Reasons for Preferring a Primary Care Physician for Care If Depressed

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BACKGROUND: Most studies showed that patients would first go to their primary care physicians (PCPs) when depressed. This choice is probably due to PCP being the entry point into the health care system. We studied the general population's initial choice of mental care in Hong Kong, where patients were unclear about family medicine and free to choose doctors of any specialty.

METHODS: A combined qualitative and quantitative approach was adopted. We held focus groups with participants recruited from community centers and a telephone survey with adults ages 18 or above randomly selected from the domestic telephone directory.

RESULTS: Of 1,647 adults successfully interviewed, 49.0% would seek help from their regular PCP, 19.3% from psychiatrists, 4.8% from any doctors, 16.5% from non-medical resources; 6.9% would not seek any help, and 3.5% were uncertain of what to do. Those who did not seek any help were more likely to be male or without regular doctors. The focus group participants highlighted the stigmatizing effect of consulting psychiatrists and expressed strong expectation of empathic relationship, time, and communication skills from their care providers. Some participants were not aware that PCP could manage mental illness.

CONCLUSIONS: Given free choice of health care service, most people would first consult their regular doctors for treatment of depression specifically because of better relationship and no stigmatization. To draw depressed patients to seek help, especially from primary care, public education of the PCPs role in mental health should be promoted, and the PCPs could demonstrate their empathy and listening skills to patients.

(Fam Med 2011;43(5):344-50.)

Many studies show that the general public tend to choose their primary care physicians (PCPs) as their entry point to mental care.[1-5] One explanation for this is that PCPs are often the patients' only accessible source of care, so their choice might not reflect a specific expectation of helpful resource.[6-7] However, in countries like the United States,[8-9] France,[10] and Germany,[11] where people have direct access to specialists, the majority still seek initial mental care from their PCP. Payment could affect the choice of the care provider, but Sturm et al[8] found that patients in the United States consulted their PCP first whether they paid for the service item or were covered by medical plans. Apart from the stigma of mental illness, which has a strong influence on the help-seeking behavior,[12,13] what else might make people go to their PCP for initial mental health care?

In Hong Kong, the general public can consult any doctor in private practice, including specialists, for any illness. There is no statutory qualification for a family physician, and any registered doctor can practice primary care. Family medicine is a relatively young discipline and not well established. Hong Kong thus provides a suitable context to study people's choices in a free market for initial care of their depression. Would they still opt for a PCP though they understand little about family medicine? If they would, what do they expect from the PCP so that continuing education could be made to meet their needs?

The present study is part of a larger project that investigated the public's knowledge and attitude of family medicine. Detailed information was collected on how the general public chose their doctors for primary care. This has been reported elsewhere.[14] We also asked our interviewees about what they would do for depression. The primary aim was to see if the public would consider

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consulting a PCP for their mental health problems, and the secondary aim was to study the factors associated with their choice.

Methods

A combined qualitative and quantitative approach was adopted for this study. Ethics approval was obtained from the local Institutional Review Board.

Qualitative Approach

Five focus groups were conducted at various community centers where their members were recruited to join the discussions. Each group consisted of five to eight participants who were sampled to ensure a range of demographic variables; there was no limitation to any chronic illness. Recruitment for the focus groups was stopped when data saturation was reached. A facilitator experienced with focus groups led the interviews, which were audiotaped and then transcribed verbatim. We used the NVivo computer software and a thematic approach for analysis of the qualitative data.

As part of the interview, the facilitator presented the following vignette and asked the participants of their choice of care:

One of your friends or family members has been feeling unhappy for the last month, losing his or her appetite, 5–6 pounds in weight, and previous interests. He or she has difficulties falling asleep and would cry without apparent cause. What would you advise him or her, going to see a primary care doctor, a psychiatrist, or someone else?

Quantitative Approach

A questionnaire was developed based on the information from the focus groups and revised after pilot-testing with 70 telephone interviews. The Social Sciences Research Centre of the University of Hong Kong, which specialized in telephone surveys, then did the interviews. The local residential telephone numbers were randomly selected from the public directory, and the successful interviewee was the member of the family with the next earliest birthday and aged 18 or above. We used telephone interviews because more than 98% of the local households have subscribed to a residential phone line.

The following specific question was asked in the telephone interview apart from questions on the choice of doctor and concepts of a family physician (Appendix 1 contains the relevant questions. Appendix 1 is available on request from the corresponding author):

If you suspect or were told that you have depression, what would you do? (Choose one option.)

- to see a psychiatrist
- to see the doctor you have seen for a long time*
- to see any doctor
- to seek help from other resources instead of a doctor
- not seeking help at all
- don't know / difficult to say
- refuse to answer

(* Since family medicine is relatively new to the general public in Hong Kong, and many do not have clear ideas about this discipline, we use the concept of "regular doctor" (continuity of personal care) as similar to, though not the same as, family physician.)

Statistical Methods

The primary objective of this study is to determine P value, the proportion of people who would seek help from their regular doctor. To ensure that the estimation error would be at most .025 with 95% confidence, a sample size of 1,537 was required when taking the most conservative choice that P=.5. Pearson chi-square test was adopted to determine whether two nominal responses were associated. A P value ≤.05 was considered statistically significant.

Results

The quantitative results show what people would do if they have depression while the qualitative data provide insight into why they would do so.

Participants

We recruited 37 participants (23 females and 14 males) to attend the five focus groups conducted between March and July 2007. Their ages ranged between 18 and 83 years, with a mean of 44.4. Of them, 12 (32.4%) had attained primary education or below, nine (24.3%) secondary education, and 16 (43.2%) tertiary education. Many participants in the focus groups recognized without difficulty that the vignette referred to a patient with depression.

During March and April of 2008, 2,438 calls were made to domestic telephone lines; 1,647 (67.6%) respondents completed the interview, while 263 dropped out and 528 refused to answer. Among those who responded, the majority had attained secondary (55.7%) or tertiary (30.3%) education, and 13.5% had primary education or below (0.5% missing data); there were 665 (40.4%) males and 982 (59.6%) females. (In the 2006 census, 30.0% of the local population had tertiary education.)

Choice of a Doctor and Concepts of Family Physician

Care of one's mental health was a relatively weak determinant for choosing a particular doctor (Table 1). Relative to the other features of a family physician, a lesser proportion of telephone respondents considered taking care of a patient's physical as well as psychological states as a characteristic.

From the focus groups, the most important factor for attending a particular doctor was the good relationship that was built on the patient's trust and the doctor's empathy:

> Apart from technical skills, the doctor's empathy is very important. This way, you have accepted him. This psychological element is so important that you are healed by more than half [each time you see him].

Table 1: People's Expectation of a Doctor

Choice of a Doctor*	Important n (%)	Neutral n (%)	Not Important n (%)	Missing Data
Clinic is conveniently located	1,254 (76.4)	246 (15.0)	142 (8.7)	5
Clinic hours are convenient	1,210 (73.8)	327 (20.0)	102 (6.2)	8
Have seen the doctor for a long time	1,197 (73.5)	323 (19.8)	109 (6.7)	18
Inexpensive fee	1,164 (71.3)	334 (20.5)	134 (8.2)	15
Doctor sees you with little delay	1,138 (69.8)	366 (22.4)	127 (7.8)	16
Doctor takes care of mental health	1,038 (60.6)	418 (25.6)	176 (10.8)	15
Characteristics of a Family Physician	**Agree n (%)**	**Neutral n (%)**	**Disagree n (%)**	**Missing Data**
Knows patient's history over years	1,582 (96.2)	43 (2.6)	19 (1.2)	3
A gatekeeper to specialist care	1,570 (95.9)	43 (2.6)	25 (1.5)	9
Has good relationship with patient	1,479 (90.0)	131 (8.0)	35 (2.1)	2
Same doctor for most if not all illnesses	1,400 (85.7)	151 (9.3)	82 (5.0)	14
Takes care of patient's physical and psychological states	1,302 (79.7)	248 (15.2)	84 (5.1)	13
First contact of all illnesses	1,266 (77.3)	227 (13.9)	145 (8.9)	9

* Details were reported elsewhere (Wun et al[14])

Table 2: Source of Help Sought by the General Public When Depressed

Source of Help	Frequency	%
The doctor seen for a long time	807	49.0
Psychiatrist	318	19.3
Other resources instead of a doctor	272	16.5
Not seeking help at all	113	6.9
Any doctor	79	4.8
Don't know/difficult to say	50	3.0
Refused to answer	8	0.5
Total	1,647	100

Choice of Initial Care for Depression

From the telephone survey, the choice of help for depression was, in decreasing order of frequency (Table 2): their regular doctor (49.0%), psychiatrist (19.3%), and non-medical resources (16.5%). A notable 7.0% would not seek any help, and another 3.0% were indecisive of what to do.

Regular Doctors

Of the 1,647 telephone respondents, 1,134 (68.8%) claimed to have regular doctors. Those with regular doctors were more likely to seek help from them for depression (Table 3). Females, who were more likely than the males to have a regular doctor, were also more likely to see their regular doctors for depression. Household income and medical fee were not determinants for choosing a doctor for mental care.

The focus groups identified quickly a psychological or mental illness in the clinical vignette. Some participants even stated depression and none queried any underlying physical differential diagnosis. Most participants would go to the regular doctor first for this condition though they would accept the psychiatrist for further management if the depression was severe. The suggested reasons for the choice of the regular doctor included the regular doctor having better knowledge about the patient's past medical history and being able to make initial assessment. Seeing the regular doctor could also avoid the stigma attached to being seen by a psychiatrist and having a better chance of appropriate referral:

> I'd recommend him to see his usual doctor first, because the doctor will have his complete medical record based on which to assess his conditions or identify any side-effects of the drugs on him and to do follow-up.

Table 3: Choice of Doctors for Depression by Personal Characteristics

Characteristics	Psychiatrist	Doctor Seen for a Long Time	Any Doctor	Total*
Gender (χ^2=9.975, P=.006)				
Male	146 (31.2%)	286 (61.1%)	36 (7.7%)	468 (100.0%)
Female	172 (23.4%)	521 (70.8%)	43 (5.8%)	736 (100.0%)
Age in years (χ^2=59.4667, P<.001)				
< 25	58 (48.7%)	46 (38.7%)	15 (12.6%)	119 (100.0%)
25–44	136 (27.9%)	324 (66.5%)	27 (5.5%)	487 (100.0%)
45–64	95 (19.6%)	355 (73.3%)	34 (7.0%)	484 (100.0%)
>64	27 (26.7%)	72 (71.3%)	2 (2.0%)	101 (100.0%)
Education (χ^2=16.2606, P=.003)				
Primary or below	30 (17.5%)	126 (73.7%)	15 (8.8%)	171 (100%)
Secondary	169 (25.5%)	455 (68.7%)	38 (5.7%)	662 (100%)
Tertiary	119 (32.2%)	223 (60.3%)	28 (7.6%)	370 (100%)
Monthly household income# (χ^2=5.4153, P=.247)				
<$8,000	43 (31.4%)	83 (60.6%)	11 (8.0%)	137 (100%)
$8,000-$39,999	169 (24.8%)	464 (68.0%)	49 (7.2%)	682 (100%)
≥$40,000	71 (29.6%)	157 (65.4%)	12 (5.0%)	240 (100%)
Inexpensive fee as a choice of doctor (χ^2=9.2850, P=.054)				
Important	220 (26.3%)	564 (67.5%)	52 (6.2%)	836 (100%)
Neutral	68 (24.2%)	187 (66.5%)	26 (9.3%)	281 (100%)
Not important	28 (26.4%)	77 (72.6%)	1 (0.9%)	106 (100%)
Has regular doctor (χ^2=48.119, P<.001)				
Yes	211 (24.1%)	628 (71.8%)	36 (4.1%)	875 (100%)
No	106 (32.5%)	177 (54.3%)	43 (13.2%)	326 (100%)
Doctor taking care of mental health as a choice of doctor (χ^2=7.4786, P=.113)				
Important	198 (24.6%)	558 (69.4%)	48 (6.0%)	804 (100%)
Neutral	86 (31.5%)	165 (60.4%)	22 (8.1%)	273 (100%)
Not important	32 (26.9%)	79 (66.4%)	8 (6.7%)	119 (100%)
Attending the same doctor for a long time as a reason for future consultations (χ^2=43.6416, P<.001)				
Important	231 (25.1%)	651 (70.6%)	40 (4.3%)	922 (100%)
Neutral	67 (34.0%)	102 (51.8%)	28 (14.2%)	197 (100%)
Not important	18 (23.7%)	48 (63.2%)	10 (13.2%)	76 (100%)

* The total number in each category varies as some respondents did not answer the question on depression, and some chose non-medical resources for help.

The median monthly household income at the time of the study was $17,250. This grouping is roughly equivalent to low-, middle-, and high-income groups.

> I would be more confident of recommending him to see the doctor whom he trusts and be able to talk with previously. If he changes doctors frequently, for convenience or less expense, I do not recommend him to see them.

> I would usually consult the family doctor first, to see if the illness is mild or severe. If I have to take drugs for long time, I need to make an appointment with the psychiatrist [in public service].

> There are many psychiatrists. I am not familiar with them and unable to identify who is good and who is not. But the family doctor could do an initial assessment and then refer me and my family to a quality-assured psychiatrist whom he is familiar with. In such case, quality of care is guaranteed.

The personal experiences of some focus group participants also indicated that their regular PCP was capable of identifying and treating their depression:

> I realized that I had mild depression, with all the symptoms you just mentioned. I then went to see my own doctor [a PCP]. He explained to me about what problems I had … He then prescribed some drugs for me and told me to return later. If I had no improvement, he would write a referral for me. Touch wood, I did not need to queue up [for the psychiatrist].

> I am one of them, a kind of suicidal intent. I had thought about three ways to commit suicide. … A doctor, a general practitioner, should know how [to treat depression]. [Interviewer: Did your doctor refer you to the psychiatrist?] No. … I am now on drugs and mentally sound.

> I struggled for more than a year, and my [regular] doctor had referred me [to the psychiatrist] twice or thrice. I finally made an appointment with the psychiatrist [in public service].

> I brought her to our regular doctor [a PCP]. Dr Wong told me, "Your wife has a mood problem. You should beware. He asked me to bring her to him from time to time. Only then I knew she had mood problems.

Psychiatrists

Males and people with higher education level were significantly more likely to see the psychiatrists (Table 3). Those aged 18–24 years were more likely to seek help from the psychiatrists than other age groups, and they were also more likely to seek help from specialists for any medical care. Males and respondents younger than 25 years were significantly less likely to have regular doctors than their counterparts (χ^2=12.61, P=.01 and χ^2=69.45, P<.001, respectively). Nevertheless, there was no association between education level and having a regular doctor (χ^2=7.34, P=.12).

From the focus groups, reasons for consulting the psychiatrist included severity of the depression in the vignette, lack of confidence in primary care doctors for treating depression, quicker specialist treatment, and no need to pay two doctors (a primary care doctor and a psychiatrist) for one disease:

> If his illness affects his daily life or his family, he should see a doctor immediately, preferably a psychiatrist if so severe.

> I think primary care doctors are for common cold, flu, fever, and dizziness. I shall go to the specialists for specific diseases.

> From the general public's point of view, if we go [to see the psychiatrist] through the family doctor, we have to pay one more medical fee. Although we pay more, it doesn't mean my family member will be cured [by the family doctor].

Other Choices of Help

For those who chose help from nonmedical sources, such as social workers or psychologists, the focus group participants perceived social and psychological stresses as the underlying cause of depression:

> [See] the social worker first. … There are many problems in the [friend's] mind. Go to the social worker [for help] to solve his worries about the family. Then go to the psychologist to solve the problems in his mind. … In fact, work stresses and family problems give rise to psychiatric disorder.

However, no matter what source of help the focus groups chose, they all expected a good relationship with the care provider who would care and listen to them:

> I think the doctor should build up a good relationship with the patient. Listen to him. Listening is very important, it is the first step. Listen to what he needs. What he probably needs is some of the social worker's or the doctor's time.

For those who did not seek help at all, they were more likely to be male (66 out of 665 males interviewed and 47 out of 982 females interviewed, χ^2=16.38, P<.001) and did not have a regular doctor (61 out of 1,134 with regular doctors and 52 out of 509 without regular doctors, χ^2=12.83, P<.001). A logistic regression analysis also showed that females and having a regular doctor were both significant factors associated with higher probability of seeking help despite the fact that females are more likely to have regular doctors.

Discussion

We studied the general public's choice of initial care for depression in a health care system that accepts direct access to specialists in the private sector and lacks clear delineation of the family physicians' role. Because we anticipated, and later confirmed, that the local people had

inadequate knowledge about family practice, we used the term "regular doctor" to study their help-seeking behavior. This regular doctor did not satisfy the conventional definition of a family physician but was certainly a primary care physician. Many more people would see a doctor whom they had established a relationship with (a regular PCP) rather than a psychiatrist (49.0% versus 19.3%), while some (16.5%) would seek help from non-medical resources.

Males, people with tertiary education, or aged below 25 were more likely than their counterparts to choose the psychiatrists. Males were also significantly less likely than females to have regular doctors. Likewise, the respondents younger than 25 years were less likely to have regular doctors than the other age groups. (The young people might not have enough exposure to have continuity of care from a doctor.) Thus, people without regular doctors were more likely to choose the psychiatrists or "any doctor."

With the exception of people younger than 25 years, regular doctor was the most preferred for all categories of respondents. Although males are more likely to consult the psychiatrist compared to the females, 61.1% would opt for a regular doctor (Table 3). Similarly, 60.3% of the people with tertiary education would opt for a regular doctor. Of people without regular doctors, 54.3% opted for regular doctors, suggesting that they would prefer one even though they did not have one. In addition, the waiting time of several months to see a psychiatrist in the public service might encourage a patient to seek the quick access of a PCP or a private psychiatrist. The long waiting time may be a confounder in the choice of doctor.

In Hong Kong, the concept of a PCP taking care of mental health and being first contact of all illnesses was not strong among the public (Table 1). What made most people consult their regular doctors for depression? The experience shared by the focus groups participants with history of depression showed that the doctor with whom they were familiar was intuitively the first choice during the crisis of depression. From the focus groups, it was not just avoiding the stigma of mental illness. People trusted their regular doctors for being able to understand and assess them and to make proper referrals if not able to cure them. This may disprove the speculation that people go to their PCP because of mere access to health care rather than with specific expectations.[6,7] They do have expectations: better knowledge of their medical history and conditions and a trusting relationship.

Established doctor-patient relationship might explain some of the factors associated with the choice of doctors for depression. Notably, 68.8% of the telephone respondents had regular doctors, but only 49.0% would go to them for depression. A plausible explanation is that some of the respondents were not aware of the PCPs' role in mental health care (Table 1). On the other hand, some regular doctors might not yet have demonstrated to their patients enough listening and empathy. People expect that their primary care physicians really care for them. PCPs need to educate and show their patients that they are ready and able to deliver care to patients' mental health.

In this study, 10.0% of the telephone respondents would not seek help or were uncertain of what to do, apparently much lower than those reported in other studies.[15-17] Male respondents and people without a regular doctor were significantly less likely to seek help at all. Perhaps a caring family physician for their coughs and colds would later turn up to be their source of help. In a two-tiered public-private health care system, it is important to encourage and facilitate patients to have continuity of care from a PCP.

Studies have shown that primary care needs improved organization for effective management of depression.[18,19] This study shows that the PCP's caring attitude and listening skill during pre-morbid times are essential to draw the patient into the caring system.

Limitations

We asked our participants what they would do when depressed, not necessarily what they did when they were actually depressed. It is thus limited by the fact that what people think they would do may not be what they would actually do, except a small percentage of participants who might have suffered from depression in the past. The actual experience of a few focus group participants who had depression did support the claim of choosing the regular doctor for initial care. Moreover, some previous studies were also done with the general population,[8,10,11] and this study setting could provide comparison.

In the telephone survey, the respondents were restricted to one choice of care provider for depression. It is possible that a respondent might wish to be under the care of both a PCP and a psychiatrist or psychologist. We, however, think it is more important to study the depressed patient's entry point to health care, and this restricted choice could better reflect the choice of initial care.

Conclusions

Sex, age, education, stigma of mental illness, and having a regular doctor affected the choice of doctors for initial care of depression. In a free market of fee-for-service, more people preferred a regular primary care doctor to the psychiatrist. The most important determinant is the established relationship, especially a trusting, doctor-patient relationship, not just for the choice of medical help but also for whether to seek help or not. The PCP's role in mental health needs more promotion in the general population and patients should

be facilitated to establish a trusting relationship with their primary care providers.

ACKNOWLEDGMENTS: The work described in this paper was fully supported by a grant from the Central Policy Unit of the Government of the Hong Kong Special Administrative Region and the Research Grants Council of the Hong Kong Special Administrative Region, China (Project No. HKU 7002-PPR-3). We thank all those individuals who participated in the focus group interviews and telephone surveys.

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