Reviewer's report

Title: Quality of care for major depression and its determinants: a multilevel analysis

Version: 3 Date: 12 June 2012

Reviewer: Marijn Alice Prins

Reviewer's report:

Discretionary revisions:

Methods:
1) Two clinics were excluded because no participants were recruited with depression (top of page 10). How was this possible?
2) Please explain abbreviations: PASW Statistics 18.0 and HLM 6.07 software (page 13).

Results:
3) What are the differences between community clinics, family medicine groups, large/small private clinics and solo clinics. People from other countries could use some extra information about these different clinic-types.
4) The authors found that age was significantly associated with the likelihood of receiving at least one minimally adequate treatment: younger (18-24 yrs) and older (65+) people were less likely to receive treatment. A study of Prins et al. (Primary care patients with anxiety and depression: Need for care from the patient’s perspective. Journal of Affective Disorders 2009; 119:163-171) found that primary care patients with anxiety or depression in the age of 18 – 24 years are significantly more likely to perceive a need for (mental health) care, especially for information compared to the older age groups (25 – 44 yrs and 45 – 65 yrs). It seems that although these younger people would like to receive more often information about mental illness, its treatment and available services but do not receive minimally adequate treatment. The authors could add this to the discussion section.

Minor essential revisions:

Background:
1) On page 6 the authors state that, to their knowledge, only one study used multilevel analysis to study the factors influencing quality of depression treatment in primary care. This is not true. Prins et al. (2010) and Smolders et al. (2010) both recently published their work on “Patient factors associated with guideline-concordant treatment of anxiety and depression in primary care” (Prins MA, Verhaak PFM, Smolders M, Laurant MGH, van der Meer K, Spreeuwenberg P, van Marwijk HWJ, Penninx BWJH, Bensing JM. Patient factors associated with guideline-concordant treatment of anxiety and depression in primary care.
Journal of General and Internal Medicine 2010; 25(7):648-655) and physician and practice characteristics that are associated with adherence to evidence-based guidelines for depressive and anxiety disorders (Smolders M, Laurant MGH, Verhaak PFM, Prins MA, van Marwijk HWJ, Penninx BWJH, Wensing M, Grol R. Which physician and practice characteristics are associated with adherence to evidence-based guidelines for depressive and anxiety disorders? Medical Care 2010; 48:240-248). These studies were based on data from the Netherlands Study of Depression and Anxiety (NESDA), a longitudinal cohort study on the long-term course of depression and anxiety. See www.nesda.nl/en/.

In the study of Prins et al. (2010), Andersen’s behavioral model of health services use was also used as a theoretical framework and multi-level analyses were used to determine which predisposing, enabling and need factors were associated with receiving guideline-concordant care (which can be seen as minimally adequate treatment). I think the results of both these studies are of interest for the authors. In these studies it was found that rates of adherence to guidelines on depressive and anxiety disorders were not associated with practice (n=21) characteristics, but to some extent with physician (n=62) characteristics. On the patient level (n=721), education level and patients’ perceived needs for care were more strongly associated with the delivery of guideline-concordant care for anxiety and depression than clinical need factors.

These two articles might also be of interest to the authors:

Methods:

2) In the methods section (page 9), inclusion criteria for the assessment on T0 and T1 are discussed. Patients were invited to participate in the first part of T1 if they had high levels of depression or anxiety symptoms in the past week of taking medication (for example). At this point in the article it is still unknown how this was measured. On page 10 one can read that the HADS and CIDIS were used to measure symptom severity and psychiatric disorders. Was mental health trajectory measured by questionnaire/ self-report? It would make more sense if this part comes first.

Discussion:
The authors state (page 17) that people more in need receive more adequate care. In this study only ‘evaluated need’ was assessed (e.g. severity of symptoms) not ‘perceived need’ (from the patient’s perspective). This should be
discussed here. Although very important, the patient’s perspective is being ignored. People who fit DSM-IV criteria for MDE do not necessarily want help or believe they need therapy. People can sometimes just do without official treatment or can deal with their problem on their own or with help from family or friends. This should be taken into account.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

'I declare that I have no competing interests'