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Diverse voices, simple desires: a conceptual design for primary care to respond to depression and related disorders

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Background. The World Health Organization and the World Organization of Family Doctors have called for 'doable' and 'limited' tasks to integrate mental health into primary care. Little information is provided about tasks GPs can undertake outside of guidelines that suggest to prescribe medication and refer to specialists.

Objectives. The reorder study aimed to gather diverse patient and community perspectives to inform the development of an effective system of depression care.

Method. Five hundred and seventy-six patients completed computer-assisted telephone interviews. Two hundred and seventy-six community stakeholders completed a modified two round Delphi. Responses were analysed to identify tasks and these were synthesised into a conceptual design.

Results. Fifteen core tasks were identified, 5 were agreed upon and a further 10 identified by each group but not agreed upon. Listen, understand and empathize, provide thorough and competent diagnosis and management, follow-up and monitor patients, be accessible and do not rush appointments and provide holistic approach and tailor care to individual needs were agreed on. Other tasks included: develop plans with patients, assess for severity and suicide risk, account for social factors, be well trained in depression care and offer a range of treatment options, appropriate and timely referral, support and reassurance, educate patients about depression, prescribe appropriately and manage medication and be positive and encouraging.

Conclusions. The tasks form the basis of a conceptual design for developing a primary care response to depression. They fit within three domains of care: the relational, competency and systems domains. This illustrates tasks for GPs beyond prescription and referral.

Keywords. Depression, doctor–patient relationship, health service management, mental health, qualitative research.

Background

The World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) have called for action to integrate mental health care into primary

care. The 10 principles listed by WHO and WONCA include identifying primary care tasks that are 'limited' and 'doable' (see Box 1).¹ Identification of GPs and primary care 'tasks' for depression treatment and management is not entirely clear. Guidelines provide

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Box 1 *WHO and WONCA 10 principles for the integration of mental health into primary care*

1. Policy and plans need to incorporate primary care for mental health.
2. Advocacy is required to shift attitudes and behaviour.
3. Adequate training of primary care workers is required.
4. Primary care tasks must be limited and doable.
5. Specialist mental health professionals and facilities must be available to support primary care.
6. Patients must have access to essential psychotropic medications in primary care.
7. Integration is a process not an event.
8. A mental health service coordinator is crucial.
9. Collaboration with other government non-health sectors, non-governmental organizations, village and community health workers and volunteers is required.
10. Financial and human resources are needed.

some examples, but GPs have been criticized for not following these.² Guidelines are often inflexible, difficult to tailor to individual needs and do not account for social context.³ Claims have been made that GPs under diagnose depression⁴ or they over diagnose it⁵ and when it is detected, it is not treated adequately.⁶ Recent evidence indicates that misidentification of depression outnumbers missed cases.^{7,8}

There is increasing recognition that depression care is complex. Yet, tasks within guidelines usually amount to no more than prescribe antidepressant medications⁹ and refer to specialists.¹⁰ The collaborative care model suggests screening and case management by other non-GP professionals^{11,12} but this has been costly in the USA and definitive results are awaited from UK and European trials.¹³ The identification of depression care tasks is complicated by the spectrum of depression seen.^{14–16} Indeed, in primary care, depression rarely reflects the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV-TR) (DSW) categories⁸ and is often a combination of depression, stress and life worries.^{15,17} Debate remains around when the label of depression should be applied and whether ‘depression’ is a useful diagnostic label for general practice.¹⁷

The aim of the reorder study (reorganizing care for depression and related disorders in the Australian primary health care setting) was to identify the tasks that GPs and primary care should be equipped with to deliver depression care. During 2006 and 2007, reorder undertook consultations with patients, academics, government, non-government organizations and health professionals. Our aim was to identify diverse perspectives on what GPs and primary care should do for depression. While there have been a number of studies to gather patient and stakeholder views about what is important in depression care,^{18–20} none have been to the scale of the reorder consultations reported on in this paper.

Method

Sample

Results presented in this paper are based on in-depth consultations held with patients in Victoria, Australia, and community stakeholders (henceforth referred to as ‘stakeholders’) from Australia wide including some international representatives. Each consultation phase was conducted separately and is described below.

Patient perspectives

Patients were identified from an existing longitudinal study, the ‘diamond’ study (the diagnosis, management and outcomes of depression in general practice). Diamond is a cohort of primary care patients who scored ≥ 16 (indicating probable depression) on the Centre for Epidemiological Depression Scale at baseline.²¹

Community stakeholder perspectives

Community stakeholders were identified using complexity theory and the social determinants of health framework.^{22–24} Researchers (JG, CD, FG, HH, KH, RK, GB, CJ and EB) participated in a 2-day workshop facilitated by RH to determine the sampling frame. Representatives were sought from federal, state and local governments in Australia, the non-government sector, the health sector and academics in Australia and internationally, including those engaged in primary care and broader research issues like migration, social inequalities and concepts of health and illness. Adequate representation was sought across aspects of the depression experience such as economic issues, work, poverty, disability, access to education, technology, history of local communities, roles of families and friends, relationship issues, the use of health care services, biology of depression, the health care consultation, health care professional attitudes and training, access to services and the organization of health care systems (all parts of the social determinants of health framework). Organizations, groups and individuals were identified by websites and publicly available directories and then contacted by email. Two hundred and ninety three participants were identified for each group of the stakeholder consultation.

Data collection

Patient perspectives. Patients completed computer-assisted telephone interviews (CATI) between March 2006 and April 2007 12 months after joining the cohort study. The structured interview guide consisted of 14 sections, 5 sections formed part of the reorder consultation. There were 54 questions, 41 open and 13 closed questions, and three open-ended questions are reported on in this paper (see Box 2). Interview questions included all three terms depression, stress and worries to capture the spectrum of depression seen in general practice. Interviews were 1 hour in length on average and trained interviewers typed responses verbatim and

Box 2 *Questions asked for patient and community stakeholder consultation*

Patient CATI Questions

- (1) What do you think are the most important tasks that GPs can do for people experiencing depression, stress or worries?
- (2) Thinking of the times you have spoken to a GP about depression, stress or worries, what was good about this?
- (3) Thinking of the times you have spoken to a GP about depression, stress or worries, what could have been done better?

Community Stakeholder modified DELPHI Questions

- (1) How should general practice/primary care respond to people experiencing depression?
- (2) What are the barriers for best practice in general practice/primary when faced with people experiencing depression?
- (3) How would we know if general practice/primary care is meeting the needs of people experiencing depression?

collated these within NVivo 7.²⁵ Patients were asked about individual experiences when seeking GP care.

Community stakeholders. Questions for stakeholders were piloted by the investigating team and then posed to each stakeholder group.²⁶ A usual Delphi incorporates smaller numbers of experts with three rounds for ranking,²⁷ this consultation was a modified Delphi process because numbers were large and two rounds occurred. Figure 1 outlines the modified Delphi process. Stakeholders were asked about the systems level perspective of what primary care as an organization should do for depression (see Box 2).

Data analysis

Patient perspectives. Patient responses to the questions were read by members of the multidisciplinary research team (academic general practice, sociology, anthropology, psychology, psychiatry and health promotion). Team discussions about assigning codes and meanings were held (RK, EB, JG, FG, HH and CJ) and 20 responses to individual questions were coded by individual members of the team to ensure consistency. Frequently repeated themes were grouped within agreed upon broader categories. A list of the 10 most mentioned themes was developed for each question.

Community stakeholder perspectives. Content analysis techniques²⁸ and inter-coder consensus were used to analyse Round 1 data. RH and BS led the process of developing a list of the 20 most frequently mentioned responses. Time emerged as such a common issue that it was excluded in Round 2. Participants were informed of this exclusion. The top 20 list was emailed back to participants in random order and they were asked to rank the 10 most important items for each question (with one being most important) (An additional ranking process was undertaken by BS and RH for the modified Delphi, which sought to identify the top 10 responses across each group. This ranking exercise is

not reported on within this paper because figures from the stakeholder's initial selection of their top 10 responses from the list of 20 have been used to conduct a proportional comparison between the two groups).

Data synthesis

VP and JG reviewed the top 10 responses provided by patients and stakeholders. Their review found that responses fell within two categories of tasks. These explain what is required in an effective model of care in the primary care system and how we would determine if the model of care and system was effective. These categories reflect the questions participants responded to (see Box 2). The tasks were seen to refer to three important domains of health care: the 'relational', 'competency' and 'systems' domains. Tasks explaining the relational domain referred to the more qualitative and subjective aspects of the consultation, the tacit aspects of the doctor-patient relationship and in particular values like trust, empathy and compassion. Tasks in the competency domain were oriented towards technical aspects of care, the skills, education, competencies and techniques needed to deliver care. The systems domain tasks identified organizational changes and infrastructure support required for effective depression care. Patients and stakeholders provided responses that identified tasks within all three domains across both categories of what is required and how could the system be assessed. The three domains provide the foundations of a conceptual design to inform a primary care response to depression.

Results

Patients

Five hundred and seventy-six patients completed CATI Question 1, 475 completed CATI Question 2 and 474 completed CATI Question 3 (see Box 2). The 100 missing responses to Questions 2 and 3 were from patients who had not spoken to a GP about their DSW. Table 1 details patient characteristics.

Stakeholders

Three hundred and thirteen stakeholders participated in Round 1 (32.9% response rate) and 276 in Round 2 (31.5% response rate). Table 2 details participant characteristics from Round 2 of the modified Delphi for which the top 10 tasks are reported.

Table 3 presents results from patients and stakeholders combined. It is important to bear in mind that each group volunteered responses: no tasks were pre-established or set out by the research team. Fifteen tasks are identified by patients and stakeholders for effective depression care. Five are agreed upon and an additional ten are mentioned by each group but not agreed upon. Agreed-upon tasks include: 'listening, understanding and empathy,' 'competent and thorough

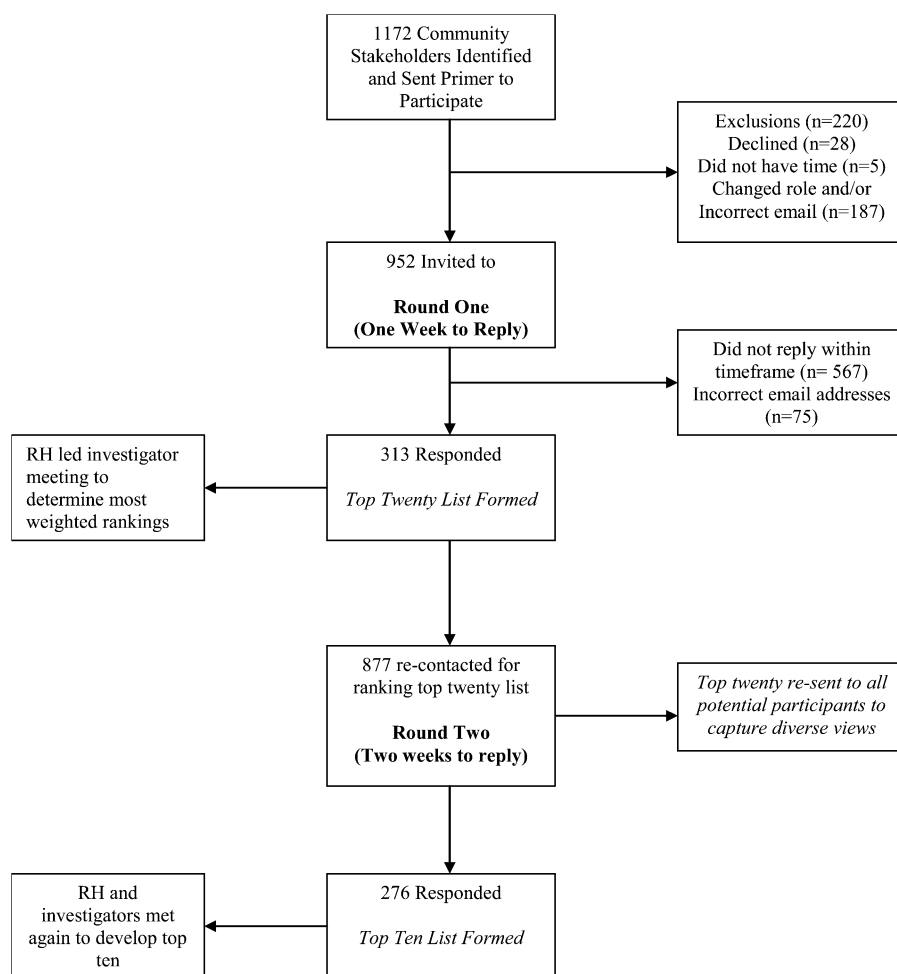


FIGURE 1 Illustration of modified Delphi process

diagnosis and management,' 'following up and monitoring of patients,' 'funding longer consultations, having more accessibility to GPs, appointments not being rushed' and 'taking an holistic approach and tailoring care to individual needs'. Table 4 provides a selection of patient and stakeholder quotes to further illustrate perspectives on the tasks, the improvements that could be made (perceived barriers) and the tasks completed effectively (including ways to measure these).

Nearly half the patients (44.2%; 210/475) suggest that listening, understanding and being empathetic is done well by their GP, and a smaller proportion (13.1%; 62/474) say GPs could improve this. Over half the stakeholders (64.5%; 178/276) identify that 'over-reliance on medication' is a barrier to good listening. Surveying patients is suggested to measure for listening, being understanding and empathetic. Responses highlight that measures need to incorporate the multi-factorial nature of care and complexity of patient experiences rather than trying for a 'one size fits all' approach. Combining quantitative surveys and qualitative interviews are ways suggested to capture the patient experience.

Patients and stakeholders also agree that 'diagnosis and management' is an important task. Similar proportions of patients (15.8%; 75/475) mention diagnosis and management as a task done well compared to those (14.8%; 70/474) who say it can improve. Nearly half the stakeholders (48.6%; 134/276) link the problem of diagnosis and management with 'inadequate general practice/primary care competency and training to recognize, assess and treat depression.' Stakeholders propose 'measuring diagnosis rates in general practice' to assess system effectiveness.

A third agreed-upon task is 'follow-up and monitoring'. Relatively small proportions (between 4% and 6% of patients) comment on this as a task done well or as a task to improve. The 'poor integration between general practice/primary care and other providers' is a barrier nominated by a large proportion of the stakeholders (70.7%; 195/276). Almost two-thirds of stakeholders (62.0%; 171/276) suggest that 'monitoring the quality and duration of follow-up' could measure effectiveness as could 'monitoring patient recovery' (56.2%; 155/276) and 'measuring functional outcomes like the capacity to function physically, socially and in the

community' (48.6%; 134/276). Functional outcome measures could also be used for 'assessment of severity and suicide risk'.

TABLE 1 Patient characteristics (n = 576)

Patient characteristics at screening		(n = 576)
Age in years, Mean (SD)		48.2 (12.9)
CES-D score, Mean (SD)		27.3 (9.6)
		<i>n</i> (%)
Gender		
Female		409 (71.0)
Marital status		
Never married/single		127 (22.2)
Widowed/divorced/separated		177 (30.9)
Married		268 (46.8)
Lives alone		131 (22.8)
Born in Australia		481 (83.5)
English is first language		556 (96.7)
Left school before year 10		86 (15.0)
Pension/benefit is main source of income		194 (33.1)
Has any health care card		236 (42.5)
Employment		
Full-time work		152 (26.5)
Part-time work		129 (22.5)
Unable to work due to sickness or disability		77 (13.4)
Unemployed		24 (4.2)
Hazardous drinking in past 12 months		130 (22.7)
Current smoker		179 (31.2)
Long-term illness/health problem/disability		287 (50.9)
At least one chronic physical condition in past 12 months		404 (70.3)
Rated health as excellent		17 (3)
Ever afraid of partner ^a		193 (35)
Ever told by doctor had		
Depression		385 (70.5)
Anxiety		291 (58.2)

Discrepancies in total due to missing responses. CES-D, Centre for Epidemiological Depression Scale.

^aIf ever in an adult intimate relationship.

Patients and stakeholders agree on the need for longer consultations. More patients (10.1%; 48/474) said that improvements in 'accessibility and appointments not being rushed' are needed compared with those (5.5%; 26/475) who said that this is done well. Stakeholders identified the need for funding for longer consultations. Both groups overwhelmingly cite 'time available' as a barrier to effective depression care. 'Measuring patient satisfaction' could determine improvements in accessibility and time.

The final agreed-upon task is 'holistic assessment and tailored treatment for individuals'. A moderate proportion of patients (10.5%; 50/475) suggest that this task is done well with a smaller number (6.8%; 32/474) saying this could improve. 'An overreliance on the medical model' is a barrier to whole-person care. Stakeholders suggest 'surveying consumers and carers' to measure holistic assessment and tailored treatment, as well as 'surveying patients'.

Results indicate that some additional tasks were nominated more highly than some of the agreed-upon tasks. For example, stakeholders ranked 'developing a plan with patients' very highly (76.8%; 212/276), patients supported this but it was not mentioned frequently. Patient results show that 'appropriate and timely referral' (30.0%; 173/576) and 'support and reassurance' (18.8%; 108/576) are mentioned more often than the agreed-upon task of 'follow-up and monitoring'. A substantial number of stakeholders (72.1%; 172/276) identify the 'lack of affordable referral options' and 'GP access to referral' as a barrier to 'timely and appropriate referral'. Stakeholders mention 'assessment of severity and suicide risk', 'accounting for social factors', 'being well trained in depression care' and 'offering a range of treatment options' more often than 'funding longer consultations'. The final three tasks patients identify

TABLE 2 Stakeholder characteristics

Occupation	Setting					Total
	Government	NGO	Academic	Health professionals	Unspecified	
Government policy advisor	25	2	1	0	0	28
Academic	2	1	55	1	0	59
CEO/Director/Manager	17	30	2	14	2	65
Research officer/project	1	7	7	4	1	20
GP	0	0	0	15	0	15
Psychiatrist	0	0	0	11	0	11
Psychologist	0	0	0	13	0	13
Nurse	0	0	0	16	0	16
Counsellor	0	0	0	4	0	4
Social worker	0	0	0	7	0	7
Consumer/carer representative	0	9	0	0	0	9
Other—refer to list	6	9	2	7	1	25
Not specified	0	1	0	0	3	4
	51	59	67	92	7	276

NGO, non-government organizations; COE, chief executive officer.

TABLE 3 Patient and stakeholder responses^a

	Tasks identified for GPs	Tasks identified for primary care	Examples of tasks done well by GPs ^b	Tasks affected by barriers to best practice ^c	Examples of tasks that could be improved ^b	Task to measure for system effectiveness ^d	<i>n</i> (%)	
							Patients <i>N</i> = 576	Stakeholders <i>N</i> = 276
Agreed-upon tasks by both groups								
Listen, understand and empathize ^e	215 (37.3)	174 (63.1)	210 (44.2)	189 (68.5)	62 (13.1)	201 (72.8)		
Diagnose and manage	177 (30.7)	181 (65.6)	75 (15.8)	134 (48.6)	70 (14.8)	144 (52.2)		
Follow-up and monitor ^f	89 (15.5)	185 (67.0)	19 (4.0)	195 (70.7)	30 (6.3)	162 (58.7)		
Fund longer consultations (accessibility and not rushing)	87 (15.1)	119 (43.1)	26 (5.5)		48 (10.1)	171 (62.0)		
Holistic approach and tailoring care to individual needs	76 (13.2)	168 (60.9)	50 (10.5)	178 (64.5)	32 (6.8)	158 (57.2)		
Non-agreed-upon additional tasks								
Develop a plan with patients		212 (76.8)				161 (58.3)		
Assessment of severity and suicide risk		163 (59.1)				134 (48.6)		
Account for social factors		156 (56.5)		204 (74.0)				
Be well trained in depression care		151 (54.7)		172 (62.3)		121 (43.8)		
Offer range of treatment options		149 (54.0)		159 (57.6)		120 (43.5)		
Appropriate and timely referral ^g	173 (30.0)		53 (11.1)	194 (70.3)	49 (10.3)	133 (48.2)		
Support and reassurance	108 (18.8)		100 (21.1)		16 (3.4)			
Educate patients about depression	60 (10.4)		44 (9.3)	108 (39.1)	13 (2.8)			
Prescribe appropriately and manage medication	41 (7.1)		53 (11.2)		41 (8.6)			
Be positive and encouraging	25 (4.4)			147 (53.3)				

^aAll results were volunteered by each group. Patient results show the 10 commonly mentioned and coded themes to open-ended questions. Stakeholder results show figures from ranking 10 most important items from the original list of 20 items.

^bNine tasks are reported for tasks done well and tasks to improve as 'nothing' was coded as the 10th task. We have not included 'nothing' in these results.

^cThe barriers to best practice identified by stakeholders have been corresponded with the task that would be most affected the barrier reported on in the results summary.

^dThe 'ways to know if primary care is meeting patient needs' have been corresponded with the task that could be measured to identify effective depression care reported on in the results summary.

^eStakeholders identified 'listening' and 'empathy' separately as important in the initial top ten list. The figure presented here is for 'listen'; 39.9% (110/276) stakeholders nominated empathy separately as important.

^fOver half of the stakeholders (56.2%; 155/276) suggest 'monitoring patient recovery' is also important to measure for effective follow-up and monitoring.

^gOver half of the stakeholders (54.7%; 151/276) also nominated 'patients not having timely access to services' as a barrier.

are to 'educate patients about depression' (10.4%; 60/576), 'prescribe appropriately and manage medication' (7.1%; 41/576) and 'be positive and encouraging' (4.4%; 25/576). 'Lack of knowledge about depression within general practice/primary care' and 'negative community attitudes' are barriers to education and positivity.

Figure 2 represents the synthesis of the 15 identified tasks outlined for GPs and primary to respond to depression this includes tasks that could be undertaken to measure effectiveness or demonstrate a reduction in the barriers. These are presented within the two categories of 'what is required to develop an effective model and system of depression care' (upper section) and 'how would we determine if the model of care and system were effective' (lower section). Figure 2 is a conceptual design to inform a primary care response to depression and related disorders.

Discussion

The reorder consultations were deliberately broad to capture diverse voices yet the results show simple desires. Patients and stakeholders overwhelmingly agree on the tasks required for an effective model and system of depression care and time undoubtedly underpins all these tasks. Patients and stakeholders show most agreement on tasks within the relational and competency domains in terms of what is required to develop an effective model of care (see Fig. 2). The doable tasks for GPs within the relational domain are listening, understanding, empathy, support, reassurance, whole-person care, involvement of patients in planning, positivity and encouragement. The doable tasks identified within the competency domain are to undertake a thorough diagnosis and management of depression, develop a plan with patients, undertake an assessment of

TABLE 4 Patient and stakeholder quotes for the conceptual design of an effective system of depression care

The five agreed-upon tasks for depression care	Tasks to improve for increased effectiveness of depression care—the barriers to tasks	Tasks done effectively—how to measure for effectiveness
Listen, understand and empathize	Improve listening—overreliance of medication	Good listening, understanding and being empathetic—survey patients
<p><i>Listen to them to start of with. If you've got a good practitioner who listens to you they can pick up straight away what's wrong with you (Patient).</i></p> <p><i>Listen, because if they listen the person gains the confidence in the GP (Patient).</i></p> <p><i>With empathy, listening to their story and spending time with the patient (Stakeholder).</i></p> <p><i>Empathetic approach – recognises and accepts cultural perceptions of wellness rather than mental illness (Stakeholder).</i></p> <p><i>By taking the time to listen to the patient's assessment of their own condition and encouraging them to talk about why they feel they are depressed (Stakeholder).</i></p>	<p><i>Listening and believing because I felt like they were waiting for me to shut up so they could give me a prescription (Patient).</i></p> <p><i>I think that he could have listened more or paid more interest in what may have been causing it. He was just happy to prescribe medication and brush it off. More clinical rather than caring (Patient).</i></p> <p><i>There is a dominance of drug therapy as first choice of treatment: this is a panacea not a treatment (Stakeholder).</i></p> <p><i>There is a lack of confidence in managing psychological symptoms. GPs are familiar with drug treatments rather than alternative supports and may prescribe medication as a first line of action knowing they do not have the time or resources to consider alternatives (Stakeholder).</i></p>	<p><i>I think that they were prepared to actually listen and not make you feel like some complete nutcase or hypochondriac, and listen with compassion (Patient).</i></p> <p><i>Survey people to find out if people feel they could raise their concerns with their GP and primary care providers without fear of rejection and stigmatization (Stakeholder).</i></p> <p><i>Conduct qualitative research into patient care by interviewing patients about their experience. This should include people who have been depressed but recovered – narratives of recovery should reveal the roles of the GP/Primary Care person in the process (Stakeholder).</i></p>
Diagnose and manage (thoroughly and competently)	Improve diagnosis and management—inadequate training and competency to recognize, assess and treat depression	Competent diagnosis and management—measure diagnosis rates
<p><i>I guess listen and be thorough and diagnose [patients] properly and explain everything in detail and follow up would be good (Patient).</i></p> <p><i>Depression is not always easy to diagnose as anyone one in the field will know. It is important that those in general practice or other health professionals in the field take the time and know how to elicit the appropriate information. There is not necessarily a specific "one cure fits all" for people suffering depression. Those in GP and/or primary care who are appropriately trained and/or have considerable experience in the area will/should provide an appropriate response to the individual's need, including the option of referral (Stakeholder).</i></p> <p><i>Above all, diagnosing the severity and nature of depression is a high level medical skill and cannot be seriously carried out without a good understanding of the patient's life situation and perspective of the problem (Stakeholder).</i></p>	<p><i>More time to get diagnosed properly the first time, not the second or the third! Not so much guessing, but trying to really find the problem (Patient).</i></p> <p><i>They could probably talk about it a bit more, probably try and get more detail from you about what was causing it before they just referred you on to other professionals (Patient).</i></p> <p><i>Earlier diagnosis, like probably it was 4 or 5 months until I was properly diagnosed I guess (Patient).</i></p> <p><i>The experience or training levels of GPs [is not adequate] to cover this issue (Stakeholder).</i></p> <p><i>There is a lack of diagnostic skill regarding depression, especially with non-typical presentations (Stakeholders).</i></p> <p><i>There appears to be a view that GP's are skilled to diagnose and treat all manner of afflictions – they are not, especially not those issues that have an emotional/psychological/social base (Stakeholder).</i></p>	<p><i>I guess it's the fact that the issue was able to be diagnosed, because I'd seen different doctors . . . just knowing what was wrong (Patient).</i></p> <p><i>The GP tended to wanted to get to the root cause and to do something positive to make a change, you know make it better. I've found psychologists and psychiatrists don't have the personal sort of touch that the GP has (Patient).</i></p> <p><i>Ultimate outcome measure = number of people screened and managed for pre-depression symptoms increases whilst number of people diagnosed and treated with clinical depression decreases (prevention versus treatment) (Stakeholder).</i></p> <p><i>Earlier diagnosis and lower incidence of severe problems (Stakeholder).</i></p> <p><i>Increased rates of diagnosis of illness (Stakeholder).</i></p>

TABLE 4 Continued

The five agreed-upon tasks for depression care	Tasks to improve for increased effectiveness of depression care—the barriers to tasks	Tasks done effectively—how to measure for effectiveness
<p>Follow-up and monitor</p> <p><i>Also to follow up and say comeback and chat for 5 minutes to see how you're getting along and even ring them, and even if the doctor is too busy, maybe like you said before have a nurse that can perform the follow up to take some of the load off the doctor (Patient).</i></p> <p><i>Regular check up and monitoring of medication and other interventions provided (Stakeholder).</i></p> <p><i>Monitoring and proactive follow up (Stakeholder).</i></p> <p><i>Ensure there are follow up opportunities to monitor progress (Stakeholder).</i></p>	<p>Improve follow-up and monitoring—poor integration between general practice/primary care and other providers</p> <p><i>I think sometimes the referrals can be done better. I think sometimes they refer you to services that are unrealistic, financially and time wise (Patient).</i></p> <p><i>Probably a better follow up on treatment advice. They put me on medication but didn't follow up. It was left up to me (which I suppose was right, I don't know), but there was no follow up on whether the medication was making you feel better or not, um, it wasn't "come back and see me in a week or if you're not feeling better." You were just given the script and that was it (Patient).</i></p> <p><i>Depression often needs a multidisciplinary approach, not just a GP to treat (Stakeholder).</i></p> <p><i>Negative attitudes by some GPs towards delegating patient education, brief interventions and follow-up of patients to practice nurses. Similar negative attitudes towards the creation of new roles in general practice, e.g. medical assistants (Stakeholder).</i></p>	<p>Following up and monitoring—monitor duration and quality of follow-up, patient recovery and functional outcomes</p> <p><i>To give them time and understanding, compassion, and like refer them on to someone who can help them further. And a follow up call from your doctor would mean a lot actually (Patient).</i></p> <p><i>More effective systems established for follow up & management (Stakeholder –quality and duration of follow up).</i></p> <p><i>Need methods for following up on care plans (Stakeholder – quality and duration of follow up).</i></p> <p><i>Measure timeliness - from onset to assessment, from assessment to treatment, from treatment to recovery (Stakeholder – monitor patient recovery).</i></p> <p><i>Evaluate the treatment the consumer or patient receives at the local level, e.g. are Cognitive Behavior Therapy interventions impacting on functioning (Stakeholder – measure functional outcomes).</i></p>
<p>Fund longer consultations (accessibility and appointments not being rushed)</p> <p><i>I think consulting times becomes an issue. You know, in and out. Here you are coming in with stress and worries and you have to be in and out in 20 minutes. And cost. You're there because things are crumbling around you but you have to be out in 20 minutes. It's a paradox. And I think cost, you have to pay for it (Patient).</i></p> <p><i>Have time to talk to [patients]. I know some of them have certain time limits and they have to get through a certain amount of people in an hour and no one wants to be told that, "that is enough time for today", you don't want to feel rushed and people might clam up again (Patient).</i></p> <p><i>Make time available for "longer" consultations to discuss problem once identified (Stakeholder).</i></p> <p><i>Provide long consultation for a proper assessment (Stakeholder).</i></p>	<p>Improve accessibility and consultations length—time</p> <p><i>I suppose they were supportive to some extent and tried to listen but you always felt that they were watching the clock and their waiting room is full and all the rest of it (Patient).</i></p> <p><i>I think they don't have much time and to sort of, to start off they should listen and advise and not rush through the appointment. A lot of people may go away and think that he didn't have much time for me (Patient).</i></p> <p><i>He is always in a hurry you don't really, I mean he asks you but you don't really feel like you have time and he is always interjecting to try and hurry you up (Patient).</i></p> <p><i>The GP appointment system usually 10 minute turn around in most GP practices does not facilitate an environment whereby people can discuss in any depth issues related to feelings of depression (Stakeholder).</i></p> <p><i>Lack of time to talk with patients in an unhurried fashion (Stakeholder).</i></p> <p><i>Feedback from our patients indicates that GPs are often too hurried and don't have time to listen (Stakeholder).</i></p>	<p>Accessibility, appointments not being rushed—measure patient satisfaction</p> <p><i>Well he listens, he's never in a hurry to get you out of the office, he talks to you, he asks you questions. He's very caring, not only with me, but all his patients (Patient).</i></p> <p><i>That he made the time. He's the only one I trust and his receptionists were ordered to give me an appointment even when they were busy (Patient).</i></p> <p><i>He's very thorough and makes sure that I'm very well informed about what I'm getting into and about what's causing the depression and anxiety, and so my appointments with him often take a while (Patient).</i></p> <p><i>We need accepted outcome measures/ clinical indicators – both for improvement over a period of time, and in relation to each individual session. These need to give centrality to the client/patient's views about what they wish to get out of the care (Stakeholder).</i></p> <p><i>Research projects to investigate patient satisfaction (people with depression) with their GP's (Stakeholder).</i></p>

TABLE 4 *Continued*

The five agreed-upon tasks for depression care	Tasks to improve for increased effectiveness of depression care—the barriers to tasks	Tasks done effectively—how to measure for effectiveness
Holistic approach and tailoring care to individual needs	Improve holistic approach and tailored care—an overreliance on a medical model	Holistic approach and tailored care—survey carers and consumer groups ^a
<p><i>I think they need to treat people as a whole and if there's some emotional type thing if they can't handle, they should have a collection of other health care of people that they can refer to—but they should have a collection because its different strokes for different folks so you need a range that you can be referred to (Patient).</i></p> <p><i>Assessing and attending to the psychological and social as well as biomedical needs of people experiencing depression (Stakeholder).</i></p> <p><i>Take a holistic approach and also look at family (Stakeholder). Engage with as a whole person (i.e. holistic), not as a set of symptoms (Stakeholder).</i></p> <p><i>They should make a holistic assessment. i.e. before reverting immediately to medication, assess what environmental (e.g. family, work, lifestyle, family violence) factors are involved in the depression that need to be addressed (Stakeholder).</i></p>	<p><i>I guess with some of them they should spend more time and not just straight away give you a referral and a prescription. Just go through the history and that kind of thing (Patient).</i></p> <p><i>The patient may think that medication may be enough to help them to recovery/relapse prevention (Stakeholder).</i></p> <p><i>Use a social model of health not just a medical model (Stakeholder).</i></p> <p><i>Focussing only on a traditional approach and not holistic (Stakeholder).</i></p> <p><i>Constrained capacity to move beyond biomedical model of health (Stakeholder).</i></p> <p><i>Many medical students pick up an attitude in medical schools that biomedical subjects are far more important than ones in the social and behavioural sciences (Stakeholder).</i></p>	<p><i>It depends on the GP, I've had a few. When its good is when they'll go through your history and talk to you and look for patterns and talk about ways to control it (Patient).</i></p> <p><i>They pointed me in some directions, some relaxation techniques, making time for myself and getting away from whatever was causing me stress (Patient).</i></p> <p><i>Community survey to identify who is depressed and then ask those people about their experience in primary care (Stakeholder).</i></p> <p><i>Consumer satisfaction (Stakeholder). Consult carer and consumer groups (Stakeholder).</i></p> <p><i>Better techniques for evaluation, including qualitative assessment of consumer outcomes (Stakeholder).</i></p>

^aSurveying carer and consumer groups could also include surveying patients, quotes for how to survey patients have already been provided earlier in the table.

severity and suicide risk, tailor care to individual needs, take into account social factors, offer a range of treatment options, prescribe and manage medication, educate patients about depression and monitor patients for recovery. These tasks will need to be supported by a system that provides funding for longer consultations and allows GPs to be accessible and not rush appointments. Mechanisms for follow-up and monitoring are important as is providing timely and appropriate referral that is affordable, funding and supporting a range of treatment options and establishing ways to integrate primary care and other providers. This includes providing professional support to general practice.

To determine system effectiveness, a number of tasks within the relational and competency domains could be assessed. For example, surveying and interviewing patients, carers and consumer groups and GPs can provide evidence to determine the effectiveness of tasks undertaken within the relational domain. Identifying if there is a reduction on reliance on medication and medical model, monitoring recovery,

diagnosis rates, monitoring functional outcomes and prescribing and monitoring the number of people with depressive symptoms could also assess the effectiveness of the competency domain. Finally, the systems domain could be measured for effectiveness by assessing referral options and rates, services available (particularly in regional areas for Australia), access and affordability, the number of patients with depressive symptoms and duration and quality of follow-up.

The three identified domains and tasks should not be seen in isolation of each other; these are interrelated concepts. For example, relational tasks are effective when GPs are competent communicators, and competent communication is dependent on systems level support through appropriate GP training and education. It is notable that patient and stakeholders agree on the importance of the tacit tasks within the relational domain like listening. However, much of the current focus within health care systems is on the technical and mechanical aspects of competent care to the exclusion of these important tacit

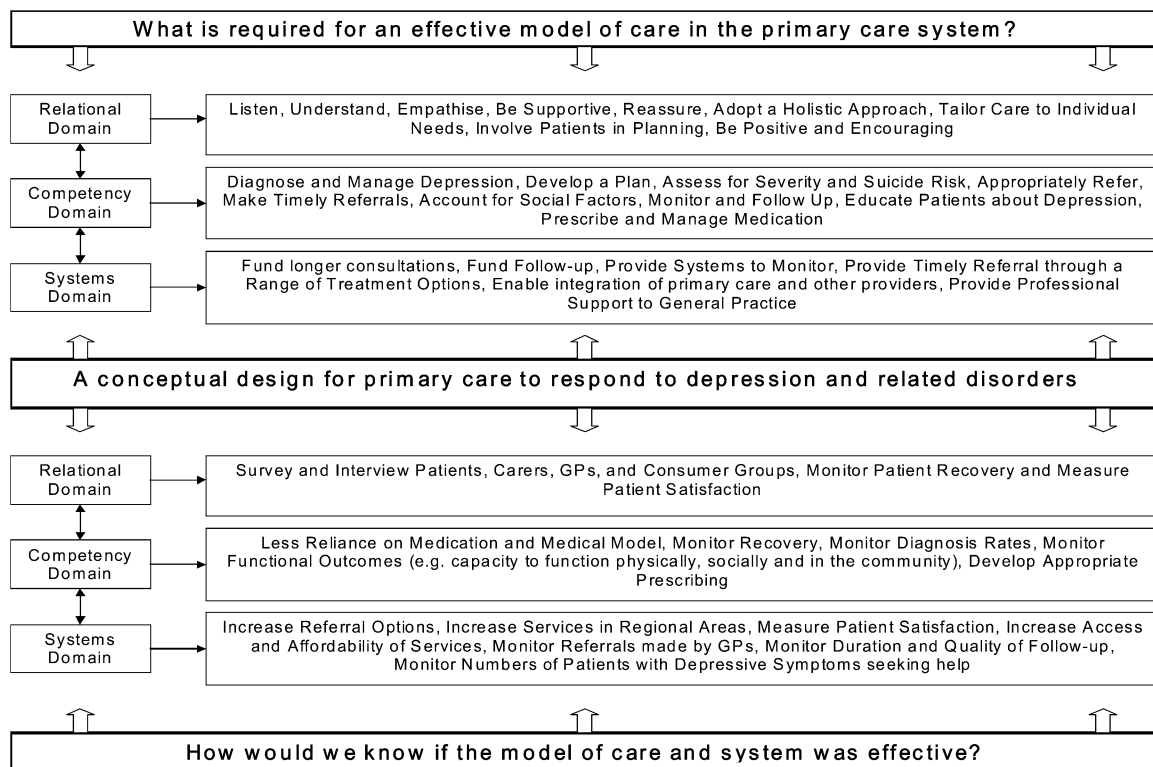


FIGURE 2 A conceptual design for a primary care response to depression

dimensions. Establishing how to give equal weight to both the relational and competency domains is fundamental to developing an effective model and system of care as our results demonstrate. This is particularly the case as patients and stakeholders have identified that both the relational tasks like listening are as important as competent and thorough diagnosis in depression care.

Strengths and limitations

One strength of this study is the diversity of viewpoints integrated in the conceptual design including non-medically trained and non-health professionals. While qualitative studies have previously elicited patient perspectives, none that we are aware of have been to the scale of these consultations and few have synthesized both patient and stakeholder perspectives. Given that Delphi response rates are known to be low,²⁷ our response rate to the modified Delphi is reasonable due to our large numbers and diverse participants.

A potential limitation to our analysis is the mixed methods used for data collection for each group. Our view, however, is that the responses from both groups assist to identify some very doable tasks for primary care beyond the limited tasks within current depression care guidelines. Additional limitations include that the patient cohort is predominantly female, from English-speaking backgrounds, well educated and in

employment. These demographics undoubtedly play a role in how this group conceive depression and its treatment and management. Future research with people from culturally and linguistically diverse backgrounds and those for whom access to health services may be difficult will be essential to determine the relevance of this conceptual design for their depression care.

Existing literature suggests GP care emphasizes the relational domains (human connection, accessibility, supportiveness and empathy) over technical or mechanical approaches where the focus is on checking technicalities of illness.² In keeping with Osler's work, medicine needs science but this cannot replace the Hippocratic tradition of working with people.²⁹ Listening is central to human connection but needs to be also understood as critical to diagnosis and monitoring of patients.²⁰ Empathy too enhances the doctor and patient relationship, yet can improve both patient and doctor satisfaction and diagnostic accuracy.³⁰ Previous research has found that patient confidence in clinical competence increases with an increased perception of receiving quality of care.³¹ This further highlights the interconnection between the three domains. While concerns have been raised that good listening and regular review and monitoring of patients increases GP workload in a time-limited setting, these tasks are obviously fundamental to patients and stakeholders for mental health care.¹⁵ Addressing the barrier of time is critical to depression care patients should not be worried about taking up GP time with unnecessary or insignificant concerns like DSW.³²

Conclusions

This study has identified a wider range of doable tasks for GPs than to simply 'prescribe' and 'refer'. There is opportunity now for GPs and policy makers to consider how to operationalize these at an education and practice level. A key challenge is how to incorporate fundamental relational tasks within everyday practice limited by time and for this to be valued by a system heavily weighted in the direction of mechanical competency. While this paper has focussed on principle four of the WHO and WONCA call for integration of mental health into primary care, there are other tasks that patients and stakeholders support, which are covered in the 10 principles.

This study illustrates that patients and stakeholders value the tasks that occur largely within the relational domain, but it is clear that they want this to be combined with technically competent care. The problem in an evidence-based world is that competency often trumps the relational and tacit dimensions because of its measurability and increasingly competency is being presented as a mechanistic deliverable achieved through ticking check boxes. The relational is far more difficult to measure and as a result is undervalued and sidelined in government policy documents. Our greatest challenge for integrating mental health into primary care is to ensure that designs for an effective model and system of care give equal weight to the relational and competency domains. These domains need to be supported by a clearly articulated systems domain suited to each local context. This will require considered attention to identify the appropriate ways to measure all of the tasks required for depression care but particularly the relational tasks.

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and GB assisted in design of questions, data analysis and synthesis with EB, JG and RK. KJA assisted in the analyses of CATI responses. VP and JG developed the conceptual design for a model of depression care suitable for the primary care setting. All listed authors have contributed to the writing, analysis and synthesis of this paper and approved the final version.

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