is for the doctor to speak Spanish. I don't speak English but most of them, they don't even listen to you because you don't speak English. Yes well if someone had to interpret. I will feel more comfortable trying to tell him that I wasn't feeling good.

Although only two patients described some element of racial/ethnic marginalization and vulnerability, this experience is still clinically important. This immigrant documentation concern barrier was best illustrated when a patient said, "I did go once, but they did not see me because one time a lady told me she needed my social security number and other paper work. I don't have a social security, so I just left. I would have liked to see her, but because of that, I did not."

Facilitators to Depression Treatment Engagement

Patients valued the social work role and liked the telephone counseling option, but desired more consistency from the social worker. Specifically, they felt more time to talk was important, in addition to depression education pamphlets, which were helpful to them in understanding their depression. Patients described how the social worker calling them on the phone, instead of having to go into her office to talk with the social worker, was preferred ([I prefer the social worker] "calling me on the phone so I can talk to her, instead of me going to see her"). These patients were most satisfied with their ability "to talk" with the social worker and receive advice: "She was very nice to me. Just talking to her made me feel better. That was good for me because I would talk to someone and she will listen and give me some advice". Patients saw the social worker as one who had the unique ability to

"understand" and empathize with problems. However, patients described needing the social worker to reach out more and take a more active role with scheduling appointments. Overall, they were satisfied with the social worker, but wanted more consistency and outreach from the social worker.

Discussion

Given the increase in ED mental health visits in publicly funded hospitals, the ED could be used as an opportunity to evaluate, treat, and educate about depression and other mental health issues. Most patients who dropped out of treatment were aware of their depression and depressive symptoms, suggesting that their lack of engagement in treatment was not due to denial of symptoms. This lack of engagement may have been due, in part, to the timing of the offering of depression treatment, i.e., when they were focused on emergency medical issues in the ED. However, they did initially consent to participate, so there was at least a brief window of opportunity for engagement. This suggests that alternative strategies may need to be used in EDs to inform and engage patients in other treatments that may be warranted and beneficial early on.

Dropout patients also expressed preference for counseling over medication. Part of the rationale for dislike of antidepressants was based on past experiences or the experiences of others, and there was also a general perception of antidepressant medication having side effects and being unappealing or inappropriate. Consistent with the literature, certain attitudes can be barriers to treatment, including believing that treatment was ineffective (Gonzaler, Alegria, Prihoda, Copeland & Zeber, 2011), and stigma or embarrassment about seeing a mental health provider (Vega, Rodriguez & Ang, 2010). To a certain extent, patients seemed to lack knowledge about what anti-depressant treatment entailed. These negative perceptions about depression medication treatment being addictive, possibly causing side effects, and being embarrassing were not necessarily barriers to study participation, but are important to point out clinically because we know ultimately perceptions drive our behavioral health decisions, participation, and adherence. These findings suggest the need for psycho-educational approaches during the early cognitive phases of treatment, which is useful in addressing some of these misperceptions about antidepressants. Clinicians can address patients' beliefs by spending more time restructuring in the earlier cognitive treatment stages, to combine emotional reactions and rational thinking with medication. This could be the beginning step to designing interventions which are tailored to the needs of those who are clinically depressed, yet have not considered

depression treatment. Since most patients described being aware and conscious of depression, future interventions might also include better motivational strategies and psycho-educational strategies to affect behavioral change.

A critical factor which might have contributed to patients stated reluctance to engage and continue with treatment, despite explicit efforts to reduce barriers, might have been misunderstandings and miscommunication. Although this study reduced many barriers, it also introduced new study communication barriers, which should be considered in future similar intervention studies. It is possible that patients enrolled in this study did not understand that that there were either no costs for appointments or medications, or that they would only incur a small sliding scale fee through the ORSA. Low-income patients thinking they would have to pay for medication or treatment, might have discouraged them from participating, which thus created a barrier to their treatment continuation.

When patients were asked what types of things the social worker could have done to help continue with depression treatment, several indicated they needed the social worker to either "give" or "change" their medication, which is not the role of the social worker.

These communication and misunderstanding barriers are important to recognize clinically, but are also potentially related to issues of whether consent to participate in treatment was truly "informed" and other ethical implications for human subjects' research and practice. It is unknown whether the reasons for this are related to language translation, educational level, health literacy, or the combination of factors. It is especially important to address communication barriers among limited-English-proficient patients, which can improve satisfaction with physician communication and care (Gany, Leng, Shapiro, Abramson, Motola, Sheild, et al., 2007). Given patients desire for talking with the social worker, and the logistical barriers, telehealth would be a good option for these patients. Telehealth has been shown to be effective for use of telecommunications (i.e. multimedia-based projects, including websites, instructive CD-ROM and video) to provide relevant and culturally appropriate health information and care across distance (Nickelson, 1998; Dick, Manson, Hanse, Huggins and Trullinger, 2007).

There were patients who expressed patient-provider interaction barriers and did not feel entitled to complain or express their thoughts and feelings to their doctors or providers. This might reflect a role of "passive compliance." Miranda et al. (2004) shows that Latinos' engagement in treatment is often related to the concept of respect. This "people-pleaser" role may be even more pronounced among Latinas (females). This is worthy of

discussion because clinicians may need to reassure patients that it is acceptable to express their dissatisfaction or disappointment about depression treatment, as well as with other treatment concerns. Thus, if the quality of interactions are not improved, and patients do not remain in treatment, sustaining treatment efficacy will not matter.

This new study provided new information on reasons for drop-out from depression treatment among predominantly Latino populations. There need to be better efforts to improve communication and understanding about the study, what is offered, and the roles of the various health care providers. Better communication and understanding will yield maximum efficacy from the intended intervention. In addition, case management, psycho-education, and motivational interventions should become standard of care for patients meeting criteria for depression in medical emergency services. This could improve use of depression treatment, thus improving treatment outcomes and potentially decreasing rates of ED overutilization and cost.

Study Limitations

Despite the many strengths of this study, there are several important limitations which need to be considered in future similar research. *First*, these telephone interviews were retrospective in nature by four months to three years requiring patients to think back to when they had the opportunity to engage in depression treatment with the social worker. There may have been poor recall and abstract recollection of the factors leading up to their depressed state, and the obstacles and reasons for dropping out of treatment. *Second*, the lack of a comparison group (i.e., those who successfully completed treatment) does not allow us to understand whether the same barriers would be faced by those who also continued treatment. If those who continued treatment also face the same barriers, then what would be the difference in the dropouts? Future studies could compare across groups. *Third*, although the goal of this study was not to focus solely on Latinos, the patients who ended up being able to be contacted were predominantly Latinos. This study's results were only applied to predominately Latinos because only one participant was not Latino. *Fourth*, we did not collect temporal enrollment data (i.e., mean and median months) of the parent study or this sub-study. This information might be important in future studies to assess average time it takes patients to engage in treatment. *Finally*, given that this parent grant was a randomized clinical trial which attempted to address barriers and improve access, the perspectives are not generalizable to all study patients in evidence-based treatment interventions because we were not able to contact most eligible patients.

13

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