

## PERSPECTIVES

# Improving Research on Primary Care Patients With Mental Health Problems: Observations from an Investigator

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### Abstract

**Background and Aims of the Manuscript** The purpose of this manuscript is to define under-recognized perspectives that the primary care research field needs to integrate into research initiatives, and to discuss practical strategies to ensure the successful implementation of these initiatives.

**Methods** Perspectives and strategies were identified through personal experience, informal discussion with ten senior investigators in the field and a selected literature review.

**Results** Research on improving treatment for the mental health problems of primary care patients will progress more rapidly if investigators explore the usefulness of a competing demands framework, integrate a readiness to change perspective in developing more individualized interventions for providers and patients, evaluate interventions for their effect on productivity and test alternative interventions particularly in patients who fail to benefit from currently accepted treatment. The implementation of these initiatives will be more successful if research teams define unique scientific agendas, invest energy in pursuing questions whose value is undisputed by multiple parties, increase the rate of inter-institutional exchange between senior and junior investigators, pilot test assumptions that affect project budget and timeline, build in a limited amount of slack time in early phases of project implementation and network effectively.

**Implications for Further Research** Investigator efforts to define critical questions for the primary care management of mental health problems will be enhanced if they revisit the definition of their research agendas in the light of new perspectives that are emerging in the field. Similarly, the implementation of these agendas will be strengthened if investigators make conscious attempts to use one or more of the strategies suggested. Copyright © 1999 John Wiley & Sons, Ltd.

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Improving research on primary care patients with mental disorders involves addressing two distinct questions. The first question involves defining under-recognized perspectives

that the field needs to better integrate across a wide range of research efforts. The second question involves defining practical strategies investigators can use to guide their efforts in producing first class research.

### What Perspectives Does the Field Need to Better Integrate?

#### *Perspectives from a Competing Demands Framework*

The application of a competing demands framework suggests that increasing the primary care clinician's skill and motivation to treat mental health problems will not be sufficient in most settings to impact the process and outcomes of care. Klinkman<sup>1</sup> makes a compelling case that primary care encounters present competing demands for the attention of the clinician because there is too little time to address all potential topics of importance or interest. Identification and treatment of an emotional problem represents an active choice from multiple clinician and patient priorities including treatment of acute illness, monitoring of chronic illness and provision of preventive services. Empirical evidence demonstrates that each co-occurring physical problem reduces the odds that a depressed primary care patient will address his or her emotional problem during the visit by 34%.<sup>2</sup>

In this paradigm, the most straightforward resolution to improving the treatment of mental health problems in primary care settings is to add more time to the visit. Because additional time is rarely an option, additional resources become critical. These resources can be technical (as in the case of computerized telephone screening the day before the visit) or human (as in the case of using nurses or pharmacists to educate and monitor patient progress over time). Additional resources, however, increase expenditures for mental health treatment at a time when payers are feverishly looking for methods to contain or reduce their health care costs.

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## Perspectives from a Readiness to Change Framework

Investigators who study behavior change needed to better manage physical disorders have developed a number of successful interventions using the readiness to change model of Prochaska and DiClemente.<sup>3-5</sup> This model points out that individuals (whether they be patients or providers) move across various stages of readiness before they are willing and able to change behavior patterns.

Although clinicians have appreciated patient differences in readiness to change for a long time, structured interventions to address mental health problems have only recently begun to use this model. The goal of interventions aimed at pre-contemplators (individuals who fail to recognize the problem and/or the solution the investigator has in mind) is to move these individuals to considering behavior change rather than rejecting it outright. The goal of interventions aimed at contemplators (individuals who have considered but not adopted behavior change) is to get these individuals to try the behavior. The goal of interventions aimed at those in the action stage is to convince individuals who are trying the desired behavior to adopt it long term.

When we apply the readiness to change model to primary care patients with current major depression, we find that approximately 52% of them are currently pursuing active treatment (the action group), approximately 35% of them indicate that currently identified treatments are acceptable although they have not begun them (the contemplation group) and 13% indicate that none of the currently identified treatments is acceptable (the pre-contemplation group).<sup>6</sup> Patients in the action group require careful monitoring to adjust their treatment as needed, and reinforcement for the effort they are making to complete a course of guideline-concordant care. Patients in the contemplation group require an intervention directed towards the barriers that keep them from beginning an active treatment, and patients in the pre-contemplation group may benefit from education about the course of the disorder without treatment and treatment alternatives.

When we apply the readiness to change model to primary care providers, we find that 73% of the 366 providers in a multi-site study of routine care report that they are currently providing guideline-concordant care (the action group), 8% report a strong interest in improving their ability to manage depression even though they currently are not providing guideline-concordant care (the contemplators) and the remaining 19% report little or no interest in change (the pre-contemplators).<sup>7</sup> Providers in the action group can potentially benefit from interventions which address the organizational barriers to providing high quality treatment for depression, the most frequent of which is limited time.<sup>8</sup> Providers in the contemplation group can potentially benefit from an intervention that increases their ability to detect and manage depression. Providers in the pre-contemplation group may need to be persuaded that depression management skills are important before a skill intervention can be expected to have much of an effect.

Table 1. Relationship between current psychiatric disorder and 30-day psychiatric work impairment<sup>9</sup>

	Work loss days	Work cutback days
Major depression	0.45	2.77
Generalized anxiety disorder	1.15	3.11
Panic disorder	1.45	4.87

## Perspectives from an Economic Framework

How can research help the primary care administrator obtain a larger portion of the health care dollar, particularly in capitated systems where everybody is fighting over the same dollar? One strategy to get more resources into the primary care system to treat mental health problems is to find out who is losing money under the *status quo*. The most common emotional disorders in primary care—*anxiety and depression*—are also the disorders which take substantial tolls on productivity<sup>9,10</sup> as **Table 1** demonstrates. Parties who potentially lose money when the substantial impairment accompanying emotional problems is not adequately treated include employers,<sup>11</sup> families<sup>12</sup> and third party payors.<sup>13</sup> Evidence that high quality treatment can diminish work loss and cutback days will provide strong incentive for employers to look for high quality mental health care as hard as they look for ways to contain its costs.

## Perspectives from an Alternative Medicine Framework

Perhaps the most startling perspective on the treatment of mental health disorders to emerge recently was the Fetzer study, which reported that 35% of patients currently in treatment for depression use one or more alternative interventions together or in place of what health professionals recommend.<sup>14</sup> These depressed patients are signaling loud and clear that alternative treatments like those listed in **Table 2** are beneficial enough (or mainstream treatments are disappointing enough) to warrant paying the cost for alternative treatments out of their own pocket. With the exception of international trials evaluating hypericum treatment for depression,<sup>15</sup> the scientific community has limited efficacy evidence about alternative treatments. The research community should consider testing treatments that

Table 2. Alternative interventions

Structured relaxation techniques	Commercial weight-loss programs
Massage	Chiropractic
Spiritual healing	Imagery
Lifestyle diets	Herbal medicine
Megavitamin therapy	Self-help groups
Energy healing	Biofeedback
Hypnosis	Homeopathy
Acupuncture	Folk remedies

patients tell us are worth paying for, particularly in patients who do not respond to already identified treatments.

## **What General Principles Does the Field Need to Apply to Progress More Rapidly?**

### *Research Teams Need to Develop Recognizably Unique Scientific Agendas*

Investigators need to consider whether the field will progress faster if research teams develop recognizably unique scientific agendas. After research teams reach a certain momentum, they begin to generate light. That light illuminates the field, but it can also deceive other research groups into thinking that somebody else has 'gotten there first' and taken all the good questions. This view of the world often leaves newly arriving investigators in understandable distress. One reaction to this distress is to propose something very close to what has been done before in the name of 'building on previous research'. This strategy produces a scenario reminiscent of first grade soccer where every kid from both teams swarms on top of one tiny ball, which gets kicked 50 times without moving a foot closer to either goal. If investigators all 'pile on the same question', the field's progress will be too slow to register. A second reaction to the distress that all the good questions are 'already gone' is to leave the swarm; however, this requires that investigators figure out what they themselves want to do and convince reviewers that their team is the team to do it. As hard as those tasks are, investigators need to tackle them to keep the field moving forward. Important sources for unique scientific agendas include the ideas that participants find themselves mulling over weeks after the conference, and excellent articles reviewing research on the delivery of mental health services in general medical settings.<sup>16</sup> Searching registers of ongoing research and using electronic mail to inquire about current investigations are also useful methods for identifying lines of inquiry other research teams have initiated before projects reach publication.

### *Research Teams Need to Tackle Questions People Can Get Passionate About*

The current scientific paradigm stresses the importance of maintaining an objective perspective regarding one's research; however, it may be just as important for investigators to choose a question that inspires emotional involvement. Emotional involvement is a signal that an investigator has found a question that matters. While it is necessary, it is not sufficient that the question matters to the investigator. A creative idea that does not turn other people on is not likely to make much of a contribution to the bigger picture. One strategy for determining whether a research project has the potential for generating widespread enthusiasm is to 'shop' the idea around to a range of people before committing oneself to the project to register their non-verbal enthusiasm. This strategy is similar to introducing the person you have

fallen head over heels in love with to friends who have known you a long time. In both cases, faint praise counts as a vote to find a different option.

### *Increasing the Rate of Exchange between Senior and Junior Investigators*

The field's ability to pursue meaningful research questions may be strongly influenced by the rate of exchange between senior and junior investigators. One model of progress can be depicted by a picture of people stepping on each other as they attempt to scramble up the ladder of success. A second model can be depicted by a picture of the same people climbing up the ladder, stopping on occasion to pull each other up to the next rung. Most investigators in this field, senior as well as junior, resonate with the second model; however, few investigators have figured out how to do it well. No matter how generative they are, senior investigators cannot readily roll up their sleeves to help with somebody else's work at the same time as they do a competent job on their own. However, the cost of having a greater demand for than supply of senior investigators is the enormous amount of energy talented junior faculty waste learning the hard way about the thousand and one pitfalls of primary care research—both on the way to getting funded and in implementing the project once it is off the drawing board.

The field has given thought to this dilemma. Center grants have been funded to develop new investigators. Under these models, mentoring is concentrated in a small number of institutions across the country, despite the fact that most of the junior faculty talent is spread across a large number of institutions. The field will progress faster if investigators can generate creative ways to increase the exchange between senior and junior investigators *across* as well as within institutions. A foundation might consider funding a senior investigator to mentor less experienced individuals in a national network to develop a coordinated research agenda. Departments with newly emerging research teams might consider funding senior investigators from other institutions to mentor their junior faculty on an ongoing basis rather than rely on one-shot consulting.

### *Pilot Testing Assumptions that Affect Timeline and Budget*

Getting a research project funded requires detailed planning. Successfully implementing a well planned research project requires pilot testing. Substituting 'expert opinion' for pilot testing does not always suffice. For example, previous investigators report that between 6 and 8% of primary care patients meet criteria for current major depression.<sup>17</sup> Rather than pilot test that assumption across 24 practices, our research team based its timeline and budget on a prevalence rate of 6%. Once in the field, we discovered that several sites had prevalence rates below 2%. This meant that the research assistant had to approach 83.5 subjects in those

sites rather than 21.5 subjects to identify one eligible patient who would agree to participate, transforming a four month recruitment timeline into a 16 month challenge.

### *Building Rational Timelines for Primary Care Research Projects*

Senior investigators have noted that the only rational timeline for a primary care project reflects that every task takes infinitely longer than one can imagine justifying to a jury of one's peers. When junior investigators begin writing grants, many think that the committee will judge how hard they are willing to work by how short their timeline is for complex and difficult tasks. Often reviewers see a positive correlation between the length of the timeline and the investigators' previous experience conducting primary care research, or, as Murphy notes, 'To spot the expert, pick the one that predicts the job will take the longest and cost the most'.

Once an investigator loses time on a project, it is very hard to return to the original timeline. For example, one needs to recruit the very last subject in the low prevalence site before one can develop weights, before one can do serious analyses, before one can draft the first paper. It is wise to build in a limited amount of intentional slack in the early phases of project implementation to avoid learning that high quality work takes time.

### *Networking and the Need to Take Risks*

Even with the best of planning, investigators oftentimes need to start an important phase of a primary care project before they are sure that all the critical players and ideas are in order. It is in these instances that the networks we build are essential. Even if networking does not provide a 'silver bullet' solution, it often provides the empathy springing from someone who has 'been there' which keeps an investigator able to continue effectively working to put the missing players and ideas in place.

### **Summary**

Research on improving treatment for the mental health problems of primary care patients will progress more rapidly if investigators consider integrating selected research

perspectives into their primary care research agendas, and incorporate the lessons previous investigators have learned in the field's early research initiatives.

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