

Research paper

Improving care in depression: qualitative study investigating the effects of using a mental health questionnaire

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ABSTRACT

Background Depression has major health and social consequences. There is concern that general practitioners (GPs), who manage most depression in primary care, are reluctant to use assessment tools such as questionnaires that might improve diagnosis and management. A Cochrane systematic review has recommended qualitative exploratory studies to explore the impact of questionnaires on GP management.

Aim To identify effects of using mental health questionnaires on views of GPs managing depression, and how this might influence patient care.

Design Qualitative, formative evaluation using principles of grounded theory in analysis of semi-structured interviews and focus groups before and after introducing the mental health questionnaire.

Setting Four practices in South London.

Participants Twenty GPs, of whom four contributed to the pilot only, and 16 completed the main study.

Main outcome measure Identification of changes in GP views as a result of using the questionnaire with patients.

Results Three themes emerged from analysis of GP views on managing depression: control and

responsibility; the doctor–patient relationship, and support for the doctor. These were influenced by GPs' experience (years in practice), and perceived time spent dealing with depression (involvement). Use of the questionnaire enabled more experienced GPs to relinquish control, encourage patient involvement, and offer alternative sources of help. They felt less responsible for overall care. Less experienced, and less involved GPs found questionnaires supportive through increasing their confidence in asking difficult questions, and were encouraged to look for depression, which they might previously have avoided.

Conclusions Using mental health questionnaires helped GPs feel more confident in detecting and managing depression, and there was greater willingness to use questionnaires than found in previous studies. Most GPs sought reduced responsibility in ongoing care, using questionnaires to involve patients and pass responsibility to them or other agencies.

Keywords: depression, formative evaluation, GP views, mental health questionnaires

How this fits in with quality in primary care

What do we know?

Depression has been identified as a priority area for improving mental health, but general practitioners (GPs) have been reluctant to use mental health questionnaires, which are recognised to improve care in depression. GPs now receive incentives through the Quality and Outcomes Framework of the NHS Primary Care Contract to use these questionnaires with the aim of improving care for patients.

What does this paper add?

This paper adds to existing research, demonstrating that GP views on depression, and their willingness to identify and manage the condition, can be influenced by using questionnaires. GP characteristics of years in practice and perceived time spent dealing with depression affected their desire to retain control and responsibility, their views on the doctor–patient relationship, and their need for support when dealing with depression. Using mental health questionnaires provided support for clinicians by increasing their confidence, helping to ask difficult questions, and allowing GPs to reduce their need for control by involving the patients more and offering other options in treatment. They were more willing to seek out depression in patients, but perceived less responsibility for ongoing care.

Introduction

Depression is common, affecting 10% of adults at any time,¹ and with up to 50% of people attending general practice having some depressive symptoms.² Although depressed mood and diminished interest are recognised as principal features, the presentation of depression is often complex, with variable symptoms and severity, and co-morbidities competing for general practitioners' (GPs') attention in the ten-minute consultation. GPs provide 90% of care in depression,³ but recognise barely half at first consultation.⁴ Recognition improves with experience, knowledge of the patient and available time,⁵ but knowledge and education alone do not improve patient care,⁶ and benefits of intensive intervention decay after intervention ceases.^{7,8} National Institute for Health and Clinical Excellence (NICE) guidelines identify care pathways to promote better care in depression, including alternatives to medication,⁹ but these require GPs to be interested and have skills in diagnosis and management.

Detection of depression can be improved by using questionnaires, which are supported in NICE recommendations, and, since 2006, have been included in the Quality and Outcome Framework (QOF) for general practice.^{9,10} Earlier questionnaires, designed for secondary care use,¹¹ have been supplanted by shorter validated questionnaires, such as the Patient Health Questionnaire-9 (PHQ-9) and Hospital Anxiety and Depression Scale (HADS),¹² which can be used as self-report or clinician-administered tools.^{13–15} Despite this, GPs remain reluctant to use them, due to lack of time and resources and distrust of their validity.^{14,16–18}

GPs do not always accurately identify those who would benefit most from treatment.¹⁹ A Cochrane systematic review questioned why well-validated questionnaires failed to influence clinicians' behaviour.²⁰ Doctors' views about depression influence their management.²¹ One study suggested that GPs in deprived areas see depression as less treatable and less rewarding to treat, believing depression to be a normal response to difficult circumstances.²² The Cochrane review recommended qualitative exploratory studies to investigate

the impact of questionnaires on clinician management.

Aim

The aim of this study was to investigate the impact of mental health questionnaires on views of GPs when dealing with depression.

Method

Design

This was a formative evaluation, using a convenience sample of GPs who agreed to participate in a semi-structured interview and focus group before and after introduction of a mental health questionnaire. Inductive principles of grounded theory were used,^{23,24} as there is little previous research to predict GP views, or the impact of the questionnaire on their views. Detailed coding of transcribed text allowed in-depth analysis. Triangulation of methods using both semi-structured interviews and focus groups allowed participants to reflect, modify and add to their contributions in different ways and at different times. This was used to increase the reliability of data and reduce potential bias, as one of the investigators was a GP, known to participants. A semi-structured format in investigation, using topic guides, ensured that emerging themes were covered and revisited in subsequent meetings, while not constraining new concepts. Topic guides evolved throughout the study (see Appendix 1). Data collection continued until saturation was reached.

Setting

All GPs working regularly in four practices in South London were included in the study, which ran over 13 months. Practices were linked as a practice-based commissioning (PbC) group, serving 25 000 patients (range 3000–10 000 per practice), spread over ten miles, incorporating practices in affluent and deprived

areas (Index of Multiple Deprivation range 7.68–25.59),²⁵ and both training and non-training practices.

Pilot

The Patient Health Questionnaire-9 (PHQ-9) was chosen as a short, practical tool with proven validity and reliability in the primary care setting,^{13,26} and piloted by four GPs over ten months in one (investigator's) practice. An electronic format was developed, which could be used with the practice database. This was found to be acceptable and its use settled to a steady rate after five months, confirming acceptability of the electronic questionnaire and determining the minimum time required between introducing and evaluating its effect on GP views.

Sampling characteristics

Twenty-one GPs were identified as potential participants. Four were involved in the pilot study, and one declined to take part, leaving 16 GPs who completed the study. This was a convenience sample, but involved a diverse group of GPs (see Table 1). One investigator was a GP in a participating practice, which helped in the formative evaluation, where investigators need close involvement and understanding of the nature and context of the study. Participation was voluntary and all contributions were anonymous. The sample of 16 GPs in this study was similar to that recommended for studies of this nature.²³

Data collection and analysis

An initial questionnaire was used to collect demographic information about participants. Individual interviews and focus groups were carried out before and six months after introduction of the PHQ-9 into the practices. Interviews and focus groups within practices were semi-structured, facilitated by the GP

investigator, and tape-recorded. This enabled themes, through evolving topic guides (Appendix 1), to be identified, explored and further developed without preventing new ideas from emerging. By holding focus groups after interviews, participants were able to contribute to themes on more than one occasion, increasing data validity.

Recorded data were transcribed verbatim by the investigators, and checked by participants (giving respondent validity) and two independent readers to increase validity and reliability. Using the principle of grounded theory, initial codes were grouped into similar concepts to form broader codes from which central categories and themes were developed. Constant comparative analysis was used until no new ideas were identified, and saturation was reached. Both cycles were compared to identify the impact of the mental health questionnaire.

Results

GP characteristics

Participant GPs varied in experience (years in practice; see Table 1) and involvement in managing patients with depression (perceived time spent dealing with depression in consultations). GPs with ten or more years of general practice experience were considered as 'experienced', and those with fewer years' experience were considered 'less experienced'. Involvement in depression care identified three groups: 'less involved', 'moderately involved', and 'more involved' (see Figure 1). The 'less' and 'more' involved groups held distinctly different views, whereas the 'moderately involved' shared some views with both of the other groups. 'Involvement' was intended to represent the perceived impact of depression on consultations. In practice, more involved GPs also demonstrated greater interest

Table 1 Characteristics and working patterns of GPs in participating practices ($n = 16$)

Practice	Number of GPs	Male	Female	Full-time	Part-time	Years in practice	
						0–9	10+
1	2	0	2	1	1	2	0
2	6	4	2	6	0	3	3
3	7	4	3	4	3	1	6
4	1	1	0	1	0	0	1
Total	16	9	7	12	4	6	10

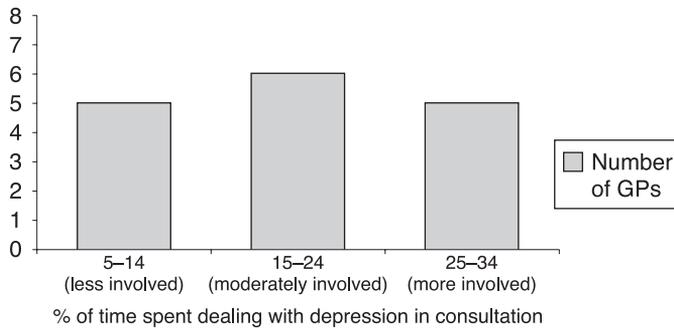


Figure 1 GP perception of percentage of time spent dealing with depression in consultations

in depression, having views in common with interested GPs in other studies^{6,11,18}

The mental health questionnaire

All practices were introduced to the PHQ-9. However, one practice decided to implement a similarly validated questionnaire (the HADS), which had also been developed in electronic format. The HADS is similar to the PHQ-9 in validity, reliability, and positive predictive value (41.3% HADS versus 55% PHQ-9), taking an equivalent time to administer (2–5 min).²⁷ Participants used only the depression score, and as the purpose of the study was not compromised the practice continued with the study.

The main themes

Three themes emerged from both the first and second cycle of data collection:

- 1 control and responsibility
- 2 the doctor's relationship with the patient
- 3 support for the doctor.

Control and responsibility

Mental health questionnaires influenced GPs' desire to take responsibility for ongoing care in depression, and their need to control the process.

Initially, experienced GPs felt a duty to retain overall care, responsibility and control. They selected patients that they could work closely with, acknowledging how they might choose patients they liked, rather than those with greatest need.

'Probably what I do is develop a relationship with them of sorts, that I tend to like them, and I will tend to spend more time with them.' (P1 231–233)

They were sceptical about using questionnaires, but after developing awareness of their controlling role, were prepared to reduce this, provided that their overall responsibility was also reduced:

'... and people – you can steer people – you could without a great deal of effort.' (S1 362–363)

Interviewees recognised patients' responsibility for the care they received, although they also acknowledged that depression could reduce patients' ability to participate. They found questionnaires intrusive, but saw advantages in allowing patients greater involvement, and adapted their use, using the screening questions less formally throughout the consultation. Participants felt that questionnaires helped define depression severity, highlighted management options, identified who to give time to based on need, and reduced prescribing. They felt that questionnaires could streamline consultations and that the time invested in completing them was worthwhile.

'I think you need to almost be able to commit it to memory and use it as a subconscious thing almost.' (S3 17–18)

'... a questionnaire encourages them to – to kind of evaluate each symptom – to think about how often it hits them.' (S1 284–285)

Less experienced GPs initially lacked confidence and skills and avoided managing depression:

'... and I'll be honest – sometimes, you know, I try and rush through the consultation hoping there isn't going to be any element of depression there.' (S2 169–170)

They did not seek control, or ongoing responsibility, but recognised their role in diagnosis and onward referral to other agencies. They expected, and found, that questionnaires helped ask difficult questions and make diagnoses, and aided management. This increased their confidence and they were more prepared to discuss depression during the consultation.

'I think it is very positive, because it not only increases my confidence in dealing with their symptoms, but it gives them confidence because I've got an objective method to use for detecting depression.' (B5 89–92)

Despite this, they did not seek more responsibility in care, and were keen to avoid patient dependency. They used questionnaires to hand over responsibility to the patient.

More involved GPs, like experienced GPs, were selective in whom they chose to manage with depression:

‘... it depends obviously on the rapport you have got with the patient over the years and the time you have been there – you know the problems.’ (S3 211–213)

They controlled how time was used and tolerated lack of improvement, but expected patient compliance with treatment. This group was least influenced by questionnaires, finding them intrusive, preferring their own questions and judgement. They felt that their main use was in persuasion, to increase patient compliance.

‘I have already decided in my head what I think we should be doing before I have used the questionnaire, and I don’t think the questionnaire often changes my mind – I can’t think if it ever changes what I want to do. I do find it helpful sometimes in explaining things to patients.’ (B3 203–206)

Less involved GPs believed their role was in diagnosis and exclusion of physical illness:

‘... they may think they have depression, but they come out with so much psychosomatic symptoms, it’s very difficult to separate straightforward depression from actual illness.’ (SU1 31–33)

Using questionnaires allowed assessment of severity, and recommendations for care. As a tool, they also felt that it reduced emotional involvement, reducing the risk of patient dependency. They felt that questionnaires helped diagnosis, but did not change their role:

‘... possibly just being there to show the patient that there are other options or to provide practical advice for other people that might be able to help, rather than feeling that you must accept the responsibility for the patient.’ (B2 96–98)

The doctor’s relationship with the patient

Mental health questionnaires encouraged GPs to take a more objective view of their patients’ symptoms and share decision making with them.

Experienced and involved GPs selected depressed patients for treatment, based on good relationships and greater likelihood of patient compliance. Good relationships increased GPs’ commitment to the patient, allowing tolerance of recurring depression or lack of improvement. It generated sufficient trust so that GPs felt valued and prepared to invest time.

‘These people value coming here – they value the support they get.’ (S1 162)

‘I think that people will develop a respect for your clinical judgement if you spend time listening to them and you appear to care what the problem is.’ (P1 195–197)

However, GPs were not always certain they were making a difference, which sometimes left them helpless and frustrated. They acknowledged that questionnaires could identify more depression, and involve patients in decision making. They felt that knowing the patient was important in interpreting responses and that questionnaires might complement this.

Less experienced GPs needed to see improvement to justify investing time. They felt questionnaires helped by asking less biased questions, and detected more depression. They avoided greater involvement in care, as they felt that emotional involvement could be difficult to cope with and might create patient dependency.

‘So it is important to have follow-up but it is important to create valid reasons for agreeing limits so that you are being safe but you are not actually breeding dependence.’ (B2 244–246)

Less involved GPs thought some patients had unrealistic expectations of instant cure, and were less tolerant where patients were stressed or unhappy, rather than depressed:

‘... because people are used to going through a drive-through now – all hours – 24 hours to get their hamburgers or cheeseburgers. They do come in here and have the same mentality.’ (P4 209–212)

They found the questionnaires helpful in distinguishing stress from depression, and more objective in measuring progress at follow-up, which facilitated passing responsibility back to patients. They believed questionnaires would become routine in future consultations, which they perceived as becoming more business like.

Support for the doctor

Questionnaires supported less confident GPs, encouraging them to discuss depression with patients.

Experienced GPs collaborated more with community and hospital colleagues, benefiting from their greater time in practice to develop better relationships. However, they were frustrated when other services let them, or their patients, down. Using questionnaires helped limit their emotional involvement, enabling them to be more detached, and feel less responsible for outcomes of care:

‘... it might take a bit longer than ten minutes on your initial interview, but I think in terms of stopping people from coming back with other things and dealing with misery it is time well spent.’ (S1 414–418)

Less experienced GPs felt vulnerable and, with little support from community or hospital colleagues, tended to avoid depression. Questionnaires increased their confidence and, by guiding management, acted as support, encouraging them to detect depression, if not manage it in the longer term.

'It's interesting because patients actually think I'm looking at them while I do it, and I can see them thinking about it, so rather than asking patients what impact does this have on your life and your family, you can actually focus down to a symptom, and it's quite broad, and it doesn't take that long.' (P5 89–93)

More involved GPs managed their own stress, but felt frustrated when they failed to receive support from colleagues. They felt patients should accept sadness as part of normal life, and that questionnaires could be used to persuade patients when they were not depressed.

'I mean, you could say to people, "yes, well everyone gets a bit low, so let's go on to the next question" – you know.' (S1 389–390)

For less involved GPs, questionnaires had increased their confidence in their management and giving of feedback to patients. They recognised their need to offer support to patients, but lacked skills, or support themselves for this, and limited their responsibility to offering options and referring to others:

'... well I feel that I am more confident in detecting depression – in trying to offer solutions and options in terms of treating people, so I have been more comfortable in the role.' (B5 13–15)

'Just, possibly just being there to show patients that there are options, or to provide practical advice for other people that might be able to help, rather than feeling that you must accept the responsibility for the patient.' (B2 96–98)

Discussion

Summary of main findings

This study highlighted the link between control and responsibility in GPs' care of depressed patients, together with the recognition that experienced GPs often selected the patients they gave more time to, based on the established doctor–patient relationship. Lack of professional support meant that less experienced GPs were less willing to seek out and manage depression.

Introducing a mental health questionnaire offered support to less experienced GPs, who, as a result, felt more confident and willing to address depression. It enabled more experienced GPs to recognise those with greatest need, and to offer options for, and involve patients in, care.

More involved GPs, who wanted to retain control and responsibility, were resistant to the questionnaires. For others, reducing control reduced their burden of responsibility, by sharing it with patients and other agencies.

Strengths and limitations of the study

Although we used a convenience sample, the study included GPs from a variety of backgrounds and types of practice. However, findings from a small group of GPs in one area cannot be generalised to all GPs. Commitment to the study, with all participants completing the process, was helped by introduction of national target payments for using depression questionnaires, which may have encouraged use of questionnaires when practitioners might not otherwise have done so. The potential bias in analysis, because one investigator was a GP, was addressed through participant and independent scrutiny, to improve the reliability and validity of the data and analysis, but an element of selection bias cannot be excluded.

The sample size was appropriate for a formative evaluation such as this, but use of a semi-structured format for interviews and focus groups, while ensuring specific areas were covered, may have resulted in information that was less rich than open discussion.²⁸ One doctor declined to take part, and this may indicate that a significant minority of doctors hold different views to those expressed by the participants.

During the study, one practice decided to use the HADS rather than the PHQ-9 instrument. This introduced another variable but did not compromise the purpose of the study. However, it did indicate that discussion had occurred in practices, which may have influenced subsequent GP views.

Comparison with existing literature

Few studies have previously explored GP views before and after introduction of a mental health questionnaire. Previous work has focused on training needs, time constraints and available resources,^{29–31} which are related to the need for support and lack of confidence identified in our findings. Baik *et al* recognised associations between GP views and specific practitioner characteristics, such as experience, interest and knowledge, but considered experience to be more complex than 'time in practice' alone,⁵ and this was recognised in this study through including involvement as well as experience. A recent study found that GPs were sceptical about depression severity questionnaires, preferring their own clinical judgement. They recognised that participating GPs were particularly interested in depression, and more involved participants from this study share many of their views.¹⁸ This may explain why time constraints have been an issue for some studies, but not where GPs were interested and confident in managing depression.³²

Control encompasses use of time as well as patient factors, such as resistance and non-compliance highlighted in other studies.^{21,33} A sense of control enabled

GPs to cope with emotional and time pressures. Non-compliance made it less likely that GPs would give them time.

GPs were able to identify that they missed depression, and did not always treat it appropriately, as shown in earlier studies.¹⁹ Previous studies, which showed that GPs gave priority to physical illness over depression,^{5,34} reflect the views of less involved GPs here, but the use of questionnaires, by accurately determining severity, enabled GPs to identify, and engage more with depressed patients.

Implications for clinical practice and future research

GP views and management of depression can be influenced by questionnaires, but are dependent on practitioner characteristics which include experience and involvement. Use of mental health questionnaires reduced need for control in experienced GPs, and increased confidence of less experienced GPs. Studies now need to examine whether these results are followed through into clinical practice, to increase detection of depression, and provide more consistent, equitable, and patient-centred care. Patient views will be needed to determine how effective these changes might be.

This study has focused predominantly on positive outcomes of using mental health questionnaires, as proposed by NICE guidelines.⁹ Work is now required to investigate negative outcomes, as was implied by experienced GPs who were more involved in management of depression here, on the quality of the doctor-patient relationship. Such studies will need involvement and feedback from patients as well as doctors.

Emerging from this study is the suggestion that, as a result of using mental health questionnaires, GPs in future will reduce their responsibility for ongoing care in depression, passing this back to their patients and other agencies. These findings should be investigated further in a multicentre survey to determine resource implications for the NHS, and how quality of care might be monitored.

Conclusions

Mental health questionnaires can influence GPs' views on, and confidence in, managing depression, and have the potential to identify more cases of depression, particularly in those with greatest need. They may help GPs involve patients and other agencies in care and reduce their need to control the process. One consequence may be that GPs will be less willing to take responsibility for ongoing care in depressed patients.

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REFERENCES

- 1 Hale AS. Clinical review: ABC of mental health: depression. *BMJ* 1997;315:43–6.
- 2 Chambers R, Boath E, Wakley G and Jheeta K. *Mental Healthcare Matters in Primary Care*. Oxford: Radcliffe Publishing, 2001.
- 3 Paykel ES and Priest RG. Recognition and management of depression in general practice: consensus statement. *BMJ* 1992;305:1198–200.
- 4 Kessler D, Bennenworth O, Lewis G and Sharp D. Three-year outcome of the detection of depression and anxiety in primary care: a longitudinal study. *BMJ* 2002;325:1016–17.
- 5 Baik SY, Bowers BJ, Oakley LD and Susman JL. The recognition of depression: the primary care physician's perspective. *Annals of Family Medicine* 2005;3:31–7.
- 6 Gallo JJ, Meredith LS, Gonzales J *et al.* Do family physicians and internists differ in knowledge, attitudes, and self-reported approaches for depression? *International Journal of Psychiatry in Medicine* 2002;32:413–19.
- 7 Lin EH, Katon W and Simon GE. Achieving guidelines for the treatment of depression in primary care: is physician education enough? *Medical Care* 1997;35:831–42.
- 8 Kendrick T. Why can't GPs follow guidelines on depression? *BMJ* 2000;320:200–1.
- 9 National Institute for Health and Clinical Excellence. *Depression: management of depression in primary and secondary care. Clinical Guideline 23*. London: NICE, 2004.
- 10 Gilbody SM, House AO and Sheldon TA. Routinely administered questionnaires for depression and anxiety: a systematic review. *BMJ* 2001;322:406–9.
- 11 Andersen SM and Hawthorn BH. The recognition, diagnosis and treatment of mental disorders by primary care physicians. *Medical Care* 1989;27:869–86.
- 12 Wilkinson M and Barczak P. Psychiatric screening in general practice: comparison of the general health questionnaire and the hospital anxiety and depression scale. *Journal of the Royal College of General Practitioners* 1998;38:311–13.
- 13 Kroenke K and Spitzer RL. The PHQ-9: a new depression diagnosis and severity measure. *Psychiatric Annals* 2002; 32:509–15.
- 14 Lowe B, Unutzer J, Callahan CM *et al.* Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. *Medical Care* 2004;42:1194–201.
- 15 Lowe B, Kroenke K and Herzog W. Measuring depression outcome with a brief self-report instrument: sensitivity to change of the Patient Health Questionnaire (PHQ-9). *Journal of Affective Disorders* 2004;81:61–6.

- 16 Spitzer RL, Kroenke K and Williams JBW. Validation and utility of a self-report version of PRIME-MD: The PHQ Primary Care Study. *Journal of the American Medical Association* 1999;282:1737–44.
- 17 Kroenke K, Taylor-Vaisey A, Dietrich AJ and Oxman TE. Interventions to improve provider diagnosis and treatment of mental disorders in primary care: a critical review of the literature. *Psychosomatics* 2000;41:39–53.
- 18 Dowrick C, Leydon GM, McBride A *et al.* Patients' and doctors' views on depression severity questionnaires intensively in UK quality and outcome framework: a qualitative study. *BMJ* 2009;338:b663.
- 19 Kendrick T, King F, Albertella L and Smith PWF. GP treatment decisions for patients with depression: an observational study. *British Journal of General Practice* 2005;513:280–6.
- 20 Gilbody SM, House AO and Sheldon TA. Screening and case finding instruments for depression. *The Cochrane Database of Systematic Reviews* 2005;(4):CD002792.
- 21 Main DS, Lutz LJ, Barrett JE *et al.* The role of primary care clinician attitudes, beliefs, and training in the diagnosis and treatment of depression. A report from the Ambulatory Sentinel Practice Network Inc. *Archives of Family Medicine* 1993;2:1061–6.
- 22 Chew-Graham CA, Mullin S, May CR *et al.* Managing depression in primary care: another example of the inverse care law. *Family Practice* 2002;19:6332–7.
- 23 Green J and Thorogood N. *Qualitative Methods for Health Research*. London: Sage, 2004, pp. 102–4; pp. 180–6.
- 24 Bryman A. *Social Research Methods* (2e). Oxford: Oxford University Press, 2004, pp. 401–8.
- 25 Bromley Annual Economic Assessment. Appendix X 2008. www.sharepoint.bromley.gov.uk/.../05-LE-PH-0112-AppI.doc
- 26 Lowe B, Grafe K, Zipfel S *et al.* Diagnosing ICD-10 depressive episodes: superior criterion validity of the Patient Health Questionnaire. *Psychotherapy and Psychosomatics* 2004;73:386–90.
- 27 Nease DE Jr and Malouin J. Depression screening: a practical strategy. *The Journal of Family Practice* 2003; 52:118–24.
- 28 Morse J. A comment on comments. *Qualitative Health Research* 2002;12:3–4.
- 29 Wright MJ, Harmon KD, Bowman JA *et al.* Caring for depressed patients in rural communities: general practitioners' attitudes, needs and relationships with mental health services. *Australian Journal of Rural Health* 2005; 13:21–7.
- 30 Lucas H, Scammell A and Hagelskamp C. How do GP registrars feel about dealing with mental health issues in the primary care setting? A qualitative investigation. *Primary Care Research and Development* 2005;6:60–71.
- 31 Miedema BB, Tatemichi S, Thomas-MacLean R and Stoppard J. Barriers to treating depression in the family physician's office. *Canadian Journal of Community Mental Health* 2004;23:37–40.
- 32 Pollock C and Grime J. GPs' perspectives on managing time in consultations with patients suffering from depression: a qualitative study. *Family Practice* 2003;20: 262–9.
- 33 Railton S, Mowat H and Bain J. Optimising the care of patients with depression in primary care – the views of general practitioners. *Health and Social Care in the Community* 2000;8:119–28.
- 34 Andersson SJ, Troein M and Gunnar L. Conceptions of depressive disorder and its treatment among 17 Swedish GPs. A qualitative interview study. *Family Practice* 2001; 18:64–70.

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ETHICAL APPROVAL

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

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Appendix 1: example of evolving topic guides for semi-structured interviews and focus groups

Phase one – topic guide for semi-structured interview

(First interview)

Feeling about depression:

- What feelings do you have about treating depression in general practice?
- How confident do you feel dealing with depression?
- How do you cope with the emotions that can be transferred when treating depressed patients?

Skills when dealing with depression:

- How do you recognise depression in a patient?
- Are there particular skills that you use with depressed patients?
- What difficulties can depressed patients pose for you?

Management of depression:

- How do you decide when to start/stop antidepressants or refer to others?
- What are the constraints you face when treating depression?

Experience:

- Do you think the time you have been in general practice affects your approach to depression?
- Have you had any training in managing depression that has helped you?
- What do you think is the best way to learn about managing depression?

Use of a questionnaire:

- Have you ever used a rating scale for depression before?
- How do you feel about using a questionnaire now?

Other issues:

- Are there any other issues that have affected the way you think about managing depression in general practice?

Phase one – modified topic guide for semi-structured interview

(First interview)

Prevalence:

- What proportion of patients you see do you think suffer from depression?
- Is this changing at all?

Feeling about depression:

- What feelings do you have about treating depression in general practice?
- How confident do you feel dealing with depression?
- How do you cope with the emotions that can be transferred when treating depressed patients?
- What sort of patients do you give more time to?

Skills when dealing with depression:

- How do you recognise depression in a patient?
- Are there particular skills that you use with depressed patients?
- What difficulties can depressed patients pose for you?
- Which patients are more difficult to deal with?

Management of depression:

- Are GPs the best people to manage depression?
- How do you decide when to start/stop antidepressants or refer to others?
- What are the constraints you face when treating depression?
- What do you think the role of the GP should be?

Experience:

- Do you think the time you have been in general practice affects your approach to depression?
- Have you had any training in managing depression that has helped you?
- What do you think is the best way to learn about managing depression?

Use of a questionnaire:

- Have you ever used a rating scale for depression before?
- How do you feel about using a questionnaire now?

Social context:

- What effect do the media have on patients' understanding of depression?
- What role does stigma play for the patient/for you?

Other issues:

- Are there any other issues that have affected the way you think about managing depression in general practice?

Phase one – focus group topic guide

(First meeting)

Practice approach to depression:

- How important is depression as a clinical issue for the practice?
- Does the practice have a policy for managing depression?
- Do all doctors take an equal share in dealing with depressed patients, or is this delegated (consciously or subconsciously) to specific doctors?
- What would make services even better for depressed patients at this practice?

Professional decision making:

- What are the things that make it difficult to recognise depression in patients?
- When is it difficult to decide how to manage depression?
- How do you decide when to refer to a counsellor or psychiatrist?

Views about depression:

- What do you think your role should be when treating depressed patients?
- What are the good things about treating depression?
- What are the bad things about treating depression?

Introducing a questionnaire:

- How do you think using a questionnaire might affect your work with depressed patients?
- What advantages could you anticipate, using a questionnaire?
- What difficulties do you anticipate introducing a questionnaire into clinical practice?

Other issues:

- Are there any other factors the group want to raise regarding managing depression?

Phase one – modified focus group topic guide

(First meeting)

Practice approach to depression:

- How important is depression as a clinical issue for the practice?
- Does the practice have a policy for managing depression?
- Do all doctors take an equal share in dealing with depressed patients, or is this delegated (consciously or subconsciously) to specific doctors?
- What would make services even better for depressed patients at this practice?

Professional decision making:

- What are the things that make it difficult to recognise depression in patients?
- When is it difficult to decide how to manage depression?
- How do you decide when to refer to a counsellor or psychiatrist?
- What factors interfere with your ideals for managing depression?

Views about depression:

- What do you think your role should be when treating depressed patients?
- What are the good things about treating depression?
- What are the bad things about treating depression?
- Does depression still have stigma attached to it?
- What role does the media play in influencing patients?

Introducing a questionnaire:

- How do you think using a questionnaire might affect your work with depressed patients?
- What advantages could you anticipate, using a questionnaire?
- What difficulties do you anticipate introducing a questionnaire into clinical practice?

Other issues:

- Are there any other factors the group want to raise regarding managing depression?