

ORIGINAL ARTICLE

Involving service users in the evaluation and redesign of primary care services for depression: A qualitative study

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ABSTRACT

Aim: To understand the experiences, expectations and needs of service users with mild to moderate depression, and to use these to inform the design and redesign of local services in primary care.

Design of study: Needs assessment using in-depth semi-structured qualitative interviews.

Setting: A single general practice in eastern England.

Methods: Nine patients with depression were identified from the practice register using purposeful sampling and interviewed by a practice nurse who had not previously provided any care to them. Ritchie and Spencer's Framework approach was used to analyse the qualitative data.

Results: Participants welcomed the

opportunity to provide feedback on their experiences. They told many positive stories which affirmed the overall accessibility and acceptability of the existing service. They reported symptoms that were distressing and difficult to live with, even when their depression was classified by health professionals as 'mild'. Participants considered they had good access to care. Despite this, many participants identified gaps in the current service such as access to information and concerns about discontinuing medication in the future.

Conclusion: In-depth interviews with patients with depression are a feasible and acceptable way of identifying service gaps and enabling users to contribute to service evaluation and redesign.

Introduction

Background: user involvement in today's NHS

The vision that health services should be designed around the needs and priorities of users is a contemporary theme in National Health Service (NHS) service design and redesign generally, and the challenge for the NHS today is the achievement of effective patient and public involvement¹. Initiatives to involve service users are an important part of improving service quality in the NHS², this may involve

working with users either locally and/or nationally. The NHS Plan³ is the far-reaching strategic vision for reform and performance improvement in the NHS. A number of relevant implementation initiatives have arisen from The NHS Plan which are summarised in Table 1 below.

Any improvement to the quality of a service needs to start from the perspective of the service user as patient views on the quality of healthcare differ from the views of healthcare professionals, managers and policy makers⁹⁻¹¹. Users often provide a different view which results in imaginative and innovative solutions

Table 1. Service user initiatives arising from NHS plan

DoH Publication	Summary of Publication
Shifting the Balance of Power in the NHS: Securing Delivery ⁴	Sets out a broad strategy for shifting power 'to empower local NHS staff and local communities' with a view to achieving the reforms envisioned in the NHS Plan.
Health and Social Care Act, Section 11 ⁵	Since 1st January 2003, all NHS bodies have had a legal duty to involve and consult the public
Performance Improvement Framework for Patient and Public Involvement ⁶	Contains guidance, standards and milestones in five key dimensions of the patient experience: access and waiting; information and choice; closer relationships (between patients and health professionals); safe, high quality, co-ordinated care; and a clean comfortable and friendly environment.
Patient and Public Involvement in the New NHS ²	Operationalised the setting up of Patient and Public Involvement (PPI) Forums and Patient Advice and Liaison Services in every NHS Trust. PPIs were initially appointed and supported by a national body (Commission for Patient and Public Involvement in Health) but the future of this body is now being reconsidered in favour of more local management and governance arrangements.
The NHS Improvement Plan ⁷	Sets out in broad terms the ways in which the NHS needs to change further in order to become truly patient led. Patients should be at the centre of a health system that focuses on quality, transparency, and value for money. To this end, it called for radical changes in the culture and systems of the NHS in both secondary and primary care. In particular, this document recognised that a patient-led NHS would require a different style of leadership and would need to be flexible and responsive at local level to emerging feedback. A development programme for both acute Trusts and PCTs, and a National Leadership Network for Health and Social Care, were established to build appropriate capacity.
Creating a Patient-led NHS: Delivering the NHS Improvement Plan ⁸	Added detail to the above document and described a range of new service models that have already been identified and rolled out across the NHS, including: See and Treat in A&E; the Patient Targeting List (PTL) system in waiting list management; advanced access in primary care; assertive outreach teams in mental health; emergency practitioners in ambulances, primary care and A&E; joint assessment and response teams with social services; and closer working links with the independent and voluntary sectors.

not previously thought of by healthcare professionals, thus reducing the risk of inappropriate services being developed².

Depression

Depression affects one in six people at some point in their lives¹²; it is common, complex and debilitating with potentially fatal consequences^{13,14} and is frequently inadequately recognised and ineffectively treated¹⁵ (15). UK studies in the 1980s and a more recent study in the USA demonstrated that approximately 10% of patients who consult their General Practitioner (GP) meet the criteria for mild to moderate depression¹⁶. Mild to moderate depression is managed almost entirely within primary care and although the majority of patients' symptoms resolve within 6–12 months approximately 20% of patients have symptoms which persist, becoming chronic and disabling. The WHO has identified chronic relapsing depression as one of the four most disabling illnesses in the world¹⁷.

Montgomery reports 95% patients visit their general practice within a 5 year period¹³. General practice is thus potentially well-placed to detect and manage the care of depressed patients. Indeed, over 90% of patients with depression are treated in general practice^{18,19}. It has been reported that patients get better more quickly if their depression is detected early²⁰; despite this, 50% of patients consulting their GP fail to have their depression detected at an early stage²¹⁻²³. Even those patients who do have their depression diagnosed, adherence to antidepressant medication is poor, leading to relapse and recurrence of symptoms^{14,24,25}. Box 1 summarises the key problems with the current management of depression.

In general, patients with depression currently receive reactive care from primary care with little evidence of structured arrangements for proactive care and support^{31,32}. A qualitative study by Gask et al explored patients perceptions of the quality of depression care in general practice and demonstrated systematic models of care improve the quality of care

Box 1. Problems with current management of depression

- Lack of identification of patients with depression; 80% patients with depression present with non-specific physical symptoms and avoid mentioning any symptoms concerned with emotions^{18,23,26}
- Variability in the threshold at which GPs label patients as needing treatment²⁷
- The majority of depressed patients in general practice receive less than the recommended doses and duration of antidepressant treatment according to clinical practice guidelines²⁸
- Patients are often reluctant to accept medication and think that counselling should be offered²⁹
- Patients often stop their medication as soon as they feel better due to worries about addiction. Symptoms return in approximately 50% of patients who stop their prescription as soon as they feel better¹³
- Inadequate follow-up of patients^{26,30}

because patients with depression are less proactive in seeking care due to reduced motivation, lower expectations of care and poor self-esteem³³.

This study set out to incorporate the perspective of service users with depression in the design and redesign of a local primary care depression service. We sought to explore what it means to suffer with mild to moderate depression from the users' perspective and what they considered was a priority for the care they receive from primary care.

Rationale for the study

Depression is clearly not optimally managed in primary care. Depression whether mild, moderate or severe imposes a significant burden onto the NHS and the economy. Improved recognition, better management, improved concordance with treatments and better support should help reduce this burden. The Drugs and Therapeutics Bulletin in their systematic review of depression management found that most research has been carried out on people with more severe depression¹⁶, highlighting a need for research to be undertaken on patients with mild to moderate depression.

User involvement at all stages of service development review and research is a key theme on the government agenda for the NHS^{2,3,34}. A regional Research and Development (R&D) pilot programme in 1998 identified a number of service user priorities for research; these included service delivery in general practice, and the health needs of people with mental health problems³⁵. This paper reports on a small-scale qualitative study undertaken as an MSc thesis by a practice nurse with an interest in research. It explored with patients diagnosed with mild to moderate depression their expectations and experience of

primary health care services. Specifically the research question was:

"What are the experiences, expectations and needs of service users with mild to moderate depression managed within primary care, and what factors are important to the service user that could inform how future services are developed?"

Methods

Study design, management and governance

This study used an exploratory qualitative methodology utilising semi-structured interviews to explore the perspectives of service users with mild to moderate depression. A research steering group was set up within the practice in order to oversee the study and represent all the stakeholders with an interest in the study.

Sample selection

The target population for this study were adults aged 18–65 years with no previous documented history of depression, currently prescribed a tricyclic antidepressant (TCA) or a selective serotonin reuptake inhibitor (SSRI) antidepressant for no more than nine months, whose care has remained the responsibility of primary care, and who have not required referral to any other agency; this target population totalled 52 patients. The rationale for including only patients prescribed either a TCA or a SSRI was that these are the recommended and most commonly used antidepressants in primary care, particularly within the group of patients whose depression management remains within primary care. Likewise, patients with a previous history of depression may be less likely to have a depression at the mild to moderate end of the spectrum of illness. It was not possible to identify patients with depression who are not in receipt of medication for their depression because current service design in the practice does not involve routinely recording a diagnosis of depression within the medical records of patients in a way which is easily identifiable. Neither are any objective measures for depression severity used. GP knowledge of those patients with depression not requiring antidepressant medication would have been possible but was not used to identify the sample because it was reliant on GP memory rather than documented evidence within the patient's medical records.

A purposeful maximum variety sample was used to identify people who were likely to be critical to the research. As broad a range of people who were likely to be able to make a critical contribution to the research were identified using the available demographic information held within the practice. The selection factors of age, gender and parenthood were deemed

to represent a breadth of experience and were utilised to identify thirteen patients; these patients were sent invitation letters, nine of whom agreed to participate in the study. Table 2 identifies the characteristics of the interview sample:

There is minimal ethnic variation within the practice population, only 0.4% of the practice population are from an ethnic minority; it was therefore unrealistic to identify and invite anyone from this minority group to participate in the research.

Research governance and the local research ethics committee approved this study; agreement was obtained from the GP Partnership to undertake this study in their practice. Informed consent and the right to withdraw are central tenets of all research; the potential research participants all received a detailed information sheet about the study and were asked to sign a consent form prior to the interview taking place.

Data collection

Semi-structured interviews were used with the interview topic guide identifying the broad general questions. Signed written consent was obtained from each participant prior to his or her interview. An interview topic guide, Box 2, was developed and agreed by the steering group and posed broad general questions in order to define what the participants considered important for their current care and future care provision. The interview was audiotaped and transcribed prior to the next interview being carried out, the interviews varied in length from 20 to 50 minutes. Eight of the nine interviews lasted between 40 and 50 minutes; interviewee 5 was the short interview, he was satisfied with his care and proved difficult to encourage to expand on service provision and design.

Data analysis

The interview transcripts were analysed using Ritchie and Spencer's 'Framework' method³⁷ (37). Framework is a qualitative analysis method which uses a thematic

Box 2. Interview topic guide

Guide to interview questions:

1. Can you tell me something about your depression experience
2. What was good about the care you received?
3. What was less good about the care you received?
4. What could have been done differently / better?
5. How do you think your depression could have been managed better in primary care?
6. What recommendations would you make for the future?

Introduce any suggestions from previous interviewees into the discussion

7. What are your thoughts on [suggestion]?

approach to classify and interpret qualitative research data using a series of thematic charts which each relate to a different thematic issue. Following repeated reading of all transcripts to gain familiarity with the broad themes covered, the data were summarised into the appropriate charts with the context retained and their location in the transcript noted, allowing us to return to the transcript to explore a point in more detail or to extract text for verbatim quotation. The charts allowed the full pattern of the participants' views to be reviewed. They also allowed the accounts of the different participants to be compared and contrasted, in order to identify both the dominant views and the alternative views.

Results

Key themes identified by the data analysis are shown in Box 3.

Lived experience of depression

The participants' personal experience of depression presented vivid images of the depths of despair depression can cause which challenged the categorization into the commonly accepted definitions

Table 2. Sample characteristics

Interviewee	Sex M/F	Age	Ethnic Origin	Children at Home If yes, age(s)
1	F	30	White, British	Yes, 3yrs, 5 yrs
2	F	29	White, British	Yes, 6 months
3	M	60	White, British	No
4	M	58	White, British	Yes, 29 years
5	M	42	White, British	Yes, 11yrs, 13 yrs
6	F	57	White, British	No
7	F	62	White, British	No
8	F	51	White, British	No
9	F	57	White, British	No

Box 3. Key themes

1. Lived experience of depression
2. Patient priorities for primary care management of depression
 - Access and continuity of care
 - Sharing care decisions
 - Medication
 - Information

of mild, moderate and severe depression. The accounts highlighted how, from the user perspective, the divide between what is mild and severe depression is arbitrary. The personal accounts also highlight themes of isolation and worthlessness experienced by people with depression, reinforcing the need to provide support in primary care.

"I was in a terrible state, I mean I would simply just break down and cry and you know feel absolutely useless and it's hard to describe really but you just – something inside of you which just starts to eat – to eat away." (Patient 3; male, 60yrs, no children).

"..... it's a funny situation 'cos you know exactly what's wrong with but you but nobody else can, knows it and those that haven't suffered with depression can't possibly know how you feel and how black everything can be. I mean it's either very very black going up to a light grey, it's never – I never sort of got a bright colour into me if you know what I mean." (Patient 7; female, 62yrs, no children).

"..... but increasingly I felt like I was dragging myself round through – wading, all I can say it was like wading through treacle and everything was very black. I, I couldn't look at anything and not see a negative. I'd be driving along some beautiful country lane and I wouldn't see the – I wouldn't see the, how lovely the trees and flowers were, I'd just see the litter." (Patient 8; female, 51yrs, no children).

The stigma associated with depression was an issue for the participants. Although no one felt stigmatised by their local health services, participants described how fear of stigma had been a factor in how they coped with their depression and treatment.

"...in the beginning I ahmm was very concerned about the [antidepressants] – even now, it wouldn't bother me people knowing now as much as it did before I started on the medication. I really didn't want anyone to know..... I kept it so well hidden that nobody knew." (Patient 1; female, 30yrs, children aged 3 and 5 yrs).

"...but there is a stigma, I mean you know there is, you always get asked these questions when you fill in these forms and everything else.....it made me feel a bit of a leper, you know." (Patient 3; male, 60yrs, no children).

".....she's [friend] feeling very depressed and I, I didn't mention it because, I think, because I, I think the image of people have of me is of someone who does cope very well so I don't want to dispel that....to admit I'm on antidepressants would be very hard." (Patient 8; female, 51yrs, no children).

Patient priorities for primary care management of depression

Quality in healthcare is a complex issue with the contrasting definitions dependent upon the interests of the various stakeholders³⁸. The participants described positive primary care encounters and had difficulty identifying negative aspects of care, they struggled to make recommendations for improvements to care. Structured follow-up, patient-centred care, shared decision-making, medication concerns, information, continuity and communication issues were all important to them.

Access and continuity of care

Ease of access to healthcare professionals was identified as a crucial dimension of care; all participants were satisfied with practice arrangements to contact healthcare professionals either by telephone or for an appointment. Rapport, familiarity and continuity of care with the same healthcare professional were important to all participants; they were highlighted as a key factor for one participant, who had previous experience as a provider of services in mental health, joining the practice.

".....and I think that's been part of the sad thing when you don't get to see your own doctor, and also in today's society people move around much more, you don't – doctors don't have that sort of family connection anymore.....down in Dorset they're now doing this horrible thing – it's that you will see 'a' doctor.....not your own..... I know it's a recipe for disaster because for some of my clients, doctors don't have time to read the notes and people that are on mental health drugs, psychotic drugs, and things like that, do need complimentary medicines to marry up and it can cause no end of trouble You do need a continuity of care and you do need to I suppose for a lot of people that are – that have been depressed for a period of time, is like you need that continuity of same face and same voice." (Patient 6; female, 57yrs, no children).

Sharing care decisions

Participants who gave examples of being involved in sharing decisions about ongoing care reported positive healthcare experiences, this contrasted with those who felt less involved.

“..... you know I was still really unsure as I didn't want to take them because I wanted to try and cope on my own and it was, well he[GP] said 'leave it, give me a call in a couple of days, see how you feel, let me know what is happening.' Ahmm, and I felt that I could do that, I felt that phoning him really wasn't a problem. I didn't feel like I'd be intruding on him at all or anything like that. I felt that he had lots of time for me, so then he couldn't speak to me at the time I called so he called me back and we had a long chat.” (Patient 2; female, 29yrs, child 6 months).

There were two occasions where participants either felt patronised by or pressurised within the GP consultation, which they resolved by seeing another GP for future consultations.

“It wasn't until I got outside that I actually thought you know how you re-talk things and you sort of think 'Wagghh, did he really say that to me?'.....I wasn't going to argue the point with him....” (Patient 6; female, 57yrs, no children).

One of the participants highlighted the importance of being involved in the decision about when the time is right to stop antidepressants, the comment from this participant identifies a conflict over who was managing the pace of treatment.

“I've not been back to see Dr [] because I don't want to come off it [medication] because I don't want to rock the boat.Yes, I should tell him [GP] really. I should really tell him, but it was with him saying 'Oh then we'll look at weaning you off them' and I thought it's too soon for me.” (Patient 9; female, 57yrs, no children).

Medication

Prompt commencement of medication after confirmation of the diagnosis of depression was highlighted as a feature of good care by the participants. An important finding in this study was the clearly expressed concerns, and reluctance in some cases, by the participants about coming off antidepressants. The majority of participants identified a paradox between being on antidepressant medication and coming off this medication because of a fear of returning to their previous state of depression.

“I'm terrified of going back to feeling how I did. I'm very worried. I'm very worried about being stuck on them for the rest of my life, but – I mean, not terrified, I, I'm not because I don't feel as they are they're having any affects other than positive ones. I, I don't know, but it is a worry to go back to feeling how I did.” (Patient 8; female, 51yrs, no children).

“You know, it frightens me to think of how I felt when I started taking the medication. I remember never ever wanting to feel like that again.” (Patient 1; female, 30yrs, children 3 and 5 yrs).

Information

Both verbal and written information was well received by all participants although a need for more information about the side effects of medication was highlighted. The patient information leaflets (PILs) on depression held within the clinical computer system were identified by participants as an authoritative source of information acknowledging the reality of their depression, improving their understanding of their diagnosis and what was happening as a result of their depression. It was important for them to be able to read that the symptoms they were experiencing were 'normal' in depression; the information helped to personalise their depression and make it less frightening and more easy to cope with.

“.....and he [GP] got me all the write up on it off the computer.....he gave me that and I took that home and he said you can read through it all and see how many of those points, ahmm you know, you've got..... [I] read through all that and it was right, lot of what was in there was happening to me sort of thing.” (Patient 5; male, 52yrs, children 11 and 13 yrs).

“.....because it [PIL] actually put a label to what I was feeling.....But to see it there in black and white and it had come from somebody who knows what they are talking about.....because you know you get in there and you think yeh you know what you're going to say but it never comes out right. But I had it there in black and white and I had, I'd highlighted all the bits and he actually took it and looked through and asked me about each bit I had highlighted which was a help because I meant I could sit down and go through everything with him.” (Patient 1; female, 30yrs, children 3 and 5 yrs).

The lack of information in the practice waiting areas was highlighted as a concern; participants considered public information displays reassure people they are not be wasting the GP's time and also provide an opportunity to stress depression is a 'legitimate' medical problem.

“.....and I suppose the one thing I notice when I've been here and I've looked for because it's been my work – there isn't any information about mental illness here. There is for drugs, alcohol, asthma, but not really about mental health.it gives them ideas of where to go or who to talk to without maybe feeling that they're going to dread being told pull yourself together.” (Patient 6; female, 57yrs, no children).

Discussion

Summary of main findings

This study has identified key themes important to service users in the design of primary care services for patients with depression. Service users do identify aspects important to them which may differ from what is considered high quality care by service providers³⁹. This study found a close similarity between the themes and dimensions of care which the literature defines as necessary for a quality service^{11,38,40,41}. It did identify several small but significant areas for improvement in the local service, despite this being perceived overall as already high quality and accessible.

The design of primary care services for patients with mild to moderate depression needs to take into account the following aspects of the patient experience:

- Perceived stigma persists as a significant obstacle to improving the quality of life in patients with mental illness. Individuals who are concerned about stigma tend to have greater unmet mental healthcare needs^{42,43}; the fear of stigma delays these patients presenting with their symptoms and acknowledging their illness within their personal social worlds.
- The use of patient information within the clinical consultation helps to clarify the symptoms of depression and provides information about the role of antidepressant medication in the management of depression. Masand²⁵, in his systematic review on antidepressant nonadherence, found that information and education about onset of action of antidepressants, side effects, and the expected duration of therapy greatly enhances adherence. Similarly, a randomised control trial (RCT) in the USA in the late 1990s found the use of educational materials played a part in improving depression treatment outcomes in primary care⁴⁴. The use of information within the consultation and in waiting room areas has the effect of validating and normalizing the experience of depression, reifying it into a disease process.
- The profound distress of patients' experience of depression even when classified as mild to moderate is important. The participants' descriptions of their depression suggest the difference between patients with mild to moderate depression and severe depression may be the intractability of symptoms and enduring nature of the depressive illness. This raises significant questions as to how healthcare professionals define depression, are definitions only confirmed in retrospect? Is it that patients with mild to moderate depression may recover their well-being in the short-term whereas the patient with a severe depression has an enduring illness. The clinical categories of depression (mild, moderate, severe) are not congruent with the lived experience of depression and therefore clinicians should be cautious about attributing any objectivity to the standard diagnostic criteria.

- Empathy with the healthcare professional and continuity of care are key elements of importance to this group of patients who, because of their illness, lack motivation and are less proactive in seeking out quality care. Patients seek positive healthcare experiences and may avoid negative experiences by seeing another healthcare professional or withdrawing from care altogether. The Picker Institute⁴⁵ found that if patients feel they are not sufficiently included in decision-making then this is a barrier to patients achieving their priorities for their care. Brooks¹ reports on studies which show shared decision-making results in better health outcomes, particularly in the management of chronic disease, as the patient is no longer a passive recipient of care.
- The anticipation of stopping antidepressants caused considerable anxiety for the patients in this study. Despite a thorough search of the literature no studies have been found which focus primarily on patient concerns or experiences when the time comes to stop their medication; the study by Garfield et al.⁴⁶ focuses on patients' experiences of taking antidepressants and identified that some patients may have concerns about the return of symptoms when stopping antidepressants; similarly the study by Grime and Pollock⁴⁷ compared lay experience of antidepressant treatment with an information leaflet, and reported that some patients worry about symptoms returning on stopping antidepressants. Neither of these papers attempted to discuss or identify strategies to deal with this worry. Drug and Therapeutics Bulletin⁴⁸ advice to doctors on withdrawing antidepressant medication considers problems of relapse or recurrence of depression and discontinuation syndromes, but no reference is made to actual or potential psychological concerns patients may harbour about stopping antidepressants. A pilot study using questionnaires and interviews by Brown et al.⁴⁹ looked at reasons for non-adherence but did not identify concerns at stopping or issues around the benefits of medication. The patient experience of stopping antidepressant medication is a neglected area in current primary care research.

Strengths and limitations of the study

This was a small exploratory study seeking views from those involved in a service in order to redesign the depression service.

The interviews were carried out by PL who works as a Nurse Practitioner in the practice where the study was conducted. No patient known to PL was interviewed to prevent problems arising from the dependent relationship but the participants were aware that PL worked in the practice. Participants struggled to identify negative aspects of care, this may have been due to the fact that they were being interviewed by a healthcare professional from the practice, or indeed that they did not have any negative aspects

of care to highlight. However, we would argue that undertaking this research in the place of employment provided increased understanding as it provided a rich contextual understanding of how care and treatment of patients with depression was approached; this provided a potential to implement quality changes that would not be available if the study had been undertaken in an unfamiliar practice.

The timescale of this research project limited the sample size to nine interviews and although very little new data emerged from the later interviews it is not possible to be confident that data saturation was reached. The participants confirmed they were adherent with their medication, generally those patients involved with a service are likely to reinforce the positives. It is the views of service users who have dropped out of the system, by fault or by default, which need to be included to inform new service development. It is acknowledged that this group were not included in this study.

Despite the small sample size the study does reveal new insights into the experience and concerns of a small group of patients which merit further investigation and consideration. We argue the findings have resonance and are legitimate and that patients' views can contribute to the design and redesign of services in primary care in order to improve the quality of the service being provided.

Comparison with existing literature

Box 4. What is already known about user involvement in quality improvement

- Initiatives involving service users are important for improving service quality in the NHS²
- The views of providers about the quality of healthcare differs from the views of the service user⁹⁻¹¹
- Service user views often result in imaginative quality interventions to improve the quality of the service²
- User involvement in research helps researchers identify priorities for research and is more likely to produce results that can be implemented and disseminated⁵⁰
- There is minimal research involving patients with mild to moderate depression which aims to improve the quality of depression management in primary care¹⁶

Box 5. What this study adds

- Patients with mild to moderate depression want the same dimensions of quality care that all other patients want
- Structured care is important in the management of depression
- Written information about depression is very useful
- Written information about the side effects of antidepressant medication helps adherence to treatment
- Patients experience feelings of fear and anxiety when the time comes to stop antidepressant medication

Implications for future research and clinical practice

This study has identified a number of issues which can inform practice and which raise questions for further research:

- The impact of stigma on how patients seek or delay access to health services for depression.
- A need to better understand and consider patients concerns and anxieties about stopping medication
- Provision of written information to patients early on in the diagnosis of depression.
- The benefit of information displays in surgery waiting areas helps to normalize depression as an illness.
- Better use of patient information leaflets by increasing awareness amongst all healthcare professionals of the availability of this information on every practice computer.

Conclusion

The literature indicates the management of mild to moderate depression in primary care can be improved; this study aimed to explore with service users their views and experiences to inform the direction of changes in the current management of depression in primary care. Most research on the management of depression in primary care has focused on supporting patients as they commence treatment and the issues of adherence to medication. The findings from this small study indicate there is a need to also understand more about the experience and consequences for this patient group of ceasing to use medication.

Details of ethics approval

Research governance approval was obtained from the East Norfolk & Waveney Research Governance Committee, 2003CM14 (153-12-2003); ethics approval was granted by Norwich Local Research Ethics Committee, REC Ref: 2003/110. Written consent was obtained from all participants prior to their involvement in the study.

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Declaration of interest: All authors declare that they have no competing interest and therefore have nothing to declare.

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