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RE-ORDER: RE-ORGANISING THE CARE OF **DE**PRESSION AND **R**ELATED DISORDERS IN THE AUSTRALIAN PRIMARY HEALTH CARE SETTING

Submitted by the re-order research team,
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EXECUTIVE SUMMARY

Depression is the single largest cause of disability burden in Australia. GPs provide a great deal of first contact and management for depression in a setting that, to date, has been neither well designed nor adequately resourced for effective depression care. There have been criticisms of inadequate recognition and management of this condition by GPs yet current guidelines are mainly derived from data collected in secondary or tertiary care and available evidence is from health care systems different from Australia (mainly the U.S.). U.S. evidence supports a chronic illness management model that is expensive to implement and has yet to become routine in the settings in which it was developed. The **re-order** study aimed to gather information to design a new model for improving depression care suited to the Australian primary health care setting. Over three phases (2005-2008), during a time of major reform, in the primary mental health care system, the project conducted extensive consultations with patient and non-patient stakeholders about their views on exemplary depression care and worked directly with six general practices to document how depression care occurs in the Australian setting. The practice phase sought to identify areas for improvement and develop ground-up, practice-driven interventions and principles for an exemplary model of depression care for Australia

SUMMARY OF PHASE 1 – THE PATIENT VOICE

576 primary care patients, who had experience of depressive symptoms, participated in a Computer Assisted Telephone Interview to document their views about depression and how it should be managed in general practice. Participants presented multifaceted aetiological accounts of their experience of depression and their narratives suggest that 'depression' is a troublesome concept for them. They conceptualised depression as either the individual's response to external events, or as psychological in nature; very few mentioned biomedical narratives. Participants gave accounts of a variety of methods of help-seeking such as seeking information via the media and internet; helping themselves and seeking support of friends and family. A clear majority of participants believed that it was possible to recover from depression. Yet, a concerning finding was that stigma about depression remained a significant issue that impacted on help-seeking. Approximately one quarter of participants were not happy to complete a screening survey in the general practice waiting room. Health professionals were seen as playing an important part in participants' management of their depression, with GPs playing a particularly central role. Participants highly valued their GP listening and empathising with them, missed it when it did not take place and saw it as a critical element of optimal care. In their view the most important things GPs can do for people experiencing depression, stress or worries are to listen to them, followed by demonstrating competence in diagnosing and managing mental health conditions and appropriate referral (timely and agreed to professional). Participants welcomed the idea of written plans, though few had one written for themselves. Participants also reported being interested in using other kinds of professional help within the general practice setting (e.g. psychologists, practice nurses) in addition to their GP.

SUMMARY OF PHASE 2 – THE VOICE OF THE COMMUNITY AND EXPERT STAKEHOLDERS

Over 300 non-patient stakeholders from a wide variety of backgrounds (community, all levels of government, non-government organisations, academia, health practitioners) were involved in a two stage modified Delphi process to develop a consensus view on how general practice should respond to people experiencing depression. Table 1 lists the ten most important things the stakeholders believed general practice could do for people experiencing depression.

TABLE 1: Ten most important things general practice can do for people experiencing depression

Listening
Undertaking a thorough diagnostic assessment
Developing a plan with the patient
Undertaking an assessment of severity and suicide risk
Being well trained in depression care
Tailoring care to individual needs
Taking into account social factors
Being empathetic
Providing longer consultations
Offering a range of treatment options

In line with the finding from the patient consultation phase, non-patient stakeholders also nominated 'listening' as the most important response that a GP could demonstrate when providing depression care. The results of Phase one and two formed a key element in the third and final stage of **re-order** – the practice phase.

SUMMARY OF PHASE 3 – THE VOICE OF PRIMARY CARE PROVIDERS

Using a participatory action research approach **re-order** worked with six general practices from Victoria and Tasmania, over one year, to map and develop processes to develop the principles for exemplary depression care. We observed that depression care is a routine and common part of everyday work in general practice and remains largely the work of GPs. Though the Better Access program provides the opportunity for social work support, this is rarely accessed by GPs. Communication between GPs and psychologists is an important concern. GPs and other practice staff presented detailed and highly sophisticated accounts of how they encountered and responded to depressive symptoms in their everyday practice. Most reported that depression care is challenging, due to the diffuse nature of the symptoms, the magnitude of the problem and the way that it represents a complex intertwining of physical, emotional and social issues. These factors, combined with the sorting process that is required to deal with multiple symptoms and problems which tend to change over time and the limited responses available; explain why depression care is seen as challenging. **re-order** identified that participation in the project was the first time that any practice had met as a group to discuss how they undertook depression care. The current system of depression care is highly individualised. Each GP has developed their individual style and is responding to each case of depression in a highly individualised way. Whilst we observed that this individualised care can have many positives for a particular person, it could also be seen as ad hoc and unsystematic. No practice had a practice population level approach to depression care. Monitoring the quantity and quality of depression care occurred at the level of the individual practitioner, mostly in an undocumented and unsystematic way. The areas that practices selected to work upon during the **re-order** project varied between practices yet covered the main aspects of depression care (recognition, clinical records, treatment and audit).

THE PRINCIPLES FOR AN EXEMPLARY MODEL OF DEPRESSION CARE

DEVELOPING COHERENCE

Principle 1: Depression work requires conceptualisation of boundaries (who is depressed/who is not depressed?) and techniques for dealing with diffuseness.

May's NPT proposes that for a 'work practice' to become routine in everyday clinical practice it requires a shared understanding as to what the work is and the meaning of that work. Hence, in an 'exemplary practice' there will be agreement on a diagnostic framework for sorting 'distress' from 'depression' (that recognises depression when accompanied by distress) and agreement on what constitutes depression care. There will be clear articulation of the variety of techniques used to deal with the range and severity of depressive symptoms and the accompanying life and health problems.

ACHIEVING COGNITIVE PARTICIPATION

Principle 2: Depression work requires engagement with a shared set of techniques that deal with depression as a health problem.

Reaching a shared understanding about *what* constitutes depression work is an important step but unless the practitioners and practice staff agree that it is *important* work to be *done,* it will not occur. NPT suggests that for depression work to be undertaken in the general practice setting it must be initiated and sustained in a way that deals with the various interests, alliances, values and opinions amongst staff and in way that is not at odds with the practice culture.

Thus, in an exemplary practice there will be engagement in a shared set of techniques for dealing with depression as a health problem (which is often meshed with complex life and other health problems) and agreement about when to diagnose depression and agreement about what to do for depression.

ENABLING COLLECTIVE ACTION

Principle 3: Depression work requires agreement about how care is to be organised, who is required to deliver care, and their structural and human interactions.

Whilst a practice may agree upon what constitutes depression work and the techniques they will use to do depression work, they also require agreement about how depression care will be organised and who will do what for a particular purpose. This principle is based upon the NPT concept of collective action, which is defined as purposive action aimed at a clear goal and is influenced by both exogenous or external factors and endogenous or internal factors. Collective action can be seen as a combination of skill-set workability (how work is allocated and performed), interactional workability (how well work fits into current practice), relational integration (accountability and confidence within care network) and contextual integration (structures and procedures that facilitate the work).

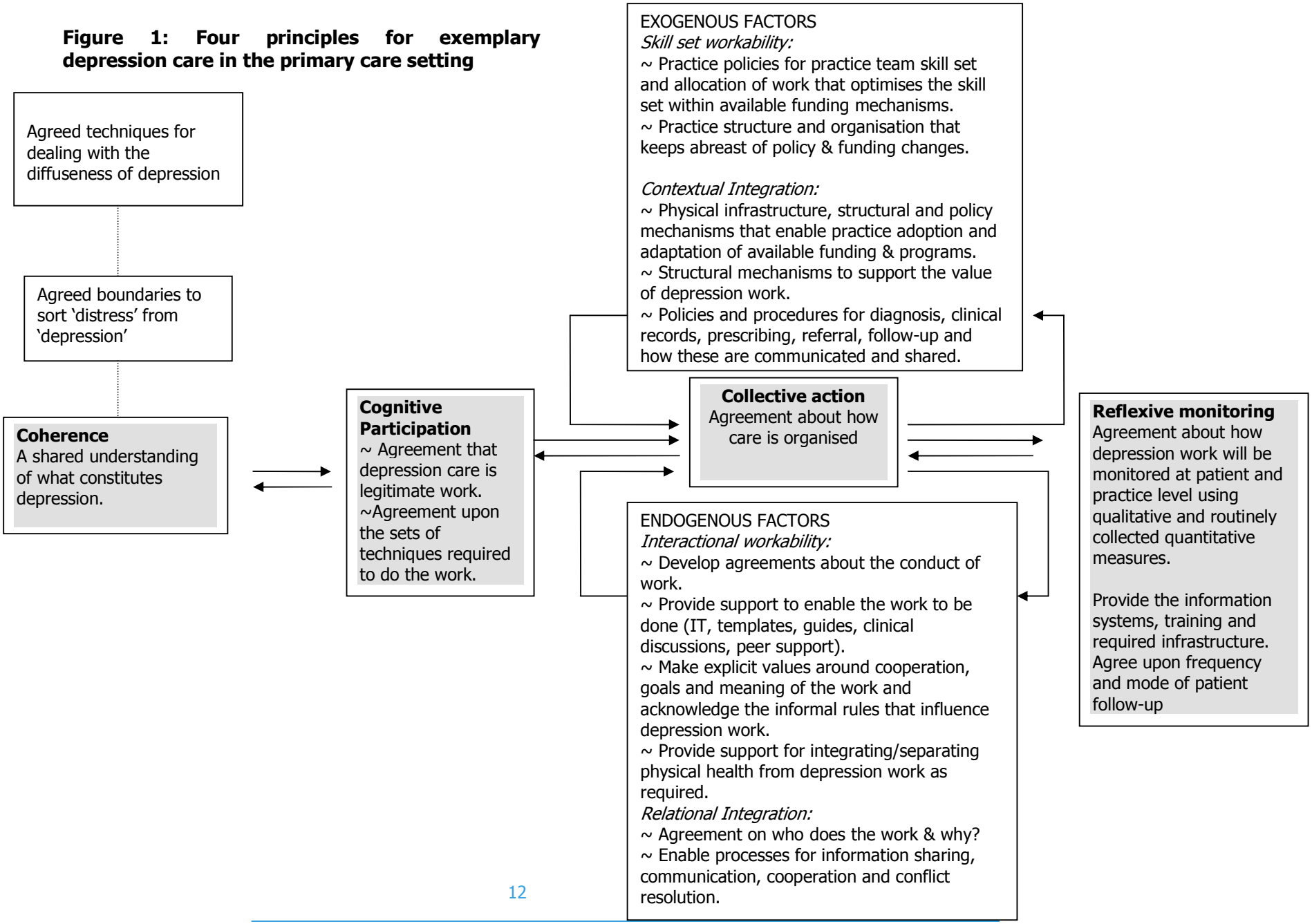
Hence, in an exemplary practice there will be acknowledgement of the complexity of care and the partnerships needed and well-developed policies and procedures about diagnosing, recording, prescribing, referring, following-up and how this is communicated and shared. There will be agreement about the skills of the team needed for depression care and how the work is allocated. There will be visible processes for information sharing, communication, cooperation and conflict resolution for depression care.

IMPLEMENTING REFLEXIVE MONITORING

Principle 4: Depression work requires the ongoing assessment of how depression care is done.

For any activity to become a routine part of clinical work those undertaking it need to be convinced that the work are they doing is worth the effort. They also need to be in a position whereby they have the flexibility and ability to change things based on formal and informal monitoring systems. Hence in an exemplary model of depression care there will be ongoing assessment of how depression care is done that uses quantitative and qualitative measures. Figure 1 on the following page provides an overview of the four principles for exemplary depression care as guided by May's Normalisation Process Theory (NPT). These are discussed in sequence, yet they operate concurrently in practice.

Figure 1: Four principles for exemplary depression care in the primary care setting



IMPLICATIONS FOR POLICY AND PRACTICE

The **re-order** project findings have relevance to the development of mental health and primary care policy now and in the future including implications for the National Primary Health Care strategy, the Health & Hospital Reform Commission, the Victorian government's mental health strategy, and future Medicare reforms. **re-order** data confirms that patients rely heavily upon GPs for their mental health care and they value this. People experiencing symptoms of depression and their families need to be involved in policy and planning. The findings presented in this report are extremely relevant for the design of the primary care mental health system and its workforce requirements. Development of models for practice of depression care should take account of the four **re-order** principles and develop structured yet flexible approaches to depression care that maintain a patient-centred relationship that is relevant to the local context. The implications for policy and practice are:

1. *Funding for infrastructure change and organisational capacity building.* General Practice requires physical and technological infrastructure funding and paid planning time to support required practice level changes. Physical meeting spaces and adequate time to discuss depression care is critical. Funding mechanisms need to be developed to support change.

2. *Facilitating sustainable inter-professional networks and communication.* Primary care providers are best suited to be coordinators of care. Communication pathways need to be established between the relevant professional groups. Depression care cannot be viewed in isolation from physical health and social context. The central and valued place of general practice needs to be accounted for.

3. *Development of methods to monitor quality and quantity of depression care.* Minimal standards for information systems used in general practices and for the routine collection of relevant clinical data need to be formulated. Patient experiences must be incorporated into this monitoring. These methods should be structured, yet flexible, and able to adapt to changing contexts.

4. *Mental health specific training for practice nurses.* If practice nurses are to deliver depression care, they will require appropriate training and support at the practice level. Funding mechanisms need to be developed to support this change.

5. *Development of models of practice for depression care in primary care.* Models of practice and the professionals required to deliver this should take into account the range of severity of depressive symptoms, other conditions and life circumstances of individuals. Funding is required to develop an evidence base generated from the Australian primary care setting to inform models of practice.

CHAPTER ONE: INTRODUCTION

1.1 DEPRESSION CARE IN THE AUSTRALIAN PRIMARY HEALTH CARE SETTING – POLICY AND PRACTICE CONTEXT

Depression is the single largest cause of disability burden in Australia (Mathers, Vos & Stevenson 2000) and is mainly managed in general practice by general practitioners (GPs) (Parslow & Jorm 2000; Henderson, Andrews & Hall 2000; AIHW 2002). This common disorder affects 750,000 Australians each year and is associated with significant morbidity and mortality (Murray & Lopez 1996; Mathers, Vos & Stevenson 2000; Vos et al, 2001; AIHW 2002). Current guidelines for management of depression are mainly based upon data collected in the secondary and tertiary sectors and while there is some emerging evidence from primary care, it is largely from health care systems that are different to Australia (Gunn et al, 2006).

Depression care is also an area of debate. Though there is agreement on the symptoms traditionally associated with the condition of depression, in recent years, debate has emerged around what these symptom clusters mean, whether they constitute a 'disorder' or illness and what should be done about them (Dowrick 2004; Callahan & Berrios 2005; Horwitz & Wakefield 2007). There is continuing debate about the effectiveness of treatments for depression. Evidence from systematic reviews demonstrates the effectiveness of both pharmacological and psychological interventions when tested in efficacy trials in well-controlled settings (Williams et al, 2000; Proudfoot et al, 2003; MacGillvray et al, 2003), yet these benefits have not proved easy to translate into routine primary care (Gunn et al, 2006). In contrast to this there is emerging evidence that the efficacy demonstrated in systematic reviews for pharmacological interventions may not necessarily be found when all data from drug trials is taken into account (Kirsch et al, 2008). This debate has entered the lay media, as demonstrated by the global media coverage that Kirsch et al's article on antidepressant and placebo effects attracted when published in 2008.

General practice has been criticised for recognising and managing depression inadequately and since the early 1990s there has been an increasing push for primary care to implement chronic illness management and collaborative care models in order to manage depression better (Dawson et al, 2004; Katon & Schulberg 1992; Lewis et al, 2003; Locock et al, 2003; Proudfoot et al, 2003; Von Korff & Goldberg 2001). A number of randomised control trials (RCTs) testing these complex interventions for depression management have now been completed and published and systematic reviews are emerging (Badangara et al, 2003; Ballanger 1999; Blij et al, 2004; Gilbody et al, 2006; Gilbody et al, 2003; MacGillvray et al, 2003; Williams et al, 2000; Simon et al, 2004; Simon et al, 2000). None of these trials have been undertaken in Australia. Indeed ten of the eleven large randomised trials of systems of collaborative care have been undertaken in the USA (Gunn 2006; Gunn et al, 2006). Despite the vast differences in the organisation in health care systems between countries there has been increasing interest across the western world in the 'collaborative' care model developed in the USA. This model of care consists of the core components (Gunn et al, 2006) of:

1. A multi-professional approach to patient care. A general practitioner or family physician and at least one other health professional (e.g. nurses, psychologists, psychiatrists, pharmacists) involved with patient care.
2. Enhanced inter-professional communication using mechanisms to facilitate communication between professionals caring for the depressed person. This includes elements such as team meetings, case-conferences, individual consultation/supervision, shared medical records, and patient-specific written or verbal feedback between care-givers.

3. Scheduled patient follow-ups. A pre-determined and organised approach to patient follow-up by telephone or in-person. Follow-up appointments aim to provide specific interventions, facilitate treatment adherence, or monitor symptoms or adverse effects.
4. A structured management plan. This is most commonly in the form of guidelines and protocols. Interventions include both pharmacological (e.g. antidepressant medication) and non-pharmacological interventions (e.g. patient screening, patient and provider education, counselling, CBT).

Whilst the components of this model of care are appealing to current policy-makers and clinicians this model of care has not become routine within the centres it has been tested in, or beyond (Nutting et al, 2007). There is currently a large randomised trial of a form of this model of care underway in the UK (Lovell et al, 2008) and we await the results eagerly, as the UK general practice setting is more relevant to the Australian setting than the USA.

Achieving exemplary depression care is a challenge and a great concern for primary care. The incidence of mental health problems is growing in primary care populations along with co-morbidity and multi-morbidities (WHO 2008; WHO 2001). In 2005, the **re-order** team set out to develop a body of research that could inform the development of a model of depression care suited to the Australian health care setting and one that could be tested using a randomised trial design. Mindful of the complex policy environment that would form the backdrop to such a model, we began by mapping the vast number of organisations, policies, laws, programs, services and reports shaping – or seeking to shape – what actually occurs in the consulting room (see Appendix 1) (Lewis, Baeza & Alexander 2008).

1.1.1 INTERNATIONAL CONTEXT

Since the 1990 Global Burden of Disease Study (sponsored by the World Health Organisation (WHO) and the World Bank and updated in 2002) and its widely promulgated projection that depression will become the second leading cause of disease burden by 2020, depression and mental health care have become a critical focus of health policy globally (Murray & Lopez 1996; WHO 2001). The WHO has made a number of important intellectual contributions to the policy debate surrounding primary health and mental health care in the last several decades. It has developed one of the two main diagnostic guidelines in use around the world, the International Classification of Diseases, now in its tenth revision (ICD-10)[1], and has also played a critical role in shaping the global health policy agenda through its annual World Health Reports (WHR). The profile of mental health was lifted internationally with the publication of the 2001 WHR (*Mental Health – New Understanding, New Hope*). This was followed by the Mental Health Atlas which in 2001, and again in 2005, mapped mental health resources in the 192 member states of the WHO, revealing them to be grossly inadequate as compared with the disease burden. Being the subject of the 2008 WHR (*Primary Health Care – Now More Than Ever*), primary care is set to experience a similar increase in attention and interest. The report is a call for renewed interest in primary health care, in view of uneven progress in health outcomes globally, changing health challenges (including the increasing burdens of chronic disease and multi-morbidity), and a drift away from PHC values in health system design in the 30 years since the Declaration of Alma-Ata (WHO 2008).

While primary health care is mentioned in the 2001 WHR, there is little focus on mental health (or any other specific disease or condition) in the 2008 WHR. WHO thinking on the nexus

[1] The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is the second widely used diagnostic guideline.

between these two areas of the health system is contained in the *Integration of Mental Health Into Primary Care*, published in 2008 in collaboration with WONCA. This report defines primary care for mental health as 'mental health services that are integrated into general health care at a primary care level' (WHO and WONCA, 2008) and argues that the vision for primary care for mental health as articulated at Alma-Ata in 1978 has not been realised (along with the broader primary health care vision). The first part of the report describes how integrated primary care for mental health works as part of the broader social and health system, and outlines seven reasons it is important. In the latter part of the report, ten principles to guide the integration of mental health into primary care are provided (see Appendix 2), as well as a series of country case studies.

1.1.2 DOMESTIC CONTEXT – NATIONAL

Over the last two decades, mental health service provision in Australia has undergone extensive reform[2]. In contrast, changes to the delivery of primary health care have been incremental, though this may soon change with the current federal government's focus on primary care as a vehicle for proposed reforms to the broader health system and the scheduled 2009 release of the first national primary health care strategy (Commonwealth of Australia 2008a). Traditionally, **mental health** policy and service delivery reform has largely focused on specialist mental health services (hospital and community-based), particularly with the acceleration of de-institutionalisation and the establishment of community-based services under the 1992 National Mental Health Policy (Whiteford and Buckingham 2005). The primary health care setting has assumed increasing importance in relation to mental health in the 2000s since the 1997 National Survey of Mental Health and Wellbeing identified that two thirds of people who were seeking treatment for a mental health problem relied solely on their GPs (Andrews et al, 1999)[3] and the Bettering the Evaluation and Care of Health (BEACH) study revealed that one in ten GP visits are for a mental health problem (AIHW 2008b). These findings have led to the implementation of new funding and training initiatives to increase GPs' skills in diagnosing and managing mental health problems and to improve primary health care patients' access to specialist or allied mental health professionals – the Better Outcomes in Mental Health Care program introduced in 2001 and Better Access to Psychiatrists, Psychologists and GPs through the MBS introduced in 2006 (Box 1).

In relation to pharmacological treatment for depression, medical practitioners in Australia in 2007-08 provided 11.6 million prescriptions for antidepressant medications subsidised under the Pharmaceutical Benefits Scheme (PBS) or Repatriation Pharmaceutical Benefits Scheme (RPBS) (Medicare Australia 2008). Data is not yet available for total scripts in 2007-08 but in the previous year this figure was 168.5 million (Commonwealth of Australia 2007). In 2006-07, GPs prescribed 85% of PBS-RPBS-subsidised anti-depressant scripts (10.6 million of a total of 12 million) (AIHW 2008b). Mant et al, (2004) reported a substantial increase in antidepressant prescribing in the 1990s following the introduction of SSRIs, though this rate of increase has since reached a plateau. In the twelve months to June 2007, eight antidepressant drugs were included in the list of top 100 highest volumes of PBS drugs dispensed, with two of these ranked in the top twenty (Commonwealth of Australia 2007).

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[2] The Australian Government's Mental Health and Wellbeing website contains a comprehensive list of all current national mental health programs and initiatives, policies, and publications: http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/home-1

[3] The 2007 National Survey of Mental Health and Wellbeing did not include this question, however did find that of all people with a 12-month mental disorder, only 34.9% had accessed any services in the previous 12 months. However, of these the most commonly accessed 'service' was a GP with 24. 7% reporting seeing a GP in the previous 12 months.

BOX 1: Better Outcomes in and Better Access to Mental Health Care Programs

In July 2001 the Australian Government introduced the Better Outcomes in Mental Health Care (Better Outcomes) program in an effort to improve access to quality mental health care. The program was funded for an initial four years and then extended for a further four years until June 2009, with total funding amounting to $263.1 million (APS 2007). Before the advent of Better Access, Better Outcomes comprised five components:

~ Education and training for GPs;
~ The GP Mental Health Care Plan (formerly the 3-step process);
~ Focussed psychological strategies (FPS);
~ Access to Allied Psychological Services (ATAPS – delivered through Divisions of General Practice); and
~ Access to Psychiatrist Support (including the national advisory service GP Psych Support).

Various Medicare Benefits Schedule (MBS) item numbers accompanied the five components to allow GPs to bill for their time in providing these services. Evidence suggests that the education and training for GPs component*, ATAPS and GP Psych Support were the most successful aspects of the program in terms of uptake (Thomas, Jasper and Rawlin 2006). While ATAPS is the only component that has been analysed for its impact on patient outcomes, this has been positive (Morley et al, 2007).

Since the introduction of the Better Access initiative in November 2006 ($538 million over five years), as part of the Council of Australian Governments (COAG) mental health reform package, Better Outcomes has continued but in a revised format. Better Outcomes now comprises three components – FPS, ATAPS and GP Psych Support. Better Access consists of some 28 new MBS numbers, for the first time making Medicare rebates available for services provided by allied health professionals (though patients must be referred by GPs), and removes the role of Divisions under Better Outcomes in brokering general practice access to allied health. Three MBS item numbers (2710, 2712 and 2713) allow GPs to bill for mental health care consultations, replacing the GP Mental Health Care Plan component of Better Outcomes. A further five item numbers (291, 293, 296, 297 and 299) cover consultant psychiatrists' services, continuing the Access to Psychiatrist Support component. As well, $54 million has been allocated for education and professional development for all professional groups involved in the program (GPs, psychiatrists, psychologists, occupational therapists and social workers), taking the place of Better Outcomes' Education and Training component.

Early evidence from the first year of Better Access indicated there was substantial uptake of five of the 28 new MBS items under Better Access – 2710 (GP Mental Health Care Plan), 2713 (GP Mental Health Care Consultation), 80010 (Psychological Therapy Long Consultation by a clinical psychologist), 80110 (FPS Long Consultation by a registered psychologist) and 296 (Initial consultation with a new patient by a consultant psychiatrist) – accounting for 90% of all services claimed (Commonwealth of Australia 2008a). Psychiatrists, psychologists and GPs provided 98% of all services. In the first 14 months of the program over 1.5 million psychological therapy services were provided and over 10,000 psychologists registered in the program, evidence according to Littlefield and Giese (2008) of 'clear and unabating demand for accessible treatment services delivered by psychologists'.

Over roughly the same period, there was a 'small but noticeable' fall (Fletcher et al 2008) across all indicators for ATAPS under Better Outcomes – the number of referrals to and services provided by allied health professionals, and the number of GPs and allied health professionals providing ATAPS services – reflecting the impact of the introduction of Better Access. Nonetheless, the latest evaluation of ATAPS predicts that these declines will plateau, and that the two programs will complement rather than compete with one another (Fletcher et al 2008), given the slightly different services that each makes available.

*There were four kinds of training available under Better Outcomes – familiarisation training (2 hours); Level 1 (6+ hours); Level 2 (20+ hours); and Mental health continuing professional development. By the end of 2005, around 20% of GPs had completed Level 1 training and 4% Level 2 (enabling them to personally deliver FPS) (Thomas, Jasper and Rawlin 2006). Initially, completing the training to at least Level 1 was a prerequisite for participating in Better Outcomes. This is no longer the case, however GPs wishing to deliver FPS must have completed Level 2 training (Fletcher et al, 2008).

More recently, there has been renewed interest in the national mental health reform process with the issue being taken up by the Council of Australian Governments (COAG) in 2006 and the establishment of new National Advisory Council on Mental Health (NACMH) in June 2008 to maintain focus on the reform agenda[4]. The NACMH is still in its infancy but three inquiries into the mental health system in 2005 and 2006[5] and a widespread sense that the reform agenda was flagging, with serious consequences for population mental health, provided the impetus for the COAG National Action Plan on Mental Health 2006-2011 (COAG 2006). The NAP aims to mobilize all levels of government to: (1) invest more in promotion, prevention and early intervention; (2) integrate and improve the care system across different levels of government, and between the government, private and NGO sectors; (3) increase community and employment participation by people with mental health problems; (4) increase workforce capacity; and (5) coordinate care (Australian Health Ministers 2008). Progress will be reported on annually.

Primary health care has been a focus of the new Federal Labor Government with the GP Super Clinics initiative[6]. Over five years from 2007-08 $275 million will be spent establishing 31 super clinics nation-wide. These will provide multidisciplinary primary health care that is accessible, affordable, culturally appropriate and has a focus on prevention. However, early reports indicate that that the uptake of this initiative has been slower than expected with only two sites of the expected first six signing up as of September 2008 (Commonwealth of Australia 2008c). Of greater potential significance for the way depression care is delivered in the primary health care setting is the formation of the National Health and Hospitals Reform Commission (NHHRC), which has the formidable mandate of reviewing the entire Australian health system and recommending both short and long-term reforms. In its first report (NHHRC 2008), the Commission identified 12 health and health care challenges that the system, as currently configured, is struggling to address.

Of particular relevance to the questions asked in the **re-order** project are the challenges put forward by the NHHRC around *redesigning care for those with chronic and complex conditions* and *recognizing the health needs of the whole person*. The report argues that mental health is a prime example of how Medicare with its emphasis on 'access to doctors and hospitals for once-off acute episodes' is unable to respond adequately to changed illness patterns and new, multidisciplinary, multi-setting approaches to care and treatment. The NHHRC is due to report its reform proposals by June 2009.

Non-government organisations or programs with a national presence in relation to depression management in primary health care include *beyondblue*: the National Depression Initiative, established in 2000 and funded for a second five-year period in 2005 to raise awareness of and de-stigmatize depression and related disorders. Evidence indicates that *beyondblue* has been effective in raising mental health literacy among Australians (Jorm, Christensen & Griffiths 2005; Morgan & Jorm 2007). Other important NGOs are the Mental Health Council of Australia, established in 1997 and the peak advocacy group representing the mental health sector; and the Primary Mental Health Care Network of the Australian General Practice Network (AGPN) which harnesses the Divisions of General Practice Network to implement programs such as Better Access and Better Outcomes. Professional bodies (the Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Psychiatrists, Australian Medical Association, Australian Psychological Society, Australian College of Mental Health Nurses, and

[4] http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/National+Advisory+Council+on+Mental+Health

[5] Inquiry into the Circumstances of the Detention of Cornelia Rau (2005); Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia (2005); Senate Select Committee on Mental Health – A national approach to mental health: from crisis to community (2006)

[6] http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics

the recently formed Mental Health Professionals Association and its associated organisation the Mental Health Professionals Network which is responsible for delivery of part of the *Better Access* training) have tended to focus on their traditional roles of training (including on government initiatives related to mental health and / or primary care, accreditation and continuing education for members) and standards. They have also engaged in some advocacy around these issues but have not played a major role in shaping broader policy or health system questions. Activities within each state and territory further complicate the national landscape – those relevant to Victoria (the main setting for the **re-order** study) are described next.

1.1.3 DOMESTIC CONTEXT – STATE AND LOCAL

Influential statewide or government organisations in Victoria include the Department of Human Services (DHS), VicHealth, and General Practice Divisions Victoria (GPV). DHS roles of particular relevance are delivery of specialist services (both hospital and community-based), funding of Primary Mental Health and Early Intervention (PMHEI) teams, and of community health centres. Specialist mental health services focus mainly on the three per cent of the population with a severe mental illness, as opposed to the 12 per cent with a more common mental health problem such as anxiety or depression (Victorian Government Department of Human Services 2008b). Primary health care providers are important for this latter group, as well as for users of specialist services – for early identification (Victorian Government Department of Human Services 2008a) and for assistance when they are not in hospital. Although the state government has limited influence on privately-provided primary health care (this being Commonwealth-funded), Victoria's third mental health policy, to be released in 2009, will likely build on earlier initiatives attempting to integrate primary health care with the specialist mental health system such as the PMHEI teams and support an expanded role for primary health providers as a 'gateway' to specialist services (Victorian Government Department of Human Services 2008b).

The Primary Care Partnerships (PCP) Strategy introduced in 2000 is another state government initiative worth noting. Using a partnership approach, the strategy aims to improve coordination within the primary health care sector in Victoria (Victorian Government Department of Human Services 2005; Lewis, Baeza and Alexander 2008) in order to improve individual health outcomes and reduce demand for hospital services. Establishment funds were provided to 31 PCPs[7] (they now receive recurrent funding) to facilitate links and service coordination between five core services – community health centres, local government, divisions of general practice, district nursing services, and aged care assessment services (and up to two other services per PCP, for example agencies supporting Culturally and Linguistically Diverse (CALD) or Aboriginal and Torres Strait Islander communities, disability support services, or statewide services such as the Richmond Fellowship) (AIPC 2005; Lewis, Baeza and Alexander 2008). Despite overall improvements in continuity of care, system efficiency and responsiveness and some improvement in engagement of GPs (AIPC 2006), a 2005 evaluation of the PCP strategy found that engaging and fostering links with general practice (Divisions or individual GPs) was more difficult than with other actors (AIPC 2005). A study of two individual PCPs by Lewis and colleagues (2008) included similar findings.

[7] 19 PCPs are rural / regional and 12 are metropolitan. One PCP usually corresponds to between one and four local government areas. Geographical organisation of health services in Victoria varies according to program (Victorian Government Department of Human Services 2004). For example, there are 21 area mental health services (8 rural/regional and 13 metropolitan) and 8 DHS regions (5 rural and 3 metropolitan). Local government areas are different again – of a total of 79, 48 are rural/regional and 31 are metropolitan.

VicHealth is responsible for mental health promotion at the state level, and developed its framework guiding this work in 1999. Like AGPN, GPDV works with Divisions of General Practice to support GPs' delivery of mental health care through training, information sharing, and one-on-one support. One of its six specialist programs focuses on mental health, it funds a Mental Health Reference Group, and it works with partners such as RACGP, RANZCP and DHS.

Locally, what occurs in the consulting room is also influenced by the availability and distribution of the mental health workforce – GPs, psychologists, psychiatrists, counsellors, social workers, case managers, occupational therapists and practice nurses – and other mental health services such as inpatient facilities, community mental health services, Prevention and Recovery Care Units (PARC), and Psychiatric Disability Rehabilitation and Support Services (PDRSS). It is difficult to paint a clear picture of the total mental health workforce, including GPs, at either the national or state level. According to AIHW (2008a) in 2006 there were 62,425 employed medical practitioners. Of these 22,981 were primary care clinicians as compared with 2,260 psychiatrists clinicians. In 2004-05 there were 22,943 full-time equivalent staff members working in (public) specialist mental health services across Australia (National Mental Health Report 2007).

The role of practice nurses in the Australian general practice setting is also undergoing rapid change (Sibbald, Shen & McBride 2004). This change is occurring partly in response to a shortage of GPs in rural, regional and outer metropolitan areas. In recent years, the Australian government has offered substantial incentives to general practices in rural areas and areas of high workforce need to employ more nurses (Commonwealth of Australia 2002). In the United Kingdom, evaluations of primary care services delivered by nurses suggest that appropriately trained nurses can undertake functions previously undertaken by GPs (Wilson, Pearson & Hassey 2002). However, there has been limited research into attitudes towards the role of practice nurses in Australia from practitioner's viewpoints (Bonawit & Watson 1996; Patterson, Del Mar & Najman 1999; Condon, Willis & Litt 2000), even less from the consumer's viewpoint (Hegney et al, 2004; Cheek et al, 2002) and none in the area of mental health. Hegney and colleagues (2004) report that consumers having absolute choice in who they see was vital for acceptance of any initiative involving practice nurses substituting for the GP and this finding was particularly important in rural and remote areas and in those consumers who had not encountered a practice nurse.

Finally, local governments' public health policies are also important as these can shape the availability of avenues for community participation, and Divisions are important in terms of providing advocacy, training and personal development opportunities, with some Divisions playing an increasing role in practice support. From this brief overview it is clear that there is a complex mix of geographical, program, organisational and professional boundaries that impact upon the delivery of depression care in the primary care setting. Whilst our program of work did not seek to directly address these issues we remained mindful of them as we progressed through the various phases of work. In the next sub-section we provide an overview of the aims of the **re-order** study and report on each phase of the study.

1.2 AIMS OF THE **RE-ORDER** STUDY

re-order aimed to gather information to assist in the design of a new model for thinking about, and improving, primary care depression care. The research program consisted of three stages and was based upon a proactive evaluation framework, designed to inform decision-making about policies and programs when there is a need for a major review (Owen & Rogers 1999). Each phase also had a unique set of data collection methods which are explained in the chapters that follow. In the first two phases, the project aimed to gather the views of stakeholders about the key elements of exemplary depression care – patients and non-patients. In the third phase we worked with general practices to document depression care as it occurs in the Australian setting, identify areas for improvement, test out interventions for improving depression care and develop principles for an exemplary model of depression care for Australia.

By undertaking this research, **re-order** aimed to benefit the community in a variety of ways including:

- To improve care and support for people experiencing depression, their families and carers in the community.
- To improve the delivery of depression care general practitioners and other health care workers in the primary care sector.
- To enhance general practices' ability to assess if they are meeting the needs of people experiencing depression who attend for care.
- To improve policy-makers' understanding of the perspectives of health professionals and others involved in depression care, resulting in more responsive policies.

The following chapters provide a phase-by-phase report on each component of the **re-order** study which includes the methods and preliminary findings for each one.

CHAPTER TWO: THE PATIENT VOICE (PHASE ONE)

2.1 INTRODUCTION

The first phase of the **re-order** project involved conducting stakeholder consultations with general practice patients who had experience of symptoms of depression and were participating in the NHMRC-funded *diamond* cohort study. In this chapter, we outline the methods of data collection and analysis, describe the sample (both GPs and patients), and present preliminary analysis of selected questions from the computer-assisted telephone interview (CATI) used as the main tool for data collection in Phase I.

2.2 METHODS

2.2.1 DATA COLLECTION

diamond is a prospective, longitudinal cohort study of patients with depressive symptoms from 30 metropolitan and rural general practices in Victoria (Gunn et al, 2008). The study began in January 2005 when thirty randomly selected GPs were recruited from across the State, from whom 789 patients were recruited. *Diamond* has been funded by three NHMRC Project Grants and is collecting detailed information from the patient perspective including measures for depression, co-morbidity, quality of life and health status, social capital and support, partner and substance abuse. Detailed health service utilisation data is also being collected. Access to this cohort provided a cost-effective way of undertaking a comprehensive consultation process with a large, representative sample of primary care patients experiencing depressive symptoms that would not have been otherwise possible. Below we provide a brief overview of the *diamond* study to place our stakeholder consultation phase in context.

DIAMOND STUDY RECRUITMENT METHODS

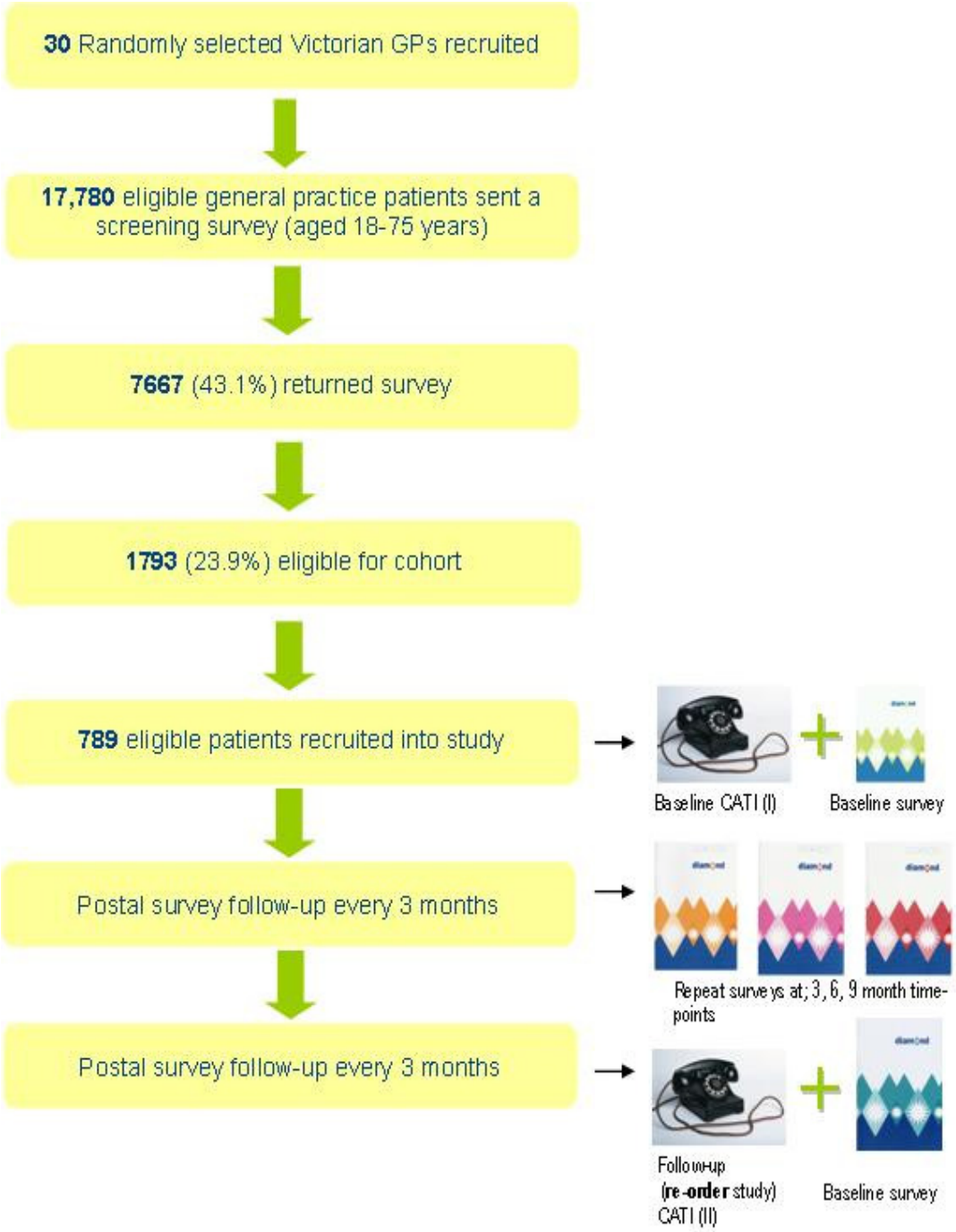
GPs were eligible to participate if they had seen at least 600 patients aged 18-75 years between 2003 and 2004, were able to generate an electronic list of patient names and postal addresses, would agree to complete a GP survey, and if no GP from their practice was already taking part in the diamond study.

A practice staff member, assisted by a research assistant, searched the study GPs' computerised patient records to identify all patients aged 18-75 years who had seen the study GP at least once in the previous twelve months. This search in most instances generated a list of approximately 1000 patients from which GPs were asked to exclude patients who: 1) were unable to read or write in English; 2) were terminally ill; or 3) resided in a nursing home. A random sample of 600 eligible patients was selected from this list.

Eligible patients were sent a postal questionnaire with a covering letter from the GP inviting them to complete and return the questionnaire by mail to the study team. A reminder letter was sent two weeks later to all patients to maximize response rate. Patients were asked demographic questions, about visits to GPs and other health professionals, about their 'usual GP' and about overall health and well-being. Included in this screening survey was the Centre for Epidemiologic Studies Depression Scale (CES-D). Patients scoring ≥ 16 on the CES-D were invited to participate in the study. A flow chart of recruitment is presented (see Figure 1). Upon recruitment into the study, participants completed a baseline postal survey as well as an initial baseline CATI (CATI 1). Following this, participants were sent postal surveys to complete every three months following the baseline time point, namely at three months, six months, nine months and twelve months following completion of the baseline survey. It was at this one-year

time-point that the **re-order** study administered a CATI (CATI 2) amongst the *diamond* study participants.

Figure 2: Flow-chart of the *diamond* study cohort recruitment and follow-up process (up to re-order CATI at 12 month follow-up)



RE-ORDER COMPUTER-ASSISTED TELEPHONE INTERVIEW (CATI)

In total, 576 *diamond* study participants between March 2006 and April 2007 completed a CATI. Investigators in collaboration with research staff developed a structured interview guide to ensure consistency in data collection with such a large number of participants. In total there were 14 sections in the interview guide. Of these, five formed part of the **re-order** study, the remainder being standard *diamond* CATI questions. The **re-order** questions were a combination of 54 open-ended and closed questions covering:

- views on concepts, causes and management of depression;
- help-seeking and pathways to care;
- social attitudes towards depression;
- views on proposed new forms of depression care in general practice; and
- knowledge and opinions about health services and care plans.

Interviews were conducted by research assistants trained in interviewing people over the phone. Most interviews were an hour long and answers were typed verbatim using a database specifically developed for the study. To strengthen the consistency of data collection, interviewers each had access to a manual specifically developed for the study containing detailed instructions relevant to conducting qualitative interviews. Quality control over data collection was further enhanced by regular meetings between **re-order** senior research staff and interviewers, as well as random checking of ten per cent of all interviews by research staff. Upon completion, textual data from open-ended questions were imported into NVivo 7 (QSR International, Melbourne, Australia) in order to aid data indexing and organisation. Quantitative data were analysed using Stata, version 10.0 (StataCorp, College Station, Texas, USA).

2.2.2 DATA ANALYSIS

DEVELOPING A CODING FRAMEWORK

The coding framework was developed by investigators and research staff with different academic backgrounds, including academic general practice, sociology, anthropology, psychology, psychiatry and health promotion, and varying levels of experience with qualitative research methods. Over the course of a number of meetings and teleconferences, consensus was reached regarding the significance of data and assigning codes and meanings attached to them to ensure coding consistency. Initial discussions focused on establishing agreement about the coding and developing mechanisms to ensure coding consistency.

The research group began by individually coding 40 answers to each question, before meeting to discuss codes and refine the framework. Once the overarching conceptual framework had been developed (consisting of concepts of a higher, more abstract order), more detailed frameworks for individual questions were then developed. Because questions differed in their nature and complexity, ranging from questions about participants' concepts of depression and its causes to simpler questions about the sources of information about depression, the decision was made to develop specific coding frameworks as appropriate for the nature of each question.

Coding frameworks for individual questions were developed using the same process – each coder would code individually, then the framework was discussed and agreed upon at a meeting. Once the frameworks for each question were developed, they were further refined by coding another 20 answers against them. For each broad coding category clear coding

definitions were developed. These were sent to other investigators for feedback and refinement. Finalised coding definitions were supplemented with examples of interview quotes, so multiple coders had as clear guidance as possible to optimize concordance in coding. To elicit external feedback, a sample question was selected and the framework for this question along with 60 answers and the code definitions was sent to all investigators to conduct trial coding and provide comments.

THE CODING PROCESS

The initial coding team was broadened to include two more coding assistants with qualitative research and coding experience using NVivo. One researcher worked with each coder individually in order to discuss the process and the content of coding and supervised them on an ongoing basis. A coding book with general guidelines, coding frameworks and the definitions were provided to coders to guide them. When coders had to develop new codes, they recorded these in the project journal then sent them to one of the researchers for review and inclusion in the definition list. After all questions had been coded, two members of the coding team then went back through all questions as a final coding check.

2.3 RESULTS

2.3.1 DESCRIPTION OF PARTICIPANTS

The characteristics of the GPs from whom patients were recruited into the *diamond* study are detailed in Table 2 below. Compared with Victorian GPs, *diamond* study GPs were predominantly male, older in age and a greater proportion recruited from rural areas of Victoria. Most were Australian medical graduates.

Table 2: Characteristics of participating *diamond* study GPs

GP demographics	*diamond* GPs (n=30)	Victorian comparison figures %
Sex n (%)		
Male	22 (73%)	64.93*
Age		
Mean (SD)	52 (9)	47.8*
Rural, remote, metropolitan area classification (RRMA)		
1 - 2	21 (70%)	77.42%† (RRMA1-2)
3 - 5	9 (30%)	22.59%† (RRMA 3-7)
		***National comparison figures n (%)**
Country of graduation n (%)		
Australia	25 (86%)	10,377 (44.8)
New Zealand	1 (3%)	370 (1.6)
Asia	0	695 (3.0)
United Kingdom	2 (7%)	651 (2.8)
Other	1 (3%)	746 (3.2)
Not stated		10,343 (44.6)

*AIHW, 2004, † DoHA, 2004

Of the 789 participants in the cohort, 576 completed a **re-order** telephone interview at the twelve month time point. Table 3 compares some key characteristics between those interviewed and those who did not participate. Compared with those who did not complete the telephone interview, participants that took part were only slightly older in age and the sample had an overall higher mean CES-D score (higher number of depressive symptoms). They were also more likely to: be widowed / divorced or separated; live alone; be born in Australia; to have English as their first language; be unemployed or looking for work; and have at least one chronic physical condition in the past year.

Table 3: Comparison of patients who participated in the CATI with those who did not participate

Patient characteristic	Study cohort (N=789)	
	CATI 2 (n=576)	No CATI 2 (n=213)
Age in years, *Mean (SD)*	48.2 (12.9)	47.6 (13.7)
CES-D score, *Mean (SD)*	27.2 (9.6)	26.7 (8.9)
	n (%)	
Gender		
Female	409 (71.0)	154 (72.3)
Marital status		
Never married/single	127 (22.2)	57 (27.0)
Widowed/divorced/separated	177 (30.9)	51 (24.2)
Married	268 (46.8)	103 (48.8)
Lives alone	131 (22.8)	36 (17.1)
Born in Australia	481 (83.5)	170 (80.6)
English is first language	556 (96.7)	198 (93.4)
Left school before year 10	86 (14.9)	48 (22.6)
Pension/benefit is main source of income	194 (33.7)	87 (41.0)
Has health care card	236 (42.5)	98 (47.1)
Not employed, looking for work	78 (13.5)	25 (11.7)
Unable to work due to sickness/disability	77 (13.4)	37 (17.4)
Hazardous drinking in past 12 months	130 (22.7)	50 (23.7)
Current smoker	179 (31.2)	70 (33.2)
Long term illness/health problem/disability	287 (50.9)	118 (56.7)
At least one chronic physical condition in past 12 months	404 (70.3)	138 (64.8)
Rated health as excellent	17 (3)	11 (5.3)
Ever afraid of partner	192 (33.3)	79 (38.0)
Ever told by doctor had:		
Depression	385 (66.8)	145 (70.4)
Anxiety	271 (48.8)	99 (57.9)

2.3.2 CATI INTERVIEW FINDINGS AND DISCUSSION

The following sections present preliminary results in summary form from key questions from the **re-order** sections of the interview. More in-depth analysis of some questions using subsets of the total sample has been completed and written up in papers published in or submitted to peer-reviewed journals (see Appendix 3). This work will continue subsequent to the submission of this report.

VIEWS ON CONCEPTS, CAUSES, AND MANAGEMENT OF DEPRESSION

In this part of the interview, participants were asked about what they thought depression was and what its causes were, ways to deal with depression, and attitudes towards and ideas about recovery from depression. Box 2 provides an overview of some of the participants' views on this.

Box 2: Overview of CATI participants' views on concepts, causes and management of depression

Concepts and causes

In the questions about what participants thought depression was and what caused people to become depressed, participants rarely focused their responses on a singular cause of depression and often presented multifaceted aetiological accounts, suggesting that 'depression' is a troublesome concept and causes of depression are perceived to be multilayered. Further, participants often had trouble distinguishing between causes of depression and the concept of depression itself. Nonetheless, our preliminary analysis indicates that many participants conceptualised depression as the individual's response to external events, or as psychological in nature. Relatively few (7.8%) mentioned biomedical narratives in their responses. The fact that around 40 per cent of all participants incorporated the use of metaphors into their responses further underlines the difficulties participants had in articulating what they understood depression to be or their experiences of it. As noted above, most participants saw depression as having multiple causes, or one dominant discourse attributed to multiple causes.

Sources of information about and how to deal with depression

The media (both the internet and traditional formats) and professionals (particularly GPs) were most commonly reported as participants' main sources of information about depression. Books and other people with mental health problems were also important sources. When asked about the most important ways to deal with depression, most participants (62.2%) mentioned helping yourself, either by behaviours such as talking about things or taking initiative for seeking help, or via cognitive approaches such as acknowledging your feelings or condition, or seeking self-understanding – as a route to change or self-acceptance. Just over a quarter of participants (26.8%) talked about professional support, 22.7% mentioned letting other people support you, and 17.8% talked about medication (not always in positive terms).

Recovery from depression

A clear majority (86%) of participants thought that it was possible to get better from depression. Of those who thought the opposite (8.2%), the most common reason given was the episodic nature of depression – that even if a person improved, it was likely that the depression would return. When asked about the signs that someone had recovered, many participants thought that this wasn't possible either because not being a physical illness depression was easy to hide, or they said that without knowing the person well or for a long time this would be hard to assess. A small number said that they thought full recovery wasn't possible. Those who did think recovery was possible talked about indications such as outwardly-oriented behaviours (socialising; engaging with others; being open), evidence of the ability to cope with normal life (being active; resuming one's normal routine), or physical behaviours such as laughter, better eating or reduced crying. Feeling happy, good about oneself or in a more stable mood were mentioned as emotional signs. External physical signs included a chirpier demeanour or improved personal grooming; internally, increased energy levels and improved sleep were mentioned as signalling recovery. Signs associated with cognition included a future or outward orientation to one's thoughts – a sense of hope or motivation, or increased interest in others or life in general. A greater ability to think positively and to see things in perspective were also discussed.

Descriptions of depression: participants' own words and experiences

The characteristics of participants' responses to this and the following question (about the causes of depression) illustrate their difficulties in identifying one 'thing' or another as the single explanation, and the categories developed are therefore not discrete, but represent the emphasis in accounts provided by participants.

Most participants describe depression as ***the individual's response to external social and situational events*** (394 out of 576). 252 respondents described depression as a reaction to life (some talking about a specific event that 'triggered' depression; others talking about life 'in general'). They often described the transition from being 'a very active person' and thus 'normal' to an inactive, disengaged person as the signifying point of depression. This is also reflected in discourses around the aetiological genesis of depression as the result of 'not coping' with the demands of particular social situations: *'I think depression is the mind not being able to cope with all of the problems that you have. It's like it overloads and it's just I have so many issues that I just can't cope with them all – I work, I have a very sick husband and a very dysfunctional family…'* (ID 05017). They also talked about a sense of emotional isolation and loneliness (*'What do I think depression is? Well, for me it's a very lonely feeling. Ummm… I'm on my own - and I tend - it tends to hit home with my work, the workload I have and being a single mum working full-time with very long hours. But it's the loneliness that triggers it off more.'*(08156); having a negative perspective on everything, depression being a *'Constant state of anxiety and worry'* (08197); and an absence of feelings present in their lives prior to depression (e.g. enjoyment); changes in the way they approached life situations (e.g. lack of rationality); and lack of control over their life. An ideal self, rationally in control of emotions, was juxtaposed against the depressed self, unable to cope; this loss of control was presented as a form of failure and defeat.

Many participants (142) commented on an impaired capacity to function, including a lack of interest in doing things, not wanting to get up, and general difficulties with daily life. Participants conceptualised depression as a set of practices, and it is these that articulate the explanatory boundaries of depression as much as the phenomenological experience of emotions as evident from the following quote: *'[depression is] when I don't want to do anything. I have lost interest in things. I have to push myself all the time. My sleep patterns are all over the place. Just even normal living is hard work, and although I realise I'm not, I feel like I am on my own – not physically, maybe emotionally.'*(07002)

The next main theme raised by participants is emphasising ***psychological aspects*** of depression (259 participants). 141 participants described depression in terms of affects and feelings, including describing depression as sadness: *'I think it's, um, it's when you feel really down and sad and you don't want to do anything and you don't want to see anyone, and it just makes you feel really, really sad'* (07036); hopelessness; and helplessness. Participants commented on issues they classified as predisposing a person to depression, and explained depression as lack of self-esteem, poor body image, insecurity and a focus on performance (perfectionism or failure).

Experiencing depression is described also as individuals' inability to realise their optimum 'sense of self' (118 participants mentioned this): *'[depression] can just affect the way you feel about yourself'*. Others described *'a general feeling of feeling inadequate, inferior, no self confidence'*. One interviewee posited depression as a negative re-fashioning of self: *'you just lose the plot and all the values which you're proud of suddenly disappear'*.

The next prominent theme identified is depression as difficulties with ***external social and situational circumstances*** (63), the most prominent sub-theme being description of depression as difficulties in interpersonal relationships: *'My depression was that I wasn't happy about certain things, like my first marriage, there were kids involved and I bottled everything*

up. I had no one to talk to. The longer it goes the harder it is. I might not be right, but…' (04012), and talking about unspecified problems: *'Oh. [Depression is] When everything seems to be going wrong you just get deeper into a pit'* (08038).

Although most participants described their distress through complex personal accounts, a few framed their discussion using ***biomedical narratives*** (45), including chemical imbalance (25): *'…it's basically an imbalance in the brain. The chemical receptors aren't getting….they've got all the terminology they use but yeah, basically brain chemistry.'* (23047) and biological and physiological discourses (23): *'Oh, it's an illness. It's biological and it's clearly inherited. It is debilitating. It is, um, manageable but I don't know that it's ever cured. I'm talking about significant depression here, major depression.'* (24030)

The difficulty in verbalizing the concept of depression is evident from the frequent use of ***metaphors*** (235 participants), to compensate for the lack of other words to capture the experience or definition of depression. Most commonly used were combinations of metaphors of darkness, depth of despair, and the inability to escape from it, as evident from the following quotes: *'I think it's like a big black hole that you don't know how to crawl out of'* (11288); *'Well for me, I see it as a dark cloud on the horizon and I know it's going to overwhelm me, or I see it as a break or a wave hitting me in the chest. It overwhelms or immobilises me'* (13146). Metaphors of dark colours tended to dominate: *'a sense of darkness'*; *'a black hole, just black'*; *'a heavy black blanket being thrown over you'*; *'a big hole — a big hole that you can't get out of'*. Other metaphoric descriptions include weight and heaviness: *'the weight of the world'* (21067); *'it's pressing down on you'* (30108); *'a tonne of weight on your back'* (17150). In these portraits depression is depicted as something that consumes and overwhelms the individual.

Views on causes of depression

When asked about what in their view causes depression, participants either talked about what they thought caused their own depression, about people in general, or they alternated between talking in general terms and about themselves. The characteristics of peoples' responses illustrated themes of exploration, navigation and discovery within uncertain terrains. This uncertainty and in particular participants' inability to identify and locate one cause or another as the sole attribute for depression supports our previous work that has identified biomedical, social and psychological all as causes of depression (Kokanovic et al, 2008). In this preliminary analysis, rather than locate our respondents' material within one causal attribute or another, we mapped their responses to the many and varied causes of depression.

In this process, we noted the continuous repetition of participant voices across many of the thematic attributes. People attributed two or three and sometimes five or more causes to depression which led us to consider that the multi-causal factors in depression required further consideration. Moreover, depression was not as easy to explain as being caused by one factor or another alone. To reflect this complexity, we categorised the responses to this question as:

- **multiple causes** (251) – incorporating multiple discourses, e.g. combination of social and biomedical: *'Um, I think it's a couple of things. I think there's hormones because it certainly affects you cyclically. A tendency to low self esteem, like a historical thing, and the other one I would have to say would be personal tragedy, like relationship breakdown or grief'* (04054).

- **multiple singular causes** (138) - one dominant discourse (e.g. biomedical or social) incorporating a number of different causes (e.g. social discourse incorporating work, family, relationships, finances; biomedical discourse incorporating hormones, genetic and chemical imbalance as causes of depression): *'I know with me it started with separation from my wife and working in a job that I didn't want to do. I was in a factory and it was too noisy and I hated it. So moving out of house and home and shitty job.'* (03286).

- **singular causes** (105) - when only one cause is nominated: *'Um, oh, well in my case it was family matters'* (ID 18176).

- **uncertainty about causes** (84): *'Haven't got a clue, to tell you the truth. Up until 2000 for about a year I felt I was heading down that road - that wasn't such a big deal - but it slowly got worse. No idea what brings it on.'* (06087)[8]

Main sources of information about depression

Most participants drew on a range of sources of information about depression, as this quote demonstrates: *'Health report on Radio National, New Scientist, um, occasionally beyondblue. The daily newspaper, the Weekend Australian – the health section.'* (05126)

As shown by the summary of main responses in Table 4, resources such as the media (internet as well as traditional media formats) were most frequently mentioned by participants as their main source of information about depression. Information from professionals was also very important. Medical professionals were most frequently mentioned – in particular GPs, followed by psychiatrists. The next most frequently mentioned group was allied health professionals, particularly psychologists and counsellors. Participants also obtained information about depression from other people such as friends and family – in particular those who had experienced depression themselves:

> *…well it's funny, it's one of those things that you don't advertise that you've got, so you choose who you tell, but you're surprised at how many people have suffered from it. So chatting with other people has been very helpful too.* (22131)

Other, less frequently mentioned sources of information included work experience in the health sector, life experience in general, and the *diamond* study.

[8] See Kokanovic et al, (2008) for the results of early analysis of the first 60 participants in the study.

Table 4: CATI participants' main sources of information about depression (N=574)

SOURCES OF INFORMATION ABOUT DEPRESSION	NO. TIMES MENTIONED	%
RESOURCES	**353**	**(61.5)**
Media	240	(41.8)
Internet	*138*	*(24.0)*
Traditional media (TV, radio, newspapers, magazines)	*110*	*(19.2)*
Books, pamphlets etc	225	(39.2)
Books	*125*	*(21.8)*
PROFESSIONAL SUPPORT	**309**	**(53.8)**
Medical professionals	240	(41.8)
GP	*205*	*(35.7)*
Psychiatrist	*56*	*(9.8)*
Allied health professionals	73	(12.7)
Psychologist	*39*	*(6.8)*
Counsellor	*26*	*(4.5)*
Health professionals in general	17	(3.0)
OTHERS	**135**	**(23.5)**
Other people with mental health problems (including friends and family)	73	(12.7)
Family	50	(8.7)
Other people in general	27	(4.7)
LIFE CIRCUMSTANCES	**46**	**(8.0)**
Work experience in health sector	44	(7.7)
SELF	**37**	**(6.5)**
Life experience	19	(3.3)
NOTHING	**35**	**(6.1)**
PARTICIPATING IN *diamond* STUDY	**11**	**(1.9)**

Participants' views on the most important ways to deal with depression

Many participants nominated a range of different ways of dealing with depression, as illustrated by the following quote:

> *…I think that you need friends and family for communication, and for them to listen and be supportive. I think animals, they're a big part [of] my life anyway; I don't have children so they're my kids. Doctors are good to keep you on the right track. Exercise, and… I'm a really big believer in self-help. Getting as much information as you can in order to help yourself…And a good outlook on life to be positive even though negative things happen. And don't give up.* (11210)

The following table shows the main suggestions provided by participants on ways to deal with depression and the number of times each was mentioned. Because many responses identified multiple options for managing depression, the sum of the figures in the right-hand column exceeds the total number of responses.

Table 5: CATI participants' views on the most important ways to deal with depression (N=538)

WAYS TO DEAL WITH DEPRESSION	NO. TIMES MENTIONED	(%)
HELP YOURSELF	**335**	**(62.3)**
Via your behaviour:	213	(39.6)
Talk about things	151	(28.1)
Take initiative for help-seeking	64	(11.9)
Keep busy	32	(5.9)
Deal with it yourself	24	(4.5)
Interact with people	18	(3.3)
Exercise	41	(7.6)
Via your thoughts and beliefs:	98	(18.2)
Acknowledge your feelings / condition	36	(6.7)
Think positively	31	(5.8)
SEEK PROFESSIONAL SUPPORT	**144**	**(26.8)**
Professional support in general	77	(14.3)
GP	38	(7.1)
Counsellor	26	(4.8)
Psychologist	18	(3.3)
Psychiatrist	9	(1.7)
LET OTHER PEOPLE SUPPORT YOU	**122**	**(22.7)**
Friends	58	(10.8)
Family	54	(10.0)
Other people in general	39	(7.2)
USE THERAPIES AND OTHER RESOURCES	**113**	**(21.0)**
Medication	96	(17.8)
Non-medical therapies / resources (e.g. CAM, group therapy, relaxation techniques, talking therapies)	31	(5.8)

Views on whether people who are experiencing depression can get better

Most participants (498 or over 86%) agreed that people who are experiencing depression can get better as shown in table 6. Their reasons, as well as those who did not know or disagreed, were explored in the next question.

Table 6: Number of CATI participants who agreed that people experiencing depression are able to recover (N=571)

ABLE TO RECOVER FROM DEPRESSION	N*	(%)
Strongly agree	291	(51.0)
Tend to agree	207	(36.3)
Tend to disagree	40	(7.0)
Strongly disagree	7	(1.2)
Don't know	26	(4.6)
TOTAL	571	(100)

Why people who are experiencing depression can't get better

> *I always thought that people took the pills for 3 or 6 or 12 months and they got better. But it comes back. And comes back. And comes back. I don't think that I'll ever be recovered from it.* (27194)

Less than 10 per cent of participants (47) thought that people who are experiencing depression cannot get better. This is a slightly higher number than the 35 participants who, in response to the question 'What helps people to get better from depression?' (discussed below), expressed doubts about whether recovery was possible. In response to the question about why people can't get better, reasons given included the beliefs that depression was episodic (14) (as expressed in the quote above); or that it could not be completely cured (though improvement was possible) (9); personal experience of not recovering (9); a belief that depression stays with you forever (7); and participants' experience of never having met anyone who had recovered from depression (6). Less commonly mentioned reasons included the belief that it was a chemical imbalance (2), that not enough experienced, professional help was available (2), or that the causes of depression were unknown (2).

How you would know that someone had recovered from depression

> *'Well, generally speaking they look better. And they look more robust and they are more extroverted rather than introverted. And they look healthy. And they want to go out and want to talk to you. They are interested in issues and they sleep better and that helps with their outlook. They eat better and are planning for the future or themselves or for their families or their children. They are humming little things, and singing a tune and listening to music. They have a bounce in their walk and exercising. They have that sense of wellbeing and they laugh. You can make them laugh more easily.'* (31033)

Of the 484 participants who ventured a response to this question, many were either ambivalent about whether or not it was possible to tell if someone had recovered from depression and if so how this would be measured (171) while some simply stated they didn't know (15). Most talked about a range of signs – particularly in relation to people's **behaviours** (199), **feelings** (164), **physical state** (141), or **thoughts** (198). While many answered in terms of a hypothetical person, others spoke directly from their own experience or that of someone they had known.

MEASURING RECOVERY

Of the 171 participants who discussed the issue of **how to measure recovery**, 49 asserted that it wasn't possible to tell if a person had recovered. A further 61 noted that unlike many physical illnesses, it was possible to hide depression: *'…it is not something that people wear on a sign around their neck, and most of us put on a pretty good act, and it is only those closest to you that see signs of depression. My husband says he can hear it in my voice and see it in my eyes. I have very chronic back pain but I walk very upright. I won't let anyone see my pain.'* (11055) Others expressed their doubts about whether full recovery was even possible (35): *'I don't know that people ever really recover from acute depression. Everyone is different… I don't know if anyone is ever really over things. You just move to a different level… I think life is just pretty hard sometimes, that is all.'* (29006), or mentioned the need to be able to observe a person over the long term.

BEHAVIOURS

The responses about being able to discern if a person had recovered from depression based on their behaviour were clustered around **outwardly-oriented behaviours** such as socialising (73); engaging with other people (46); and being able to disclose one's feelings or experiences to others (42). The manner and content of a person's conversation was also mentioned here: *'…like my friend, she's reduced her medication, and you [can] tell in her voice, her whole attitude has changed, there's no darkness in her voice.'* (13200) Other comments were grouped around **behaviours demonstrating the ability to cope with life**, for example, being more active (26). *'Well, you're happier to go out and do more things - I think when you're depressed you want to hibernate.'* (17095) Resuming one's normal routine was another behaviour that signalled recovery (25). Some participants also mentioned being able to tell if a person had recovered from depression based on **physical behaviours** (29), for example, reduced crying, better eating, and laughing more.

FEELINGS

Many participants talked about being able to tell that a person had recovered from depression simply because they seemed (or they themselves felt) happier (94): *'Well, I reckon you can see when someone's depressed, they're sad, they're down. And when they get better they do things, they're chirpy, they're happy.'* (23056) Others mentioned feeling better about or having more confidence in oneself (32) while other participants noted that a better, more stable mood could be a sign of recovery (29): *'They would not be so moody… they wouldn't tend to either go to the extremes or literally lose their grip on things, or go into a shell.'* (26143)

PHYSICAL STATE

Responses addressing aspects of a person's physical state that could indicate recovery from depression were divided into external (121) and internal elements (38). External elements included a person's demeanour (71): *'Interestingly enough a lot of people have said to me that I've got the sparkle back in my life, the light has been switched back on. So yeah, body language, you can visually see when someone is coming out from the other side.'* (14186) or general appearance including self-care (25): *'My grandmother had depression and we would know that she was better when she wore lipstick and got her hair done. So I suppose when people start caring about themselves and their appearance…'* (24038). Internal elements included energy: 'Their general energy levels, their willingness to participate in life again, to go out the front door - you go from a recluse to being a normal person again' (16003) and improved sleep.

THOUGHTS / BELIEFS

Thoughts or beliefs demonstrating a future orientation (113) were mentioned by many participants as an indicator that a person was recovering from depression – particularly optimism or a positive attitude (104). A greater sense of motivation and fewer suicidal thoughts were mentioned by other participants. Many participants mentioned thoughts or beliefs relating to the ability to cope with life (68), particularly a sense of being able to cope (59): *'I wouldn't feel that bad all the time - you'd have your ups and downs but your downs wouldn't be that bad. You'd deal with situations better. When things go wrong you can deal with it - it doesn't take over so much.'* (17187) Other factors like greater control over life or their own feelings were mentioned (8). An outward orientation to a person's thoughts or beliefs (49) was also frequently noted, for example, a greater interest in life or less self-absorption: *'I think one of the indications is that people become more giving. I think generally speaking depressed people can be quite self absorbed and quite selfish. They are just more active I suppose.'* (20294)

HELP-SEEKING AND PATHWAYS TO CARE

In this part of the interview, participants were asked a series of questions about their help-seeking and pathways to care. This included questions about the people and professionals they had spoken to about their depression, stress or worries, when they had first spoken to someone else about it, other kinds of help they had sought, and what it was about those encounters that they had liked or disliked. Summary responses to selected questions are presented below.

Box 3: Overview of participants' views on help-seeking and pathways to care

First thing participants did when they realised they had an issue with depression, stress or worries

Three in five participants said the first thing they had done when they first realised they had an issue with depression, stress or worries was seek or receive professional support, especially from GPs (47.2%). One in three said they had managed it themselves, primarily through positive patterns of thinking or behaviour (e.g. self-help, keeping busy, positive thinking). A minority of participants mentioned seeking or receiving help from other family or friends (16.5%), doing nothing (8.6%), or using medication or other therapies (7.0%).

People involved in participants' depression care

GPs were very important in participants' depression care, along with family, friends and the person themselves. Half the participants said the first person they'd spoken to when they first realised they had an issue was a GP, reflecting their responses to the previous question, and a further 23.1% said they had spoken to a family member. 496 or 86% of participants reported ever seeing or talking to a GP about their depression, stress or worries, as compared with 72.7% having talked to friends and 70.1% family. For 67.7% a GP was the first person they ever saw specifically for their depression, stress or worries. Family (43.8%) and friends (22.2%) were more commonly mentioned as the people participants felt most comfortable discussing their real feelings, however among professionals GPs were mentioned by 16.5% as compared with 5.2% of participants nominating a psychiatrists or psychologist or 3.7% a counsellor. Finally, participants most frequently reported being the main person caring for their depression, stress or worries (44.9%) followed by a family member (23.4%) or a GP (13.5%).

Duration since participants first spoke to GP and what prompted them to do this

At least half the participants had spoken to a GP more than five years ago. When asked what had prompted them to talk to their GP, 293 or 61.9% of participants said that it was their own thoughts or beliefs, feelings or behaviours, ranging from being unable to cope or consistently feeling low through to grief, constant tearfulness or disrupted sleep. About a quarter of participants said they had either been referred to a GP, their GP had picked up their condition, or something about the GP had made it easy for them to disclose their concerns to them. Other things that had first prompted participants to talk to their GPs were significant life events, symptoms, or other people suggesting the participant see a GP.

Experiences and views about of GP care of people experiencing depression, stress or worries

Finally, when asked about their experiences of their GP's care of their depression, stress or worries and what they thought was the most important thing GPs could do for people with these concerns, participants identified listening, understanding and empathy as being very important. They also valued competent diagnosis and management, timely and appropriate referral, and a supportive and reassuring approach. Elements of care that were valued by participants, but not always present, were accessibility of the GP (through timely and sufficiently long appointments) and follow-up and monitoring.

THE FIRST THING PARTICIPANTS DECIDED TO DO ABOUT THEIR DEPRESSION, STRESS OR WORRIES WHEN THEY FIRST REALISED THEY HAD AN ISSUE

Many participants mentioned more than one thing or a sequence of events rather than one "first" thing. This is illustrated in the following quotes: *'Ahh…let me see. I decided to do more positive things for myself. I thought one way of overcoming that thing was to do exercise and more hobbies and be with people.'* (15107) and *'I suppose that I spoke to my husband about it and tried to work out who would be best to speak to. And some support groups as well… with the medical problems I had, it was support for infertility/IVF.'* (10131)

Nearly two thirds of participants said they had sought or received professional support (60.6%), which was mainly medical support (53.6%). Less than ten per cent had sought or received support from non-medical professionals such as counsellors, psychologists or nurses. Of all medical professionals mentioned, GPs were particularly important; almost half the participants (47.2%) had seen one. Around 30% of participants talked about various ways of managing it themselves, ranging from positive approaches such as self-help, talking about their depression, stress or worries, or keeping busy, through to destructive or unhelpful reactions such as denial or attempting suicide. 90 participants (16.5%) said they had sought or received help from other, non-professional people such as family or friends, and 8.6% said when they first realised they had an issue, they did not actually do anything about it: *'Nothing probably - I did nothing for a long period of time, I just thought it was normal.'* (30109)[9]

[9] See also the results of early analysis of the first 100 participants in Dowrick et al, (2008). Full reference details are provided in Appendix 3.

Table 7: The first thing CATI participants decided to do about their depression, stress or worries when they first realised they had an issue (N=545)

FIRST THING PARTICIPANTS DECIDED TO DO ABOUT THEIR DEPRESSION, STRESS OR WORRIES WHEN THEY FIRST REALISED THEY HAD AN ISSUE	N	(%)
SOUGHT OR RECEIVED PROFESSIONAL SUPPORT	**330**	**(60.6)**
Medical	292	(53.6)
GP	257	(47.2)
Hospital	25	(4.6)
Non-medical	53	(9.7)
Counsellor	23	(4.2)
MANAGED IT THEMSELVES	**168**	**(30.8)**
Thoughts & beliefs	98	(18.0)
Positive (e.g. self-help, self-understanding)	68	(12.5)
Negative (e.g. denial, anger, keep it secret)	30	(5.5)
Behaviours	78	(14.3)
Positive (e.g. talk, initiate help-seeking, keep busy)	51	(9.4)
Negative (e.g. attempt suicide, over-eat, withdraw)	18	(3.3)
SOUGHT OR RECEIVED HELP FROM OTHER PEOPLE (NON-PROFESSIONALS)	**90**	**(16.5)**
Family	56	(10.3)
Friends	21	(3.9)
NOTHING	**47**	**(8.6)**
USED THERAPIES OR RESOURCES (e.g. complementary medicine, self-help resources, medication)	**38**	**(7.0)**
Medication	21	(3.9)
ENGAGED IN ACTIVITIES (e.g. exercise, gardening, hobbies)	**13**	**(2.4)**
ENGAGED IN SUBSTANCE USE	**12**	**(2.2)**

Due to multiple responses the numbers in the right hand column do not add up to N.

MAIN HEALTH PROFESSIONALS AND OTHER PEOPLE INVOLVED IN CARE OF PARTICIPANTS' DEPRESSION, STRESS AND WORRIES

Table 8 on page 41 presents the main people (professional and non-professional) involved in participants' depression care. As the data show, GPs played a critical role. Almost half the participants (48.4%) said the first person they'd talked to when they realised they had an issue with depression, stress or worries was a GP. A family member was the next most frequently mentioned person (22.2%). In terms of health professionals or other people ever seen or spoken to for participants' depression, stress or worries, some 86.1% had see a GP, followed by 72.7% and 70.1% for friends and family members, respectively. The proportion of participants who said they'd ever seen a psychiatrist, psychologist or counsellor was roughly similar at 39.2, 46.5 and 40.5% respectively. And again, two-thirds of participants said the first person they ever saw for depression, stress or worries was a GP, a figure that is consistent with the 1997 National Mental Health and Wellbeing Survey results.

These findings about the people participants reported seeing or talking to about their mental health, particularly when they *first* realised they had an issue, contrast with the results for the questions about who participants felt most comfortable discussing their real feelings with or who they considered to be the main person caring for their depression, stress and worries (bottom two rows of Table 8). Family members (43.8% - partners in particular by 25% of participants) or friends (22.2%) were mentioned more frequently than were GPs (93 or 16.2% of participants) as the people participants felt most comfortable talking to about their real feelings. The most frequently mentioned person caring for participants' depression was the participant him or herself (253 or 44.9%), followed by a family member (135 or 23.4%) followed by a professional (115 or 20.4%). Of professionals, GPs were most commonly mentioned – 77 participants or 13.5% said a GP was the main person caring for their depression.

Psychiatrists, psychologists and counsellors figured less prominently in comparison to GPs – relatively few participants had first spoken to (between 1.9 and 3.5%) or first seen them (5.4 – 6.3%) for their depression, stress or worries, relatively few had nominated them as the main person caring for their mental health (1.4 – 5.2%), and markedly fewer said their psychiatrist, psychologist or psychologist was the person they felt most comfortable (3.7 – 5.2%) discussing their real feelings compared with their GP. This lower profile may reflect the smaller numbers of psychiatrists, psychologists and counsellors relative to GPs as well as the design of the Australian health care system.

Table 8: Main health professionals and other people involved in care of CATI participants' depression, stress or worries

	N	PROFESSIONAL						NON-PROFESSIONAL				
		GP n (%)	Psychiatrist n (%)	Psychologist n (%)	Counsellor n (%)	Other* n (%)	TOTAL** n (%)	Family n (%)	Friend(s) n (%)	No-one / self n (%)	Other n (%)	TOTAL** n (%)
Person first talked to when realised first had an issue with DSW	**554**	279 (50.4%)	19 (3.4%)	11 (2.0%)	20 (3.6%)	43 (7.8%)	**337 (60.8%)**	128 (23.1%)	78 (14.1%)	58 (10.5%)	12 (3.4%)	**262 (47.3%)**
Health professionals or other even seen / spoken to about DSW	**576**	496 (86.1%)	226 (39.2%)	268 (46.5%)	233 (40.5%)	383 (66.5%)	**N/A**	404 (70.1%)	419 (72.7%)	21 (3.6%)	**N/A**	**N/A**
First person ever seen about DSW	**555**	376 (67.7%)	30 (5.4%)	32 (5.8%)	35 (6.3%)	37 (6.7%)	**488 (87.9%)**	27 (4.9%)	15 (2.7%)	24 (4.3%)	3 (0.5%)	**67 (12.1%)**
Person most comfortable talking about real feelings with	**573**	93 (16.2%)	30 (5.2%)	30 (5.2%)	21 (3.7%)	19 (3.3%)	**179 (31.2%)**	251 (43.8%) Partner = 143 (25.0%)	127 (22.2%)	46 (8.0%)	18 (3.2%)	**417 (72.8%)**
Main person caring for DSW	**569**	77 (13.5%)	30 (5.2%)	8 (1.4%)	n/a†	n/a†	**115 (20.4%)**	135 (23.4%)	39 (6.8%)	253 (44.9%)	**N/A‡**	**427 (75%)**

* Other professionals - nurses, occupational therapists and social workers. Non-professionals – community and support groups.

** Figures in these columns (total professional support and total non-professional support) are not necessarily a sum of the preceding columns. This is because for the four questions worded so as to elicit a single response, some participants nevertheless mentioned more than one "first thing", "first person", person with whom they were "most comfortable" or "main person" and responses were coded accordingly. For the question about professionals or people ever seen or spoken to, most participants predictably mentioned more than one professional / person.

† Professions other than GP, psychiatrist or psychologist not included in drop-down list of responses for this question.
‡ The remaining 27 responses to this question were categorised as 'other'.

WHAT PROMPTED PARTICIPANTS TO TALK TO THE GP ABOUT DEPRESSION, STRESS OR WORRIES

473 participants (82%) answered this question, providing multiple responses. Among these, participants' own **thoughts or beliefs, feelings and behaviours** were most frequently mentioned (293 times) as what prompted them to talk to a GP. These included thoughts and beliefs (136) such as a sense of being unable to cope (62); having suicidal thoughts (18) or needing help or support (16); feelings (108 mentions) such as feeling bad (61): '*It was just the way I was feeling I guess. At that stage I was feeling down and miserable.*' (13240) or grief, bereavement or separation issues (46); behaviours such as constant crying (38) ('*I remember saying to him I was sick of wearing my sunglasses everywhere, I was crying all the time.*' (18015)) or anxiety becoming unmanageable (17); and physical behaviours (31) such as disrupted sleep (28).

Next most frequently mentioned were **professionals** (118). 30 participants said other professionals (e.g. nurses, physiotherapists, counsellors etc) had directed them to a GP, whereas 93 had talked to their GPs either because the GP had recognised their depression, stress or worries (57 – '*Actually went there for something else, I think it was a pap spear or something. I think she actually prompted me by asking how I was feeling generally. That led me to talk about it a little bit.*' (15015)) or because of various characteristics of the GP (e.g. confidentiality, accessibility, understanding and empathetic approach) that made it easy for them to talk to them (29).

Life circumstances such as significant events (66) (e.g. relationship breakdown or conflict (32): '*I was stressed beyond belief - I'd had a family business break up with my father and brother and it had me in such a state that I couldn't do a thing*' (30109); or the loss of a loved one (24)) were mentioned by 110 participants. Another prominent theme was participants' **physical state** (106). 83 people mentioned presentation of symptoms (for example, a reduced sense of wellbeing (18), pain (12) or a nervous breakdown (10)), with a further 20 talking about co-morbid physical problems ranging from cancer to Huntington's Disease). Finally, **other people** in participants' lives (mentioned 102 times) were commonly mentioned as having prompted them to see a GP – whether directly (e.g. 41 people mentioned that person advising or taking the participant to see GP) or indirectly (e.g. loss of a loved one ('*I lost a child - that first time. And I just lost interest in things. Didn't care.*' (07002) or relationship breakdown). Participants mentioned family members most often (87) and in particular partners (38).

DURATION SINCE PARTICIPANTS FIRST SPOKE TO A GP ABOUT THEIR DEPRESSION, STRESS OR WORRIES

At least half the participants first spoke to a GP about their depression, stress or worries more than five years ago, as shown in Table 9.

Table 9: Duration since CATI participants first spoke to a GP about depression, stress or worries (N = 576)

DURATION SINCE FIRST SPOKE TO A GP ABOUT DEPRESSION	N	(%)
≥ 1 month but <6 months	5	(0.9)
≥ 6 months but <12 months	5	(0.9)
≥ 12 months but <3 years	68	(11.8)
≥ 3 years but <5 years	59	(10.2)
≥ 5 years but <10 years	87	(15.1)
10 years or more	205	(35.6)
Missing	72	(12.5)
Not applicable / did not speak to a GP	75	(13.0)
Total	**576**	**(100)**

GP CARE OF PEOPLE WITH DEPRESSION, STRESS OR WORRIES: PARTICIPANTS' EXPERIENCE AND OPINIONS

Table 10 on page 44 summarises the results of a series of open questions about people with depression, stress or worries and their experiences of and views about GP care – what was good or unsatisfactory about their own experiences, and what they saw as the most important things GPs could do for people with depression, stress or worries. The different categories emerging from their responses have been grouped into aspects of the doctor-patient relationship, the GP's clinical and technical skills, and elements of the system of care. GPs are perceived by many people with DSW as being good at **listening, understanding and empathy** and this is considered important by patients. Listening was most frequently mentioned (210 times) as a positive aspect of encounters with GPs about their depression, stress or worries, as an element of desirable GP care of people with these issues (215 times), and was second most frequently mentioned in relation to what could have been done better in encounters with GPs (62 times) after **competent diagnosis and management** (70 times). In short, participants' appreciated their GP listening and empathising with them, missed it when it didn't take place, and saw it as a critical element of optimal care.

A minority of people experiencing symptoms of depression, stress or worries volunteered that a 'good' aspect of GP care was **diagnosis and management** (15.8%) and **appropriate and timely referral** (11.2%) yet around a third (30.7 and 30%) mentioned these skills to be important.

In terms of the system of care, very few participants nominated **accessibility and appropriate consultation length** (5.5%) and **follow-up and monitoring** (4%) as positive aspects of their encounters with GPs. This contrasts with what participants perceived as the most important things GPs can do for people experiencing depression, stress and worries – 15.1% said more time and more access to GPs and 15.5% said better follow-up and monitoring.

Finally, when asked what could have been done better during their encounters with GPs for their depression, stress or worries, almost half the participants (48.3%) reported that they were satisfied with their care.

Table 10: GPs and people with depression, stress or worries: A summary of CATI participants' views on (i) what was good about the times they spoke with their GP about these issues; (ii) what could have been better; and (iii) the most important things GPs can do for people experiencing depression, stress or worries[10]

		DOCTOR-PATIENT RELATIONSHIP			CLINICAL-TECHNICAL SKILLS						SYSTEM OF CARE			
	n	Listening, understanding and empathy	Support for and reassurance of patient	*n (%)*	Competent diagnosis and management of DSW	Appropriate and timely referral	Prescription and management of medication	Holistic approach to DSW and tailored treatment	Education of patient about depression	*n (%)*	Accessibility, appointments not rushed	Follow-up and monitoring	*n (%)*	Nothing n (%)
1: Things about the times participants' had spoken to a GP about DSW that were good	475	210 (44.2%)	100 (21.1%)	*264 (55.6%)*	75 (15.8%)	53 (11.2%)	53 (11.2%)	50 (10.5%)	44 (9.3%)	*230 (48.4%)*	26 (5.5%)	19 (4.0%)	*44 (9.3%)*	41 (8.6%)
2: Things about the times participants' had spoken to a GP about DSW that could have been better	474	62 (13.1%)	16 (3.4%)	*72 (15.2%)*	70 (14.8%)	49 (10.3%)	8 (1.7%)	32 (6.8%)	13 (2.7%)	*140 (29.5%)*	48 (10.1%)	30 (6.3%)	*73 (15.4%)*	229 (48.3%)
3: Most important things GPs can do for people experiencing DSW	576	215 (37.3%)	108 (18.8%)	*300 (52.1%)*	177 (30.7%)	173 (30.0%)	41 (7.1%)	76 (13.2%)	60 (10.4%)	*382 (66.3%)*	87 (15.1%)	89 (15.5%)	*166 (28.8%)*	6 (1.0%)

[10] The data presented here are a summary only of the top ten most frequently mentioned categories in response to each of the three questions analysed as well as the response 'nothing'.

SOCIAL ATTITUDES TOWARDS DEPRESSION

In this section of the interview we asked participants whether they agreed or disagreed with a series of statements about social attitudes towards depression. The results highlight that participants perceive that significant stigma about depression persists.

Table 11: CATI participants' views about social attitudes that may exist towards depression (N=576)

SOCIAL ATTITUDE	AGREE		DISAGREE		DON'T KNOW	
	N	(%)	N	(%)	N	(%)
A person with depression would be embarrassed if others knew about it	512	(88.9)	49	(8.5)	10	(1.7)
People hide their depression from others	549	(95.3)	14	(2.4)	8	(1.4)
People avoid relationships with those who have depression	402	(69.8)	107	(18.6)	62	(10.8)
Those with depression only have themselves to blame	161	(27.5)	389	(67.5)	21	(3.7)

*Denominator variation is due to missing data

To further explore social attitudes towards depression we identified the 126 participants who answered 'agree' to all four of the social attitude questions and examined their responses to all the **re-order** open-ended survey questions, which were not specifically about social attitudes to depression. From these questions we extracted all comments made by participants which in some way related to social attitudes to depression. This has been completed for 58 of the 126 participants so far.

There were comments in response to open-ended survey questions that reflected how they answered the questions about social attitudes to depression (see table above): *'They've got to help themselves before anyone can do anything for you.'* (11269); *'It's their own fault.'* (06238); *'most people don't know about me. I cover it quite well'* (15085). One participant tended to stay away from people – not *'worthwhile company'* (10088) and another said *'you lose friends because you've got nothing to give back to them'* (19208).

We examined the comments of participants for evidence that they considered being strong as an individual to be related to depression, either through lack of strength as a person as a cause or if they saw their own inner strength as a way out of depression. Although all of these participants had agreed with the statement that '*Those with depression only have themselves to blame',* of the 58 participants only 24 mentioned this in their comments. This may suggest that this needs to be specifically asked about to elicit this attitude.

All but two of the 24 participants who mentioned themselves as a key player in their depression mentioned other factors in causing or relieving their depression. Of the two who didn't, one was a drug addict and said *'only me can get myself well'* (10078). The other person said the best way to deal with depression was trying to be positive everyday. They specifically ruled out talking to anyone about it because *'no one would be interested'* (19197).

Of all the 58 participants whose comments we examined, 53 mentioned at least one other cause of depression other than themselves.

The changing nature of depression and attitudes to it could be detected in a number of participants' comments. One talked about coping with depression by acting as though nothing was wrong and shutting themselves off from it, adding a comment about the future: *'I know it's going to catch up with me one day but I don't know what else to do. I'll deal with it when it catches up with me'* (17187). Four participants talked about the past when they had seen themselves as the key player in relation to their depression but had moved on from this approach. One said *'I figured this is the way it is and I'll find a way around it'* (15085) until she had had a 'breakdown' and had been encouraged to go into hospital; two said they had been trying to believe they were OK, going on as though nothing was wrong, rather than listening to health professionals (15033) or *'having the right people around you'* (20120); a participant who saw depression as a *'lack of inner resource that other people seem to have'* (20104) seemed to have moved on to recognise the importance of being with people and doing things for enjoyment although still wary of talking to *'a whole load of people about it'* (20104). The data suggests that while experiencing symptoms of depression people may at times consider either their own lack of strength as a person as a cause of depression, or their own inner strength as a way out of depression; but this may change over time.

We examined the comments of participants for evidence of how they talked about the role of other people in relation to depression. Of the 58 participants' responses examined, 33 specifically mentioned the importance of talking to others or being with people: '*talking to others is important'* (23018); *'peer support is the way out of depression'* (08130); and '*being in contact with other people is really helpful to deal with it'* (22020). Participants mentioned family, friends and health professionals as people they talked to or spent time with. Of these 33 people, 12 were people who had identified themselves as a key player in relation to depression. This suggests people who consider either their own lack of strength as a person as a cause of depression, or their own inner strength as a way out of depression may also see contact with other people as important in their recovery.

When reading the 58 participants' responses across all the open questions, the use of words about being judged was striking. We therefore searched for their use. Fifteen respondents specifically mentioned the importance of people being non-judgemental. This comment was made about family, friends and health professionals. All but two of these 15 respondents had spoken about the importance of talking to someone. Two participants mentioned the importance of not judging but they did not specifically mention talking to people, for example, one said the most important thing health professionals can do is to not judge (08193). For one respondent the GP was the only person they talked to about their depression and confidentiality was very important to them: *'because it is not going to get back to anyone and no one's going to judge you'* (09297).

Four participants talked about feeling judged by others including friends, family and health care professionals. For example, participant 10198 felt the GP was judgemental because he was a family friend and 22164 said *'I should have told my friends about it but I wasn't sure they'd understand'*. Not feeling judged seems to be important to a significant minority of participants, as this was mentioned when responding to open questions about various aspects of depression. This is not unexpected since these participants had agreed with all four of the questions about social attitude to depression.

Sixteen participants felt they had not been listened to, not tolerated or dismissed by others, and of these 15 specifically mentioned doctors: *'Doctors don't seem interested in helping you, only sending you on'* (15007) and *'[the GP] wasn't very tolerant'* (15129). One expressed a sense of having been disbelieved by a counsellor (15124). From their comments, this experience appeared to have had considerable impact on these people.

VIEWS ON PROPOSED NEW FORMS OF DEPRESSION CARE THROUGH GENERAL PRACTICE

In this section of the interview, participants were asked about whether they would agree to various new forms of assistance from their general practice in relation to depression, stress or worries. The results are summarised in Tables 11 – 13.

Box 4: Overview of participants' views on new forms of depression care through general practice

Most participants were very happy to be proactively followed up by their general practice. They were relatively flexible about how they were contacted or even who they saw when attending appointments. This indicated that people were open to receiving assistance from other health professionals based at the clinic, such as practice nurses or psychologists. While 60% were happy to receive written screening questionnaires in the waiting room, 38.7% were opposed to or unsure about this proposal.

As shown in Table 11, levels of reported willingness to be seen or contacted by another health professional within the general practice clinic were high, with over 80% of participants stating they would agree to be seen by a practice psychologist or to consult a practice nurse (who was appropriately trained), or receive a follow-up phone call from a practice nurse. Given the current limited role of practice nurses in Australian general practice in the area of mental health (Keleher et al, 2007; Halcomb, Patterson and Davidson 2006), the acceptance of a role for a practice nurse is striking.

Almost 90% said they would be happy to receive a reminder from their GP clinic about their next appointment – see Table 12. In terms of the form of the reminder, traditional forms of communication were most popular – phone calls (82.1%) and letters (71.7%). Emails or text messages were most popular with only 41.2% and 37% of participants respectively saying they would agree to that kind of contact. Almost a quarter of participants (23.4%) were happy with any form of reminder.

Finally, while a majority of participants (60.8%) said they would agree to complete a written checklist in the waiting room to identify people with depression, stress or worries, significant percentages said they would not agree (27.4%) or were unsure (10.9%) – see Table 13.

Table 12. Number of CATI participants who would agree to be seen by another health professional in the GP clinic for help in dealing with depression, stress or worries

ASPECT OF CARE	YES		NO		UNSURE	
	N*	(%)	N*	(%)	N*	(%)
Be seen by a practice psychologist	479	(83.2)	74	(12.9)	18	(3.1)
Consult with a trained practice nurse	466	(80.9)	82	(14.2)	23	(4.0)
Receive a follow-up phone call from a practice nurse	492	(85.8)	67	(11.6)	9	(1.6)

*Cells do not add horizontally to 576 due to missing data

Table 13. Number of CATI participants who would agree to receive a reminder from their GP clinic about their next appointment related to their depression as well as their preference for the form of reminder

	YES		NO		NOT APPLICABLE	
	N*	(%)	N*	(%)	N*	(%)
Reminder from their GP clinic about next appointment	512	(88.9)	59	(10.2)	0	0
Phone call	473	(82.1)	35	(6.1)	59	(10.2)
Reminder letter	413	(71.7)	95	(16.5)	59	(10.2)
Email reminder	237	(41.2)	262	(45.5)	68	(11.8)
Text message reminder	213	(37.0)	290	(50.4)	64	(11.1)
All of the above	135	(23.4)	352	(61.1)	80	(13.9)
Don't know	3	(0.5)	226	(39.2)	321	(55.7)

* Cells do not add horizontally to 576 due to missing data

Table 14. Number of CATI participants who agree a written checklist whilst waiting to be seen by a GP is a useful way to identify people experiencing depression, stress or worries (N=571)

RESPONSE	N*	(%)
Yes	350	(61.3)
No	158	(27.7)
Unsure	63	(11.0)
Total	**571**	**(100)**

VIEWS ABOUT AND KNOWLEDGE OF HEALTH SERVICES AND CARE PLANS

In this section of the interview, participants were asked a series of questions about their knowledge and views about services available for people experiencing depression, stress or worries, with a particular focus on the Better Outcomes in Mental Health Initiative and written mental health plans.

Box 5: Overview of participants' views about and knowledge of health services and care plans

The Better Outcomes in Mental Health Initiative (Box 1, Introduction) was not widely known, but nonetheless most participants agreed with the statement "I feel I have enough information / knowledge about services for depression". When asked about who they felt should be responsible for informing people about such services, most named medical professionals (and overwhelmingly GPs), followed by the government, media or individuals themselves.

A large majority of participants were very positive about the concept of written, step-by-step care plans for recovery from depression, stress or worries. A small number expressed negative views about the potential benefits of a written care plan (saying they would be too much to absorb, too simplistic or too rigid). Most thought benefits would include a sense of direction, empowerment, a better understanding of their condition, and reduced isolation. Some could see both benefits and problems such as the requirement for support to be available for the plan to be effective, or for it to be sufficiently flexible or tailored to the patient. A minority of patients (33) had written care plans with their GPs – again, most had found this to be helpful with a small number reporting a negative experience.

Finally, when asked about what else should be available for people with depression, stress or worries, key themes were: more information and education about these conditions; more peer or group support; better availability, accessibility and targeting of services; more opportunities for social interaction and connectedness; better funded and more affordable services; and telephone help lines.

HEALTH SERVICES FOR PEOPLE EXPERIENCING DEPRESSION, STRESS OR WORRIES: KNOWLEDGE AND OPINIONS

As shown in Table 15, two thirds of participants felt they had enough knowledge or information about the services available, while only 16% had heard of the Better Outcomes initiative. The latter finding is not surprising – even if participants had experienced the effect of the BoiMH initiative in the form of mental health care plans, it is unlikely that their GP would have emphasised the name of the program with them. That a majority of participants reported feeling they had enough information about services for depression is encouraging, though a third disagreed.[11]

[11] Note that this question differs from that reported on page 32 which asked participants what sources they had used for information on depression as a condition, rather than *services* for people experiencing depression.

Table 15. CATI participants' knowledge of information about services available for people experiencing depression and the Better Outcomes Initiative (N=571)

STATEMENT	AGREE		DISAGREE	
	N	(%)	N	(%)
I feel I have enough information / knowledge about services for depression	385	(66.8)	186	(32.3)
Aware of the Better Outcomes in Mental Health Initiative	92	(16.0)	479	(83.2)

* Denominator variation is due to missing data

Medical professionals (particularly GPs) and the government were seen as the key groups or organisations responsible for informing people about services for people experiencing depression. Many participants felt that some personal responsibility had to be taken for finding out about services, and the media was frequently mentioned as well.

Table 16. CATI participants' views on people / organisations responsible for informing people about health and support services for people experiencing depression (N=576)

PERSON / ORGANISATION RESPONSIBLE FOR INFORMING PEOPLE ABOUT HEALTH / SUPPORT SERVICES FOR DEPRESSION, STRESS OR WORRIES	NO. TIMES MENTIONED	(%)
PROFESSIONALS	**431**	**74.8**
Medical professionals	397	68.9
GPs	383	66.5
Medical professionals in general	12	2.1
Services (e.g. community health centres, hospitals, specialist mental health services)	46	8.0
Community health centres	22	3.8
Health professionals in general	29	5.0
Allied health professionals (e.g. psychologist, counsellor, social worker)	23	4.0
OTHER ORGANISATIONS AND PEOPLE	**196**	**34.0**
Government	167	29.0
Schools	13	2.3
Family and friends	12	2.1
THERAPIES AND RESOURCES	**90**	**15.6**
Media	63	10.9
Traditional media (TV, radio, newspapers, magazines)	28	4.9
Media in general	26	4.5
Internet (e.g. beyondblue)	24	4.2
Advertising	29	5.0
SELF	**57**	**9.9**
TOTAL	**576**	**100**

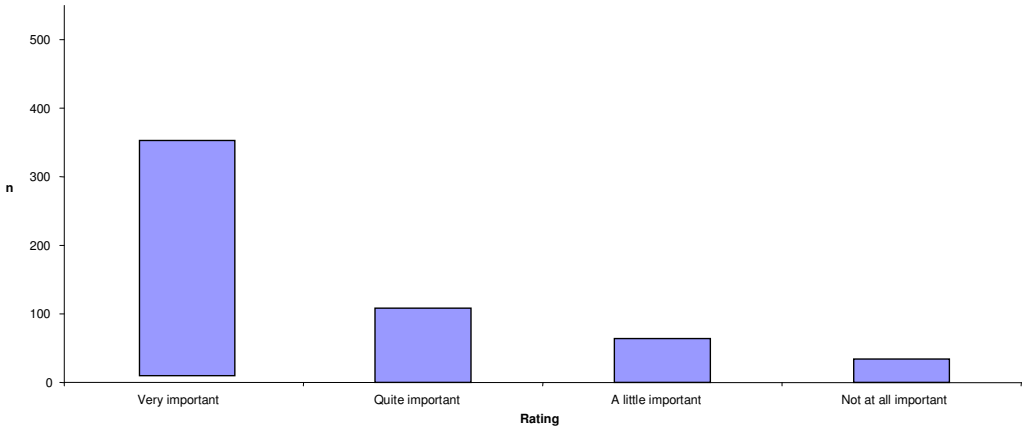
HOW GPS SHOULD INFORM PATIENTS ABOUT SERVICES FOR PEOPLE EXPERIENCING DEPRESSION, STRESS OR WORRIES (N = 355)

Participants made a range of suggestions as to how GPs should inform patients about services for people experiencing depression, stress or worries. The most common suggestions were using leaflets (167), to simply tell or talk to patients about services (141), and direct referral to services (95). Other suggestions included making discussion of services part of the normal consultation (34) and displaying posters in the clinic (23).

MENTAL HEALTH CARE PLANS: OPINIONS AND EXPERIENCE

When asked about the importance of a written, step-by-step plan about how to recover from depression, stress or worries, a clear majority thought this was 'very' or 'quite' important, as shown in Figure 4.

Figure 3: CATI participants' rating of the importance of access to a clear 'step-by-step' written plan about how to recover from depression, stress or worries



Asked to identify the benefits of access to a written care plan, most participants' responses were wholly or partly positive as Table 17 shows.

Table 17: CATI participants' views on the benefits of having access to a clear, 'step-by-step' written plan to recover from depression, stress or worries – main categories of responses (N = 550)

BENEFITS OF HAVING ACCESS TO A CLEAR STEP-BY-STEP WRITTEN PLAN TO RECOVER FROM DEPRESSION, STRESS OR WORRIES	NO. TIMES MENTIONED	(%)
Don't know	18	3.3
Positive responses	454	82.5
Negative responses	26	4.7
Mixed responses	102	18.5
Total	**550**	**100**

The key positive aspect of such a plan identified by participants was that it would provide direction – a sense of progress or guidance for action (mentioned 313 times): *'My own experience from two years ago when I was in the middle of mania, it would have been a road map, like a reality check. When my GP and family were telling me, I was so in the middle of it I couldn't see. If I were presented with something like that I'd be forced to look at it.'* (15033) A sense of empowerment was another benefit participants focused on (102 mentions) – a plan's potential to help patients feel in control, motivated, confident, and hopeful that their depression would end: *'It has to be very clear. It gives you options, but it also puts you back in control. The illness often takes things out of your hands, but to give you some sense of control will also give you hope.'* (16003) Others talked about a plan enhancing patients' understanding of their condition: *'It can stop people from that procrastination crap. If it's a no-brainer it's easier to get started.'* (23170) A fourth major benefit participants identified was the ability of a plan to reduce feelings of isolation (54 mentions) – a sense that the patients' feelings and condition has been acknowledged, that help is available, and that they are being cared for: *'You sort of know that you are not alone, and you have all theses services available. You can take these small steps. And small steps boost your confidence.'* (32166)

Of those who were negative about the benefits of a written plan, many felt that the depressed person would be unable to absorb the information (11): *'Zero [benefits]. You're not going to look at it. One thing that comes along with depression is denial. So it doesn't exist. I don't know whether you've spoken to [people] who have had serious episodes, intermediate or low level, but that all goes out the window, it would be an absolute waste of time. That form of reality doesn't exist.'* (18198) Others were concerned that the approach was too simplistic or too uniform (10): *'If there was a simple 10-point plan about how to recover I am sure a lot of people would be following it, but according to my psychiatrist and myself, such a plan doesn't exist. Or I would have stopped going to the psychiatrist long ago.'* (13056)

Many participants had mixed views, arguing that plans would be effective only under certain conditions such as if support was available (28 mentions): *'I think that it would possibly keep you on track but somebody has to monitor what is going on. Someone to discuss and talk about things. Like AA.'* (21133) or if there was sufficient flexibility built in (10): *'[It needs to be] a flexible guide, not a cut and dry method. People could use different steps from [it]…'* (22020) Others pointed out the ability of a plan to assist really depended on the patient, their situation and their preferences (mentioned 36 times): *'The journey is not always so clear, and if they don't achieve those milestones then they can find it disempowering. It depends on the therapy, for example cognitive therapy has a very precise plan and I don't think that is a good therapy and psychodynamic therapy has a wandering approach and that is my preference. I think plans are dangerous in that way.'* (18009)

Of the 568 participants who answered the question 'Have you made a written plan with your GP, as part of him / her helping you to get better?', less than 6% (33 participants) reported doing this. Of these, 26 stated they had had a positive experience, while six had a negative experience.

A further two made neutral comments. Positive experiences included finding the plan helpful (16), or feeling that it provided a sense of direction (11): *'I think you feel like you've got some direction and you know someone is going to be there to follow it up.'* (23151). Other participants commented on feeling that their progress was being tracked (7), reduced anxiety (4) and a sense of feeling cared for (4). Negative responses included that the plan was not right for them (3) and that it wasn't helpful (3): *'…I've found it fairly futile, it told me nothing I didn't already know, but it didn't give me the enablers to get there.'* (18198)

OTHER THINGS THAT SHOULD BE AVAILABLE FOR PEOPLE EXPERIENCING DEPRESSION, STRESS OR WORRIES (N = 570)

Possibly because of the wording of this question ('Apart from what you mentioned about General Practitioners[12], what else should be available for people experiencing depression, stress or worries?'), most participants focused on things that professionals could do (281 mentions) – medical professionals (113) and GPs (78) in particular. Nonetheless, some major cross-cutting themes did emerge, as shown in Table 18.

Table 18: CATI participants' views on what should be available for people experiencing depression, stress or worries

THINGS THAT SHOULD BE AVAILABLE FOR PEOPLE EXPERIENCING DEPRESSION, STRESS OR WORRIES	NO. TIMES MENTIONED
Information and education (self-help resources, more information, and better public awareness	136
Group support (Support groups / Group therapy)	93
More available, more accessible and better targeted services	79
Opportunities for social interaction and connectedness	72
More affordable, better funded services	70
Helplines	51

12 This question followed a question on the most important things GPs could do for people with depression, stress or worries. The results of that question are presented in Table 9.

2.4 CONCLUSION

> *Just remember to look at the nice stuff, stop and look at the roses. It's such a real thing. And tune into the beauty of stuff, think nice thoughts. You have to change the way you think, you only have to change the way you think about yourself and the rest is okay. That's what I have found anyway. And it's hard, the feeling of self-worth is a hard thing, and when you haven't had a lot of that it's hard to recognise what it all means. And self-worth is a really hard thing to accept in yourself. We can get rid of a few maths lesions and have these lessons instead, it would make their lives a bit easier. But society is different now. I came through the dark ages.* (27219)

The results presented above are summaries of key questions asked in the first phase of **re-order**. Our analysis suggests that participants perceive many different factors in the genesis of depression. We can also conclude that people with depression, stress or worries seek information, help themselves and seek help from people other than health professionals. Another clear finding is that stigma remains an issue. Health professionals are seen as having an important role in participants' management of their depression, stress or worries with GPs playing a particularly important role.

GPs are good at listening, understanding, and being supportive, which is also what participants think is the most important thing GPs can do for people experiencing depression, stress or worries, followed by competence in diagnosing and managing mental health conditions. Their ability to diagnose and direct patients to appropriate management and referral depends on their own knowledge but also on available referral/treatment pathways. The results also clearly show that participants welcomed the idea of written plans, though few had had one written for themselves (most probably because at the time of the CATI interviews – January 2006 through to March 2007 – mental health plans were still relatively new, having first been introduced in November 2005). Patients also reported being interested in using other kinds of professional help (e.g. psychologists, practice nurses) in addition to their GP.

Key limitations of this phase of **re-order** included the very large number of participants – it is unusual to conduct open-ended survey interviews with such a large cohort. This meant that the organisation and analysis of the transcripts using NVivo was a very labour and time-intensive process. Additionally, the coding was conducted in such a way as to try and capture multiplicity and richness of participants' responses and as such does not lend itself to numerical or statistical interpretation or presentation. There will be the opportunity to progress the analysis of this data in tandem with the ongoing NHMRC funded *diamond* project and this is likely to yield further information on what happens over time for people experiencing depression.

CHAPTER THREE: THE VOICE OF THE COMMUNITY AND EXPERT STAKEHOLDERS (PHASE TWO)

3.1 INTRODUCTION

This phase of **re-order** aimed to investigate the views of key non-patient stakeholders involved in the care of people with depression. In particular, it sought to elicit their ideas about the best ways to manage depression in the primary care setting; create a list of key elements based on their particular perspectives; and gain consensus about the most significant elements to be included in the management of depression in primary care settings. A two-round modified Delphi consultation process was employed in order to develop formal consensus among stakeholders.

3.2 METHODS

3.2.1 SAMPLING

For this exercise, stakeholders were purposefully sampled. This process involved identifying determinants of health as relevant to various contexts as outlined below and possible non-patient stakeholders relevant to these categories:

- the individual experiencing depression within the wider society;
- the individual within their context over time;
- the individual within their family / immediate social network;
- the individual, their biology and lived experience;
- the health professional within their health service context; and
- health care services within the wider health care context.

A database of potential participants was established including relevant stakeholders from government, NGOs, allied and health professionals, and academia (see Box 6 for more detail). Investigators and research staff together produced a matrix of determinants of health against potential stakeholders in order to check links between determinants and stakeholders, and identify any gaps or missing stakeholders. From the matrix, the research team (six staff) brainstormed possible groups and organisations; searched websites, publicly available directories and lists to check for further gaps; and mapped the list against existing networks (e.g. websites of relevant organisations, the *Diamond* Research Network, team members' professional contacts). Stakeholders identified through this process received letters of invitation to participate. Participants could also self-select in response to advertisements about the project through professional newsletters, patient newsletters, and relevant websites. Recruitment continued until the research team had established and obtained email addresses for a diverse group of 1172 national and international stakeholders. Of these, we successfully made contact with 952.

BOX 6: Main non-patient stakeholders identified

A total of 1847 potential stakeholders were identified. The research team obtained email addresses for 1172 individual participants.

Government: 293 government stakeholders were identified. At the federal level these included the Assistant Director of the Mental Health Promotion Branch, Commonwealth Department of Health and Ageing; the Executive Director of the Australian Sports Commission; and the Branch Manager of Social Security Relationships and Compliance, Commonwealth Department of Families, Community Services and Indigenous Affairs. At the state or territory government level, stakeholders identified included the CEO of the NSW Aboriginal Health and Medical Research Council and a solicitor from the Northern Territory Legal Aid Commission, and at the local government level, a Councillor from the Manningham City Council in metropolitan Melbourne, and the Arts Manager for the Central Goldfields Shire Council in regional Victoria.

Non-government sector: 328 stakeholders from the NGO sector were contacted, including a consultant from Ausienet (the Australian Network for Promotion, Prevention and Early Intervention for Mental Health), the CEO of Carers Queensland, and the Manager of the Migrant Resource Centre in Canberra.

Allied health and health sector: The Team Leader, Barwon Primary Mental Health Team (Geelong, Victoria), the Practice Manager of the North Richmond Community Health Centre, the CEO of the Australian Acupuncture & Chinese Medicine Association, and the CEO of the North East Valley Division of General Practice were among the 833 allied health and health practitioners / organisations contacted.

Academics: 393 Australian and international academics were identified, including academic GPs, health economists, medical sociologists, and social policy scientists publishing in depression in primary health care by searching the databases of Medline and PsycInfo.

3.2.2 DATA COLLECTION AND ANALYSIS

A two-round modified Delphi consultation process was used to elicit the views of stakeholders on the key elements of depression care in primary care. In the first round of the consultation, a written survey was emailed to 1172 stakeholders. Recipients were asked to provide up to five answers to the following three open-ended questions that had been developed and piloted by the research team:

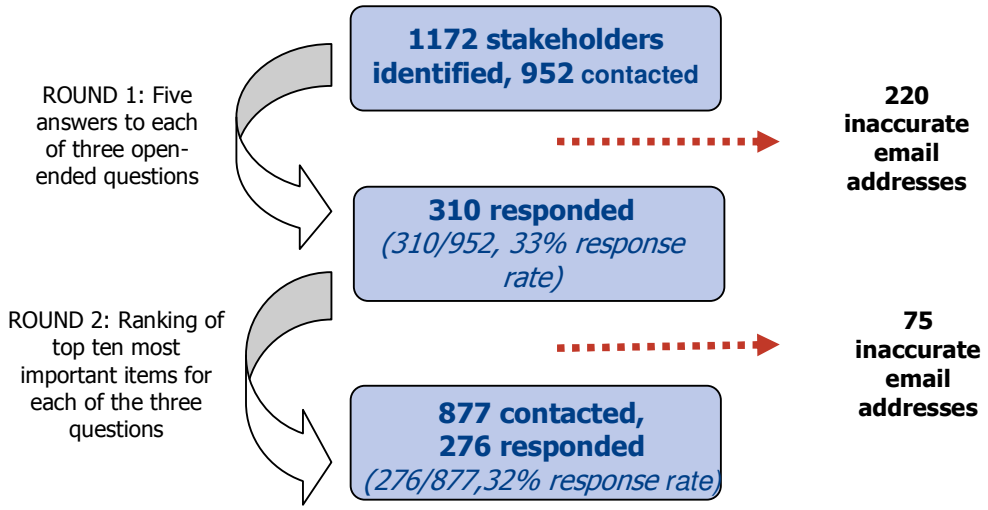
1. How should general practice / primary care respond to people experiencing depression?
2. What are the barriers for best practice in general practice / primary care when faced with people experiencing depression?
3. How would we know if general practice / primary care is meeting the needs of people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

Research team members developed a coding framework to identify the twenty most frequent responses for each question. The coding framework was constructed on the basis of reading the responses and iteratively developing codes, and re-reading responses and checking codes as new codes emerged. Two or three research staff then coded the responses individually and compared their choices, and discussed until consensus was achieved.

In Round Two, participants were asked to rank in order of importance from 1 to 10 the twenty most frequent responses from Round One which the research team had analysed, refined into a list, and then sent out again for review to include rating and ranking for a list of twenty randomly ordered items (Mullen 2003; Jones and Hunter 1996).

Figure 4 depicts the overall consultation process. Because of the large number of participants consulted, and the fact there were only two rounds, the process used cannot be characterised as a true Delphi.

Figure 4: Overview of Modified Delphi consultation



RESULTS

In Round One of the non-patient stakeholder consultation, 310 completed surveys were received from a total of 952 participants for whom we had correct contact details (220 email addresses were inaccurate), yielding a 33% response rate. This included 62 stakeholders from government organisations, 80 from NGOs, 65 allied and health professionals, and 103 from academia. In Round Two, there were 276 responses from a total of 877 stakeholders (another 75 email addresses were found to be problematic), a response rate of approximately 32%.

The "top ten" ranked items in Round Two are presented for each question below, with sample quotes taken from the open-ended questions asked in Round One to illustrate the kinds of responses coded.

Table 19: Non-patient stakeholders' views on how general practice / primary care should respond to people experiencing depression - ten items most frequently nominated in participants' top five

No.	Item	N = responses
1	Listening	147
2	Undertaking a thorough diagnostic assessment	136
3	Developing a plan with the patient	120
4	Undertaking an assessment of severity and suicide risk	113
5	Being well trained in depression care	95
6	Tailoring care to individual needs	92
7	Taking into account social factors	77
8	Being empathetic	67
9*	Providing longer consultations	65
9*†	Offering a range of treatment options	65

* equal ranking with at least one other item
† lower ranking items not reported here

Listening captured responses such as: *'Use good communication skills and listen carefully'* and *'Listen to their story and create a safe, nurturing response. Provide assurance.'* Responses coded as **undertaking a thorough diagnostic assessment** ranged from *'Take a life history and look for factors which could be the cause of depression… pay particular attention to childhood experience.'* and *'Take a history, check on use of drugs, perform a screening physical, do a mental status exam.'* Further down the list, **Being empathetic** was used to code responses such as *'Understand the anxiety associated with presenting to GP'* or *'Listen and ask questions that help client to feel understood but not interrogated'*.

Table 20. Non-patient stakeholders' views on barriers for best practice in general practice / primary care when faced with people experiencing depression apart from time - ten items most frequently nominated in top five (apart from 'time')

Time emerged as a very significant issue in response to this question – as such it was not included in Round Two (though participants were informed of this).

No.	Item	N = responses
1	An over-reliance on prescribing medication	123
2	Reliance on a medical model	114
3	A lack of affordable referral options	109
4	Poor integration between general practice / primary care and other providers	96
5	A lack of services in regional areas	89
6	Inadequate general practice / primary care competence to recognize, assess and treat depression	84
7	Inadequate general practice / primary care training to recognize, assess and treat depression	78
8	A lack of professional support for general practice / primary care when providing depression care	77
9*	The lack of knowledge about depression within general practice / primary care	73
9*†	Patients cannot access services in a timely manner	73

* equal ranking with at least one other item † lower ranking items not reported here

As noted, many participants identified **time** as a barrier to best practice depression care in general practice / primary care. Responses included *'Lack of time to talk with patients in an unhurried fashion'*, *'GPs are too busy to do proper assessments'* and *'Remuneration for time'*. **Over-reliance on prescribing medication** was used to code responses such as *'Dominance of drug therapy as first choice of treatment – this is a panacea, not a treatment'* and *'Pharmaceutical options are usually the primary (and sometimes, the only) treatment offered and patients are often reluctant to use these'*. *'GPs being too focussed on medical solutions only'* and *'Lack of understanding of the reasons for depression – a social model of health would enable a more holistic approach to care rather than just a medical model approach'* were some of the responses coded as **reliance on a medical model**.

Table 21. Non-patient stakeholders' views on ways of knowing if general practice / primary care is meeting the needs of people experiencing depression - ten items most frequently nominated in top five

No.	Item	N = responses
1	Surveying and interviewing patients	137
2	Measuring patient satisfaction	114
3	Monitoring the number of patients with depressive symptoms who seek help from general practice / primary care	96
4	Surveying carer and consumer groups	89
5	Monitoring patient recovery (for mental health conditions)	88
6	Measuring diagnosis rates in general practice	78
7	Measuring functional outcomes (e.g. capacity to function physically, socially and in the community)	77
8	Monitoring the quality and duration of follow-up (for mental health issues)	75
9	Surveying and interviewing GPs	68
10	Monitoring referrals made by general practice / primary care	60

Responses coded as **surveying and interviewing patients** included *'Ask the patients'* and *'Conducting research with people who identify as having depression and seeking their feedback on treatment received from general practice / primary care'*. Typical responses for **monitoring patient recovery (for mental health conditions)** were *'lower relapse rate'*, *'decreased disability among people with depression'* and *'people get better! i.e. if they recover from their depression and can lead productive lives.'* Comments such as *'increased referrals to counselling/support'* and *'possible lowering of referrals to specialist care'* were coded as monitoring referrals made by general practice / primary care.

3.4 DISCUSSION

Our aim with this phase of **re-order** was to capture views from a wide range of stakeholders, including those not usually considered a part of depression care (for example, sections of the Treasury who allocate government funding to various components of the system and drought officers involved in counselling farmers experiencing economic hardship). When we embarked upon this approach there was much discussion within the research team about whether it would work. There were conflicting views about asking those whom were not involved in patient care to comment on health care for depression. However, as our work was informed by complexity theory we pushed ahead with this inclusive approach[13].
We found, as demonstrated above, that response rates were similar across the various stakeholder groups. Considering our broad-based approach, response rates of around 33% were very pleasing. Indeed, one of the longest and most passionate responses was received from a Drought Officer who indicated that most of their work was dealing with the emotions and not the finances of drought and its effects. Of course, the two are inextricably linked, yet a traditional approach to a stakeholder consultation would not have included such a respondent. Did our approach yield a different set of responses? It is difficult to be certain. What is more apparent is the agreement that exists between the groups; although a careful review of the findings broken down by sub-group presented in Appendix 4 shows that subtle differences do exist.

The most overwhelming finding is the importance of listening and good communication skills to both patient and non-patient stakeholders. Listening to the person, hearing their life story and trying to see things from their point of view in the context of their life were recurring themes. In the following section we move to working with practices as they go about their daily work. We present a first-hand account of what is going on with depression care in Australian general practice.

[13] See Introduction to Chapter Four on the use of complexity theory in **re-order**.

CHAPTER FOUR: THE VOICE OF PRIMARY CARE (PHASE THREE)

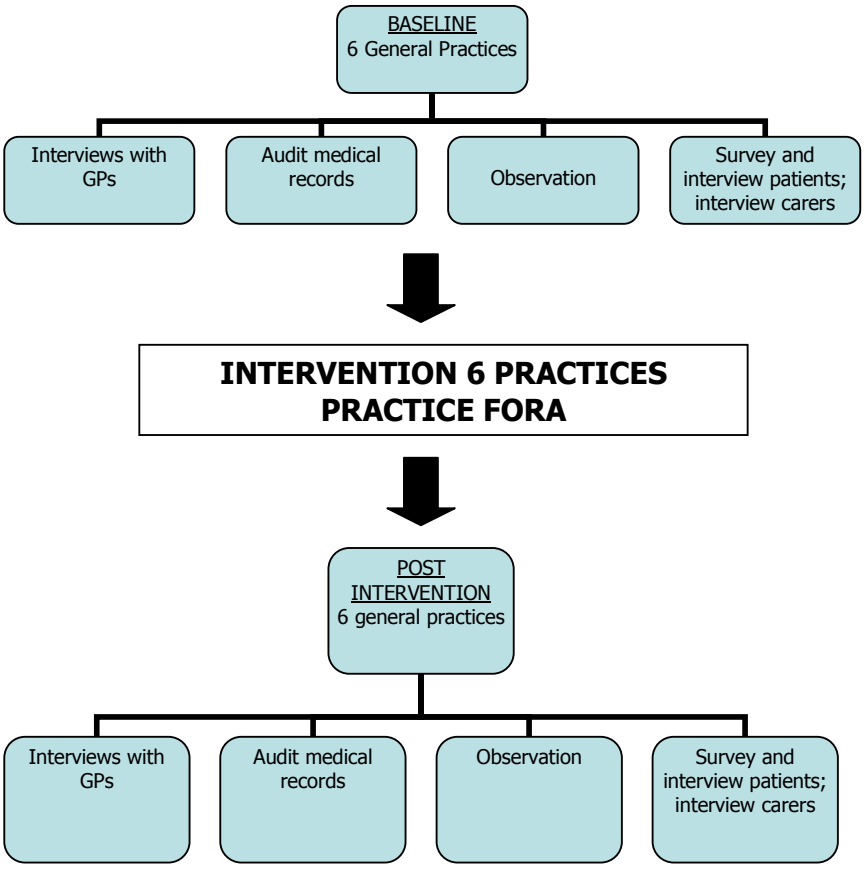
4.1 INTRODUCTION

re-order aimed to develop practice level improvements informed by the theoretical framework of complexity theory (Sweeney & Griffith 2003; Byrne 1998). Data collection tools were designed to appreciate practices as complex adaptive systems which Byrne (1998) describes as those which:

1. consist of members/components;
2. are dynamic, interactive and interdependent;
3. are adaptive and have the capacity to change and to self-organise;
4. have shadow systems operating that influence daily work;
5. have emergent properties that are more than the sum of the individual parts; and
6. show initial conditions which can markedly influence what happens in a study.

We worked with practices over a 12-month time period. Where possible we shared findings from the research conducted in previous phases. Data collection aimed to illuminate these elements of complex adaptive systems and their interactions and to inform researchers about **members** of practices such as: reception staff; managers; nurses; doctors; patients of different ages and backgrounds; allied health staff and **components** within sites such as: spaces (private and public); infrastructure; technology; tools and equipment; information, resources and information systems; culture and values. Observational data highlighted how each practice was a setting full of human interaction and interdependency (what happens at the reception desk influenced what happened in the consulting room and vice versa). Observations assisted us to understand the **initial conditions** of each practice; the **difficulties in predicting** exactly what would happen in each in practice; and the role of **time** in everyday work. We looked for evidence of **adaptation,** patterns and/or consistent ways of working or comfort zones, with particular attention given to the possible presence of the so-called **shadow system**, or informal ways of working. **Emergent properties** of practices, where the whole is greater than the sum of its parts, were explored and we attempted to understand initial conditions that can markedly influence what happens in a study. To collect this information a selection of quantitative and qualitative methods were used: a medical record audit, participant observations, environmental checklists, a written GP survey and facilitated practice forum meetings. Figure 5 shows the methods of data collection used in this third phase of **re-order**.

Figure 5: Practice phase methods of data collection



4.2 METHODS

4.2.1 RECRUITMENT

Practices were purposefully sampled from metropolitan, outer metropolitan and regional locations of Victoria and Tasmania. Purposeful sampling is a common method of recruitment in qualitative research and sites are selected to provide information rich cases that reveal in-depth 'understanding rather than empirical generalisations' (Patton 2002: 273). **re-order** aimed to recruit a selection of solo or two person owned practices, group practices, community health centres and corporate owned practices in a mix of locations. Once identified, a researcher telephoned the practice manager or principal GP to explain the study. Practices were sent a formal letter of invitation and an information brochure (see Appendix 5) and a whole of practice meeting was scheduled. A 30-minute presentation was delivered to practices outlining study aims, policy and research evidence and the data collection processes. Practices were paid $5000 each to remunerate them for the time spent participating in **re-order** over a one-year time period.

4.2.2 SURVEY OF PARTICIPATING GENERAL PRACTITIONERS & INTERVIEWS

Once practices agreed to participate all GPs were invited to complete a brief written survey. Survey data informed practice characterisations (reported in results section), it gathered information about GP education, training and special interests, clinical hours, including practice information. Written surveys were utilised directly for selecting participants to the PhD study attached to **re-order**. The PhD candidate Dr Caroline Johnson conducted individual structured interviews with selected GPs at commencement and on completion of the practice phase. Her study was focused on the GP-patient-carer triad with a focus on monitoring for depression care (see Appendix 7).

4.2.3 MEDICAL RECORD AUDIT

In addition to GPs completing their surveys, each practice participated in an audit of electronic health records before, during and after their chosen intervention. The audit method is a standard quality assurance process, and is widely used in general practice, for example, the Australian Primary Care Collaborative Program (APCCP – see http://www.apcc.com.au). The purpose of the audit was to collect data about patients aged 18 to 75 years to identify:

1. The number of different patients that visited the practice in the last 12 months
2. The number of patients who received a diagnosis of depression
3. The number of prescriptions written for anti-depressant medications
4. The frequency of visits to a GP at the practice by patients with a diagnosis of depression
5. The number of Medicare Mental Health item numbers (2710, 2712, 2713) billed
6. The number of referrals to mental health professionals, and;
7. The number and type of co-morbid conditions of patients with depression

Electronic billing software i.e., PracSoft®, was searched for information on the relevant MBS item numbers billed and Medical Director or another Electronic Health Record keeping system used by the practice was used to ascertain numbers of patients and diagnoses of depression. Where practices used a paper-based billing system the practice requested a report from Medicare Australia. Data from the audit was used to develop a picture of how depression care happened at practices and to monitor the intervention and its effect on practices.

4.2.4 PRACTICE OBSERVATIONS & CHECKLIST

A graduate anthropologist conducted observations at all practices and completed an environmental checklist. Checklists were used to identify practice composition (staff, opening hours, floor plans), the physical environment (notes about waiting rooms and information available to patients), patient flow, squeeze-ins and the appointment system (Appendix 6). GPs were observed in consultations with their patients over three and four hours per session. Patients were asked for consent prior to entering the consultation and for reasons of practicality and ethics clearance, all cases were observed in the course of a day, not just those exclusively focussed on depression. The observer took hand-written notes during consultations and returned to offices to record these in word format at the end of the day. In addition to observing GP-patient consultations, time was spent observing other activities within the practice including reception staff and practice nurses. Practice observations provided further information to characterise depression care at the sites.

4.2.5 PRACTICE FORA

Practice forum meetings were designed to develop practice-driven interventions around depression care using ground-up action research methods. Participants followed the action

research cycle to plan, do, study and act with pre-designed activities for the five meetings. Meetings were scheduled for one hour, were whole of practice focussed – encouraging reception staff, nurses and other professionals to attend – meetings occurred once audits, surveys and observations were completed. Table 21 details the forum activities undertaken. These were facilitated by a non-medically trained researcher familiar with action research methods; this was an intentional method deployed for intervention development and it differed slightly to more traditionally applied complex interventions in health care, which:

> [w]hether therapeutic or preventative, comprise a number of separate elements which seem essential to the proper functioning of interventions although the 'active ingredient' of the intervention that is effective is difficult to specify. (…) Complex interventions are built from a number of components which may act both independently and interdependently. The components usually include parameters of behaviours (e.g. frequency, timing) and methods of organising and delivering those behaviours (e.g. types of practitioner(s), setting and location) (MRC 2000 as cited in May et al,. 2007b: 43).

Rather than implement top-down interventions aimed at changing a particular behaviour or trialling a pre-conceived technique for depression care (like screening patients and measuring for change), **re-order** sought interventions devised by practices, for practices. The aim was to identify where practices were at in terms of their depression care and to document what change they focussed on. We used the principles of complexity to design activities that could lead to change (Miller & Crabtree 1998).

Table 22: Activities designed for practice forum meetings

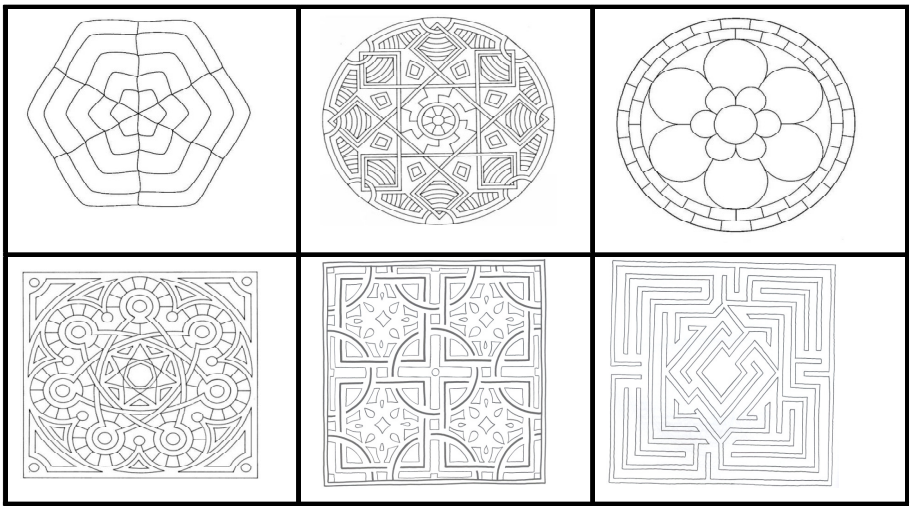
Forum	Activities
1	Reflection on depression care. Identification of Strengths, Weaknesses, Opportunities and Challenges. Discussion of stakeholder expectations for depression care. Discussion of first audit findings of medical record system.
2	Reflection on participation observations. Discussion of depression care. Identification of 'system' of depression care.
3	Discussion of collated SWOC summations. Identification of Opportunity, Challenge or Weakness to address. Development of change process or intervention.
4	Re-visiting the intervention. Monitoring what is happening. Discussion of the process.
5	Reflection on intervention process. What did participants learn? Did anything about depression care change?

Forum activities were thus designed to facilitate planning, doing, acting and reflecting on depression care within practices. Meetings one and two were reflective sessions that aimed to allow groups to develop their ideas and understanding about depression care and to think about potential changes. The principle focus was for the intervention to develop from within the group. To this end, the first two meetings used techniques such as a reflective Mandala activity, a strengths, weaknesses, opportunities and challenges (SWOC) activity, sharing preliminary findings about expectations for depression care from the earlier patient and non-patient stakeholder phases of **re-order** (see Chapters 2 and 3) and the initial participant observer impressions. In a ground-up intervention, the first meeting is crucial to facilitating ownership of research processes and achieving the ideals of participatory action research (PAR). For this reason meeting one and two encouraged participants to share their ideas and views about depression and to become co-researchers rather than objects of investigation (Reason & Bradbury 2006). The two meetings consistently reinforced the study's focus on developing exemplary models of depression care.

Meeting one also provided the opportunity to identify if practices could articulate an existing system of depression care. Because the participants were busy professionals who were likely to be focussed on practical tasks, it was anticipated that asking for them to think about and share conceptual information about exemplary depression care and models might prove difficult. To assist in eliciting such information from the participants, the facilitator designed a short reflective activity using six Mandala images. Having trialled this method previously with other groups, she had found using visual tools helpful for sharing complex information that is difficult to articulate and needs to be gathered quickly. Visual mapping such as this is particularly useful when discussing systems or organisations with groups. Different values, principles and ways of perceiving issues or phenomena can be explored as a group.

Table 23 shows the six Mandala images provided to participants. The images were not chosen because they provided a 'right' or 'wrong' answer about depression care. Rather, it was thought that their circular, square or non-symmetrical shapes would assist people to describe depression care. In a visual form, what might appear to be a non-existent system of depression care may seem easier to explain. Participants were given the six images at the start of session and asked to select the one that best described, for them personally, how depression care happened at the practice. They were allocated ten minutes to write down their ideas about their practice's 'system' of depression care for collection by the facilitator. If comfortable to do so, participants could share their thoughts and images with the group as part of the reflective process.

TABLE 23: Reflective Activity – Mandalas



This information about how depression care was perceived by participants was helpful for informing our understanding of the initial conditions at practices. Hearing participants' views on the top ten stakeholder expectations of depression care by patients and non-patients was anticipated to provide further information for intervention developments. And providing the results of the brief medical record audit and the initial impressions from the observer was meant to encourage participants to think about their information systems and systems of depression care.

In addition to the observer attending forum meeting two, participants were also provided with de-identified collated SWOC material to consider. Groups were reminded that SWOC data could be used to identify their intervention by focussing on a challenge or opportunity they had collectively identified. Meeting three was facilitated with this in mind and the focus of this session was for participants to identify and develop their ground-up intervention. The facilitator encouraged participants to select an intervention and to describe how they would implement, monitor and evaluate this; a key question for this exercise was, 'How would you know if you were providing good depression care?' For meeting four, groups were asked to provide their version of how the intervention had gone and for meeting five they were asked to reflect on if this had improved, or could improve, depression care. Meeting five also asked participants to share ideas and information about exemplary models of depression care and to reflect on the processes of being engaged in the study overall.

4.2.6. METHODS OF ANALYSIS

Each dataset was combined and considered as a whole case. Baseline audit data provided a picture of how depression care was occurring before interventions. It was also used as a monitoring tool for during and after interventions. Audit data was analysed by frequency counts. Observational notes, forum transcripts and checklist data were de-identified and pseudonyms allocated to all practices and staff members. Data analysis took an iterative approach, and during regular research team meetings data and early impressions were discussed and debated as a group. Researchers developed a picture of how depression care occurred at practices through this research team dialogue; similarities and differences across practices were looked for. As practices devised their interventions, researchers discussed these and the potential outcomes. The team also examined data for patterns of work, emergent properties, shadow systems and how depression care was organised according to complexity theory, at times early participant observation notes and practice forum transcripts were reviewed during research team meetings to facilitate this.

As data was collated from environmental checklists, the SWOC and Mandala activities, the research team reviewed these to appreciate the organisation of depression care at the practices and the challenges of delivering exemplary depression care. GP survey responses were recorded within STATA and analysed for preliminary information about GPs and their practices. Observation notes were taken over the course of the study and forum meetings were audio recorded and professionally transcribed. Investigators provided thoughts and reflections on depression care at the practices during a series of data meetings. In final analyses datasets were combined to facilitate understanding of depression care at practices before interventions (practice characterisation), how practices tried to improve their depression care (interventions) and what happened in relation with this (outcomes).

The sections below report on the results as follows. Section 4.3.1 (**Practice characterisations**) provides the results from analysing GP surveys, environmental checklists, observational notes, and some activities completed in forum meetings one and two. Section 4.3.2 (**Interventions**) provides further information from forum meetings and the results of ground-up developed practice changes combined with audit data which formed a part of

interventions. Section 4.3.3 (**Outcomes**) provides the results as detected in post-intervention medical record audits.

4.3 RESULTS

4.3.1 PRACTICE CHARACTERISATIONS

Six practices were recruited to the **re-order** practice phase. Four were privately-owned practices, one was corporately-owned and one was a community health centre. Four practices were located in metropolitan areas, one in a regional setting and one in an outer metropolitan area. Five practices were located in Victoria and one was located in Tasmania. Table 24 presents the characteristics of participating general practitioners, by practice.

Table 24: General practitioner characteristics by practice

GP characteristic	*Practice*						*diamond study GPs (N=30)*
	Eastvale (N=5)	*Gibson* (N=1)*	*Frank Street (N=4)*	*Southville (N=7)*	*Coopers (N=7)*	*West Sanders (N=9)*	
Gender n (%)							
Male	3 (60)	0	3 (75)	6 (85)	2 (29)	5 (56)	22 (73)
Female	2 (40)	1 (100)	1 (25)	1 (15)	5 (71)	4 (44)	8 (27)
Age							
Mean (SD)	46.4 (10.7)	52	53 (5.4)	52.6 (10.8)	46.4 (9.4)	55.6 (11.9)	52 (9)
Country of graduation %							
Australia	(100)	(100)	(75)	(71.4)	(100)	(88.9)	25 (86)
Qualifications *n (%)*							
Vocational registration	3 (60)	1 (100)	3 (75)	5 (71)	4 (57)	7 (78)	19 (63)
FRACGP registration	5 (100)	1 (100)	1 (25)	5 (71)	3 (43)	8 (89)	11 (37)
PhD	1 (20)	0	1 (25)	0	1 (14)	0	1
Master in Mental Health Psychiatry	0	0	0	0	1 (14)	0	0
Other Masters, Diploma, Certificate	3 (60)	1 (100)	3 (75)	3 (43)	2 (29)	4 (44)	20 (67)
Number of years in general practice in Australia							
Mean (SD)	13.4 (7.6)	24	22.8 (8.7)	24.4 (10.8)	17 (8.4)	28.3 (11.6)	20.2 (11)
Hours of clinical general practice a week *Mean (SD)*							
Clinical - General practice	45.2 (6.9)	32	24.3 (14.6)	31 (8.8)	19.9 (5.8)	29.4 (11.6)	39 (14)
Number of GPs with other roles in a usual week							
Clinical - Hospital	0	1	0	0	0	0	6
Administration	2	0	1	4	1	0	11
Teacher / Educator	0	1	1	3	1	1	7
Research	1	1	1	1	2	1	1
Division of General Practice	1	0	0	1	0	1	4
Other	1	0	0	0	2	0	2

*There are two GPs at this practice, however only one participated in the study.

Practices showed a variation of gender with Coopers Road Medical Centre having the highest proportion of female doctors. The GP ages ranged from 31 to 70 years; Eastvale Family Medical Centre and Coopers Road Medical Centre had the lowest mean age of all GPs. Fewer GPs from Coopers Road Medical Centre and Frank Street Medical Centre had FRACGP registration. The GPs at Eastvale had a lower average number of years practising medicine in Australia, but had the highest numbers of clinical hours in general practice. The GPs were engaged practitioners, with four practices having a GP who had completed PhD or Masters level qualifications, and all practices having GPs with diplomas or certificates in addition to their medical training. Table 25 reports on the scope of specialist interests of these GPs, which varied across the group.

Table 25: GP specialist interests (N=33)

Specialist interest	n (%)
Women's health	12 (36)
Obstetrics	10 (30)
Other interest	10 (30)
Preventive medicine	9 (27)
Psychiatry/Mental health	8 (24)
Paediatrics	7 (21)
Diabetes	6 (18)
Geriatrics	6 (18)
Cardiology	3 (9)
Computers	2 (6)
Counselling	2 (6)
Nutrition	2 (6)
Occupational/industrial medicine	2 (6)
Acupuncture	1 (3)
Asthma	1 (3)
Dermatology	1 (3)
Sports medicine	1 (3)
Surgery	1 (3)
Anaesthetics	0 0

33 GPs participated in **re-order**. Twelve (36%) were interested in women's health or obstetrics and eight (24%) were interested in psychiatry and mental health. Two GPs (6%) nominated computers as a special interest. Figure 6 represents the overall percentage, by practice, of GPs' estimates of the number of adult patients they saw in the past twelve months where depression was a significant part of the clinical picture.

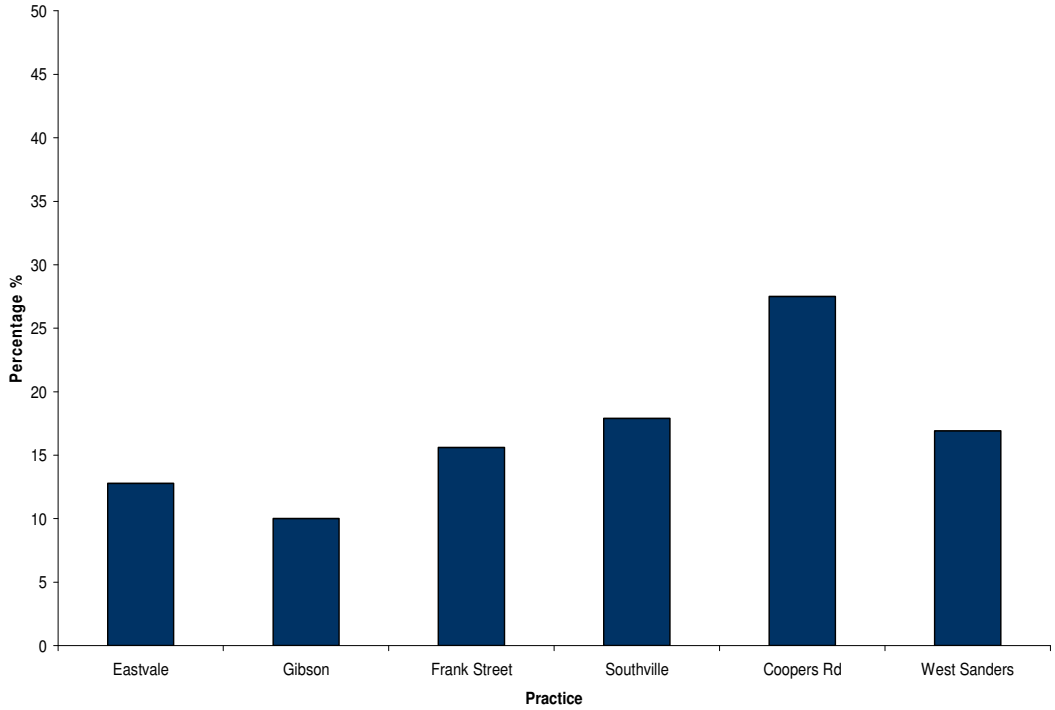


Figure 6: Percentage (estimated by GPs) of adult patients seen in the previous twelve months where depression was a significant part of the clinical picture, by practice

Figure 7 shows the percentage of patients with depression and comorbid physical health problems, as estimated by GPs.

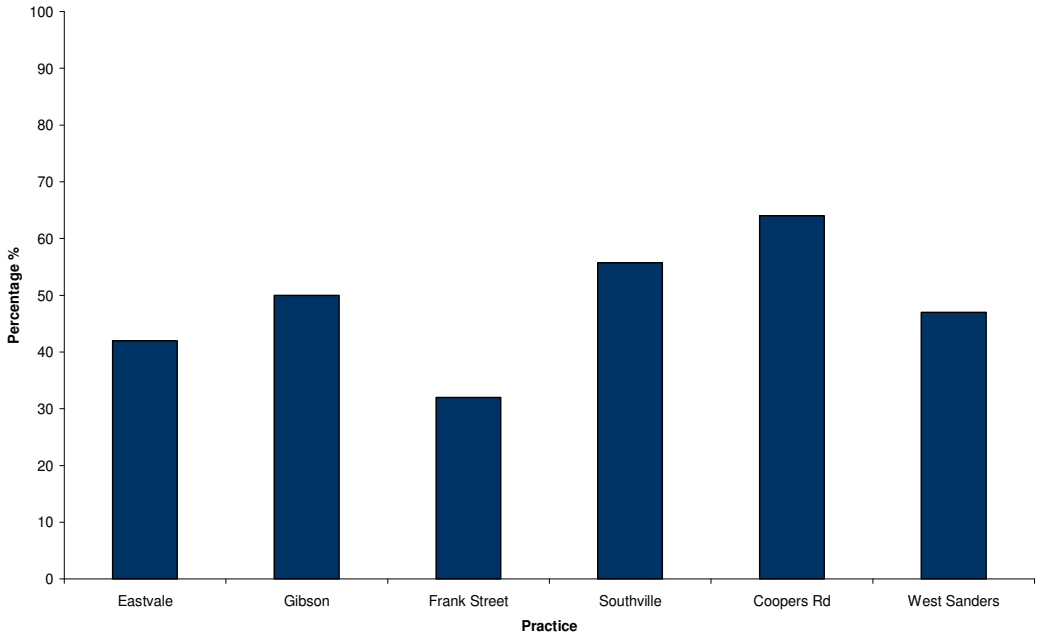


Figure 7: Percentage (estimated by GPs) of adult patients seen in the previous twelve months with depression and a co-morbid physical disorder, by practice

The GPs were also asked to reflect on their management of depression. Figure 8 summarises, by practice, the percentage of patients with newly diagnosed depression for whom GPs schedule a series of visits. These figures are average percentages across practices.

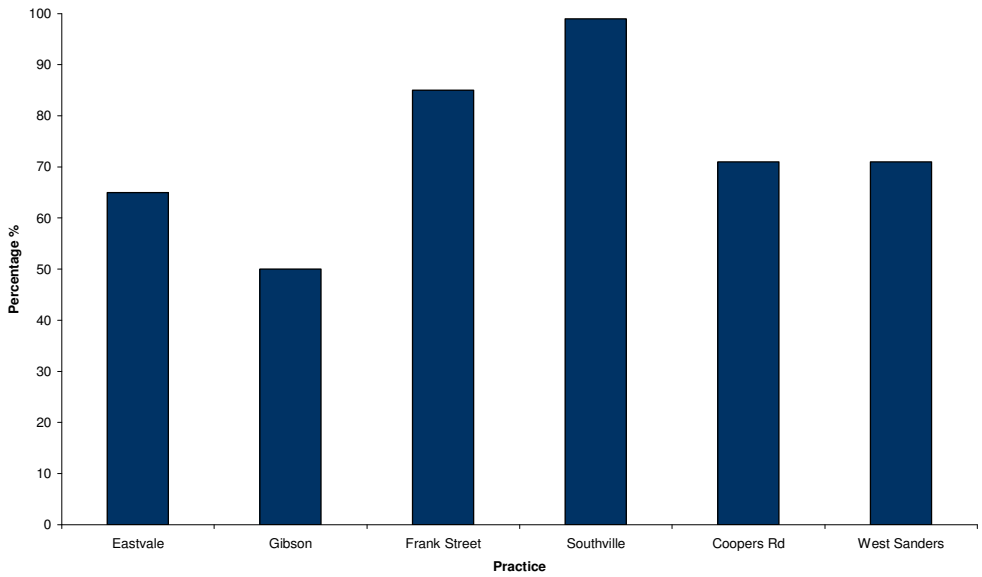


Figure 8: Percentage of adult patients seen with newly diagnosed depression for which a series of visits would be scheduled to manage their depression, by practice

GPs reported that between 50 and 99% of patients with newly diagnosed depression had a series of visits scheduled in order to manage their depression. At Southville Clinic, GPs reported that almost all patients with newly diagnosed depression were scheduled in for a series of visits. This approach was shared by all other practices, though less so at Gibson Street Practice than others. In summary, these GPs represent a broad spectrum of general practitioners where a number have postgraduate qualifications, two are academic general practitioners, some are involved in general practice research and others are involved with their local Divisions of General Practice. Table 26 describes the larger practice setting.

Table 26: Overview of the six practices that participated in the re-order study practice phase

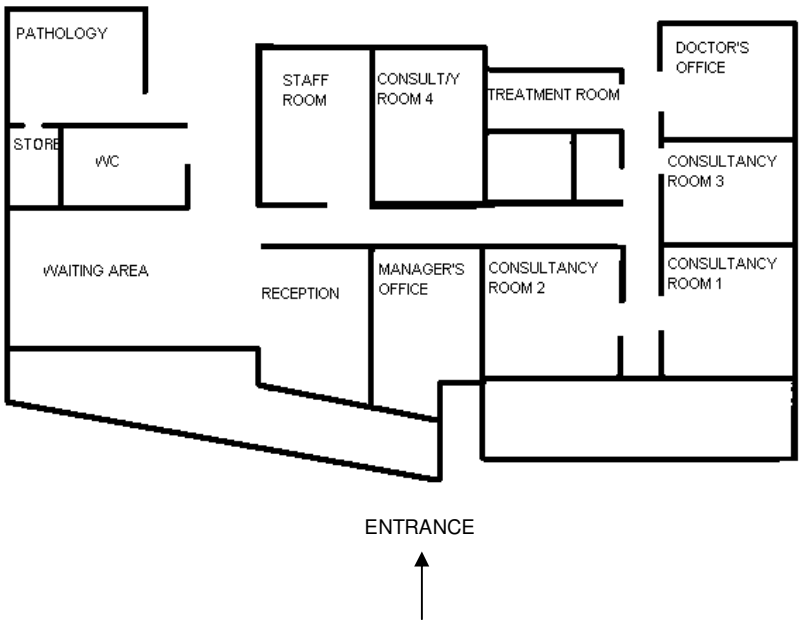
Practice characteristics	*Practice (n=number of GPs)*					
	Eastvale (n=5)	*Gibson (n=1)*	*Frank Street (n=4)*	*Southville (n=7)*	*Coopers (n=7)*	*West Sanders (n=9)*
Practice setting						
Private general practice	Y	Y	Y	Y		
Corporatised general practice						Y
Community health centre					Y	
Practice location						
Metropolitan	Y	Y			Y	Y
Outer Metropolitan				Y		
Regional			Y			
Personnel employed in the practice (in total)						
GP(s)	6	2	4	8	8	14
Practice nurse(s)	2	3	2	4	2	3
Registrar(s)	1	0	0	0	0	1
Psychologist	1	1	0	2	1	1
Practice manager(s)	1	0	1	1	1	1
Receptionist(s)	6	2	3	10	5	7
Other	2	0	2	7	10	0

All participating practices had practice nurses available, two practices had GP registrars, five had co-located psychologists, one practice had a diabetes nurse educator and another had a dietician. The practices reflected a sample of metropolitan, outer metropolitan and regional primary care sites in Australia. In the next section we describe in more detail the characteristics of each practice to appreciate them as complex adaptive systems.

4.3.1.1 FURTHER CHARACTERISTICS OF PRACTICES

1. "Eastvale Family Medical Centre" (An Efficient Practice)

The Eastvale practice is a private group practice situated six kilometers from the city centre in a primarily residential area. It is a relatively inner, increasingly middle class suburb with a high proportion of young professionals which differs from the predominantly blue collar workers of previous decades. However there are areas of disadvantage within the suburb. Eastvale is housed in a building that spans two residential blocks. The practice building is a recent amalgamation of a 1930s weatherboard house (which would have been built when the area was first settled as a residential suburb) and a newer building. From both the exterior and interior the amalgamation appears relatively seamless, with the building as a whole constituting a bright, new, modern-looking practice. Eastvale is open from 8:30am – 6pm Monday to Thursday, 8:30am – 5pm Friday, 8:30am – 12 noon Saturday, and was the only practice to open on a Sunday (albeit from 9-10am only with no bookings). The practice building has a medium-sized waiting room, overlooking a reception area. The practice manager noted that there was usually adequate space in the waiting room however it did get crowded when the doctors ran over time with appointments. A room used by a pathology service provider and a bathroom are located off the waiting room. A corridor runs from the waiting area and reception, off which are situated all the other rooms in the building. Off the corridor just opposite the waiting area is a small tearoom. Up the corridor from the tearoom is one of four consulting rooms. The practice manager's office sits behind reception and has a mirrored window overlooking reception and the waiting room. Further up the corridor there is a relatively open area that constitutes the treatment room (predominantly used by the practice nurses), a small nurses room (used mainly by the nurses for vaccinations), and three consulting rooms. At the rear of the building there is a 10-space car park and the whole building is disability accessible.



Eastvale staff described themselves as empathetic, understanding, providing good, patient-centred, holistic care, and being supportive. They proposed in forum meetings that their practice employed a multi-team approach and patients had reasonable access to GPs. The practice believed it combined personal, medical, family and psychological knowledge and skills in their care, and because they were established in the local community, families trusted them. The group prided themselves on being professional, including producing a monthly newsletter where the study had been advertised to staff and patients. Reception staff gave the impression that they were consistently busy in the practice and Monday mornings were said to be busiest. They communicated via an internal office messaging system between GPs and reception, via email and via opportunistic activities such as cleaning up the GP consultation room. Overall, the practice was seen to have a constant flow of patients described as a 'staccato rhythm' of flow and interaction.

Time constraints were presented as a problem but staff reported that they were still able to contact a GP when they were concerned about a patient's condition; demonstrating their care and commitment. Practice nurses were seen to have extended periods of time available for listening, compared with the 10 to 15 minute time constraints of the GP consultation. Nurses were seen as doing more depression care than reception staff. Nursing staff told the observer that because the doctors were busy they often picked up on patients' mental health issues and then informed doctors of these problems. Eastvale practice also had a psychologist located within the practice which was noted as good for some, but not others.

Clinical meetings at the practice explored more technical, bio-medical cases and rarely discussed depression or other related issues. The psychologist did not attend the weekly clinical meetings held by GPs, nor any of the practice meetings. Nurses did not attend the clinical meetings either, but were briefed afterwards.

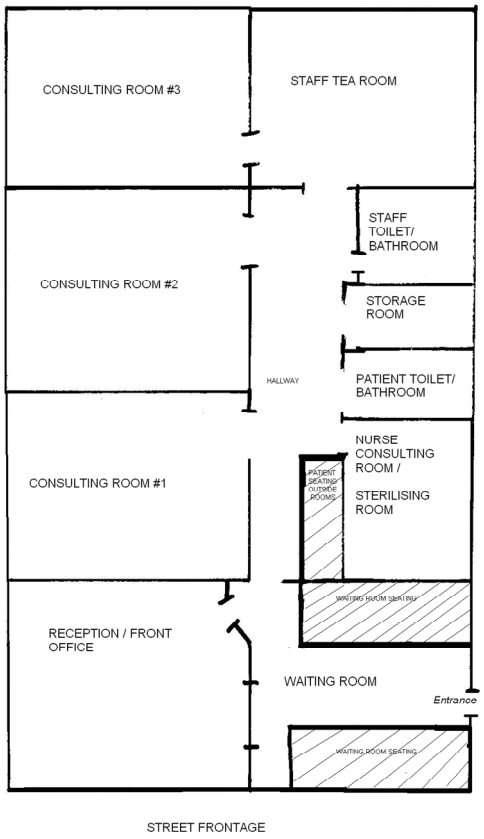
Nurses had an office and a treatment room, their own appointment book and one nurse was responsible for immunizations and education programs. Nurses needed to be flexible and they had a high work load. One of the nurses appeared to have a more extended role and did a great deal of wounds and dressings, and also diabetes care, heart disease and double checks recalls for pap smears. Nurses at this practice were engaged in chronic disease management. One of the nurses was seen to actively look for emotional distress while doing other disease management tasks. They also completed recall letters and re-stocked and re-ordered for the store room. The nurses were observed as semi-autonomous, with involvement in mini-style consultations, but with the GPs playing a checking-in role. The practice saw that they had opportunities to coordinate care and increase their team approach which was discussed consistently throughout their participation in **re-order**.

Reception staff seemed to want to be able to find out more information to be able to help certain patients, but their role in depression care was definitely not seen as central. For example the observer suggested spending some time with the receptionists, but one of the GPs was not supportive of this idea because they did not really see receptionists as having much involvement with depressed patients. Reception staff suggested that they could benefit from training in the recognition of the signs of depression. There was no formal register system for patients with depression within the practice. However, an informal system was in place whereby GPs informed reception about particular patients at risk in terms of mental health, and told them to notify the GP immediately or put the patient through directly to that GP if they contacted the practice. The practice noted that sometimes it was difficult for their patients to see the GP of their choice even with bookings made well ahead of time. Reception staff observed the well-being and health of patients in the waiting room, taking on an informal 'triage' role according to perceived medical needs. Reception staff did not have a directly acknowledged role in depression care, but rather took on an informal role about providing patients with access to the GP of their choice, ensuring longer consultations, and listening to patients who disclosed their mental health status and responding accordingly. A continual theme for the practice staff was around time pressures and meeting demands.

2. "The Gibson Street Practice" (A Homely Practice)

Gibson Street is a private general practice situated six kilometers from the centre of a large metropolitan city in a residential area increasingly seen as an affluent inner suburb. The demographic composition of the area has changed in recent years, from a mainly elderly migrant population, to an increasingly younger demographic; young families with infants and young children. The practice has two GPs, three nurses (only one works at a time and all three are part-time), and two receptionists (only one works at a time). There is also an on-site psychologist who is there part-time. Whilst the psychologist and the nurses do not share patient records with the GPs, the psychololologist provides them with written reports. The practice is open for appointments from Monday to Friday between 8am to 6pm and is not open on weekends. The practice is housed in what had been originally designed as one wing of a flat "complex". At the entrance end of the building there is a small waiting room. Seating is arranged in two paralell rows where people face each other. A display of pamphlets is afixed to the wall next to the front entry/exit door. This is overlooked by a small reception area. From the waiting room and reception area there is a corridor that runs down the length of the building. Off this corridor there is a nurses' room, a treatment room, a sterilising room, and three consulting rooms. At the very end of the corridor there is a small tearoom.

Figure 9: Gibson Street practice floor plan



This practice had practice nurses and receptionists who were often the first people to greet and discuss with patients how they were feeling. The practice described itself as having approachable doctors. They had a traditional model of general practice and a long-standing history of having practice nurses involved in patient care, though they did note opportunities for increasing this role in depression care. Our practice observations confirmed that reception staff knew the practice population very well and it was noted that when making appointments for patients by phone there was rarely a time where the receptionist did not end up having a bit of a chat. One instance of observation revealed that even when scheduling a new patient the receptionist went out of their way to engage in a social interaction. When asked about this following the call, the receptionist said, "Now when the patient comes, despite it being her first visit, I will make her feel at home and as if she had always been coming here."

The group also discussed the possibilities for building on greater public awareness of and reduced stigma associated with mental health problems. More recently, a part-time psychologist had joined the practice from a public mental health care system. The practice described the psychologist as available and accessible, indeed, it was the only practice where the psychologist was running group therapy based on cognitive behavioural therapy (CBT) directly in the practice. Observations indicated that the psychologist focused on the technical and bureaucratic issues of the delivery of mental health care, perhaps reflecting their public mental health background. The psychologist held the view that the GP had learned a lot from their being located within the practice but did not indicate that they had learned quite as much about general practice.

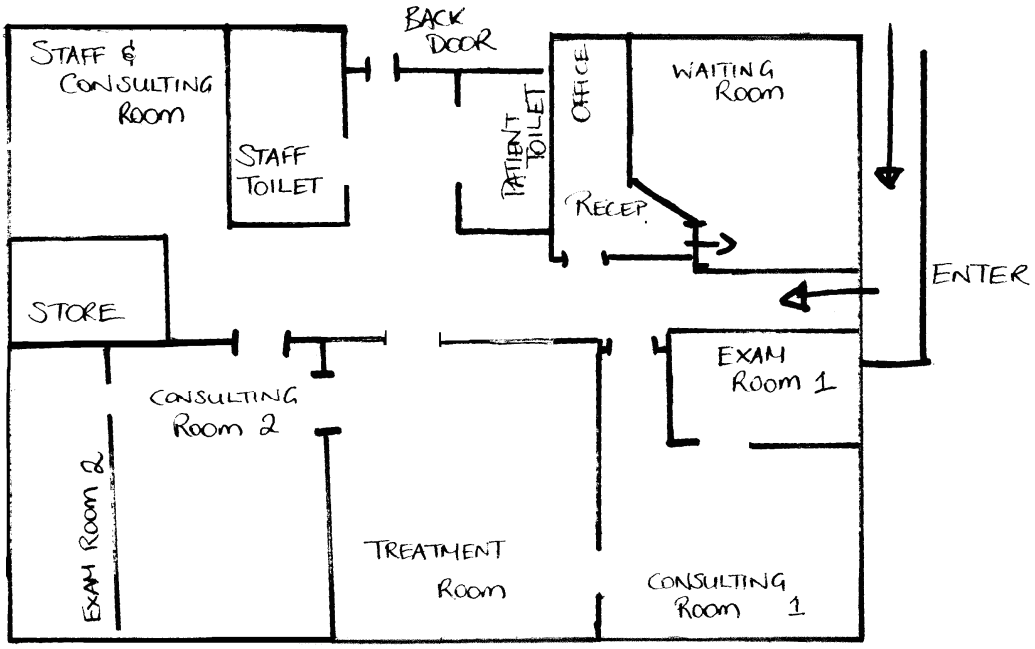
The practice had suggested that they could make better use of psychologists within the practice. The practice did make use of the CBT group for patients with depression and other mental health problems and actively discussed the importance of this group during practice meetings. The GP was particularly frustrated by the amount of bureaucracy around mental health plans and Medicare, and noted that there was an opportunity to provide patients with rebates for attending group sessions. The GP often encouraged their patients to access support groups within the practice and enabled them to feel safe, offering reassurance. This GP made consistent attempts to access affordable services and supports for their patient groups and used their knowledge of suitable local services to refer patients to for drug and alcohol or post natal support. The practice said that receptionists filtered patient needs and there was ongoing communication between the GP and nurses. The practice also prided itself on a culture of patients feeling comfortable confiding in staff. The GP had worked as a GP obstetrician for many years and the practice often discussed patients being from second and third generations. Patients at the practice seemed relaxed and comfortable but perhaps looking for more reassurance and guidance than patients at some of the other practices involved in **re-order**.

Some of the challenges for this practice in relation to depression care were not enough time, difficulties referring easily and quickly, limited available services, administrative requirements associated with mental health plans, and the need to look after their own mental health in order to adequately support patients' mental health. Record-keeping issues were a separate set of challenges – the practice had both paper and electronic records, faced difficulties in keeping records in electronic health record systems, and experienced limited ability for patient recall. The practice also commented on structural building issues, i.e. their waiting room. In contrast with other practices, Gibson Street did not seem to have as many recall systems for chronic care.

3. "Frank Street Medical Centre" (A Practice in Transition)

The Frank Street Medical Centre is also located approximately six kilometres from a city centre, in an area that is home to a number of large retirement villages and similar accommodation for senior citizens. It is situated in a relatively small commercial centre of what is a well-established suburb, and has a supermarket and other shopping facilities. Opening hours are 8am to 6pm Monday to Friday, and 9am to 12 noon on Saturdays. The practice is closed on Sundays but participates in a state-wide after-hours locum service. The practice has implemented a system of computer-generated reminders, sends patient reminder letters, has computer recall systems, and the practice nurses and office staff conduct telephone recalls. The practice is set back from the main street and accessed by a small driveway that runs to the side of the building, it is between a hardware store and an opportunity shop. The building is relatively small and was purpose-built some 35 or so years ago. The interior is very much of its era (circa 1970s) and maintains a warmth and sense of reassurance in its maturity. The front door of the practice opens into a small hall where a display of pamphlets is located on the wall to the left (on drug taking and the harmful effects of cannibis use, diabetes, asthma, exercise / lifestyle, and immunisations - there were no visible pamphlets about depression or mental health). The positioning of this display at the entrance / exit to the clinic enables patients to take a pamphlet discretely without others seeing. From this small entrance one turns right and enters into a very cramped waiting room. The reception is based here too and an administration nook where paper files stand behind the receptionist's desk. Straight ahead is the entrance to the three GP consulting rooms, one treatment room, and a nurses' room that doubles as the tea room. The chairs in the waiting room face the front desk and the distance between the desk and the person seated furtherst away is just two metres. Telephone conversations can be clearly heard, and waiting patients may be privy to telephone conversations, discussions amongst practice staff as well as GPs and patients on their way out. There is a small television elevated by a bracket on the wall in the waiting room, showing commercial television programming. There is a relatively large piece of artwork hanging on the wall, and notably there are few posters with health messages posted in the waiting room. A single broad corridor runs down the short length of building.

Figure 10: Frank Street practice floor plan



Frank Street was due to re-locate into purpose-built premises late 2008 which shifted to 2009 during the course of the **re-order** project. Many discussions involved futuristic thinking and planning for the shift to the new premises as a resolution for problems and challenges they currently faced. Staff felt the new premises would offer opportunities to resolve some current issues within the practice, notably lack of space and staff. Some staff did express the view that though the move was to occur, practice planning still needed to be based on the 'here and now.' This was a practice in transition in terms of building and staff moving on during the study.

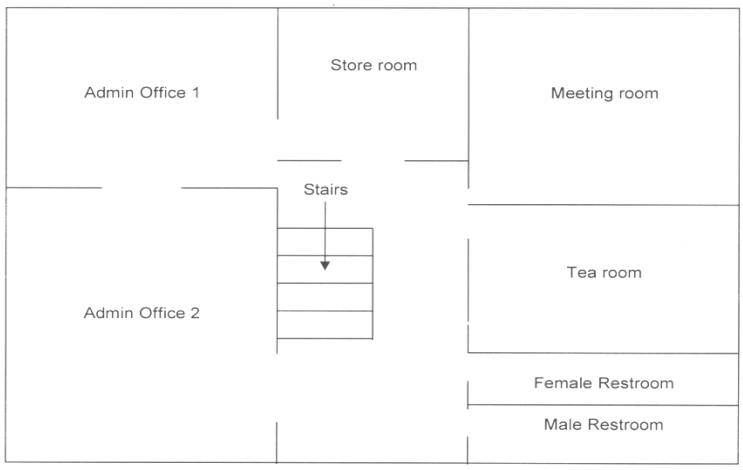
Frank Street appeared to have challenges around the use of computerised information systems and meetings revealed that the quality of notes and record keeping were seen by the GPs as areas to improve. The facilities were small and some of the GPs had worked in the practice for a long period of time. Many of the GPs were part-time at the clinic which they noted as a weakness to delivering optimal depression care in the context of continuity of care for patients. A couple of the GPs had an obvious interest in young people and saw troubled teens. Practice staff felt that they were affected by the GP workforce problem particularly in their regionalised location and it was a challenge to make good staff appointments as a result. Anecdotally, the GPs had said it had taken a number of years to fill one GP position. The practice was in a state of flux and change throughout the study and sometimes discussions occurred around how they could respond to their staffing needs. One suggestion was that having a nurse working alongside the GPs could increase their capacity; this was not necessarily a view shared by everybody in the practice.

Staff noted increasing work pressures related to time, cost, managing computer systems and confidentiality. As with other practices the nurse here made a comment that when GPs were busy the patients revealed their needs to them and they would make notes for the GPs in the patient records. The nurse completed immunizations at the practice and reception staff appeared to be more involved in administrative tasks and filing than active care processes. The GPs noted they all had different styles of practising. The practice was using both paper and electronic medical records and the GPs differed in terms of who was using which filing and record keeping system. The observer had discussions with some of the GPs about the limitations of different ways of recording information; either through systematic, pre-coded check boxes versus non-systematic records.

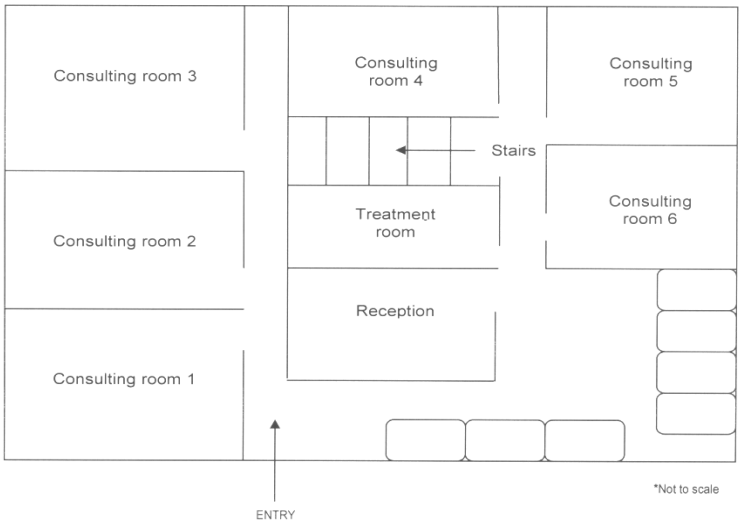
The practice suggested that there were challenges around finding good psychiatrists, improving assessment between practitioners (mental health assessments), and welcomed opportunities to meet more psychologists and talk with them as they were finding it challenging to find good psychological support in their local area. Psychologists were not co-located at the practice but the observer noted instances of referral to psychologists. The *Better Access* program (see Box 1 in Chapter 1) was seen as an opportunity for GPs to access psychologists. Some commented that mental health plans had prompted more use of the psychology referral pathway, and helped to develop more formal methods of inter-professional collaboration in depression care treatment and management. Staff saw the practice as having an opportunity to improve patient education.

4. "The Southville Clinic" (A High-Tech Practice)

The Southville Clinic is a private group practice that is situated in the main commercial area of an outer, satellite suburb some 40km from a city centre. The area is in close proximity to major manufacturing and transport hubs. The practice has been in its current location for some time, but it recently renovated and extended its building – now relatively large and comprising two storeys. Opening hours were the longest of all six practices – from 7:30am – 8pm Monday to Friday and 8am – 4pm Saturday. At the ground floor entrance is a somewhat cramped waiting area (given the size of the practice), in the middle of which is a horseshoe-shaped, spacious reception area. If the GPs run late with appointments the waiting room becomes extremely crowded whereby office staff resort to asking patients to return after a period of time. Seating in the waiting room equates to two chairs per consulting room. Behind the reception area there is a nurses' room, and behind that a small treatment room. On either side of the nurses' and treatment rooms are corridors (two in total), off which are six doctors' consulting rooms. A corridor running in the opposite direction off the waiting room leads to two other rooms used by other health professionals. Upstairs is a large admin area, a seminar room (replete with large flat screen TV and other assorted IT equipment), and a large tea room.



Upper level



Lower level

Southville's physical building showed characteristics similar to a mini-hospital arrangement with two levels of consulting rooms upstairs and downstairs and a large office for the practice manager and staff upstairs. Nurse rooms were well-resourced, the nurses were observed taking blood pressure and sugar levels (if applicable) while patients were waiting to see GPs and had a bookings system not observed at other practices. The practice had new technological materials available and a large meeting space complete with video and DVD-viewing equipment, a data projector and a shared drive arrangement where resources and information could be shared by GPs. One of the principal GPs here was extremely systems-focussed. The practice had ultimately wanted to be paperless but was challenged by the need to provide resources to patients and also to share an understanding of the resources they had available between staff. Southville were proud of the technical equipment and infrastructure available and proud also that they had over 46 years of experienced GPs working there. Staff saw themselves as having strengths in empathy and listening, believed there was continuity of care for patients, and saw GPs as having good diagnostic skills.

The practice had been in the area for many years which also meant staff often had knowledge of patients' social networks. They commented more on a lack of psychiatric services being available and difficulties of accessing hospital beds for some patients. Staff saw that they could improve on current practice and interact more with their patients' other carers, both GPs and non-GPs. Like at Frank Street, Southville staff felt there were opportunities to link more with psychiatrists, and to know the different professionals they and their colleagues were referring to. The group noted they had the scope to offer group therapy for patients. Being grounded in family practice was viewed as a strength, in that it allowed better understanding of inter-family relationships. The practice staff commented that the wider public appeared to be more aware of depression and were thus seeking treatment. They also had psychologists on-site which they saw as a huge benefit following the introduction of the Better Access program, although the psychologists did not participate in **re-order** forum meetings.

Staff, particularly practice nurses, commented that they would benefit from further training in the management of depression. They felt that utilising nurses for depression care meant they would need to invest in a mental health nurse because in their view speciality skills were required for depression care. Despite working with some clients from older population groups with depression, practice nurses felt they were not specifically trained in this. Similarly to other practices, reception staff at Southville did not appear to undertake an active role in depression care. The observer noted on an occasion that reception provided a patient with information from the web about a surgeon and they called a patient to inform them that a claim to the Department of Human Services (DHS) had been rejected. Whether reception would provide additional information for depression or mental health care more broadly was not known but these actions suggest that reception staff take on a role of informing and following up for some problems.

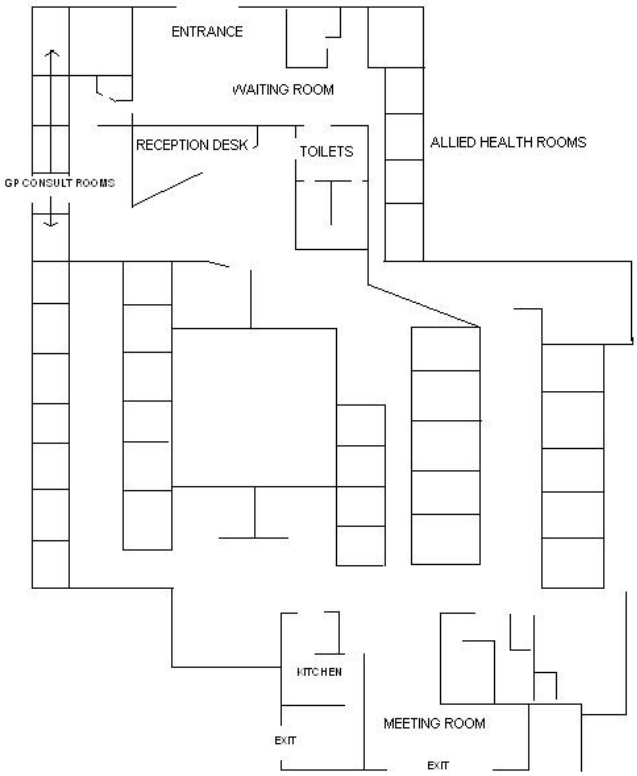
Southville was one of the few practices where the availability of newer medications like SSRIs was actually mentioned as a part of their system of depression care. Being a larger-sized practice, there was also the perception that they could provide extra time for depressed patients and provide longer consultations if necessary. Staff said they had the opportunity to discuss the care of patient with the "team" but did not seem to have a formalised approach to team care for depression care. The practice saw they were a clinic that could provide a resource for clients and refer to other resources if needed, but noted that accessing psychiatrists or emergency staff for a suicidal assessment at short notice was a key challenge. A key point of difference between this and other practices was that they felt they could use research data to guide directions of changes to care.

5. "Coopers Road" (The Diversity-Driven Practice)

The Coopers Road Medical Centre forms part of a community health centre that is situated amongst a public housing development in an inner suburb of a major metropolitan city that over the last 30 years has been the home to migrant communities. Its opening hours are 9am – 8pm Monday to Thursday, 9am – 5pm Friday, and 9-11am Saturday. The community centre is housed in a large one-storey building. Most of the front of the building is taken up by a large waiting area, overlooking a large reception area. As one of the GPs reflected, "the waiting room has no alcoves and is very open and confronting for some patients, there is no privacy… it could be a space that is friendlier; it's a bit stark and confronting." In forum meetings the group referred to the new purpose-built building they were awaiting in the future and, though they were excited by the ideas of having more space, there was also concern about losing some of the ways of working together that had developed. Participants felt that there was a risk that they would lose their current identity in the new building and that this should be considered in planning for the transition.

From corridors leading off either side of reception (which are for the most part inaccessible to the public on account of security doors) there were myriad rooms and spaces, including four GP consulting rooms. The other rooms and spaces in the community health centre were used by a range of other social and health professionals (e.g. social workers, translators, counsellors, and drug and alcohol workers). The GP consulting rooms were no larger or better furnished than most of the other rooms in the building. Overall the building seemed in need of repair and refurbishment.

Figure 12: Coopers Road practice floor plan



Coopers Road staff viewed themselves as being supportive, collaborative and flexible with enthusiasm and commitment. They believed staff had a happy working environment and their physical location was a strength. Language support services, having multi-lingual staff available and being culturally diverse were also noted as key strengths with staff suggesting they had multiple programs available for patients to access. Many patients observed came from culturally and linguistically diverse backgrounds which sometimes complicated interpretation and sharing of information within the consultation. One example of this was with a patient who had travelled from a suburb some 80km away to visit a GP at the Centre who also referred to the nurse as their doctor, which created confusion. Other GPs in the meetings discussed patients who attended from areas geographically distant. When the group referred to their weaknesses, they noted access as an issue for patients, particularly around paying for psychological services and providing written information to people with high-levels of illiteracy.

The practice said they provided a breadth of services across treatment, prevention and social connectedness. They viewed their care as 'personal' and not program or systems-focussed. They held a centre meeting once a month, where all staff attended and GPs appeared to meet together as required rather than on a formal basis. The nurse at the centre provided outreach support to patients and the observer noted that they and some of the GPs observed took on social elements of care, indicating a blurring of roles into social worker domains. It was not clear what role social workers were playing given this, but the overlapping of roles appeared to be a common practice within the centre with receptionists providing patients with social support also. There were observations of bilingual support staff taking on the receptionist role when needed and an indication that additional support activities at the centre were more integrated than the GP role. Reception staff were observed reading mail for older clients, mainly women, for whom English was a second language.

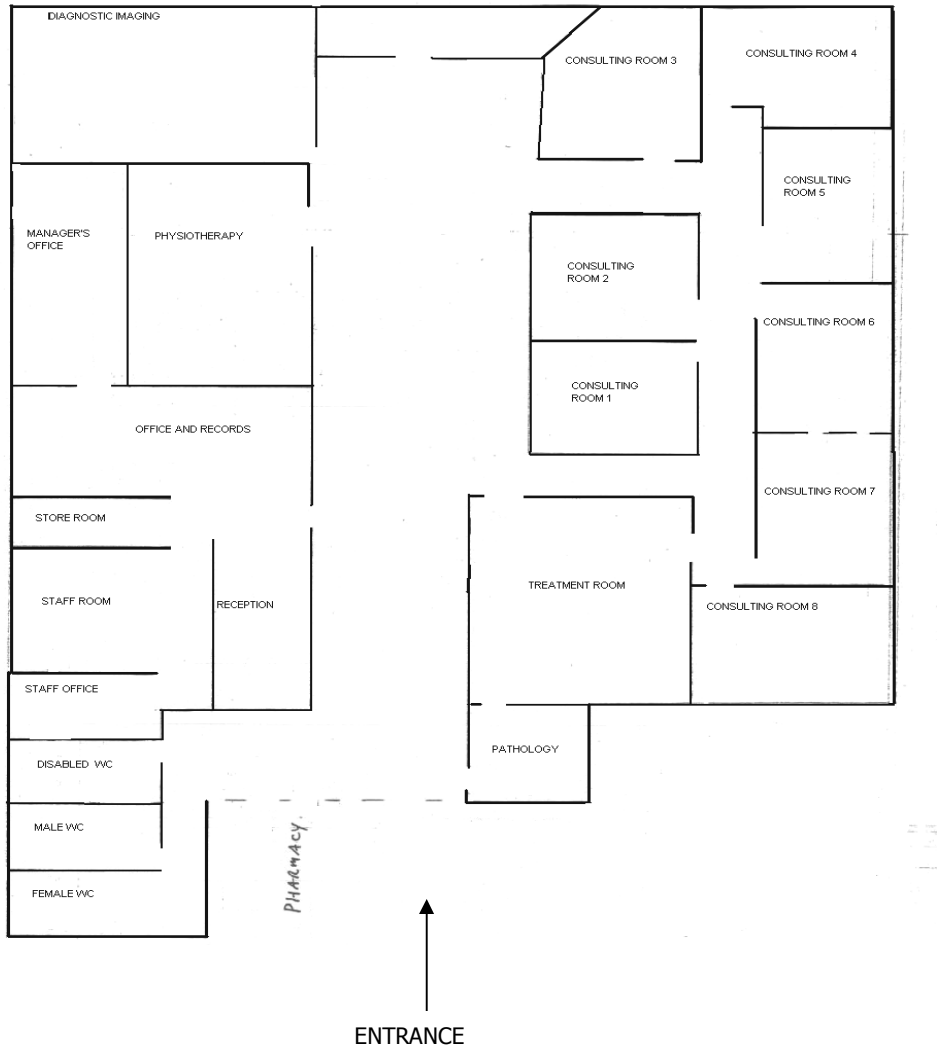
The centre's large size and professional mix provided them with the opportunity for different minds, opinions and capacity to think about depression. Staff noted that the depression experience was sometimes chaotic, fragmented and disconnected. Coopers Road described their team as multidisciplinary and striving to manage depression in a multidisciplinary way. In spite of these strengths and opportunities there was a perception within the group that the practice functioned largely as an informal team rather than being intentionally cross-disciplinary and having a formalised approach to their work together. The clinicians demonstrated integrity and an interest in problem solving for patients. They were experienced clinicians used to having access to the expertise of other service providers. Nurses, social workers and a co-located dentist were available. Reception staff did not appear to take on a formalised depression care role, and did not participate in meetings, though observations showed that they spent a great deal of time supporting the GPs and patients in the waiting room.

This diversity-driven practice also noted that emerging culturally and linguistically diverse communities presented new opportunities. Given their status as a community health centre, their social support activities sometimes appeared to be driven by funding opportunities dictated by the State government or for newly arrived migrants and refugee groups. There were perceived opportunities to expand some roles within the centre. For example, GPs were seen as doing limited counselling – some GPs noted that they personally did not have well-developed therapeutic techniques for working with people with depression – but there were also other trained professionals available at the practice such as social workers who were seen to provide this service. They acknowledged their need for better links with psychiatrists and to provide more `psychological services to patients. Additional opportunities were seen to be available in other services like arts programs provided at the practice. Staff noted that the **re-order** practice meetings were the first time some staff had got together and talked about centre issues.

6. "West Sanders Medical Centre" (An Experienced Practice)

The West Sanders Medical Centre is situated in the main commercial area of an inner, middle class suburb of a large city. It is open from 8:30am – 6:30pm Monday to Friday and 8:30am – 12 noon Saturday. The centre is a long-established practice with over a forty year history, although it has only recently moved to its current premises (having had two previous locations within the same suburb). The latest move coincided with the practice being bought by a large medical services company (which has since been bought by another company, which in turn recently sold the practice to another company). The building in which it is housed is a purpose-built commercial building. It has a large waiting room with a a reception desk at one end. This runs parallel with the part of the length of the waiting room such that it does not look out over the whole of the waiting room as is usually the case. In one corner of waiting room there is a sectioned children's play area. Behind reception there is quite a large tearoom and a series of rather cramped spaces for administrative staff. Walking through the admin area brings you to the practice manager's office. On the other side of the building there is an x-ray and pathology room, a large treatment room, and seven consulting rooms. None of the rooms have any natural light. There are about ten car parks on the street out the front of the building that are allocated for the exclusive use of patients visiting the practice.

Figure 13: West Sanders practice floor plan



West Sanders staff considered their extensive experience of being practitioners as one of their greatest strengths. They described themselves as people who cared about patients and strove for best practice. They acknowledged that depression could be individually challenging and they were not sure that they all knew how each other practised in terms of depression care. Some of the practitioners said they had decades of experience in dealing with depressed people and one GP had worked previously in a psychiatric institution which shaped their understanding and experience of depression care. Many patients were reportedly loyal to the practice which enabled the practitioners to provide continuity of care. Other characteristics they used to describe themselves were being supportive, empathetic and providing a listening setting.

Reception staff appeared busy and started the day responding to a large number of phone calls from patients who wanted appointments with doctors they could not get in to see. Receptionists were observed as playing a 'gatekeeper', or protective, role with GPs (a practice common at many of the sites) and appeared to have more power than those at other sites.

This was an experienced practice where the longitudinal nature of the GP-patient relationship figured strongly in their descriptions of perceived strengths in depression care. A practice nurse was available who mainly provided blood pressure monitoring, dressings and injections rather than depression care. Knowledge of the family and of the dynamics of dealing with many generations, and knowing patients and their medical histories were considered strengths. The GPs acknowledged that nurses played the role of finding out information that patients were not willing to tell the GP. Mental health workers were also available, though their role and function within the practice's system of depression care was not really explained. The practice also had a psychologist on-site, but practitioners still talked about time constraints for providing GP counselling and the need to change their referral base.

Opportunities that practice staff noted included using **re-order** to improve depression treatment, to pool thoughts on how the staff treated depression and try to achieve best practice, talking in a group setting about problems so that treatment could be less individual and more consistent across the group. Staff felt that mental health plans had been revealing and they had not used check lists with severity scores as part of routine depression care. GPs also highlighted that patients' resistance to taking medication was a challenge. Practice staff felt some of the weaknesses at the practice related to working in isolation, depression care not being an ordered process, poor training on mental health issues in the past, lack of communication about depression, and limited dialogue between GPs in the practice about how they tackle depression as a practice. The group reinforced the need to develop peer support and learn from each other about the different methods of dealing with depression within the group. These areas were noted as opportunities for integrating their approaches and talking with each other about depressed patients. Being an experienced practice also meant that some of the staff thought this would limit their ability to change their practices with some patients. Other staff questioned if the waiting room environment was appropriate for depressed patients.

4.3.2 INTERVENTIONS

Practices participated in five meetings which resulted in five to eight hours in total of focussed discussion on depression care over the course of the study. Table 27 provides a breakdown of total staff who attended each practice forum meeting.

Table 27: Staff Participation across practices

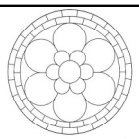
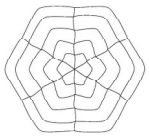
Study Practice	Participants (Total number in practice)						% PARTICIPATION
	GP‡	PM†	PN◊	REC*	OTHER^	TOTAL	
Eastvale	4	1	2	3	0	10	71.4
Gibson Street	1	0	3	1	0	5	71.4
Frank Street	3	1	0	0	4	8	72.7
Southville	7	0	3	0	2	12	48.0
Coopers Road	4	1	1	0	5	11	55.0
West Sanders	9	0	0	0	0	9	36.0
TOTAL	**28**	**3**	**9**	**4**	**11**	**55**	**53.9**

‡ GP= General Practitioner, † PM= Practice Manager, ◊ PN = Practice Nurse, * REC = Receptionists, ^ OTHER = includes other practice health professionals

Attendance figures show GPs had the highest participation rates compared to other staff. Frank Street Medical Centre had highest overall participation (72.7%), that is participation at the practice level, and Eastvale and Gibson second highest (71.4%). West Sanders, one of the larger corporate practices had the lowest overall staff participation rates (36.0%).

Two practices had large meeting spaces (Coopers and Southville); two had minimal space with meetings occurring in a tiny tearoom (Eastvale) and in a storage room (West Sanders); two had limited to no meeting rooms seeing the group meet in consultation rooms (Gibson and Frank). The purpose of these forum meetings, as explained in the methods section, was to develop ground-up interventions. Participants were provided with set activities that gave them the opportunity to reflect and develop their ideas on how depression care was happening at their practice. The Mandala activity formed a key part of understanding participant perceptions of depression care. Table 28 provides an overview of the selected images according to total number of participants in forum meetings.

Table 28: Mandalas Selected by Forum Participants

MANDALA IMAGE	Number Selected (n=49)	Percentage Total Participants
	15	30.61%
	13	26.53%
	7	14.28%
	5	10.20%
	5	10.20%
	4	8.16%

Participants provided a range of explanations for the images they selected. They allocated descriptive terms in relation to the images that best reflected how depression care happened for them at the practice. From top to bottom according to Table 27 these were 'the bordered flower', 'the interconnected circles', 'the maze', 'the web', 'the shattered star', and 'the quadrant'. While there were some participants who used different explanatory terms, these themes were repeated overwhelming across practices. Of the 49 people who completed Mandalas, the **bordered flower** was most commonly selected to describe how depression care happened. This was followed by **interconnected circles** and the **maze**. Quotes from a selection of participants related to each image provide further illustration of how participants saw depression care occurring at their practice.

The Bordered Flower:

Participants often interpreted the edge around the flower as a border or representing a pathway for the patient. They discussed themes related to the patient getting access to care but once being 'inside' the wall, so to speak, they would be OK.

> *My theory is much more simplistic. I picked the one with the flower. Just because I saw the surrounding as the wall and the barrier… Just because my theory of depression in general practice is that it seems to be getting diagnosed initially is the barrier. And it seems to be once you're diagnosed then it opens up and something will happen* (Eastvale Receptionist PF #1:10).

> *Yes, I'm one of the nurses. So I really don't come across [depression] too often, but I mean, yes anyone dealing with, you know, obviously might have current depression in the past or whatever, but I had a different take on what the GP said. I saw the same thing as in bricks on the outside, and I thought maybe that would have represented maybe a, like a hurdle or a barrier to providing care for the depressed. The next sort of role of the circle is being obviously interdisciplinary care, and the middle one I saw as a flower being like happiness so that everything working together, the end result, yes.* (Southville Practice Nurse PF # 1: 8-9).

The Interconnected Circles:

This image was used to describe services and interconnection between GPs, families, patients and the external community for treating depression. Some interpreted this image at a systems or practice level, while others saw it more specifically as their individual approach.

> *I saw mine a bit more similarly to Jim, as more a systems thing. It's the client and their complex and multiple issues in the middle, and the circular points being the various programs and teams like GPs, counselling, and case work. There is an interaction that happens as need be, with clients, episodically. The referrals are informal sort of. We're all working together, but not totally structured. Especially for a program like us that's not always involved with everyone. We have some shared clients but we cover a lot a lot wider area.* (Coopers Social Worker PF # 1: 9)

The Maze:

The maze was often used to describe the process of diagnosing and treating depression by general practitioners. It related to themes of a journey and walking through with patients.

> *From my point of view it reflects what I do here, just trying to find a way out or a solution. It's not just going around, it's moving from this area which I sort of saw as a puzzle for the person, or whatever it was that making them depressed or helping them move through there. I sort of thought that it's a bit of a journey, it's a bit confusing, but eventually, hopefully we'll find a way out of it.* (Coopers General Practitioner PF # 1: 6).

> *I felt that in a sense, solving patients with depression it's almost like a maze, you've got to identify it first. So, the first thing we have to do is be able to identify which patients are depressed and which patients aren't, and go through the differential diagnoses. Sometimes it's a bit mysterious because you might see people who've just got chronic pain, and in the past they'd just be straight people with pain and disabilities. But in actual fact they can suffer from depression, and that's one of the steps that we've got to elicit from. So I feel that as we work through this maze we can eventually get to helping the patient sorting out their problems and eventually you hit the jackpot in the centre and fix them up.* (Southville General Practitioner PF # 1: 10-11).

Some participants were surprised that everyone did not pick the same image as they did, as the following comment from one of the Eastvale GP demonstrates:

> *I thought everyone was going to choose the maze…Yes, I guess just a fairly, you know, it's a dead end, and a bit difficult to get through and out the other side and, ah yes, a bit of a journey … sort of idea. I sort of thought we were kind of all walking through it together and ending up...Well yes, and walking through with the patient.* (Eastvale General Practitioner PF # 1: 13).

The Web:

As indicated above, not all participants used these particular terms to describe their images. One GP saw this image more as a network:

> *Yes, I see it as a network of care, basically but it's a fragile network for which the patient can fall through at any one time. The old story, no man is an island entire of themselves.* (Southville General Practitioner PF # 1: 10).

Another GP suggested:

> *I didn't see a web?! You're placing your own meaning on it and I didn't see a web at all! It is a little bit flower-like, also, but I just sort of saw it with the layers representing the issues, or complexity and layers of a patient's life experience - recent events, family social supports and so on. There's some sort of core there, and it's criss-crossed by - well I don't know whether these lines are things that bind it together or fracture it. You know stop it. Where I am in this is trying to peel the layers off to get to some sort of core. It's difficult to do because it's not a nice neat layer, and you take that off and you get to the next one. It's all going to come off in bits and pieces. But you're trying to get to some sort of core issue which is at the heart of the person's depression.* (Coopers General Practitioner PF # 1: 7).

The Shattered Star:

Participants often discussed the need to contain the experience of depression for both the patient and themselves. Interconnectivity was commonly referred to and a sense of having satellites that assisted in the process was important.

> *I liked the maze, but it seemed too orderly. I wanted something similar but a little bit more chaotic So I picked this um… that one there [others are saying which one – which one? I didn't get that one no hang on I chose it!! – it looks different with you holding it up!!] …The patients start at the centre and the other satellite things represented both the different services that may be enlisted to try and help support the patient, but also represented the other variety of issues that might need to be addressed - whether homelessness or job, or all the sort of issues that patients have that contribute to their experience of depression. I quite like the circle around the edge because it represented to me a sense of containment which often seems to be required for us and for them. A sense of actually you can, sometimes it feels totally amorphous, and it's good to feel you can contain it - both for myself and the patient. A sense of sort of wholeness* (Coopers General Practitioner PF # 1:6).

The Quadrant:

Few participants selected the quadrant but where they did similar themes emerged in relation to fragmented care. There was a sense that the opportunity for working together was there, but people worked in separate squares lacking interconnection.

> *I chose that one for two reasons. The bold lines in that one are almost interconnected but they're not, they're separate and fragmented. There are a lot of other fragmentary discs, and I feel this is often - my experience of dealing with depression is that I'm doing a little bit and somebody else is doing a little bit, and somebody else is doing a little bit, and we don't often do a lot of communicating to, ah, so we know what each other is doing. And also the*

> *way we see the patients is often fragmentary, we'll see them for a couple of months this year and then in three years' time we'll see them for another couple of months, because they've encountered another obstacle. So it feels very fragmentary in a lot of the way we do the care.* (Southville General Practitioner PF # 1: 11).

Mandalas thus provided participants with the opportunity to share their perceptions on how depression care happened. Very few discussed the systems or practice level interpretations of their images and many shared their personal approaches. Mandala activities were designed to facilitate people thinking about depression so that they could document their perceived strengths, weaknesses, opportunities and challenges (SWOC) their practices faced with depression care. Overall, commonly mentioned **challenges** across all practices related to time, needing space for patients in distress, more team approaches and changing information systems. Practices commented on the appropriateness of waiting rooms and how they lacked privacy, challenges in referring patients on, and being aware of their own mental health. They felt there were challenges in working together as a team with part-time staff and sharing records. Practices noted that the quality of notes in their systems could improve particularly in relation to working together with others. Some practices also identified thinking about improving their practices and systems as a challenge. All practices felt they had **strengths** in their staff, particularly in relation to their characteristics of empathy and listening skills. Because some participating practices were smaller and well established in their local areas they felt they were trusted by patients and this enabled them to know patients and their families. One or two practices noted having a psychologist on site as a strength, but others listed this as a challenge.

Participants were encouraged to use the SWOC material to develop their interventions. Some practices focussed on a challenge directly from the SWOC activity while others selected an intervention not mentioned in SWOC. Table 29 provides a summary of the interventions devised by participants.

Table 29: Summary of Practice Interventions

PRACTICE	INTERVENTION TOPIC AND FOCUS
Eastvale	Diagnosis of depression: The practice chose to focus on guides to depression care currently being developed by David Clarke at beyondblue. This included a focus on diagnostic processes.
Gibson	Information and resources for depression care: The practice elected to focus on their information and resources available for depression care and to create a friendly waiting room poster that welcomed people with mental health problems.
Frank Street	Record keeping and patient history notes: Frank Street chose to audit their records in an alternative format to the brief medical record audit used by the research team and explore the differences.
Southville	Information and resources for depression care: The practice undertook to review all their resources, and to review their psychologist and psychiatrist lists by sharing information and experiences referring to them, and check details for accuracy.
Coopers	Case presentations from social workers and GPs: This practice chose to focus on case presentations from two different professional groups to examine differences between professional approaches and to share information about who people access to provide resources for patients.
West Sanders	Case presentations: The practice chose to present a case to share information about processes undertaken and what other GPs in the practice might do differently.

Practice interventions related to the availability of basic resources for patients about depression and other related disorders, knowing what resources were available in local communities, having clear diagnostic criteria and tools for GPs to use, knowing other professionals within the community (particularly psychologists), having established pathways of communication (directly between psychologists and GPs), and establishing knowledge of either GPs' and/or social workers' delivery of depression care by sharing cases. The pre-intervention audit report presented back to practices in forum meeting one prompted participants to think about record keeping. Four practices selected interventions related to identified challenges and weaknesses, while two selected interventions not noted on SWOC material.

Frank Street's intervention was directly related to the medical record audit report and it shows their attempt to identify within a practice population who had depression. The re-auditing undertaken for their intervention found that only 32% of people on SSRIs in their system had a recorded diagnosis of depression in the past history section of the record and 13% of people could be identified by looking in the recorded progress notes. This established that 56% of people with a SSRI prescription did not have a diagnosis of depression entered in the record (Frank PF #4: 3). Frank Street GPs found this surprising given that they were all prescribing SSRIs for depression and related conditions only. GPs at Frank Street continuously re-visited this theme of auditing their own notes for quality throughout each meeting.

Gibson Street and Southville both chose information and resources for depression as their area of intervention. Keeping patient resources up to date was considered challenging as there was no-one to 'chase up all of these sorts of things and ring up' (Gibson PF #3: 23). There were challenges around lending out books and having them returned, not having a system of recording this information or an allocated staff member to supervise. No-one was identified to order new materials, and they did not feel able to judge whether material was suitable for patients (particularly that developed by pharmaceutical companies). The sheer variety of materials that need to be collected for general practices presented a challenge. Traditionally receptionists seem to have conducted the resource role, but in both Gibson and Southville (where information and resources was their chosen intervention) these were led by practice nurses. At other practices interventions were led by GPs.

Participants struggled to think about changes around depression exemplified by one practice nurse saying, "because depression isn't the main reason everyone is coming here, and it's difficult to identify so that you could have a module or a system in place to cope with that" (Gibson PF # 3: 21). Southville GPs also noted that the nature of general practice – as individually focussed on each patient as they present every day – meant that 'often [they had no] time to be planning' (Southville PF #2: 2). Like other practices in the study, Southville mentioned individualised approaches to depression care were a challenge to delivering exemplary depression care. One GP felt that the practice had not had the opportunity to share the information they had… "I mean each of us have developed our own strategies to cope with [depression]" (Southville PF # 2: 10). West Sanders were equally preoccupied with idea that individual GPs practised differently, a regular subject of discussion within forum meetings which they felt was linked to not having scheduled meetings about depression or broader mental health care. This related to material identified in their SWOC about knowing what other GPs were doing. GPs often remarked that they did not know what each other did, or how they each engaged with the problem of depression. This prompted the West Sanders group to undertake the task of case presentations by one GP to the group as their intervention. At this presentation the whole group agreed on the approach that the presenting GP had taken to this case and after subsequent exploration of their own processes for diagnosing and managing depression GPs also felt they had more in common than not.

Southville and Coopers Road staff also felt that GPs might use resources that others were unaware of and that discussing and sharing these ideas could result in improved depression care. As a diverse practice situated in a well-established culturally mixed community at the foot of a tall public housing complex, Coopers was quite a different practice to Southville. Coopers Road's diversity was also reflected in the range of services that they provided to their patients,

the patients who attended for treatment and support, and the participation of different professionals within the practice forum meetings. Indeed, the practice prided itself on being 'diversity-driven' and this was not at all surprising given that it was a community health centre structure where funding was shaped by the emerging cultural groups within the local and surrounding community. However, during practice forum meetings staff expressed sentiments of not feeling a sense of cohesion and a similar theme to West Sanders evolved, that staff felt that they did not know what each other were doing around depression care. As one social worker suggested:

"So, what you are saying is that we're not modelling what we're expecting them [patients] to do for good health. We're not even modelling it here [within the practice] and we're expecting our clients or our patients to be able to tap into it. Maybe we need to start by being more connected ourselves." (Coopers Social Worker PF # 3: 13).

Other staff supported this view, with one GP proposing that given the structure and organisation of this site it might be assumed that they were supposed to be across the "whole multidisciplinary thing". This GP's view was that 'given that we're only having meetings once a month and if you happen to miss it, then, it's once every two months, the multidisciplinary thing doesn't really happen unless – well it doesn't happen really'. Similarly to other practices outside of these monthly business meetings, other meetings appeared to happen in an ad hoc, unscheduled manner and were dependent on staff 'happening to see someone' or to 'bump into someone'. There was a feeling from another of the GPs that 'I don't see them, I don't talk to them. We always used to be able to discuss patients and say oh I've got this person and can you do this with this?' These themes were not unique to Coopers Road; all practices shared these concerns in their forum meetings and development of interventions. People felt that:
Maybe we're wasting a lot of time trying to find out where we can send people, whereas if we had a better idea of what other services were around we could get them in and I tend to agree (Coopers General Practitioner PF #3: 18).

Interestingly, another GP commented that they too should be accessing the social workers within the practice and they pointed out that they were aware, for example, of what one social worker did but they did not know who necessarily worked with them and what they did. One GP's suggestion was:

> *'It sounds at the very least like we need to come together and share ideas about what we do around managing people with depression'.* (Coopers General Practitioner PF # 3: 19)
>
> *… 'Or what sort of cases we'll take,' said Sonia. Grant replied, "how many people we tend to see and how often we tend to see them'.* (Coopers General Practitioner PF # 3: 19).

At Coopers Road this resulted in two case presentations: one by a GP and the other by a social worker, to explore the potentially different styles of assessment and treatment. Part of Coopers Road's intervention was to also share resources, which was a common desire of all practices, but Coopers staff did not prepare this information for their intervention meetings. In their discussion of the challenges faced around diagnosing depression, Eastvale GPs also shared individual cases of depression. Their efforts concentrated on developing an understanding of the spectrum of depression in conjunction with a discussion held by Professor David Clarke currently completing guides to depression care for general practice with beyondblue.

The issue of resources was exemplified in Gibson and Southville interventions. At Gibson, staff also thought that the intervention could provide an opportunity to streamline patients by having more notices in the waiting room with information about symptoms [of depression] and what to do (PF # 3: 21). Eastvale shared this view too and discussed the notion of a waiting room sign for patients and scheduling long appointments, even pondering the possibility of screening in the waiting room (though the findings from Phase One of **re-order** suggest that a significant minority of patients are not comfortable with this idea). The following section reports on the outcomes of interventions at practices.

4.3.3 OUTCOMES

On completion of the intervention phase, medical record audits were repeated to identify any changes during interventions and post interventions. Five of the six practices operated the clinical software program Medical Director® (MD) and one used MedTech33®. The MD database generated data for the following queries:

- the number of different patients aged 18 to 75 years that had consultation/s at the respective practices during each of the time-points (see Table 29);

- the number of patients aged 18 to 75 years that visited the respective practices during each time-point and had a category of 'depression' noted in their medical record (see Table 31). (Note: these were not necessarily new diagnoses that occurred within the respective time periods.);

- the number of current active scripts for antidepressant medication amongst patients aged 18 to 75 years during each audit time period (see Table 33).

The tables that follow compare audit results by practice and across the following three audit time periods; the twelve months prior to the re-order study commencing work with the practices (Pre), during the re-order intervention (During) and from the final practice forum to the date of the audit (Post). Table 30 presents figures for the number of days within the three audit time periods; the practice population numbers, proportion of the twelve month population visiting the practice per day, the number of GPs in the practices, the average number of clinical hours per GP per practice and the annual patient population proportional to the number of practicing GPs. The annual patient population across the six practices ranged from 1905 at Coopers Road Medical Centre to 6971 at West Sanders Medical Centre. The number of patients seen per day remained stable across the time periods for all practices except West Sanders Medical Centre where there was an increase in the number of different patients attending across the time periods.

Table 30: GP and practice population details and clinical hours available per patient per year

Practice	Audit period (days)	Practice population	No. of GPs	Average no. clinical hrs per week per GP per year	Average number of clinical hours available per patient per year
Eastvale					
Pre	365	4102	6	45.2*	3.2
During	379	4416			
Post	27	968			
Gibson					
Pre	365	2840	2	32.1	1.1
During	260	3136			
Post	123	1699			
Frank St					
Pre	365	2101	4	24.3	2.2
During	160	1800			
Post	61	1459			
Southville					
Pre	365	5789	7	31	1.8
During	299	5614			
Post	37	2437			
Coopers Rd					
Pre	365	1905	7	19.9	3.5
During	232	1739			
Post	76	1115			
West Sanders					
Pre	365	6971	14	29.4*	2.8
During	146	5644			
Post	73	4525			

Note: 'Pre' indicates the 12 months prior to the reorder study commencing at the practice; 'During' reflects the time period that the reorder team were working with the practice; and 'Post' reflects the time immediately following the reorder intervention with the practice. * Average clinical hours per GP for Eastvale Family Medical Centre is based on the total clinical hours of 5 of the GPs. Information on the number of clinical hours of one GP was not available.

Table 30 shows the GP and practice population details as well as estimating the clinical hours per patient per year. Whilst these are estimates only they provide a means of comparing patient load and access to general practice care. The striking observation is that, apart from Eastvale, most GPs are working part-time. The average number of clinical hours available per patient, per year, ranges from 1.1 hours at Gibson to 3.5 hours at Coopers Rd. Also, the footnote should read; These calculations are based on the assumption that each GP works an average of 48 weeks per year. * These estimates are calculated on the figures provided by the GPs who completed a postal survey.

The conditions listed in Table 31 are depression related diagnoses that were listed in the drop-down list in MD that reflect the main 'reason for patient contact'. In the instance that a patient presents with multiple health complaints, and depression not being considered as the main complaint, depression could remain unrecorded. Diagnoses were recorded according to these categories available to GPs in the drop-down list of MD.

Table 31: Depression and depression related DOCLE diagnosis categories listed in Medical Director®

Condition
Depressed
Depression
Depression-endogenous
Depression-major
Depression-minor
Depression-postnatal
Depression reactive
Depression recurrent
Depressive anxiety disorder

Table 32 below presents a monthly attendance rate of patients with a depression condition recorded in their medical record.

Table 32: Number of patients with a diagnosis of 'depression' recorded in their medical record and had at least one consultation with a GP of the study practices (presented as a monthly rate of attendance)

Depression category and audit phase	*Rate per month*					
	Eastvale	Gibson	Frank St	Southville	Coopers Rd	West Sanders
Depressed						
Pre	3.5	0.6	0.3	0.2	1	0.4
During	3.1	0.6	0.4	0.3	1.4	0.8
Post	2.3	1.2	0	1.6	3.6	2.1
Depression						
Pre	30.3	11.3	5.8	46.1	13.4	46.2
During	30.1	26.7	0.4	60.9	19.6	95.1
Post	45.1	40.1	36.4	297*	47.7	164.7*
Depression-endogenous						
Pre	0.2	0.3	0.6	0.4	0.4	2.2
During	0.2	0.5	1.3	0.3	0.7	5.2
Post	0	0.7	3	0.8	1.2	8.3
Depression - major						
Pre	0	0.3	0.8	0.7	0.3	0.9
During	0	0.4	3	0.9	0.3	2.1
Post	0	0.7	150.2*	4.9	0.8	4.2
Depression - minor						
Pre	1.6	0	0	0	0.3	0.3
During	0	0	0	0	0.1	0.4
Post	0	0	0	0	0	0.4
Depression - postnatal						
Pre	0.7	0.4	0.3	1.5	0	1.7
During	2.1	1.3	1	1.8	0.3	3.3
Post	5.6	2	3	7.4	1.2	3.3
Depression - reactive						
Pre	0	0.8	0.8	2.7	0.8	2.1
During	0.4	1.3	1.7	3.7	0.8	5
Post	1.1	2.2	4	20.6	1.2	10.4
Depression - recurrent						
Pre	n/a	n/a	0	0.1	0	1.1
During	n/a	n/a	0.2	0.2	0.1	0
Post	n/a	n/a	0.5	1.6	0.4	0
Depressive anxiety disorder						
Pre	6.1	1.3	1	5.6	0.8	7
During	11.8	3.2	2.3	9.9	1.7	13.8
Post	15.8	4.7	6.5	51.8	4	20.8

* Note that these are projections and are unreliable due to the short audit period

The attendance rates per month of patients with either a past or present diagnosis of depression (recording available in MD does not necessarily indicate diagnosis of depression, but the main purpose of the visit to the GP) indicates that 'Depression' as a condition was the most common category selected of all the depression-related conditions listed in the MD. Results for the 'Pre' and 'During' time periods are reliable estimates of monthly rates. However, given the shorter 'Post' time periods projected estimates are less precise.

Of all the depression-related conditions listed in the drop-down list of MD as well as MedTech 32®, 'Depression' was the most frequently used category to classify the main purpose of patient consultations at each of the practices. Increased use of all categories was seen at the Gibson

Street Medical Centre, The Southville Clinic and West Sanders Medical Centre. Similarly, GPs at the Coopers Road Medical Centre also increased use of all categories except the condition 'Depression-minor' where a gradual decrease pre to post intervention was noted. GPs at the Frank Street Medical Centre decreased their use of the term 'Depressed' but increased their use of all other categories from the drop-down list. There were also considerable increases in the use of the category 'Depressive anxiety disorder' amongst GPs at the Eastvale Family Medical Centre, The Southville Clinic, and West Sanders Medical Centre. The Southville Clinic GPs increased their use of 'Depression-reactive' to classify the main purpose of patient consultations.

Table 33 below reports the number of MBS items of the Better Outcomes / Better Access to Mental Health Care that were billed by practices across the three audit time periods. Presented is the number of items billed as well as the percentage of patients that had a mental health plan prepared (2710), reviewed (2712) or had a mental health consultation (2713). This data is accurate as they were extracted from practice billing software and for Coopers Road Medical Centre, figures were obtained from Medicare Australia.

Table 33: Monthly billing rate of Better Outcomes +/- Better Access to Mental Health Care item numbers.

Practice *(patient population at audit time point)*	Monthly rate of MBS Item Numbers Billed (n)		
	2710 - Prepare a MH plan	2712 - Review a MH plan	2713 - MH consultation 20 to 40 min
Eastvale			
Pre (4102)	15.3 (184)	4.9 (59)	0.25 (3)
During (4416)	17.8 (222)	9.2 (114)	6.8 (85)
Post (968)	6.7 (6)	11.3 (10)	5.6 (5)
Gibson			
Pre (n=2840)	6.4 (77)	1.75 (21)	0 0
During (3136)	10 (85)	5 (43)	0 0
Post (1699)	10.9 (44)	0 0	5.2 (21)
Frank St			
Pre (2101)	3.5 (42)	1 (12)	0.08 (1)
During (1800)	4 (21)	1 (5)	0.2 (1)
Post (1459)	4.5 (9)	1 (2)	0 0
Southville*			
Pre	5.3 (63)	0.3 (4)	1 (12)
During	12.4 (122)	4 (39)	2.6 (26)
Post	37 (45)	4.1 (5)	4.9 (6)
Coopers Rd^			
Pre (1905)	1.2 (15)	0.08 (1)	13.8 (166)
During (1739)	2 (15)	0.9 (7)	10.4 (79)
Post (1115)	4.8 (12)	0 (0)	20.8 (52)
West Sanders			
Pre (6971)	22.5 (270)	0.02 (102)	5.1 (61)
During (5644)	24.4 (117)	9.6 (46)	20.2 (97)
Post (4525)	25.9 (62)	11.7 (28)	30.4 (73)

'Pre' dates are based on financial year prior to study intervention 1/7/06 to 30/6/07, figures for 'During' period is between 1/7/07 to 30/6/08, and figures for the 'Post' intervention period are based on usage between 1/7/08 to 30/9/08.

Monthly billing rates presented in Table 33 above indicate that there was an increase in the use of all item numbers during the intervention at most practices with the exception of Frank Street Medical Centre. The monthly billing rates at Frank only slightly increased for the item number linked to preparing a plan (2710), remained the same for reviewing a plan (2712) and there was decreased use of item number 2713. There was also a decrease in the use of item number 2710 at the Eastvale Family Medical Centre, but this returned to levels more in line with rates at other practices. The monthly billing rates for Coopers Road Medical Centre are based on the services provided by three of the four participating doctors. During the intervention there was only a marginal decline in the use of item number 2712, with increased use of 2710 and 2713. Doctors at the Southville Clinic and Coopers Road Medical Centre generated a larger number of mental health plans (item 2710) with patients when compared having patients return to review the mental health plan (item 2712).

Table 34 presents data on the number of current active antidepressant prescriptions held by patients of the respective study practices. Search criteria used to generate this data included; all patients aged 18 to 75 that held a current prescription for antidepressant medication(s). It should be noted that it was unknown whether these patients actually obtained the medication or whether they were continuing to take the medication(s) prescribed. MD enables accurate recording of antidepressant medication, therefore data on antidepressant prescribing are more reliable than diagnostic data from this software.

Table 34: Number and percentage of patients aged 18 to 75 years with a current active prescription for antidepressant medications

Practice *(patient population at audit time point)*	Antidepressant Medication n (%)							
	SSRI Antidepressant^	Tricyclic Antidepressant	Antidepressant 5HT receptor blocker	Antidepressant MAO inhibitor‡	SNRI Antidepressant±	Antidepressant other	Antidepressant RIMA*	*All*
Eastvale								
Pre (4102)	486 (11.8)	145 (3.5)	0	3 (0.07)	109 (2.7)	68 (1.7)	16 (0.4)	827 (20.2)
During (4416)	475 (10.7)	200 (4.5)	0	5 (0.1)	123 (2.8)	70 (1.6)	13 (0.3)	886 (20.1)
Post (968)	34 (3.5)	23 (2.4)	0	0	10 (1.0)	0	0	67 (6.9)
Gibson								
Pre (n=2840)	323 (11.4)	100 (3.5)	2 (0.1)	1 (0.03)	117 (4.1)	43 (1.5)	0	586 (20.6)
During (3136)	337 (10.7)	95 (3.0)	3 (0.1)	1 (0.03)	113 (3.6)	48 (1.5)	16 (0.5)	613 (19.5)
Post (1699)	230 (13.5)	86 (5.1)	2 (0.1)	1 (0.06)	80 (4.7)	34 (2.0)	12 (0.7)	445 (26.2)
Frank St								
Pre (2101)	121 (5.8)	44 (2.1)	3 (0.1)	1 (0.05)	116 (5.5)	54 (2.6)	46 (2.2)	385 (18.3)
During (1800)	274 (15.2)	160 (5.1)	2 (0.1)	1 (0.1)	104 (5.8)	45 (2.5)	40 (2.2)	626 (34.8)
Post (1459)	236 (16.2)	123 (8.4)	3 (0.2)	1 (0.1)	90 (6.2)	40 (2.7)	34 (2.3)	527 (36.1)
Southville								
Pre (5789)	415 (7.2)	88 (1.5)	0	2 (0.03)	203 (3.5)	29 (0.5)	14 (0.2)	751 (13.0)
During (5614)	421 (7.5)	87 (1.5)	0	2 (0.04)	209 (3.7)	31 (0.6)	14 (0.2)	764 (13.6)
Post (2437)	248 (10.2)	63 (2.6)	0	1 (0.04)	129 (5.3)	21 (0.9)	7 (0.3)	469 (19.2)
Coopers Rd								
Pre (1905)	140 (7.3)	34 (1.8)	0	0	27 (1.4)	20 (1.0)	1 (0.1)	222 (11.7)
During (1739)	127 (7.3)	40 (2.3)	0	0	24 (1.4)	15 (0.9)	2 (0.1)	208 (12.0)
Post (1115)	101 (9.1)	34 (3.0)	0	0	16 (1.4)	12 (1.1)	2 (0.2)	165 (14.8)
West Sanders								
Pre (6971)	480 (6.9)	130 (1.9)	0	1 (0.01)	127 (1.8)	30 (0.4)	0	768 (11.0)
During (5644)	908 (16.1)	272 (4.8)	10 (0.2)	0	252 (4.5)	71 (1.3)	26 (0.5)	1539 (27.3)
Post (4525)	765 (13.6)	229 (5.1)	8 (0.2)	1 (0.02)	217 (4.8)	62 (1.4)	28 (0.6)	1310 (29.0)

^ Selective serotonin reuptake inhibitors
‡ Monoamine oxidase inhibitors, non-selective
± Serotonin and noradrenaline reuptake inhibitors
* Reversible inhibitors of monoamine oxidase - A

The most commonly prescribed antidepressants amongst the study GPs were SSRIs followed by SNRIs and Tricyclic antidepressants. In the twelve months prior to the **re-order** study, the overall number of active scripts issued by practices ranged from 11% at West Sanders Medical Centre to 20.6% at Gibson Street Medical Centre. By the 'post' intervention period, the figures ranged from 6.9% at Eastvale Family Medical Centre to 36.1% at Frank Street Medical Centre. The former figure reflects new or repeat prescriptions written during the respective time period. At the Eastvale Family Medical Centre new or repeat prescription figures declined across each of the antidepressant medication types. A female GP left this practice during the study period and according to the practice manager, she did a great deal o f the 'depression work' within the practice. This may explain the decline in prescriptions. Across each of the other practices the % of active scripts increased for SSRI antidepressants, with minimal increase in antidepressant MAO-inhibiters at Frank Street, Gibson Street and Southville Medical Centres. Percentage increases were also seen in scripts for Tricyclic antidepressants across all practices with the exception of Eastvale Family Medical Centre. SNRI antidepressants were also higher for Frank Street, Southville and West Sanders Medical Centre.

Table 35 presents a summary of overall changes in diagnosing and recording, antidepressant prescribing and use of MBS mental health item numbers, compared with the practices changes made as a result of participating in **re-order**. It shows an overall effect of being engaged in **re-order** and indicates that some practices changed their approach to diagnostic processes and prescribing.

Table 35: Summary of overall changes in diagnosis and recording, antidepressant prescribing and use of MBS mental health item numbers compared with the practice changes made as a result of participating in the re-order study.

Practice	Agreed practice focus with regards to depression	Overall participation rate	Relevant practice changes during study phase	Diagnosis & recording	Antidepressant prescribing	Rate of Mental Health Plan use
Eastvale	Diagnosis of depression and diagnostic processes via case sharing	71.4	Female GP left the practice - she saw many of the practice patients with depression	increased recording of all except 'depressed', 'Depression-endogenous', 'Depression-minor'	small decrease in prescribing across all antidepressants, with the largest decrease seen in scripts for SSRI	increase except item number 2710
Gibson	Information and resource updating and improvement for depression care	71.4	Moved form being partially electronic practice to fully computerised	increase	increase in all exept 5HT receptor blocker	increase
Frank St	Record keeping and patient history notes	72.7		increased recording across all categories of drop down list except 'Depressed'	increase	increased use of 2710, item number 2712 remained the same and 2713 decreased
Southville	Information and resources for depression care, development of shared knowledge base of pyschologists and psychiatrists used for referrals	48		increase	increase in all exept 5HT receptor blocker	increase
Coopers Rd	Case presentations from social work and GP, development of lists of resources used individually for depression care to share collectively	55		increase recording of all except 'Depression-minor' which decreased	small increase in SSRI, Tricyclic Antidepressants, RIMA, and other	information pending (medicare australia)
West Sanders	Case presentations, implementation of a regular meeting for discussing mental health/depression	36		increased recroding of all except 'Depression-recurrent'	increase in all exept 5HT receptor blocker	increase

The audits of medical records show increases in the rate of depression recorded diagnoses, antidepressant prescribing and use of MBS mental health item numbers during and following the **re-order** intervention. Triangulation with practice forum data indicates that GPs in the study practices increased their diagnosis and treatment of depression. The increased use of the item numbers seems to be explained by an intervention-effect. The study's presence in the practices appears to have lead GPs to become more observant for cases of depression amongst their patients. Certainly the GP from Gibson Street Medical Centre mentioned during discussions at practice forum four that she had increased her use of the mental health item numbers to "at least two a day and sometimes even four." Eastvale GPs also mentioned that mental health plans had increased.

For many practices this was the first time they had met as a whole group and discussed depression care. Some of the outcomes of these interventions are difficult to measure and they relate more directly to relationships within practices. Some noted in forum discussions that they were talking as a team, they had a more ordered structure, more coordination of resources for patients, and had discovered new resources. A number of practices noted that facilitated meetings, by an independent person to the practice, were a useful technique and they probably would not have held discussions about depression care without this. In addition to monitoring outcomes via the audit, a brief evaluation survey was distributed to participants. Figure 15 provides a summary of participant responses to the question of which practice phase activities people found most useful in improving depression care in their practice.

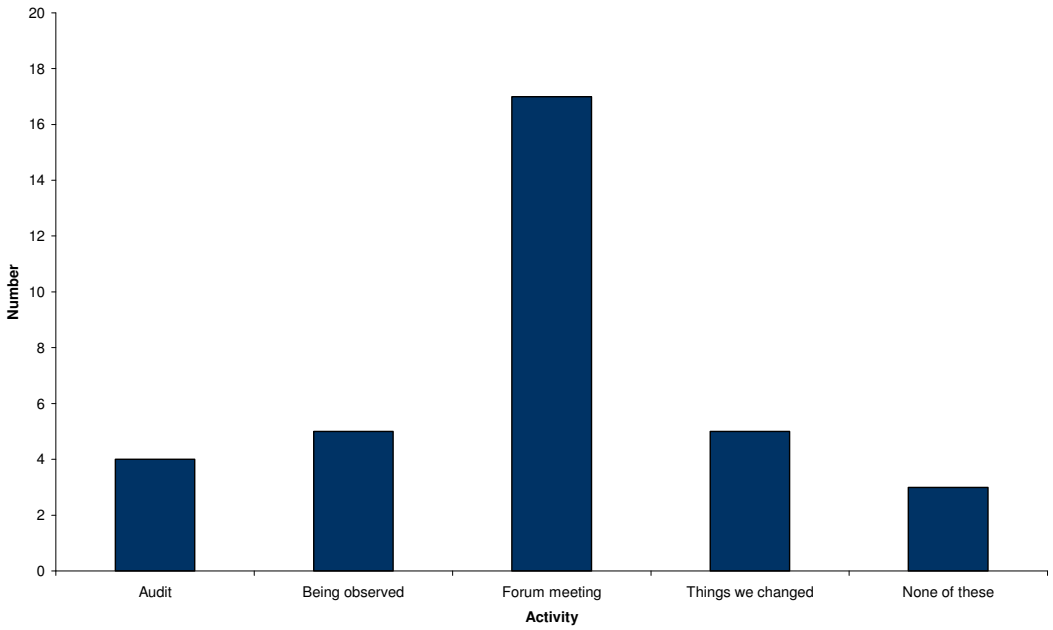


Figure 15: re-order study activities participants found useful in improving depression care in their practice

Results indicate that participants found facilitated practice forum meetings to be the most overwhelmingly useful activity in terms of improving their depression care. Three of the respondents felt that none of the activities were particularly useful in improving depression care. Some participants acknowledged things they changed as being beneficial.

21 of the 22 participants provided responses as to why they found activities beneficial or not beneficial. Most participants provided positive responses about their participation. GPs particularly mentioned that the fora provided the opportunity to gather as a practice to discuss depression cases, treatment strategies and to exchange ideas. Other GPs valued the opportunity to hear from other practice health professionals and their experiences in working with patients

who have depression. Three of the practice nurses mentioned that for them, the forum meetings raised their awareness of depression care in their practice, the resources available to assist patients and one also stated that it demonstrated for her where the practice could improve in their care for depressed patients. Overwhelmingly, when asked to describe the benefits of taking part in re-order, most stated that it was the opportunity the study provided to gather and reflect on an area of practice as a group. One GP stated;

> *"It was helpful to spend time with colleagues, discussing our ideas on depression management." (GP)*

Less useful aspects of the project were noted as the ground-up fluid approach to intervention (or the self-defined intervention) development, one of the GPs felt there were too many meetings, another health professional did not feel they could contribute much to the forum discussions and one of the GPs did not find the medical record audit beneficial. One GP stated that he/she did not change their depression care as a result of participating in the study. However another GP stated that he/she enjoyed being part of the study despite initial skepticism. West Sanders reported since intervention completion that they had continued with a mental health focussed meeting and Eastvale were eager to continue work around questions of diagnosis with Professor Clarke.

DISCUSSION

Using a participatory action research methodology enabled us to document and appreciate the variety of practice types that existed, even within this highly motivated, research friendly group of practices. The adaptability of the practices to accommodate change was evident. Each practice reflected the community in which it was located and the staff that worked within it. The link between the kind of patients and the problems they brought to the encounter demonstrates the dynamic nature of general practice and its ability to adapt to the community that it serves. This is not to say that there is not room for improvement, nor that all problems and patient groups are adequately served, but it indicates that general practice has the *capacity* to meet these needs. Being mindful of the adaptable, independent and flexible nature of general practice may help to develop innovative solutions to health problems that would not be found by a top down 'control and command' approach.

There was an underlying sense from practices that self-defined change was a difficult process. Participants were challenged by the prospect of identifying their own intervention; in particular something at a systems or practice level. Literature does suggest that small change, driven by participants is more sustainable than change which is imposed, because participants will develop change that they can manage (Greenhalgh 2007). The changes developed through **re-order** interventions may reflect those which are manageable at present. Practices noted in their SWOC material that physical infrastructure impacted on their ability to deliver depression care. Waiting room issues and having places to meet presented difficulties for many participants. Many practices were provided with free information produced by beyondblue. It was a surprise that practices were unaware that brochures, DVDs and posters were available freely to them from this source.

re-order worked with six highly motivated, atypical practices who were ultimately extremely busy delivering individual care that made practice level changes are difficult to implement. The Frank experience confirms the need for better information systems for practices. Eastvale intervention and all Mandala discussions show that diagnosing depression is a complex task. Participants are extremely busy doing depression care with little time to plan, there is a sense that it is difficult to share information and resources within practices, let alone across practices.

Mandala activities indicate that there are some shared understandings by participants about what depression is and how it is happening which was reflected in the high rates of those selecting the bordered flower, interconnected and maze images. Participants talked about the challenges of identifying the right kind of supports in their case presentations and discussions. We already have noted that physical infrastructure of practices does not provide adequate meeting space, but in addition to this, it was difficult to obtain and maintain whole of practice participation with part-time staff and varied meeting times. Practices met with research staff during either busy peak times or lunch times; these were limitations of forum meetings.

It is important to note several other limitations of the practice phase data. For audit reporting the limitations of software impacted on records that could be accessed. The consistency of the record keeping practices of GPs and other practice staff affected the meaningful accuracy of audit findings. There were limitations in the skills of practice staff in assisting the researcher to collect data relevant for the audit (e.g. referrals and use of item numbers within particular time periods). There were several limitations to the search capabilities of Medical Director; for example the query function of the software was unable to generate accurate data on -- the number of new diagnoses of depression, the frequency of visits by patients with diagnoses of depression, the number of referrals of patients with depression to mental health professionals and the co-morbidities of patients with depression. Additionally, follow up for intervention changes was conducted within a short period of time due to funding limitations. Therefore, interrogation of the MD database for the purpose of the audit was limited; nevertheless it was the only electronic database that contained the relevant information.

Practice observations provide rich illustrative information that supplement practice forum meetings, but they are records of one independent staff member observing within time restrictions. The method of action research worked in terms of feedback from practices that they felt a part of the research process and valued throughout, but some participants noted they would have preferred a more tailored and pre-designed intervention. Practices are not really thinking about data systems and interrogating their systems, they are, as these real-life action research shows, doing the busy work of primary care.

We have found that depression care remains largely the work of GPs in practices and it is certainly a routine part of their clinical day to day work. Observations and forum meetings show this. The observation notes and the forum transcripts reveal that, in the main, GPs accept a mental health role as integral to whole person care, yet some find it burdensome due to the magnitude of the problem. They also reveal that practice nurses are seen by many as an avenue for delivering some depression care, but at present, they largely gather information that is handed on to the GP to conduct the formal work. Many practice nurses also felt that mental health care was a specialist field which required specialist training and they were not suitably trained to deliver this care. The main barrier to accessing currently available mental health nurses was seen as time to apply for and access funding. Participants also queried whether the infrequent nature of mental health nurses attending practice would be suitable for people with depression considering the way in which physical, emotional and social issues present to general practice as inextricably linked.

It is possible to see interactivity and interdependencies between the GP and practice nurse roles but it is certain that this is not formalised. Interdependency is also evident between receptionists and GPs, but not necessarily between receptionists and nurses; only one of the practices had a booking system for nurses. A shadow system appears to operate in all three of these relationships in relation to depression care. The first shadow system relates to the informal manner in which nurses gather information, pass it on, but leave it to the GP to decide if it is important or not. The second shadow system relates to the protective role that reception staff play for GPs and their power in determining who can be squeezed in for an appointment and why. A third shadow system in these relationships is that reception continues to receive the brunt of patient frustrations where GPs and nurses usually do not. These frustrations were raised in forum meetings and remain a concern for receptionists who struggle to provide access to preferred GPs with limited appointments. Receptionists play informal support roles to patients

via the telephone or following up on appointments and tests, psychologists at practices are utilised for referral but not for a formalised system of team based care.

The study outcomes presented suggest that **re-order** interventions did have an overall effect though this cannot be guaranteed to be directly related to our presence. What we can suggest is that while practices can change, self-organisation efforts for depression care remain informal and depression care is highly individualised between the GP and patient. The use of psychologists for referral is common, but interventions also showed that other allied health staff are not highly utilised. In addition to this, many participants are cautious about referring to psychologists that they do not know. In general participants were keen to seek to understand the resources and processes their colleagues are using in depression care. This indicates that there will be a need for greater collaboration and communication models for primary care delivery of depression care. The six practices in this study are highly active and exemplary in terms of their support, motivation and participation in research studies such as this. The GPs involved were experienced and highly trained individuals open to reflection and the discussion processes used, but they too struggled to implement interventions from the bottom-up. This suggests that Australian primary health care settings in the future will require active attention by skilled facilitators and practice staff to improve and implement exemplary models of depression care. It is also clear that non-patient planning time and significant infrastructure support is required if practices are to have a chance at developing and implementing exemplary depression care.

CHAPTER 5: DEVELOPING AN EXEMPLARY MODEL

5.1 INTRODUCTION AND METHODS OF DATA SYNTHESIS

The overarching aim of **re-order** was to develop the principles for an exemplary model of depression care suited to Australian primary care. The earlier chapters of this report document each phase of the research program which took place from 2005 to December 2008. It is worth restating that we were working with a set of highly motivated general practices supportive of research in primary care. They varied in size, funding arrangements and scope of practice. Each displayed different characteristics in terms of systems of depression care, how the work was allocated, the skill set mix of GPs and nurses, and the ways in which they utilised other health care professionals and monitored depression. Though there were subtle differences within and between the practices, most saw depression care as integral to general practice and all strived to do the best they could for each patient that attended them. They described depression as a complex problem of a diffuse nature that was often confusing and rarely straightforward. It was also seen to be never-ending and at times overwhelming work. There was a strong commitment to ensure that no physical problems were missed in someone who may be experiencing depression. No practice provided an outstanding example of exemplary depression care at a practice level, yet all staff was committed to providing high quality, individualised depression care.

Our time spent within each practice found that depression care was very much the domain of the medical staff and it was not thought of as a 'system' of care, but rather in individual terms of 'particular' patients with 'particular' problems. Where there were practice nurses within sites they were not actively engaged in the doing of depression care work on a routine basis. Some nurses mentioned that if they noticed a patient was down or 'picked *something* up', they mentioned it to the GP but they did not formally follow up on this; leaving it up to the GP to decide what happened next.

Hence in 2008, in six Australian general practices, depression care was viewed as a highly individualised activity with no practice having a particular system that they could describe. Each could talk about their processes for diagnosis, re-booking an appointment and the time taken to deliver depression care, but the term 'system' was actively questioned and perceived as non-existent by all participants. Prior to participating in **re-order** no practice had ever met to discuss how depression care was undertaken in their practice. We found very few examples of formal clinical discussions in any of the practices, for any condition. However, practices were much more likely to report that they had spent time discussing diabetes care. The one practice that did report having regular clinical meetings had never discussed depression; and agreed that they usually discussed complex diagnostic issues, or 'unusual' cases within this meeting. All agreed that having time set aside to discuss depression care was a unique, useful and rewarding experience.

All practices discovered during the course of **re-order** that their electronic medical record system was inadequate to support their depression work. They struggled to make sense of the codes available for recording depression and could not monitor their work effectively, nor follow numbers or outcomes of referrals or mental health plans.

There was evidence of a deep understanding of depression care and practices associated with exemplary delivery of care, but there was little sense of organisation within the practices and indeed dis-organisation was a common thread throughout discussions. At the practice level it seems there has not been time available to focus on the organisation of mental health care in a systematised way. All practices struggled to cope with the constant flow of face to face patient care. Regular, specific time set aside for planning and reviewing clinical care *at the practice level* was not noted during the observation phase of **re-order**, nor was it reported by the practice**.** At the most basic level we found that the majority of the practices did not know that they could access free patient education and information resources from places like *beyondblue* – many of

them relied upon information provided by pharmaceutical companies, much of it out of date. In almost every practice we provided them with free printed patient information from *beyondblue* to update their patient resources.

Within the practice fora there was a strong theme of the need to have integrated care, to share the load of depression care with psychologists and counsellors, and importantly to have people with the right training and skills to be a part of the care process. Practice staff spoke of the complex task required to integrate physical and mental health care needs in light of the fact that multiple morbidities/problems were the norm, rather than the exception, for general practice. Designing the principles for an exemplary model of depression care requires that we remain mindful of the potential risks involved in taking a single-disease focus.

This chapter is based upon a synthesis of the findings presented earlier and puts forward a set of principles that could guide depression care delivery at the practice level. We utilized normalization process theory (NPT) (May 2006; May et al, 2007a; May et al, 2007b; May and Finch 2009) to guide our approach to data analysis and synthesis. We selected NPT to guide the analysis as normalization is a theory that explains how sets of practices, work or ideas become normalised and routine and hence, offered us a way of identifying key principles that might underpin a sustainable system of depression care. Normalisation process theory is based upon four interactive principles of coherence, cognitive participation, collective action and reflexive monitoring. The theory postulates that in order to become a routine practice work has to be done to define and organise the objects of a practice (coherence), participants have to enrol in a work practice (cognitive participation), work has to be undertaken to define and organise the enacting of a practice (collective action) and work has to define and organise the knowledge upon which appraisal of a practice is founded (reflexive monitoring) (May and Finch, in press). To test the applicability of NPT to the task of data analysis we first read through transcripts from the practice fora and looked for evidence of the principles of NPT occurring naturally in the data. This proved an easy exercise with many examples of each of the principles of NPT being evident.

To develop a coding framework that could be used for data analysis the principal investigator and research fellow, in discussion with Professor Carl May firstly went through a process of reading and discussing the strengths, weaknesses, opportunities and challenges activity completed by each practice during a practice forum. We then developed four propositions related to the components of NPT. Next, we examined transcripts for evidence of coherence and cognitive participation and the ways that collective action was occurring for depression care. This informed the development of the following four propositions:

P1. Coherence

Depression work requires conceptualisation of boundaries (who is depressed/who is not depressed). Depression work requires techniques for dealing with diffuseness.

P2. Cognitive Participation

Depression work requires engagement with a shared set of techniques that deal with depression as a health problem.

P3. Collective Action

Depression work requires agreement about how care is organised, who is required to deliver care, and their structural and human interactions.

P4. Reflexive Monitoring

Depression work requires the ongoing assessment of how depression care is done.

5.1.1 TESTING THE PROPOSITIONS AND SUITABILITY OF NPT

To test whether the four propositions were going to provide an adequate coding frame for the data, investigators (not involved in the analysis to date) were asked to code a selection of forum transcripts using the statements to guide their coding activity. The four statements were presented to these members using an analysis template. The template provided each statement and explained to investigators to read transcripts for evidence of confirming and disconfirming examples of these. At this stage these investigators did not have any information about how the statements were devised, nor were they informed they were using NPT, nor were the NPT component terms made visible in the coding document. This test of the coding framework worked well, with all investigators completing the coding task and agreeing that it worked, examples of confirmation and disconfirmation were found.

Following this activity, we conducted a series of coding meetings during which complete sets of the practice forum transcript data were read and discussed. Two reviewers discussed content and its relevance to a particular statement and, on agreement, copied blocks of text and quotes that referred to statements. This was undertaken until data saturation occurred.

All relevant text was allocated to the particular principle that it informed. Disconfirming evidence was sought for each of the propositions. We then returned to the Audit data, forum transcripts and the notes made during participant observation to seek confirmation of these principles. We did this via reading, checking and discussing whether the resultant principles captured the key issues noted in each data set. When reviewing the data sets we were searching for examples of how participants:

- explained depression and depression care;
- talked about sharing techniques for dealing with depression;
- worked together, how skill-sets, procedures and policies influenced their work;
- knew, or could know, that depression care was being delivered.

In conjunction with the analysis of transcripts the team facilitated a final evaluation workshop with interested participants to test out the developing principles.

EVALUATION WORKSHOP SESSION ON THE DEVELOPMENT OF THE CORE PRINCIPLES FOR THE EXEMPLARY MODEL

The developed set of principles for the exemplary model were presented back to the participating practice staff via a linkage and exchange evening workshop held at the Department of General Practice, The University of Melbourne on October 6 2008. 51 participants across the six practices were each sent a letter of invitation and we encouraged each practice to send at least two participants. Each practice was represented and 12 people attended. In addition to the 12 participants, seven RE-ORDER team members attended (including the project leader Professor Jane Gunn, investigator Professor Helen Herrman and Dr Caroline Johnson the PhD candidate). A member from the funding body, APHCRI also attended and observed the evening. There were two aims to the evening:

1) The team wanted to thank participants for their generosity in time and assistance with the study;
2) The team wanted to share some of the early stage initial findings from the practice phase, in particular, those related to the early stage development of principles for the exemplary model of depression care.

The evaluation evening was held from 5pm to 7pm and began with a presentation by Professor Jane Gunn which re-visited the initial goals of the study, illustrated the levels of participation by different practices, and provided an introduction to May's Normalisation Process Theory and how the team had started to apply the theory to the data from forum meetings. The second part of the evening involved a short workshop session based on the four evolving principles for an exemplary model of depression care.

The Workshop on Principles

After hearing the early ideas about NPT and the principles, participants broke into four groups. Each group was asked to workshop the practical application of one of the four principles. Where possible, each group was allocated a principle that corresponded with their intervention. For example, Eastvale had spent time examining diagnosis as part of their intervention so they were allocated the principle of 'coherence'. Gibson and Southville had engaged in change processes that were about improving the information, education and resources available to both patients and staff on depression, both practices appeared to consistently discuss referral to psychologists as a positive and shared technique for dealing with depression so they were allocated 'cognitive participation'. West Sanders had discussed how they worked together as a collective group and their discussions intimated that questions of skill set workability, contextual integration, relational integration and interactional workability were important. Thus they were allocated "collective action" for their small group activity. Their intervention had centred on one GP delivering a case presentation to illuminate the different skills of practitioners and to discuss how they all worked together in the context of depression care. While Coopers Road attempted a similar intervention to West Sanders, the participants from that practice were combined with Frank Street due to the numbers on the evening. The Frank group had, for their intervention, tackled questions around auditing to establish correct numbers of people with a diagnosis of depression and how to improve patient history information and record keeping in the practice. Thus, Frank and the Coopers Road participants examined 'reflexive monitoring'.

To emulate the time constraints of clinical practice meetings participants were given only 30 minutes to discuss and map ideas around their allocated principle. A member of the RE-ORDER research team sat with each group to facilitate discussion and take notes. The participants were also asked to make notes and discuss as a group how they would apply the principle in their practices.

Here are the four principles as they were provided to each group:

Coherence

Agreement on a diagnostic framework for general practice for sorting 'distress' from 'depression'. Agreement on what constitutes depression care (patient centred, choice of treatment, for example, medication, psychological therapies, and referral pathways).

Cognitive Participation

There is engagement in a shared set of techniques for dealing with depression as a health problem and agreement about when to diagnose depression and agreement about what to do for depression.

Collective Action

There will be well-developed policies and procedures about diagnosing, recording, prescribing, referring, following-up and how this is communicated and shared. There will be agreement of the skills of the team needed for depression care and how the work is allocated. There are visible processes for information sharing, communication, cooperation and conflict resolution for depression care.

Reflexive Monitoring

Use of quantitative and qualitative measures to evaluate depression care.

RESULTS

During the small group discussions we observed participants engaged in the task of discussing and using the principle presented to them to start thinking about their own practices. Participants agreed that the task (whilst lasting only 30 minutes) prompted them to consider fundamental issues related to providing depression care. Interestingly, the group discussing the principle of coherence made the most notes, with the other three groups taking fewer, yet similar amounts of notes.

Coherence

This group recognised that they would need to spend some time in group discussion and reflection before they could confidently come to a shared understanding of what constitutes depression (the first principle for exemplary depression care). They noted that to reach this understanding would require them to think about the 'greyness' of depression and the spectrum of presentations within their practices. They could find common agreement around the major symptoms such as insomnia, lack of appetite, lowered mood and poor concentration. Yet they all discussed (as they had many times in the practice fora) that these symptoms were often present in general practice consultations and were not necessarily indicative of depression, as they viewed it. Once again, the spectrum of depressive symptoms as seen by them in general practice and the way in which these symptoms were mixed in with physical and social problems was discussed. Their solution to this dilemma was to note the importance of time and social context in sorting out what was really going on for a particular patient. They noted that they could all agree that significant distress over time was likely to be something that they could label as 'depression'. The use of simple patient completed screening tools (the K10 was mentioned) was discussed but noted that they were only using it because they 'had to' (as a requirement of conducting a mental health plan); but that they thought it could be an useful tool for tracking how things were going.

Cognitive participation

This group discussed and easily agreed that depression care is legitimate work. Reaching agreement about when to diagnose depression and what to do about it proved difficult, not just because of the time constraints of the exercise. Whilst they all agreed that they did 'need to agree' if they were to implement a practice based system of depression care, it was evident that reaching agreement could be a difficult task. The reasons they were likely to find it difficult to agree were practical (having a lot of part-time staff, so never being able to have the discussions required; lack of time to discuss these things due to their heavy workload), professional (like having differing views about roles) and philosophical (having different views about the value of various techniques for dealing with depression, e.g. listening).

Collective action

This group noted that collective action would be difficult because diagnosis is problematic. They spent time discussing the difficulty of sorting distress from depression (coherence). They felt that unless they sorted out how they were going to diagnose and label depression they could not agree upon collective action. They also noted that their participation in **re-order** had enabled them to *'just start to get a grip on the issues.. and likely to take another 12 months of meetings'* to sort out.

Reflexive monitoring

This group discussed the audit of routinely collected quantitative clinical data and all agreed it would be valuable to do on a routine basis, if it was easy to do. There was considerable debate around what constitutes depression care and whether validated measures exist. The group noted that any measures put in place should be supported by evidence that they were meaningful. It was noted that it would be difficult to monitor depression care at the practice level; as patients had varying views of whether they were depressed, or not. There was interest in exploring the idea of a Balint style group for depression care as this would have the dual role of group monitoring and provide an organised support mechanism for GPs.

Conclusion

Feedback from participants at the linkage and exchange evening and the results of the small group activity held during the evening confirmed for us that the principles we were developing were useful for general practice. In the next section we detail the four principles for exemplary depression care, linking each principle to the findings of our fieldwork.

5.2 SYNTHESIS: PRINCIPLES FOR AN EXEMPLARY MODEL OF DEPRESSION CARE IN AUSTRALIAN GENERAL PRACTICE

The following principles, guided by May's Normalisation Process Theory (NPT), form the basis for developing a practice-based system of depression care. Figure 1, as presented in the Executive Summary, provides a visual overview of the principles organised according to NPT. Whilst they are presented in a sequence they should be thought of as operating concurrently in practice, as the system will only function seamlessly if all are present and functional.

DEVELOPING "COHERENCE"

Principle 1. Depression work requires conceptualisation of boundaries (who is depressed/who is not depressed?) and techniques for dealing with diffuseness.

May's NPT proposes that for a 'work practice' to become routinised into everyday clinical practice it requires that there is a shared understanding as to what the work is and the meaning of that work. The term 'depression' was in common use in every practice. Participants quickly engaged with conversations about depression and depression care. But in line with NPT we sought to understand the meaning that the term 'depression' held within the practices. It quickly became apparent that the term depression was used in many ways. We found examples of lay usage, as a term of feeling 'a bit down', a reaction to a challenging life event, a response to an intractable social situation, right the way through to usage to denote a serious mental health problem. It was also clear that the practice staff had never discussed as a group what the term meant to them and how they might use it in their clinical work. These discussions tended to lead to the groups identifying that the general practice understanding of depression and depression work differed in some ways from a traditional 'mental health' or psychiatric viewpoint. In every practice, the meaning and usefulness of the term for the general practice setting was discussed in detail.

We encountered many discussions in which participants expressed highly sophisticated understandings of how 'depression work' was conceptualised and the lack of documentation of the general practice view of this understanding. The practices spoke about the work of general practice around responding to the problem of distress and it was clear that for many of the practice staff, sorting distress from depression was a complex task. This is not to suggest that practitioners were unaware of the diagnostic criteria of Major Depressive Disorder according to the DSM-IV for psychiatric disorders, but rather that they questioned the usefulness of these criteria in the general practice setting. This often led to participants speaking about the interplay between physical and mental health symptoms and the everyday (and not so everyday) 'problems of living'. We encountered many examples of practice staff discussing how they went about sorting the physical from the psychological and the social and how at times these just could not be separated. Deciding when depression is needed as an extra explanation for distress, added on to the life and health problems that are often present is a key challenge for general practice. Just as health problems are typically clustered, so are health and social problems; indicating that depression is legitimate work in primary healthcare. Some GPs do this by first making sure they are not missing a major or serious physical health problem (e.g. cancer, thyroid disease) before they go on to diagnose, or consider, the problem being one of depression; whilst others manage these tasks concurrently. Investigating whether these two approaches lead to differences in clinical outcomes is worthy of exploration.

There was much discussion of how families, lifestyle and social situation were often the triggers for seeking general practice care and inextricably linked to whatever symptoms or problems may be brought as the reason for the consultation. Examples were discussed, and observed, of patients presenting with distress and a diffuse set of physical and emotional symptoms in a wide range of life circumstances and the GPs sorting through these presentations, often over time.

They spoke about how they started with a set of presenting symptoms or problems and then used their clinical skills, their prior knowledge of the person and their social situation and their communication skills to sort out what was going on. They highlighted the messiness of their clinical encounters and their view that sorting people into a 'depressed' category was artificial in many cases, as they noted that no 'gold standard' diagnostic test existed for depression; like it did for diabetes. They also commented on the changing nature of the intensity of depressive symptoms and there were many examples from experienced GPs of how they had worked, over many years, with particular families who experienced the entire spectrum of emotional ups and downs that they found difficult to 'name' as the clinical problem of 'depression'. They were sceptical of the usefulness of tools (such as the K10, PHQ, DASS) and they expressed quite strong views about the 'illusion of certainty' that surrounds the area of depression. Very few GPs or practice staff put forth the view that depression is a discrete illness that could easily be disentangled from life circumstances or physical ill-health. In this way it was apparent that GPs were more likely to think in terms of depressive symptoms on a continuum (ranging from mild distress to severe and life-threatening) rather than thinking in terms of the disorder of Major Depression as a discrete and meaningful category. There were occasional exceptions to this finding – a few GPs expressed views of using DSM criteria within their practice.

re-order demonstrates that the general practice setting is one in which a sophisticated process of sorting takes place. Rather than sorting people into diagnostic categories (minor depression, major depression, dysthymia etc) general practice seeks to sort people into: those that might have a serious physical problem that cannot missed; those that might have a psychological problem that needs treatment; those that might have both; those that are experiencing a transient period of distress which needs treatment (or not) and those for whom life circumstances bring often seemingly insurmountable obstacles, for which the best 'treatment' on offer from the GP, is to 'be there'. Most participants were not convinced that current screening and diagnostic tools were needed, or useful (it should be noted that very few were using such tools in any systematic manner and there was a degree of openness towards their 'testing' them out). No general practitioner participants asked for assistance or training in how to identify people with depression, though practice nurse participants did express their need for training around depression care in some practices. The sophisticated views that were held by participants cautioned us against using psychiatric diagnostic criteria for this work and they preferred that any 'new' model of care should be based upon a GP perspective and be flexible to the diversity of the general practice context. The practice fora and the participant observation demonstrated to us that the diagnostic process surrounding depressive symptoms was complex due to multiple morbidities and the overwhelming finding that emotional symptoms were hardly ever the stated reason for the encounter; but rather they were variously hinted at, or hidden by the patient and discovered, or not and either; ignored or addressed by the doctor. Participants repeatedly expressed that a major barrier to the sorting process required for diagnosis was the time available in the consultation.

These findings highlight the first challenge in designing a model for exemplary depression care, which is to reach agreement about the meaning and usefulness of the term 'depression' and 'depression care' in the general practice setting. But more than reaching agreement, a practice will need to have a coherent and shared view of what depression is. Our work with the practices identified that this may be challenging for some where divergent views exist amongst staff and there is no system level support to assist consistency of terminology, or treatment. A holistic, individual, tailored treatment approach and a view of distress and depression forming a continuum was expressed by almost all participants, from reception staff, nursing staff to GPs with many years experience, and is, in many ways, at odds with introducing an organised, population health approach to depression care. Yet, on the other hand, participants agreed that treatment decisions need to be made and that having a shared understanding of whom was likely to benefit from interventions aimed at reducing depression was important. There was also a deep understanding of the responsibility to identify those at risk of suicide.

Hence our first principle states that in order to achieve coherence around depression care, work must be done by those involved to conceptualise the boundaries they will use to sort who is

depressed from who is not depressed. This will require that primary care professionals develop techniques for dealing with the diffuseness of how problems present to general practice as a mostly complex mix of physical, psychological and social signs, symptoms and problems. This process must acknowledge, as a starting point, that no gold standard for diagnosis exists and that whatever mechanism is chosen, for undertaking the sorting process and agreeing on boundaries, it will always be imperfect and subject to change according to the dynamic nature of general practice. Hence there must be mechanisms developed and put in place to respond to instances that may 'fall between the gaps'. In the case of depression the importance of review (time passing) was often stressed as an important tool to assist in diagnosis combined with 'watchful waiting'. The tight interplay between physical, psychological and social problems suggest that condition specific tools are limited in the busy clinical setting and that functional assessments (coping with usual activities, having functional social networks, able to undertake self-care, having a healthy lifestyle) might be more useful in assisting general practice to identify those most in need of more detailed assessment and those whom may benefit from a therapeutic intervention.

We could see within **re-order** that by meeting as a group and discussing the complex issues that surround the use of depression as a diagnostic category, then reviewing the audit findings, practitioners began to adopt more consistency in the use of the terms within their electronic medical software. We took this as evidence that our engagement with practices in these ways had prompted the development of coherence around the problem of the depression.

Hence, in an 'exemplary practice' there will be agreement on a diagnostic framework for sorting 'distress' from 'depression' (that recognises depression when accompanied by distress) and agreement on what constitutes depression care. There will be clear articulation of the variety of techniques used to deal with the range and severity of depressive symptoms and the accompanying life and health problems.

ACHIEVING COGNITIVE PARTICIPATION

Principle 2. Depression work requires engagement with a shared set of techniques that deal with depression as a health problem.

Reaching a shared understanding about *what* constitutes depression work is an important step but unless the practitioners and practice staff agree that it is *important* work to be *done,* it will not occur. NPT suggests that for depression work to be undertaken in the general practice setting it must be initiated and sustained in a way that deals with the various interests, alliances, values and opinions amongst staff and in way that is not at odds with the practice culture. This principle focuses on the need to get practice staff to actively engage and 'join-in' with depression work. NPT describes this as achieving cognitive participation or put another way, having shared 'buy-in'. An obvious prerequisite to achieving cognitive participation is agreement on what constitutes depression and on the required response to the identified problem.

The practice fora identified multiple and diverse opinions about the set of techniques that would best deal with depression as a health problem. There were two main areas of discussion that are relevant to developing the principles for the exemplary model. Firstly, discussion emerged around diagnostic techniques and the secondly around management or treatment techniques.

Most of the discussion around the task of diagnosis centred on the way that clinicians used a mixture of clinical acumen and experience, prior knowledge of the patient and time. Prior knowledge of the patient and the use of time were seen as important elements of the diagnostic process that were unique, in many ways, to the general practice setting. Some discussion around the use of tools to assist with diagnosis arose spontaneously within the groups, usually in the context of not adding much to what was already known by the doctor. Rarely, the option of a

second opinion was mentioned as a useful diagnostic tool, as was a 'trial of treatment'. It was difficult to conclude from the practice fora whether GPs were likely to agree upon the diagnosis of a particular patient. This could be said to be linked to the 'individualised' nature of depression care at present, and the sense that the doctor-patient encounter is a somewhat unique relationship, that varies from practitioner to practitioner and patient to patient. However, in the context of the three practices, *West Sanders, Eastvale* and *Coopers,* where case presentations were shared between GPs and other professionals as part of their interventions, most agreed that the diagnosis and approaches used by presenters were the same ones that they would have applied, in the same set of circumstances. In two instances there was an external participant (psychiatrist) to the facilitator present to listen to these case presentations, and they too agreed with diagnosis and treatment pathways. The participant observations demonstrated a wide range of attention to psychological health within consultations (from rarely to almost always).

All practice fora discussed the role of medication and referral to psychology and psychiatry, as well their own management techniques, as essential techniques for engaging with depression as a health problem. There was evidence of three common approaches, those whom preferred pharmaceutical options, those whom preferred non-pharmaceutical therapies administered, in the first instance by themselves and those whom preferred to refer (usually to psychology). Usually, the clinician would be able to provide many clinical examples of how their preferred approach 'worked'. There was also much discussion about the role of the patient and family in 'buying in' or 'not' to depression care and the need to give the patient choice. This was an important element of cognitive participation in depression care because when patients did not buy-in to techniques, for example, taking medication, it meant that the GP needed to draw on another technique for dealing with depression. A view was also expressed by a few GPs that recording diagnoses of mental health problems in the medical record was a highly sensitive and confidential matter and may lead to adverse outcomes for patients in the future (in terms of gaining health insurance etc) and hence they saw that making a recorded diagnosis of depression must firstly be discussed and agreed with the patient before it was entered into the medical record.

Hence our second principle states that in order to achieve cognitive participation around depression care at the practice level work must be done by those involved to agree upon the set of techniques that will be used within their practice to deal with depression as a health problem. Importantly, this will need to be a spectrum of techniques. The need to firmly acknowledge the importance of agreeing upon these techniques if a practice based system is to be introduced requires leadership, communication pathways, time and work. Our learning-exchange evening highlighted the challenge of doing this in the context of part-time staff, underdeveloped communication pathways within a practice, differing views about the roles of team members and inadequate technology to support the required process.

There was evidence within the **re-order** process that some practices were beginning to tackle these issues as discussions emerged around the nursing role and the need to invest time into practice meetings and their IT systems. However, in each case the level of progress was minimal with most preferring to continue with their individual approach to depression care within the confines of their consulting room. Getting 'buy-in' to any new model of depression care will require attention to the drivers for change and is likely to require a substantial financial driver.

Thus, in an exemplary practice there will be engagement in a shared set of techniques for dealing with depression as a health problem (which is often meshed with complex life and other health problems) and agreement about when to diagnose depression and agreement about what to do for depression.

ENABLING COLLECTIVE ACTION

Principle 3. Depression work requires agreement about how care is to be organised, who is required to deliver care, and their structural and human interactions.

Whilst a practice may agree upon what constitutes depression work and the techniques they will use to do depression work, they also require agreement about how depression care will be organised and who will do what for a particular purpose. This principle is based upon the NPT concept of collective action, which is defined as purposive action aimed at a clear goal and is influenced by both exogenous or external factors and endogenous or internal factors. Collective action can be seen as a combination of skill-set workability (how work is allocated and performed), interactional workability (how well work fits into current practice), relational integration (accountability and confidence within care network) and contextual integration (structures and procedures that facilitate the work). **re-order** found that these processes, at present, are underdeveloped, largely informal and ad hoc within practices.

If depression care is to become a practice-level activity using a systematic approach it will require external factors to support and enable this goal. This will require practice policies about the required practice team skill set and how the work is to be allocated to optimise these skill sets within available funding mechanisms. For example, decisions about whom will undertake mental health plans, whether to include a psychologist within the practice, what the role of practice nursing staff will be, whom will be referred to where (psychology, psychiatry, social work, addiction services), whom will deliver practice-based treatments to whom (GP, nurse role in individual and/or group; pharma vs non-pharma). Many of these decisions will be influenced by what is available within the skill-set of existing staff, available networks and within the current funding policy. In turn, the practice structure and organisation will need to keep abreast of policy & funding changes and will need to have mechanisms in place to ensure that such policies are reviewed.

Making these decisions and having such polices available is only a part of the work; these also need to be easily integrated into the context in which they are to operate and staff need to engage with them. This will vary from practice to practice (e.g. small to large practices, urban/rural differences, corporate versus community health centre). *Contextual Integration* requires structural and policy mechanisms that enable practice adoption and adaptation of the available funding mechanisms and structural mechanisms that support the value of depression work. This will be easiest to achieve if the ways of working fit within already recognisable work patterns and behaviours. It is likely to require the identification of someone to be responsible for the process who has the skill-set and technological and leadership support required. This will also require functional communication pathways within the practice (both between staff and with patients) of both the technological (e.g. messaging systems, electronic medical record support, newsletters and emails to patients; sharing of medical records within and beyond practice; issues of confidentiality) and the personal (e.g. practice meetings, conflict resolution mechanisms).

Having established how depression work is to be allocated and performed and put in place the structures and procedures to facilitate the work, getting the work to become a routine part of practice requires that it can easily fit into the current pattern of working. Ensuring interactional workability for depression care requires that practitioners and patients agree that the work is valid, co-operate to undertake it and can both see tangible advantages of participation. One can broaden this out to include the practice as a whole and state that the practice leadership also need to be convinced of the tangible benefits to their practice, staff and patients in fully routinising such work.

Our work with the practices in **re-order** suggest that to achieve interactional workability of depression care, whereby *engaging* in that care becomes *routine* because it makes practice more rewarding and easier than *not* engaging, will require that a practice develops agreements about how the work will be supported. These need to tangible and practical supports. For example,

deciding upon things such as sharing medical records with nursing staff and/or psychologists, having templates for letters and care plans that make the work easier and providing for case discussions and support whilst doing the work are likely to enhance the workability. Making explicit the values around cooperation between staff and the short and long-term goals and meaning of the work may also help. Our practice observations suggest that it would be worthwhile to acknowledge the informal rules that are operating within a practice that influence depression work. For example, we found a number of examples where co-located psychologists were rarely consulted about a patient and often bypassed as a referral point. Trying to understand why these work practices have emerged may assist a practice striving to implement a system of depression care.

A key factor to be worked through is the way in which a practice will deal with the complexity of integrating or separating physical healthcare from depression work. We saw two distinct practice styles in operation during our time in the practices – clinicians tended to be either integrators (seeing physical and mental health as inextricably linked dealing with both within a single consultation) or separators (those who tended to deal with physical health and mental health separately). Working out ways to deal with these practice styles may well yield many benefits in terms of how workable depression care can become on a routine basis and may facilitate identifying some of the flow on effects that dealing better with mental health care might have on physical health.

Of course, within the daily delivery of depression care a key factor to be acknowledged is how relationships evolve around who is doing the work. Ensuring that it is clear who is responsible for particular components of depression care, ensuring that confidence exists between the various practice staff and patient groups that the person responsible is capable and trustworthy is paramount. For example, a practice may decide that a practice nurse can deliver psychoeducation and activity scheduling but if the patients attending the practice do not have confidence and trust in this new way of doing things, it will not succeed. Hence attending to the importance of relationship management across the network of caregivers and patients is key work for any practice implementing a system of depression care.

Hence, in an exemplary practice there will be acknowledgement of the complexity of care and the partnerships needed and well-developed policies and procedures about diagnosing, recording, prescribing, referring, following-up and how this is communicated and shared. There will be agreement about the skills of the team needed for depression care and how the work is allocated. There will be visible processes for information sharing, communication, cooperation and conflict resolution for depression care.

IMPLEMENTING REFLEXIVE MONITORING

Principle 4. Depression work requires the ongoing assessment of how depression care is done.

For any activity to become a routine part of clinical work those undertaking it need to be convinced that the work are they doing is worth the effort. They also need to be in a position whereby they have the flexibility and ability to change things based on formal and informal monitoring systems. At present reflexive monitoring of depression work is highly individualised, invisible and unsystematic. The **re-order** experience was the first time, for all practices, that they thought about their *practice* approach to depression. GPs we worked with tended to rely on their current individualised approach to wait and watch, and re-book patients who they are not certain about for a follow-up visit as a primary way of finding out if depression care is working for a particular individual.

When presented with their first audit findings, practice staff recognised that there was no consistent approach to recording diagnostic information about depression or distress. In almost every practice, staff noted that they did not have a system in place for ensuring accurate records on diagnosis or treatment. No practice could produce a list of people currently being treated for depression (either by a GP or via referral) other than those currently prescribed antidepressants. Most agreed that prescribing information was the only reliable information that they recorded in a systematic way for people with depression; yet they also stated that many patients were not using prescription drugs for the management of depression. The only other accurate recording of depression work was that obtained via the billing software for mental health item numbers that were charged. However, it was noted that not all practices were using the mental health item numbers for all patients, some using the more generic chronic disease care plan item numbers. Also, there was discussion around the allocation of a mental health diagnosis, such as 'depression' to enable a patient experiencing a disabling life event to access psychological therapies; even though they may not satisfy the full criteria for Major Depressive Disorder according to the DSM IVR. So it quickly became apparent that the audit results presented provided a very incomplete picture of what the load of depression work was within their practice.

No practice or practitioner had reviewed how effective they were at identifying and managing depression for their patient population prior to their **re-order** involvement. Hence implementing reflexive monitoring within Australian general practice, whilst presented last in this report, may form a good starting point for practice change. However, our report highlights the current limitations of lack of meeting space, poor information systems and lack of paid time away from the clinical encounter for this kind of work to occur. Even in practices with co-located psychologists or social workers there was no current system for discussing patient management and treatment; it occurs in busy hallways and crowed tea rooms, if at all. We observed interactions between reception staff and patients as an informal monitoring of how the individual is performing in the real world (outside the intimate clinical encounter).

The current practice environment is limited in the extent to which a systematic approach to reflexive monitoring could be implemented without substantial improvement in practice infrastructure or ongoing financial support. Even within the **re-order** group of highly motivated and research interested GPs there was a wide variety of practice infrastructure. For example, the space for meeting as a group was adequate in only two out of the six practices, the part-time nature of the work patterns meant getting everyone together on paid time was impossible at all sites and even the practice with the most sophisticated electronic medical records system could not produce the data they desired to monitor the depression care they were delivering. It was clear from the practice forums that monitoring care will require thinking about care at the individual patient level as well as at the practice level. It was also apparent that both qualitative and quantitative measures were worthwhile. Practices were very engaged with reviewing the audit data, despite the inaccuracy and limited nature of it. There was substantial debate about the accuracy of the data compared with their clinical experience of everyday work. The opportunity to compare their data with National figures was welcomed and encouraged in-depth discussion of the process and outcomes for depression care at the patient and practice level. Nevertheless, practices were a long way from monitoring depression care at level of the practice population. Engaging in a practice level facilitated discussion group seemed to be an acceptable and useful form of 'reflexive monitoring'. Reflexive monitoring will require that clinical data is always interpreted carefully by those aware of the contextual nuances from which it is derived.

Reflexive monitoring was also seen to require a process for reviewing the communication pathways between general practitioners and others involved in depression care, particularly psychologists. Forum discussions noted the lack of communication between general practice and psychology and the need to remedy this. Interestingly, co-location may not be a simple solution, as to our knowledge, none of the co-located psychologists were using, or had access, to the general practice medical record.

Participation in **re-order** involved many of the GPs being observed during their clinical work by a trained anthropologist. An un-intended consequence of this activity was the role that it played in prompting the clinician to reflect upon their behaviour. The observer noted on a number of occasions that the GP would turn and ask "How did I go with that?" or "How do I compare with the other GPs?" or "Did I pass?". In addition, some GPs noted the need for mechanisms by which they could personally reflect on the quality of their performance of depression care which was more than an audit of their workflow or prescribing.

To implement a practice wide system of depression care that encompasses the important process of reflexive monitoring will require agreement about how depression work will be monitored at patient and practice level. Whilst the use of brief patient completed routine measures (such as K10, PHQ9) may seem an appealing method of tracking what is happening over time for those being managed for depression **re-order** participants expressed uncertainty about the place and meaningfulness of these measures. Understanding the place and purpose of monitoring at the patient level is complex and as a part of the **re-order** project Dr Caroline Johnson will complete her PhD on this issue in mid 2009 (see Appendix 7). Agreement about how information systems will be used in the routine monitoring of depression care is important. Whether this is done at a practice level or at Divisional, State or National level needs careful consideration. In line with NPT it seems essential that monitoring is undertaken using routinely collected data if it is to be interactionally workable, sustainable and useful for the practice.

At present the schedule for patient follow-up and monitoring is individually tailored by the individual clinician and the patient concerned. There is no systematic way of ensuring that patients return for follow-up, or of checking on whether they have attended when referred. There is no agreement on how often visits should occur. Reaching agreement about patient follow-up and monitoring needs to occur if a system of care is to be introduced, but it will be important to avoid losing the whole person and individualised care that is the strength of current practice.

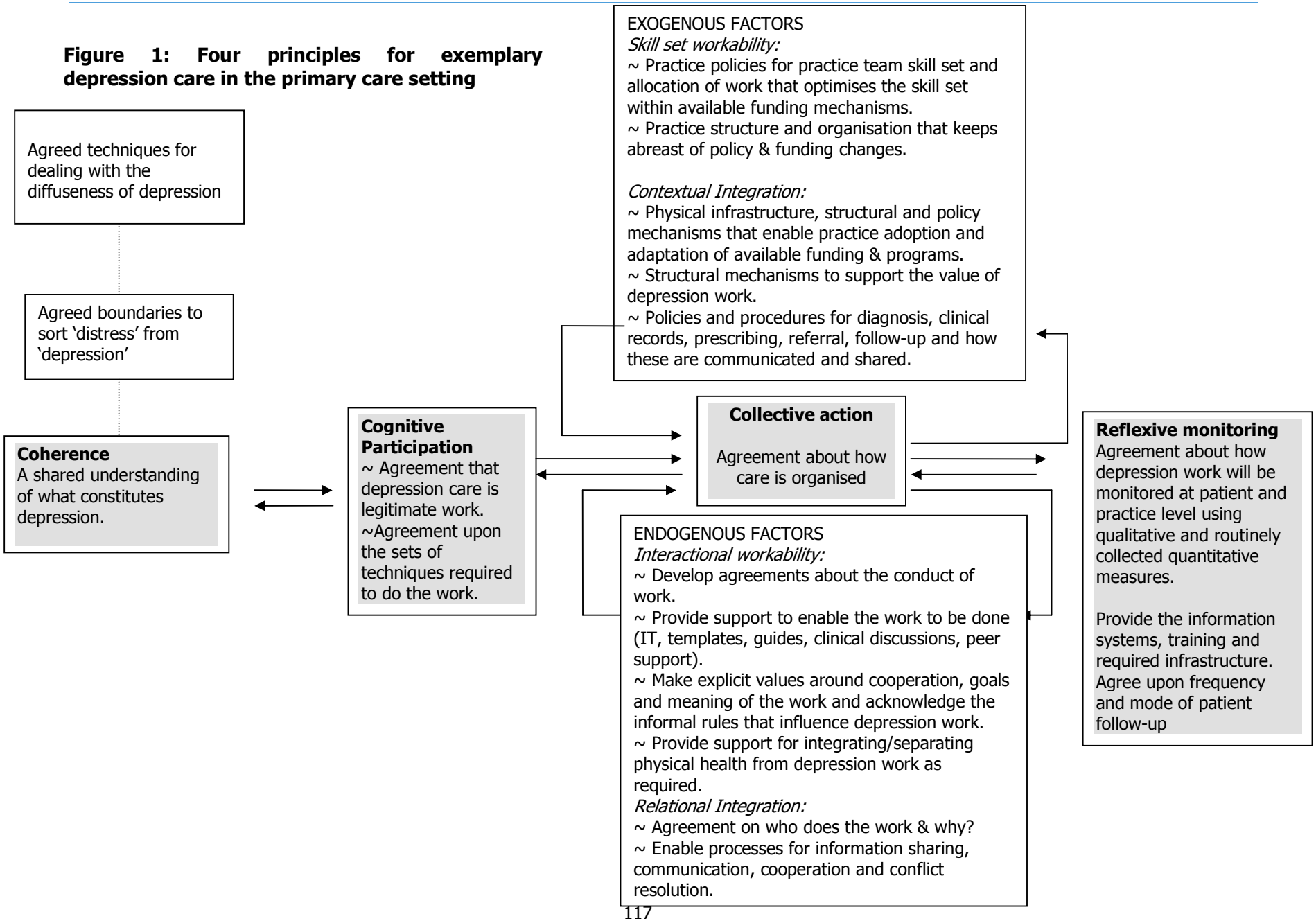
Based on our earlier discussions a system of reflexive monitoring might also include a review of understanding of what constitutes depression and review of techniques, as with changing populations and the passage of time, what is considered depression may change, and the techniques available to identify and manage it will evolve. Ensuring that a practice keeps up to date with these developments is an important part of the monitoring process.

Hence in an exemplary model of depression care there will be ongoing assessment of how depression care is done that uses quantitative and qualitative measures.

5.3 CONCLUSION

It was a privilege to work with the practices involved in the **re-order** project. The opportunity for our research team to see a practice hard at work over a sustained period of time provided a realistic view of the strengths and challenges of arranging depression care in the Australian primary care setting. It is hard to know how well these practices were really doing at depression care; as the routine clinical data is either absent, or impossible to retrieve in a reliable manner. Therefore it is difficult to estimate the size of the problem that may require fixing. Our aim was to develop a set of guiding principles that could be applied in various contexts across the Australian primary care setting. Rather than develop a rigid set of guidelines, unlikely to ever be implemented, we have deliberately developed principles that can be used by the practice, for the practice, to inform a flexible, locally relevant approach to depression care. Our next step will be to obtain funding to test out whether applying such principles to depression care at the practice level can lead to better health outcomes for patients and a more effective primary care service.

Figure 1: Four principles for exemplary depression care in the primary care setting



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APPENDICES

APPENDIX 1: MAPPING THE POLICY AND PRACTICE CONTEXT FOR DEPRESSION CARE IN GENERAL PRACTICE IN AUSTRALIA

	PLAYERS	POLICIES / LEGISLATION	PROGRAMS / SERVICES	INFORMATION
INTERNATIONAL	World Health Organisation (WHO) Dept of Mental Health and Substance Abuse, Office of Noncommunicable Disease & Mental Health	* WHO Essential Package for MH Policy, Plan & Service * WHO Essential Package for MH Legislation & Human Rights	* MH Gap Action Programme * WHO MIND (Mental Health Improvements, Nations' Development)	* Atlas Project (2005) * 2001 World Health Report – Mental Health * WHO Bulletin (journal)
	WHO – Office of Family & Community Health	n/a	* 30 year anniversary of Alma Ata declaration in 2008	* 2008 World Health Report – Primary Health Care: Now More than Ever
	World Psychiatric Association	* Core Curriculum for Psychiatry * Anti-stigma recommendations	* Various programs to support psychiatry in developing countries	* World Psychiatry (journal) * Atlas on Psychiatric Education & Training * Atlas on Child & Adolescent Mental Health Resources
	WONCA			* Integration of Mental Health into Primary Care (2008) – Joint WHO-WONCA Report
	International academic research community – mental health and primary care (incl. DSM group)	n/a	n/a	* Global Burden of Disease Study (2002) * International academic research on mental health and primary care
	WFSAD (World Fellowship for Schizophrenia & Allied Disorders – includes depression)			

NATIONAL Table 1.	National Health & Hospital Reform Commission (NHHRC)	* Beyond the Blame Game – Accountability and performance benchmarks for the next ACHAs (2008)	n/a	n/a
	Council of Australian Governments (COAG) (also under STATE below)	* National Action Plan on Mental Health 2006-2011	* National (& Victorian) Implementation Plan	* COAG NAP on MH 2006-2011 Progress Report 2006-07 (2008)
	Department of Health and Ageing (DoHA) – general		* Australian Health Care Agreements * MBS * PBS	
	Department of Health and Ageing (DoHA) – Primary and Ambulatory Care Division	* National Primary Health Care Strategy (in development submissions due for discussion paper February 2007)	* National Primary Care Collaboratives * GP Superclinics	
	Department of Health and Ageing (DoHA) – Mental Health & Workforce Division	* National Mental Health Strategy (1992) including 3 National MH Plans, National Action Plan on Depression (2000), LIFE Framework (2000), various other policy documents – 4th national MH Plan in development	* Better Outcomes in Mental Health Care (2001) (including GP Psych Support) * Better Access to Psychiatrists, Psychologists and GPs through MBS (2006) * More Allied Health Services Program (2001) * MH Nurses Incentive Program (2007) * Mental Health National Outcomes and Casemix Collection (1998) * Lifeline * Mindmatters (MH promotion initiative for secondary schools) * Kidsmatter (MH promotion initiative for primary schools) * Promoting Better Mental Health – Youth Mental Health Initiative / National Youth Mental Health Foundation (headspace) * DepressioNet (co-funded by MBF and Wyeth)	* National Mental Health Report (2007) * National Survey of Mental Health and Wellbeing (1997 and 2007 – to be released) * various program evaluations
	National Prescribing Service (NPS)		* Guidelines for prescribing pharmacological treatments for mental health problems	
	Australian Institute of Health and Welfare (AIWH)	n/a	n/a	* Mental Health Services in Australia 2005-06 (2008) * General Practice Activity in Australia 2006-07 (2008) * BEACH (Bettering the Evaluation and Care of Health) (1998 onwards)

NATIONAL **Table 2.**	Australian Bureau of Statistics (ABS)	n/a	n/a	* National Health Survey (2004)
	National Advisory Council on Mental Health (2008)			
	beyondblue National Depression Initiative (2000)	* Strategic Plan	* Research funding	
	Mental Health Council of Australia (MHCA)		* Advocacy and research on mental health issues for consumers and mental health professionals	* Time for Service report (2006) * Smart Services report (2006)
	Royal Australia New Zealand College of Psychiatrists (RANZCP)		* Training, accreditation and continuing education for psychiatrists	* Aust NZ J Psychiatry
	Royal Australian College of General Practitioners		* Training, accreditation and continuing education for GPs	* Australian Family Physician
	Australian Medical Association (AMA)		* Advocacy for all medical professionals	* Medical Journal of Australia
	Australian Psychological Society (APS)		* Training, accreditation and continuing education for psychologists	* Australian Journal of Psychology * Australian Psychologist
	Australian College of Mental Health Nurses (ACMHN)		* Training, accreditation and continuing education for mental health nurses	
	Australia General Practice Network (AGPN)		* National representation, advocacy and support for GPs and general practice	
	Mental Health Professionals Association (MHPA)		* Collaboration between psychiatrists, GPs, psychologists and MH nurses	
	Multicultural Mental Health Australia (MMHA)		* Advocacy and research on MH issues for CALD populations	

STATE	Victorian Government		Victorian Mental Health Act (1986)	
	Chief Psychiatrist	* Chief Psychiatrist's Guidelines		
	Department of Human Services – Health Portfolio			* Victorian Burden of Disease Study (updated in 2001)
	Department of Human Services – Mental Health & Drugs Division, Mental Health Portfolio	* Because Mental Health Matters – Consultation Paper (2008) * New Directions for Victoria's Mental Health Services 2002-2007	* Public specialist mental health services – clinical (inpatient, residential and community-based) & PDRSS (Psychiatric Disability Rehabilitation & Support Services) * Primary Mental Health Early Intervention Initiative (2002)	
	Department of Human Services – Rural & Regional Health & Aged Care Services Division, Health Portfolio	* Primary Care Partnerships Strategy (2000) * Working with general practice Position Statement	* Primary Care Partnerships	
	GPDV		* State-level representation, advocacy and support for Divisions, GPs and general practice * Specialist Mental Health support program	
	Department of Education		* Primary and secondary schools	

LOCAL / PRIVATE	Local Councils	* Municipal Public Health Plans	* Immunisation services * Maternal and Child Health services * Community Health Centres	
	Divisions of General Practice Networks		* Support for and representation of member general practices and GPs	
	Private GP clinics / GPs			* practice-level research activities
	Private Psychiatrists			
	Psychologists			
	Counsellors (incl. specialty counsellors – D&A, abuse, torture etc)			

APPENDIX 2: TEN PRINCIPLES FOR INTEGRATING MENTAL HEALTH INTO PRIMARY CARE (WHO AND WONCA)

From: WHO and WONCA (2008). *Integrating mental health into primary care: A global perspective*. WHO Press, Geneva.

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, nongovernmental organisations, village and community health workers, and volunteers is required.
10. Financial and human resources are needed.

APPENDIX 3: PAPERS AND CONFERENCE PRESENTATIONS ON THE RE-ORDER STUDY TO DATE

PUBLISHED JOURNAL ARTICLES

2008

Dowrick C, Kokanovic R, Hegarty K, Griffiths G, Gunn J (2008) 'Resilience and depression: perspectives from primary care'. *health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine.* 12(4): 439–452

Kokanovic R, Dowrick C, Butler E, Herrman H and Gunn J. (2008) 'Lay accounts of depression amongst Anglo-Australian residents and East African refugees.' *Social Science & Medicine*, 66: 454-466.

2007

Hutton C and Gunn J. (2007) 'Do longer consultations improve the management of psychological problems in general practice? A systematic literature review.' *BMC Health Services Research*. 7:71

Johnson, C. (2007) 'Managing mental health issues in general practice'. *Australian Family Physician*. 36(4)

2006

Gunn J, Diggens J, Hegarty K, & Blashki G. (2006) A systematic review of complex system interventions designed to increase recovery from depression in primary care. *BMC Health Services Research.* 6(88): 1-11.

<u>Journal Articles accepted for publication:</u>

Kokanovic R, May C, Dowrick C, Furler J, Newton D, and Gunn J. The Politics of Conducting Research on Depression in Cross-cultural context. *Qualitative Health Research*. (Accepted for publication 23 September 2008.)

Hegarty K, Gunn J, Blashki G, Griffiths F, Dowell T, and Kendrick T. 'How relevant are national primary care depression guidelines? A quantitative and qualitative review.' British Journal of General Practice. (Accepted for publication 31 October 2008.)

PRESENTATIONS TO KEY POLICY ORGANISATIONS

2008

Gunn J. "Mental Health in Primary Care". Presentation to the Department of Human Services (DHS) 3rd September 2008.

CONFERENCE PRESENTATIONS

2008

Gunn J. "Mental Health: Routine or Special General Practice?" Panel Presentation to 'A Celebration of Diversity' The WONCA Asia Pacific Regional Conference, Melbourne, October 6 2008

Johnson, C., Gunn, J. "Mental Health Outcome Measurement in the General Practice setting", Australasian Mental Health Outcomes Conference, Melbourne, 2008
Johnson, C., Gunn, J., Kokanovic, R. "Monitoring Depression – Case studies from Australian General Practice", WONCA Asia Pacific Regional Conference, Melbourne, 2008

Johnson, C., Gunn, J., Kokanovic, R. "Recovery from depression – what do patients say about it?" GP&PHC conference, Hobart, Australia, 2008
http://www.phcris.org.au/elib/render.php?params=6256

Kokanovic R, Palmer, V, Philip B, & Grey, F. "The Misery of Depression: from normative emotions to pathological expression". The Australian Sociological Association Conference (TASA).Melbourne, VIC December 2008.

Kokanovic R, Armstrong D., Pilgrim D. Rogers A. & Dowrick C. "Medicalization – Demedicalization of depression". British Sociological Association (BSA) – Medical Sociology Group Conference. Brighton. UK. September 2008.

Kokanovic R., May C, Evert H. & Gunn J. "'A long persistent sorrow': A cross cultural accounting of the work of being 'depressed'". (2008) British Sociological Association (BSA) – Medical Sociology Group Conference. Brighton. UK. September 2008.

Palmer V. & Gunn J. 2008. Stakeholder Expectations for Depression Care: General Practitioners' views of the evidence. Presented to 'A Celebration of Diversity' The WONCA Asia Pacific Regional Conference, Melbourne, October 5 2008.

2007

Gunn, J., Kokanovic, R., Johnson, C., Butler, E., Potiriadis, M., Dowrick, C., and the re-order team. "Consumer views on the elements of collaborative care". World Psychiatric Association International Congress, Melbourne, 2007
http://www.informaworld.com/smpp/section~content=a783864394~db=all~start=783864558~fulltext=713240929~dontcount=true#s783864558

Johnson, C., Gunn, J., Kokanovic, R. "The Mouth Can Speak Words but the Eyes Tell You What's Really Going On: Discerning Depression Recovery – The Consumer Perspective" NAPCRG conference, Vancouver, 2007
http://www.stfm.org/fmsup/napcrg/fmconferencesupplement.cfm?confid=131

Johnson, C., Gunn, J., Kokanovic, R. "Routine mental health outcome measures – do they have a role in general practice?" GP&PHC conference, Sydney, Australia, 2007
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Kokanovic, R, Killingsworth, B.,Tran, H., & Dowrick, C. "A Care-full diagnosis: three Vietnamese – Australian women and their experience of becoming mentally ill". The Australian Sociological Association Conference (TASA). Auckland, NZ. December 2007

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Kokanovic R, Butler E, Gunn J, Dowrick C & Griffiths, F. "A qualitative study to explore lay concepts of depression amongst Australian health care consumers experiencing depressive symptoms". Primary Health Care Research and Development Conference. Sydney, NSW, May 2007.
Gunn, J, Butler E, Shrimpton B, Kokanovic R, Hurworth R, Griffiths F & Dowrick C. "A stakeholder consultation to determine the optimal ways to manage depression in the primary care setting". Primary Health Care Research and Development Conference. Sydney, NSW, May 2007.

2006

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APPENDIX 4: NON-PATIENT STAKEHOLDER CONSULTATION - BREAKDOWN OF FINDINGS BY SUB-GROUP

HOW GENERAL PRACTICE / PRIMARY CARE SHOULD RESPOND TO PEOPLE EXPERIENCING DEPRESSION – COMPARISON OF TEN ITEMS MOST FREQUENTLY NOMINATED IN TOP FIVE OVERALL AND BY SUB-GROUP

Item	**Overall (N = 310)#**	**Government (n = 51)**	**NGO (n = 59)**	**Academic (n = 67)**	**Health professionals (n = 92)**
Listening	**1**	1	2	1*	1
Undertaking a thorough diagnostic assessment	**2**	3	1	1*	2
Developing a plan with the patient	**3**	2	3	3	4
Undertaking an assessment of severity and suicide risk	**4**	6	4	2	3
Being well trained in depression care	**5**	4	6	4	7
Tailoring care to individual needs	**6**	Not included	5	5	5
Taking into account social factors	**7**	5	Not included	8	6
Being empathetic	**8**	8	Not included	7	9
Providing longer consultations	**9***	7	9	Not included	8
Offering a range of treatment options	**9*†**	Not included	8	6	Not included
Monitoring and proactive follow-up	***Not included***	*9**	*Not included*	*Not included*	*Not included*
Responding in a way that is inclusive of family members etc	***Not included***	*9*†*	*7*	*Not included*	*10*
Making appropriate referrals	***Not included***	*Not included*	*10*	*Not included*	*Not included*
Not using medication as the first option	***Not included***	*Not included*	*Not included*	*9†*	*Not included*

Due to low numbers a top 10 for the 'unspecified' category was not developed and therefore the numbers in the top four right-hand cells do not add to 310.

* Equal ranking with at least one other item

† Lower ranking items not reported here

BARRIERS FOR BEST PRACTICE IN GENERAL PRACTICE / PRIMARY CARE WHEN FACED WITH PEOPLE EXPERIENCING DEPRESSION – COMPARISON OF TEN ITEMS MOST FREQUENTLY NOMINATED IN TOP FIVE OVERALL AND BY SUB-GROUP

Item	Overall (N = 310)	Government (n = 51)	NGO (n = 59)	Academic (n = 67)	Health professionals (n = 92)
An over-reliance on prescribing medication	**1**	1	3	3	1*
Reliance on a medical model	**2**	2	2	1	2
A lack of affordable referral options	**3**	7*	4*	2*	1*
Poor integration between General Practice/Primary Care and other providers	**4**	6	4*	2*	3
A lack of services in regional areas	**5**	5*	1	8*	6
Inadequate GP/PC competence to recognise, assess and treat depression	**6**	3	NI	4	5
Inadequate GP/PC training to recognise, assess and treat depression	**7**	7*	4*	7	7
A lack of professional support for GP/PC when providing depression care	**8**	5*	7†	NI	4
Patients cannot access services in a timely manner	**9**	5*	6*	NI	8*
The lack of knowledge about depression (within General Practice/Primary Care)	**10**	4*	NI	5	NI
Depression is difficult to recognise and treat	***Not included***	*4**	*NI*	*NI*	*NI*
Patients do not seek help	***NI***	*7*†*	*NI*	*6*	*NI*
GP providers lack knowledge about available support services	***NI***	*NI*	*5*	*NI*	*NI*
When General Practice/Primary Care is unable to access mental health specialists for referral	***NI***	*NI*	*6**	*NI*	*8**
Negative community attitudes / stigma regarding depression	***NI***	*NI*	*NI*	*8*†*	*8*†*

* equal ranking with at least one other item

† lower ranking items not reported here

WAYS WE WOULD KNOW THAT GENERAL PRACTICE / PRIMARY CARE IS MEETING THE NEEDS OF PEOPLE EXPERIENCING DEPRESSION – COMPARISON OF TEN ITEMS MOST FREQUENTLY NOMINATED IN TOP FIVE OVERALL AND BY SUB-GROUP

Item	Overall (N = 310)	Government (n = 51)	NGO (n = 59)	Academic (n = 67)	Health professionals (n = 92)
Surveying and interviewing patients	**1**	1	2	1	1
Measuring patient satisfaction	**2**	2*	1	6*	2
Monitoring the number of patients with depressive symptoms who seek help from general practice / primary care	**3**	7	3	2	3*
Surveying carer and consumer groups	**4**	4	4	7*	3*
Monitoring patient recovery (for mental health conditions)	**5**	5	7	3	3*
Measuring diagnosis rates in general practice	**6**	6	5	6*	6
Measuring functional outcomes (e.g. capacity to function physically, socially and in the community)	**7**	NI	8*	5	3*
Monitoring the quality and duration of follow-up (for mental health issues)	**8**	8*	NI	4	4
Surveying and interviewing GPs	**9**	8*†	6	NI	5
Monitoring referrals made by general practice / primary care	**10**	NI	NI	7*	NI
Monitoring the number of general practice / primary care providers undertaking accredited training	***Not included***	*2**	*9†*	*NI*	*NI*
Monitoring collaboration between general practice / primary care and other support services	***NI***	*3*	*NI*	*NI*	*NI*
Monitoring the appropriateness of referrals by general practice / primary care	***NI***	*NI*	*8**	*7**	*NI*
Conducting an audit of Medicare case notes etc	***NI***	*NI*	*NI*	*6**	*NI*
Monitoring public acceptance of general practice / primary care as a provider	***NI***	*NI*	*NI*	*7*†*	*7†*

* equal ranking with at least one other item † lower ranking items not reported here

APPENDIX 5: LETTER OF INVITE & BROCHURE

Dear

GPs provide most care for depression in the community.
This is an invitation for <u>your</u> contribution to depression care to be recognised.

Thanks for your time by phone recently. This letter is to invite your practice to hear more about the **re-order** study (re-organising care for depression and related disorders in the Australian primary health care setting). Re-order builds on the *diamond* study: a first-ever large scale study of the way depression is actually diagnosed and managed in Australian general practice. Information about the *diamond* study can be found at www.diamond.unimelb.edu.au

Re-order is led by Jane Gunn, an academic GP and chair of the Primary Care Research Unit at The University of Melbourne. The study is about re-examining the way in which people experiencing depression are cared for in the community. We would like to invite your practice to join this nationally and internationally significant research on the third phase of reorder***. This phase is designed for our team to work with general practices to develop exemplary models of depression care.*** We have received funding from The Australian Primary Health Care Research Institute which is supported by a grant from the Australian Government Department of Health and Ageing to undertake this program of research.

Why should you consider our request?
We are GPs like you and we understand the current pressures on GPs and their staff in general practices. We know you may be too busy and are tired of being asked to contribute to projects that don't seem relevant to your practice. Yet we suspect that, like us, you are sick of being told what to do by people who do not understand general practice. You will be contributing to:

- Significant national and international research.
- The development of exemplary models of care that can be translated to other complex medical conditions.

You will also receive:

- RACGP Group 1 QA&CPD activity – *Active Learning Module + Learning Plan* (80 Group 1 points in total satisfying all triennium points (08-10) if both activities are undertaken (application in progress).
- Reimbursement of $5000 for your time and expenses.

Enclosed is a brochure about the study for you to share with other practice staff, we hope that you might schedule a time to hear our presentation to consider whether your practice might participate in the study. Please do not hesitate to contact us if there are any further questions about this research.

Yours sincerely,

Professor Jane Gunn

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

WHAT IS RE-ORDER?

We are looking for a small number of rural and urban Victorian general practices and/or community health centres to take part in this significant research into the management of depression in primary care.

We have consulted over 300 stakeholders including GPs, mental health practitioners (e.g., psychiatrists, psychologists), state and federal policy makers, and almost 600 patients about what they believe are the components of an ideal model of care for effective mental health care. We now need your input. Together with your input we hope to identify an exemplary model of practice for depression care in general practice.

Our vision: *'A primary care system that promotes emotional well-being and provides people experiencing depression with accessible, responsive and effective management options to assist recovery and maintain well-being'.*

Left: Prof Jane Gunn (Principal Investigator)

OUR COLLABORATORS

Study Investigators:

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PRIMARY CARE RESEARCH UNIT

RE-ORDER

WWW.REORDER.UNIMELB.EDU.AU

re-order

Re-organising care for depression and related disorders in the Australian primary health care setting

DEPARTMENT OF GENERAL PRACTICE

THE UNIVERSITY OF MELBOURNE

APPENDIX 6: ENVIRONMENTAL CHECKLIST OF PRACTICES

Practice Environment Checklist

The researcher should complete this sheet with the assistance of the practice manager or head receptionist during Baseline Data collection. Data should be collected by observation and during key informant interviews of practice members knowledgeable in the particular data element being collected.

Commencement date: ☐☐ ☐☐ ☐☐☐☐ (Day Month Year)

Site ID: ☐☐ ☐

Facilitator Initials: ☐☐

Completion date: ☐☐ ☐☐ ☐☐☐☐ (Day Month Year)

RESEARCHER OBSERVATION

1. Practice location

- Rural ☐1
- Urban ☐2
- Suburban ☐3

2. Adequacy of space in the;

	Low	Medium	High	N/A
Reception area	☐1	☐2	☐3	☐4
Waiting room(s)	☐1	☐2	☐3	☐4
Consulting room(s)	☐1	☐2	☐3	☐4

Notes:

3. Waiting room impressions (give a brief description of the waiting room, for example, is it a large space, does it have ample seating, is there health related material for patient information available, is there a television in the room – what is showing?

Description

4. Office floor plan (please sketch)

5. Is there information or materials displayed in the waiting room or does the practice provide the following materials on depression? If *Yes*, where are these materials displayed?

	Entrance / hallway	Front desk / waiting room	Consultation room	N/A
Waiting room poster(s)	☐1	☐2	☐3	☐4
Exam room poster(s)	☐1	☐2	☐3	☐4
Video	☐1	☐2	☐3	☐4
Pamphlets	☐1	☐2	☐3	☐4
Chart stickers	☐1	☐2	☐3	☐4
Recommend websites	☐1	☐2	☐3	☐4
Other *(please specify)*	☐1	☐2	☐3	☐4

6. Please comment on the ease in identifying these resources:

OBTAIN FROM PRACTICE STAFF

1. Type of practice

- Private general practice ☐1 → Group practice ☐1; Solo practice ☐2
- Corporatised general practice ☐2
- Community health centre ☐3
- Other ☐4

2. Hours the practice is open for appointments

Day	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
After hours arrangements:		

Notes:

3. On-site service options and whether patient records are shared *(tick all that apply)*

	Available on site	Patient records shared
Psychologist	☐ 1	☐ 1
Counsellor	☐ 2	☐ 2
Practice nurse	☐ 3	☐ 3
Other (specify)	☐ 4	☐ 4

4. Number of personnel in the practice

	Today	Total
GPs		
Practice nurse(s)		
Registrar(s)		
Practice manager(s)		
Receptionist(s)		
Other (specify) _____		

5. Reminder systems (tick all those observed)

Computer generated reminders	☐ 1
Patient reminder letters	☐ 2
Computer recall systems	☐ 3
Telephone recall by nurse / office staff	☐ 4
Periodic chart audit	☐ 5
Checklists / flowcharts	☐ 6
Risk factor chart stickers	☐ 7
Other *(specify)*_____	☐ 8

6. What is the patient flow on a typical day?

Number of patients seen	
Percentage of long appointments	
Percentage of "squeeze-ins"	
Numbers turned away	
Average waiting time for appointment	
Number of "did not attends"	

(if yes, how are these handled?)

_____

_____

7. Does the practice have a protocol for dealing with distressed patients?

_____

_____

_____

_____

_____

APPENDIX 7: MONITORING: THE PHD COMPONENT OF **RE-ORDER**

ABOUT THE PHD STUDY

One of the key elements of the chronic disease model of care as described by Wagner, Austin is a system of monitoring or pro-active follow up of patients (Wagner, Austin and Korff 1996). This model of care has been adopted and tested for primary care of depression, on the assumption that for many people, depression is a chronic, or at least a relapsing and remitting condition (Katon et al, 1996). Collaborative care models for depression described in the literature all include some form of follow up or monitoring of patients with depression (Gilbody et al, 2006; Kates and Mach 2007). In Australia, GPs receive financial incentives to follow up patients attending for mental health care under the Better Access to Mental Health Care initiative (Johnson 2007). Part of this process includes the completion of a written plan in consultation with the patient and the administration of an outcome measurement scale, both of which are intended to be reviewed at a period of time after the initial assessment.

A review of the literature on depression and outcome assessment in the primary care setting reveals that, despite this interest in monitoring as a potentially important part of an intervention for depression, there is very limited understanding of either the process of monitoring or the outcomes being measured for depression care in routine clinical practice. There is virtually no understanding of this issue in the context of Australian general practice. The experiences and opinions of GPs and their patients about monitoring depression are also generally unreported.

The practice phase of the re-order project thus represented an excellent opportunity to examine how general practitioners monitor the effectiveness of the care they provide for people with depression. As well as trying to find out how monitoring depression happens, there was an opportunity to investigate the views and experiences of those potentially taking part in the monitoring process; the GP, the patient and the carer (or significant other). The aim was to use this information to determine how monitoring should best take place, from the viewpoint of those who deliver and receive depression care.

APPROACH AND METHOD

This part of the re-order study adapted Stake's multiple case study approach to examine these questions about monitoring (Stake 2006). All GPs at the six re-order practices were invited to complete a survey describing their practice, their mental health skills, and how they provide depression care to patients. From these surveys (n= 33), eight GPs were invited (using maximum variation sampling) (Patton 2002) to participate in an in-depth face-to-face interview about their experiences of providing care to people with depression. These eight GPs then passed on invitations to their patients with the diagnosis of depression over 4 consecutive weeks (and up to 12 weeks), until at least 2 and up to 10 patients had accepted an invitation.

Patients who accepted the invitation were contacted and invited to complete a postal survey that collected basic demographic information, some information about their contact with health professionals for depression care and a CES-D score (as a measure of the current severity of their depression). The surveys returned (n=48) were used to sample 2-4 patients per GP

(again using maximum variation sampling). This enabled in-depth interviews of 22 patients. These participants were also invited to nominate a carer or significant other who they identified as supporting them with their depression, leading to 16 carer interviews.

The eight GPs who participated in the in-depth interviews were re-interviewed at the conclusion of the practice phase, to examine whether any changes have occurred in their views or experiences of providing depression care as a result of the re-order intervention. Analysis is currently underway of the GP, patient and carer triad and their views on how best monitoring can be undertaken.

DATA ANALYSIS AND SYNTHESIS

In accordance with case study methodology, other available data from the practice phase (such as the practice audit, practice observations and fora) will be triangulated with information from the interviews about monitoring depression. These case studies will be compiled and analysed using the strategies of rival explanations and cross-case synthesis (Yin 2003). "Rival explanations" refers to the researcher being aware of possible alternative interpretations of the findings and then specifically looking for evidence to confirm or refute these rival explanations. "Cross-case synthesis" requires the researcher to look for similarities and differences across the different case studies, to ascertain if any generalisations can be made. A template analysis of key themes, modified from the method described by Stake (2006) is planned to permit cross-case analysis of the eight case studies.

PRELIMINARY CONCLUSIONS

At this point in time a system or process of monitoring depression is not embedded in Australian general practice, despite the introduction of incentives for GPs to do MH plans and administer outcome measures. However there is a "type" of monitoring going on and it is less linear than the "3 step: assess, plan, review" process implies. It appears to be much more about continuity of care, relationships and even friendship (between doctor, patient and carer) than it is about goals, plans and measurement tools.

The thesis will specifically examine issues such as the "subjective" versus "objective" assessment of outcomes in depression care, the harms and benefits of any overly systematized approach to monitoring, and the different roles that clinicians, patients and carers adopt in the monitoring of depression outcomes. It aims to use these insights to propose new approaches to monitoring that might help us to know with more certainty that we are meeting the needs of people experiencing depression.

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