

**Understanding Depression and its Treatment:  
GP, Patient and Pharmacist Perspectives**

**Final Report of the Concordance Fellowship**

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## **Research Aims**

To contribute to a greater understanding of patient and professional concepts of depression and its treatment as a prerequisite for developing concordance in the clinical encounter. The research findings will increase an understanding of

1. How doctors and patients communicate about depression.
2. The extent to which patients feel able and willing to participate in decisions about treatment for depression.
3. The role and contribution of community pharmacists as a source for patients of expert knowledge about treatment for depressive illness.
4. The significance of shared understandings of illness and treatment between patients and doctors as a determinant of concordance, treatment adherence and outcome.

## Chapter 1

### Introduction

#### *Overview*

The research involves a qualitative, interview based investigation of patient and professional understanding and experience of mild to moderate depression within primary care. It aims to consider concordance between lay and professional models of illness as a factor influencing patients' commitment to medical decisions about treatment, adherence to prescribed medication and evaluation of illness outcome. The intention is to compare the experience and perspectives of patients who have been recently diagnosed with depression with those of patients who have greater experience of the illness, and/or who have sought support and help from sources outside the formal health care sector. The experience of 32 patients diagnosed and treated for mild to moderate depression in general practice is compared with that of 30 members of the Depression Alliance. Thirty of the 32 general practice patients took part in a follow up interview approximately six months after the first. Professional involvement is represented primarily by GPs (19) and community pharmacists (15) as the most immediate sources of treatment and knowledge of anti-depressant drugs. The perspectives of two practice counsellors are also included as representatives of an additional and commonly utilised source of support for patients.

#### *Background*

Depression is the cause of extensive morbidity in the general population and an extremely common presenting condition in general practice<sup>1-14</sup>. Hale<sup>15</sup> considers that one in twenty patient consultations in general practice involves depression. Paykel and Priest<sup>16</sup> put the population prevalence of major depression at 5% and state that each year 3% of the UK population will be diagnosed by their GP as suffering from depression. Case finding studies indicate that for every patient who presents with symptoms of depressive illness, at least as many remain untreated in the community<sup>14;16-21</sup>. This

raises the question why some people consult with symptoms of depression while others do not, and points to the importance of lay interpretation and understanding of personal distress as well as patient expectations of medical support and treatment in furnishing an answer.

Most cases of diagnosed depression are dealt with in the primary care sector<sup>12;16;22-26</sup>. However, it has become a commonplace observation that depression is frequently undetected by general practitioners<sup>1;7-10;12;15;16;18-20;22;25;27-29</sup>. There are also doubts about the appropriateness and effectiveness of treatment. These relate to the prescribing of tricyclic antidepressants in primary care at doses which are regarded as subtherapeutic in the secondary sector<sup>6;9;15;21;29-33</sup>. There is a debate about the best choice of antidepressant as well as the overall cost effectiveness of prescribing the newer and more expensive SSRIs<sup>9;15;31;34</sup>. Despite the fact that antidepressants are the standard and often the only form of treatment<sup>3;5;12;26;27</sup>, there is evidence that they are of limited effectiveness in the treatment of the mild to moderate depression generally dealt with in primary care<sup>1;35;36</sup><sup>37</sup>. A number of reviews have found psychological treatments to be as effective as antidepressants in such cases<sup>1;4;5;38;39</sup> and the preferred treatment of many patients<sup>3;20;38</sup>. Many cases of depression in general practice patients are recognised to be self limiting<sup>5;27;40</sup>. Given the substantial placebo effect resulting from treatment with antidepressants,<sup>1;4;36;41</sup> their therapeutic efficacy is hard to assess. To a greater extent than most physical conditions, the diagnosis and treatment of depression (as with other psychiatric disorders) remains uncertain and contested among health professionals<sup>26;36;42;43</sup>.

Professional uncertainties about depression are paralleled by patient doubts about the validity of diagnosis and the effectiveness and appropriateness of treatment, particularly antidepressants. The high rate of patient drop out and

non-compliance with prescribed medication is well established <sup>1;20;28;39</sup>. Side effects are considered to be an important deterrent, particularly those associated with tricyclic antidepressants <sup>9;16;20;21;29;30;32;33</sup>. The delay between starting antidepressants and recognising any beneficial effects is also thought to discourage many patients from continuing with treatment <sup>15;16</sup>. Lack of information about side effects or the likelihood of delayed therapeutic effects reinforces the resistance of many patients to long term drug use because of a general dislike of taking tablets, as well as a fear that antidepressants induce dependency and addiction <sup>3;5;20;28;44</sup>.

Professional disagreement about treatment for psychiatric disorders is paralleled by the dissatisfaction of many users with a perceived over-reliance on antidepressants as the dominant form of therapy and the exclusion of other viable treatment options <sup>45-48</sup>. A recent membership survey by the Depression Alliance <sup>24</sup> revealed that users did not feel that there had been any significant increase in the effectiveness of treatment over the previous four decades. In this, as in other studies <sup>3;20;38</sup> users sought greater availability of non-drug treatments such as counselling and psychotherapy, as well as increased access to less formal sources of social and personal support. Patient and carer dissatisfaction with treatment information and the quality of communication with professionals is a recurring theme throughout the literature <sup>45-49</sup>. The uncertain and contested nature of treatment for depression makes a strong case for the greater involvement of patients in decisions concerning management and therapy.

Despite the prevalence of depression within the population and the high degree of personal and social cost it entails, little is known about either lay constructs of mental distress or the 'working models' or explanatory constructs of health professionals <sup>22;26;43</sup>, although survey results reported by <sup>50;51</sup> indicate that there is a considerable distance between these. An



understanding of the impact of such understandings on patient illness responses and treatment behaviour remains undeveloped<sup>22;43;52</sup>.

Evidence that concordant consultations result in improved relationships between patients and professionals, and measurable improvements in healthcare outcomes is growing. Dowell et al<sup>53</sup> show the benefits of doctors investing time in involving patients in treatment decisions and emphasise the importance of a mutual understanding between GP and patient of how the other is evaluating the effectiveness of treatment. They describe the transition from a 'diagnostic' to a 'therapeutic' encounter which involves an exploration of the 'discomfort zone', when discrepancies in the understandings of patient and doctor become exposed, providing an opportunity for negotiation and, possibly, resolution. This research reinforces a growing awareness of the importance of patients' illness concepts in determining their treatment choices and related behaviour<sup>22</sup>. Several studies point to the discrepancies in patient and professional understanding of depression as a contributory cause of the underdiagnosis, inappropriate and ineffective treatment of depression in general practice<sup>43;51</sup>.

### *Depression and Concordance*

The sheer scale of the morbidity and distress and associated personal and social costs caused by depression combine with lay and professional dissatisfaction with treatment and lack of consensus about the nature and diagnosis of the disorder to make depression a fascinating and highly relevant area for concordance research. Where diagnosis and treatment decisions rest on the effective communication and interpretation of subjective symptoms it is particularly important that patients and health professionals achieve a good understanding of each other's perspectives. A principal aim of the study is to contribute to a greater understanding of patient and professional concepts of depression and its treatment as a prerequisite for developing concordance in the clinical encounter and enabling patients to participate in decisions about

how their illness should be managed. This is developed in the analysis of patient and GP perspectives on the appropriateness and effectiveness of antidepressants that is presented in Chapter 4 of this report.

A further aim of the research is to examine the role and contribution of community pharmacists as a source of expert knowledge about treatment for depressive illness and to consider the extent to which pharmacists relate to patients in a concordant manner. The study findings open up the complexity of the interrelations between patients and a range of different health professionals, and reveal the extent to which the scope for concordance with patients can be compromised by the demands of inter-professional working and its associated etiquette (e.g. governing the relations between pharmacists and GPs). This topic is taken up for discussion in Chapter 5.

Concordance involves the recognition of the legitimacy of patients' illness outcome goals which may be at variance with the accepted canons of medical 'rationality'. The goal of the consultation moves from engineering compliance in accordance with professional agendas to achieving a negotiated consensus, or at least a mutual understanding, between patient and practitioner. Both parties can then work to optimise treatment within the context of the wider goals and commitments that mould patient preferences and acceptance of therapy. Compliance research was oriented to developing ways of changing patient behaviour through the provision of effective information: this was seen as the lever for 'rational' (compliant) behaviour<sup>54;55</sup>. Concordance acknowledges the importance of patient input to changing the prevailing medical culture, but places a greater onus on practitioners as catalysts for such change. It is professionals, rather than patients, who are primary targets for re-education. Our research endorses the importance of disseminating an understanding of concordance through a widespread programme of information and training. However, it also exposes some of the deeply engrained organisational and structural constraints that impede

the wider implementation of concordance in medical consultations. Education and information are, once again, necessary but insufficient conditions for engineering cultural and professional change. This issue is taken up for consideration in relation to the management of the interrelations between patient, GP and pharmacist in Chapter 5, in the discussion of GP and patient perspectives of the management of time in the consultation in Chapter 3, and in the wider discussion of Concordance in Chapter 6.

## Chapter 2

### Research Design and Method

A qualitative interview based methodology was chosen as the most suitable means of carrying out an in depth exploration of respondents' understanding of depression, and to providing a context in which patients would feel comfortable disclosing the story of their illness, and discussing their views concerning the effectiveness of treatment.

#### *The GP and counsellor interviews*

Nineteen GPs and two practice counsellors were enlisted from eight West Midlands practices varying in size, location and catchment (Table 1). We did not aim to recruit a representative sample of doctors within a qualitative study of this type. It is likely that the GPs in this study became involved in the research because they had a particular interest in depression and were confident in their ability to treat it. In this respect they may not be typical of many of their peers. However, our respondents extend across a wide range of different ages, practice type and working experience (from registrar to senior partner) enabling us to explore a range of different views and perspectives (Tables 2 and 3). The counsellors were recruited from the only two practices that offered in house counselling at the time of the study. Interviews took place in the professionals' offices and most lasted about an hour. The GPs and counsellors received an honorarium of £100 in recognition of the time they contributed to the interview and patient recruitment.

#### *The patient interviews*

A convenience sample of 32 patients with recently diagnosed mild to moderate depression was recruited by the general practitioners' lists and the counsellors' case load. All 32 patients had an initial interview, and 30 of the patients took part in a follow up interview six months later. General practitioners and counsellors varied in their strategies for recruiting patients: some did an audit of practice records; others identified suitable patients

during consultations. All patients received a written personal invitation from their general practitioner or counsellor.

Judgements about mild to moderate depression were left to the individual professionals. We asked the doctors and counsellors to recruit patients with "typical" depression of the kind they would routinely deal with in general practice, and none had any problem in recognising such a category.

However, the doctors had a fairly elastic notion of "recent" diagnosis.

Although we initially aimed to recruit patients who had been diagnosed with depression within the preceding six months, some respondents turned out to have suffered from the illness for rather longer, while five remained uncommitted to the diagnosis (Table 4).

#### *The Depression Alliance interviews*

We wanted to compare the views of relatively new patients with those of people who had more experience of dealing with depression and had accessed information and support outside the formal health service. An additional group of 30 respondents was recruited from the regional membership of the Depression Alliance. These respondents were interviewed once. Respondents gave written consent at the start of the interviews that took place in their own homes. These were wide ranging discussions which incorporated respondents' own concerns as well as a number of core issues of predetermined interest to the researchers.

The patient and Depression Alliance groups differed in some ways, but for the purpose of the analysis presented in this report they constituted a uniform set. The response rate in both groups was predictably low, at around 50%. We assumed that patients who were more severely ill, had opted out of treatment, or were of lower socio-economic status were less likely to take part. As this was a qualitative investigation respondents do not constitute a representative sample, but their accounts illustrate the range of views and experiences of patients suffering from depression. Respondents varied in

age, occupation, socio-economic group and marital status. Both patient and Depression Alliance groups were similar in terms of age, sex, marital status and occupation (Tables 5 - 9). Women outnumbered men by nearly three to one (46 to 16 ). Most interviews with patients and Depression Alliance respondents lasted about one and a half hours, with a range from forty minutes to two and a half hours.

### *The Pharmacist Interviews*

The purpose of this series of interviews was to obtain a range of perspectives of pharmacists of their role in the management of mild to moderate depression. Topics included how pharmacists recognised and responded to depression in patients and customers, their evaluation of treatment efficacy and their contact with patients and GPs in relation to depression. The research was conducted in one health authority in England, in a different region from the GP and patient interviews. Respondents were recruited purposively to ensure a mix of characteristics covering age, gender, ethnic origin, work experience and qualifications and type of pharmacy (Table 10). Twenty three of the forty nine pharmacists approached agreed to take part in the research. The target of twenty interviews was completed, each lasting about an hour.

Fieldwork extended from October 1999 to June 2001. The research was approved by the appropriate Local Research Ethics Committees.

### *Interview topics and data analysis*

The research interviews were taped and fully transcribed for content analysis. Analysis of the pharmacist transcripts was undertaken manually (by ML). An established qualitative data analysis software programme (NUD\*IST) is being used in the analysis of the GP, counsellor and patient interviews (by KP and JG). In the few cases where permission to record the interview was not given, or the recording failed, the interviews were typed up from extensive

notes immediately afterwards. In addition to the interview transcripts, detailed field notes giving a 'profile' of each interview, and descriptions of other relevant contacts and meetings were also entered into the data base, and included in the analysis.

Interviews were loosely structured round a topic list which served as a prompt for the interviewer to cover a range of core issues, but also allowed sufficient flexibility for the discussion to pick up and develop concerns of particular salience to individual respondents. Our aim was to provide an appropriate setting for patient and Depression Alliance respondents to feel comfortable in recounting the story of their illness: its cause and development, the decision to seek help, and from what sources; recognition and explanation of the problem, what happened during consultations with professionals, factors governing the choice and duration of treatment and how treatment and care were evaluated. The GP and counsellor interviews started by asking respondents to recall and describe a recent patient who had consulted with a developing depression. Having focused on a real case, the interview moved on to consider respondents' understanding of the nature and causes of depression, making and sharing the diagnosis, consultation style, treatment options and effectiveness and eventual outcome of the illness. Pharmacists were asked how they recognised depression, their experience of doing so, the action they took once these signs were recognised and about their perceptions of the effectiveness and appropriateness of antidepressant medication. Aspects of compliance and concordance were explored by examining the nature of pharmacists' interaction with patients and GPs, especially when there was a difference of opinion concerning illness and treatment.

Coding categories were identified from identification of themes arising from repeated scrutiny of the interview transcripts and field notes<sup>56</sup>. A coding frame was developed through an iterative process in which the researchers

repeatedly checked their understanding of the data through joint discussion and reflection. Analysis of the data develops as a continuing process of reflection and refinement. This process starts with the identification of basic categories, such as respondents' ideas about cause and their explanatory models of depression. Each section of relevant text is indexed to all thematic categories to which it relates. As the analysis progresses each basic category can be subdivided in terms of sub-themes arranged as branches of the parent category, and the text is recoded accordingly. As familiarity with the material increases, it is possible to re-inspect and refine the coding of the texts. Some themes, such as the recognition and treatment of depression, were obvious and of predetermined interest. The salience of individual themes and the identification of additional topics emerged during the process of working through the transcripts: time was one of these. Analysis of the data is built up and continuously extended through a progressively more detailed scrutiny and sorting of the texts, both over time, and through the collaborative input of each individual researcher. More extended accounts of the research methodology are given elsewhere<sup>57-59</sup>.

Each series of research interviews has produced a very substantial body of data, far more than it has been possible to analyse in the time available: a rich resource remains for future exploration. The remaining chapters of this report summarise the results of our analysis to date. Chapter 3 gives an analysis of GP and patient perceptions of time, and their implications for achieving concordance in the consultation. Chapter 5 is concerned with community pharmacists' support for patients suffering from depression, and a consideration of some of the obstacles to concordance between patients and pharmacists. Chapter 4 presents new work on the analysis of data relating to patients' and GPs' understanding and experience of antidepressants and the significance of the distance between these for patients' decisions about treatment. Chapter 6 summarises the implications of the study findings for concordance and future research.



## Chapter 3

### Time and Concordance in the Consultation

#### *Introduction*

There is widespread concern that time shortage in medical consultations is a major constraint in general practice and a limiting factor in the quality of care provided to patients<sup>60-63</sup>. Consultation length has *increased* over recent decades. However, it is argued that the demands on doctors' time have also intensified, with more complex consultations involving a greater number of tasks<sup>64-66</sup>.

Shortage of time is considered a major obstacle to the realisation of a more patient centred (concordant) medical practice that actively involves patients in treatment decisions<sup>40;65;67;68</sup>. However, the relationship between the length and outcome of medical consultations, including those for psychosocial problems, is complex and currently unresolved<sup>69</sup>. Some studies point to a direct relationship between consultation length and quality of care<sup>65;67;70-73</sup>. Other findings are more equivocal, and suggest that additional factors, such as case mix and the skill of the practitioner in using time well, rather than simply how long the consultation lasts, are more important determinants of outcome<sup>63;74-80</sup>.

Consultation length is a particular concern in relation to depression. Hurried consultations in which there is pressure to get through a complex series of tasks and issues are not conducive to the disclosure and recognition of mental distress. Shortage of time has been implicated as an important factor in GPs' failure to detect up to half of the cases of depression among their patients<sup>8;12;26;61;72;81</sup>. A number of studies have also found that doctors are more likely to record psychological problems in longer consultations<sup>8;61;72;73</sup>.

Discussion of the duration and quality of consultations has paid little attention to the direct experience of patients and GPs and their subjective judgements

about the adequacy of time as a resource in general practice <sup>82</sup>. In this chapter, we outline the GPs' and patients' experience of time in the consultation as it emerged from their accounts of dealing with depression, before going on to consider the significance of consultation time for the achievement of concordance in general practice consultations. More detailed accounts of both GP and patient perspectives on managing time are given elsewhere <sup>83:84</sup>.

### *GP perspectives of time*

Most of the doctors worked with standard booking times of eight or ten minute appointments. However, it was evident that the allocated time was fairly nominal. As has been reported in other studies there was a wide variation in the length of consultation time <sup>75:78:80</sup>. The doctors agreed that consultation length was determined primarily by clinical need rather than allocated booking time, and that depression typically required longer than most other conditions. This was particularly true of the first consultation, which was likely to extend to two or three times the length of routine visits. GPs could accommodate such variable demands through their willingness to run over time with their surgeries, and because there was considerable flexibility in allocating less time to other patients whose needs were more quickly and easily dealt with.

Although depression was common in general practice, new or severe episodes were relatively unusual. The first consultation required time to draw out the patient's concerns and establish the diagnosis and treatment plan. The doctors were sensitive to the risk of rebuffing patients through failure to acknowledge the validity of their problems or to encourage their disclosure. They recognised that many patients were helped simply by being able to unburden themselves in this way. Taking time in the first consultation to understand the problem and develop trust with the patient was viewed as a worthwhile investment, which would save time in future consultations, and produce a more effective response to treatment. Even within a short time,

key tasks could be accomplished and the ground prepared for more routine consultations in future.

The doctors were fairly relaxed about the overall availability of time even within the acknowledged constraints and pressures of general practice. However, they recognised that a range of situational factors influenced the amount of time given to individual patients, as well as perceived need. GPs used a number of strategies for managing time. Closing down a complex consultation – in some cases even an initial presentation of depression – with the offer of quickly arranged subsequent and sometimes explicitly extended consultations was one option. Another was simply to accept that other patients should be forced to wait for their turn to see the doctor. A further strategy was referral to another agency, though ease of access and the range of services available were also important constraints on use of such services.

The GPs varied in their interest and confidence in dealing directly with patients' psychosocial problems and in the amount of time they felt able or willing to give to these. However, virtually all of respondents considered that the support they provided directly for patients in the consultation constituted a significant 'added value' to their treatment with antidepressants, regardless of whether or not this extended to formal counselling. Even those doctors (about a third) who explicitly adopted a counselling role with patients considered that it was possible to provide effective support within the time constraints of general practice. Some respondents offered counselling across a series of extended consultations. Others felt that a considerable amount could be achieved even in a fairly short time, especially in cases of relatively mild or 'reactive' depression, when patients mainly needed effective, but not necessarily extensive, support to assist them in developing or recovering coping skills.

### *Antidepressants*

The GPs acknowledged the pressure of working conditions in modern general practice that time was limited and that access to specialist services was often inadequate. However, none of our respondents indicated that time constraints impeded his capacity to provide effective treatment and support for patients suffering from depression. Scarcity of counselling resource (either through themselves or referral) was a source of frustration for some doctors. Several expressed the view that there was an inverse relationship between giving time and prescribing drugs. Having more time to give to patients, either in active counselling or a more passive listening role, could reduce the need for antidepressants. Deep and complex problems were recognised to require an extensive input of time. Respondents were aware that counselling was a popular choice of therapy among patients. Nevertheless, for most cases involving depression, antidepressants were considered a very effective treatment, to which counselling could be a useful adjunct. Antidepressants were thought to work more quickly than talking therapies and so to reduce the extent and duration of patients' distress. They had the advantage of being readily available and without restriction. Most doctors considered that most cases of depression could be adequately (if not optimally) treated within the resources available to them in general practice.

### *Patient perspectives of time*

In contrast to the relatively relaxed attitude displayed by the doctors, time emerged as a source of considerable anxiety and concern for patients. These were shared by general practice patients and Depression Alliance respondents alike, although the topic seemed to have a greater salience for patients whose onset of depression was more recent. A concern with time featured in 23 of the 32 first interviews with general practice patients, compared with nine of the 30 follow up interviews and 13 of the 30 interviews with Depression Alliance respondents.

### *Entitlement to time*

Patients often expressed anxiety about 'wasting' their doctor's time by presenting with inappropriate or trivial complaints. General practitioners were viewed as very busy people whose time was scarce and valuable.

Respondents were concerned not to take more than their fair share and, particularly, not to disadvantage other patients whose needs they perceived to be more urgent than their own. Patients often referred to a time entitlement of no more than five or ten minutes with their doctor. An internalised, unspoken norm governed their sense of how long a consultation should last, although depression was recognised as requiring more time than many physical ailments. Explaining mental health problems was often a more difficult and lengthy process than describing physical symptoms.

### *Management of time*

Patients reported taking on themselves the pressure of time they felt their doctor to be under, and assumed some responsibility for helping the doctor to manage his time. They were concerned to play their part in keeping the appointment system running to time, and their apprehension was reinforced by the presence of other patients in the waiting room. Because they felt under pressure of time, many patients felt unable to express their concerns or respond constructively to what the doctor was saying. Their presentation of symptoms and concerns was often heavily edited. They did not feel able to make best use of the consultation as a result even when they recognised that their doctor was willing to extend the time beyond the normal booking slot. Patients saw their entitlement to time as running across consultations, and they assessed this entitlement in terms of the demand resulting from the totality of their health problems, not just depression. There was a limit to the number of issues that could be raised within a certain period – another factor in patients' rationing of their consultation time. Patients were not critical of the shortage of time and did not hold their doctors responsible for what they perceived to be a consequence of the scarcity of resources in the NHS. They

sympathised with the pressures they felt their GP to be under and tried to help by exercising restraint in the demands they made on the system.

### *Extended time*

Despite the sense of pressure expressed by many respondents, it was not uncommon for patients to have a longer consultation than the standard 5 – 10 minutes, especially in the first consultation. In some cases, when presented with extreme distress, doctors had responded immediately and somehow found the means to provide an extraordinary amount of time. The GPs' readiness to respond to such urgent need was deeply appreciated by patients. Several described such episodes as literally 'life saving'.

### *Quality time*

Having the time and opportunity to talk about their problems was widely appreciated by patients and experienced as intrinsically therapeutic. However, longer consultations were not necessarily felt to be better. How time was used was crucial, and even short consultations could be experienced as effective. It was not so much the amount of time that mattered, as the subjective perception of the quality of time spent with the doctor. The doctor's manner could be as important as the amount of time available. A too brisk consultation could send a strong message about how the doctor viewed the legitimacy and substance of the patient's problems. Doctors varied in their ability to convey interest, empathy, the feeling of not being under pressure and acknowledge the validity of the patient's distress.

### *Time for talking*

Perceptions of time entitlement influenced how patients evaluated the service they got. They made allowance for what could realistically be achieved in the time available and adjusted their expectations accordingly. Although patients generally acquiesced in the time allocated to them in the surgery and from referral agencies, they were active in appraising the quality and outcome of

the services they received. Across a range of consultations and with different professionals there was no clear relationship between the length and perceived quality of time. It was not necessary for a consultation to be long for it to be effective. Indeed, a number of patients considered their meetings with professionals to have been a waste of time.

#### *General Practitioner and patient perspectives compared*

The doctors acknowledged that time was short, and that being able to spend more time with patients would be desirable. However, their accounts did not contain the sense of acute time urgency or anxiety about time that characterised many of the patient responses in the study. Nor did the doctors consider that time constraints prevented them from providing adequate treatment for depression. They had confidence in antidepressants as an effective treatment for depression, as well as their skills in providing counselling support and their capacity to use time flexibly in allocating variable consultation time to patients according to specific need. Time management was part of the doctor's working routine, and a range of strategies helped them achieve this. Several GP respondents emphasised the importance of the use of time rather than its extensiveness. The doctors lacked awareness of the intensity of patient concerns about time or the extent to which this impaired patients' capacity to benefit from the consultation. GPs seemed to be operating with a different sense of time from patients. Thus, patients did not appreciate the extent to which consultation times could be flexible, or that doctors were working with a notional 'average' length of five or ten minutes for each consultation.

GPs and patients alike interpreted a crowded surgery and a long wait for booked appointments as indication of a conscientious, caring and popular doctor. But while the GPs tended to view this as evidence of their willingness to allocate time according to patient need, the effect on patients was to intensify their sense of time pressure and concern not to overrun the allotted

time when their turn came. The effect of a long waiting time was to undermine patients' already fragile sense of time entitlement and inhibit the disclosure of their problems when they did get to talk to a doctor<sup>26;81</sup>. In effect, patients took upon themselves the task of rationing time within the consultation<sup>85</sup>.

Some GPs referred to a 'consultation' for depression as extending across a series of meetings, giving time for a range of issues and problems to be discussed. Patients, on the other hand, tended to approach each consultation as a discrete episode, or at least confronted the uncertainties and problems associated with seeking medical help anew each time they considered the decision to consult. Patients' reluctance to consult and fear of wasting professional time reflect a norm that professional help should be sought only in cases of extreme and genuine need. Whether and when to seek medical advice are judgements that are particularly difficult for people experiencing psychological distress<sup>26</sup>.

The contrast between the lay and professional experience of consultation time is a striking finding of the research. It exposes a tension between patients and the medical system in setting boundaries to entitlement and access to care. The study points to the need for GPs to be more aware of patient anxieties in this regard, and to devise effective means of raising patients' sense of time entitlement in general practice consultations<sup>85</sup>.

Despite their anxieties about time, some patients reported receiving more than they expected, especially during a first consultation for depression. In cases where patients presented in severe distress, their doctors managed to extend the consultation for up to an hour or more. These instances show what can be achieved even within the current constraints of general practice and the scope for flexible and creative use of time that still obtains. Although much of the debate about time scarcity focuses on the 'average' length of 5 – 10 minutes, research also shows a wide range of consultation time<sup>60;74;75;80</sup>.



Perhaps the preoccupation with average length of consultation is misplaced. Doctors' ability to allocate time flexibly and according to individual need is what is really critical. The quality of patients' relationships with their doctor is fashioned over a series of consultations, and it is important to take account of the extension of time across these consultations as well as what happens in discrete episodes. Some consultations will require more time than others. Shorter consultations may still be effective where they build on support and shared understandings developed through past encounters<sup>80;86</sup>.

#### *Time and concordance in the consultation*

Our evidence reinforces other findings that it is often patients rather than doctors who take the initiative in rationing time<sup>85;87</sup>. Patient perceptions of low entitlement to consultation time and anxiety about wasting professional time discourage them from making appointments and inhibit their disclosure of problems<sup>26;81;85;87-90</sup>. As a result they often fail to capitalise on the resource that is on offer, feeling unable to use the time their doctor is willing to extend to them. They leave the surgery with questions unasked, and issues unexplored. This must reduce doctors' capacity to provide effective support for patients presenting with depressive disorders. It also inhibits the development of more patient centred and concordant consultations. Paradoxically, it may be patients' concern to keep within their perceived time entitlement that causes time to be 'wasted' in ineffective and superficial consultations from which they derive little benefit.

Perceived quality of time, not just quantity, is critical to patients' experience of the consultation. Doctors, by conveying the impression of having time for the patient, can express a powerful message about their interest and concern<sup>26;67;77;81;87</sup>. In this they legitimate patients' problems, validate their decision to consult, and confirm their need for treatment and support. Positive reinforcement of this kind is essential for patients' sense of entitlement to be

increased to the point where they can contribute more effective – and more concordantly - to the consultation.

## Chapter 4

### Antidepressants

#### *Introduction*

Patients' and doctors' accounts of antidepressants differ in a number of significant respects. These help to explain patients' use of these drugs, and raise some interesting issues for concordance. This chapter focuses on three specific issues: starting antidepressants, stopping antidepressants 'early', and stopping according to the GPs' plan. The analysis relates only to the accounts of patients their GPs.

#### *Starting antidepressants*

##### *GPs' views*

The GPs varied in their assessment as to what percentage of patients presenting with depression would be prescribed antidepressants. However where a clear diagnosis of depression had been made then antidepressants were the treatment of choice for all but one of the doctors who favoured psychological/talking therapy. GPs saw antidepressants as safe, non-addictive and effective drugs.

*So I am fairly comfortable about giving people treatment, particularly these days as antidepressants are so safe and because drugs are the tools that we work with. (Dr 508)*

Antidepressants emerged as the principal form of treatment for depression. Approximately a third of the GPs offered some kind of psychological support to patients and two practices had their own counsellor at the time of the study. In most cases, however, counselling was used as an adjunct to antidepressants, rather than an alternative.

GPs quite often distinguished between mild to moderate depression caused by a psychosocial trigger (reactive depression) and an endogenous or 'biological' type of depression. Antidepressants could lift the patient's mood, but this by itself may not resolve the problem in the long term.

*-if you accept that the vast majority of people have a reactive depression erm.....then I think that erm.....they (antidepressants) improve mood but unless you, unless you deal with the cause of the depression it is going to return (Dr 502)*

For the 'biological' depression antidepressants were regarded as a sufficient and effective therapy that worked by correcting the brain's biochemistry. For reactive depression they were seen more as a means to an end. In lifting patients' mood and helping them to feel better antidepressants enabled patients to identify and hopefully sort out the factors causing their depression, or at least re-establish coping strategies for accommodating adverse circumstances that could not easily be changed. .

The GPs acknowledged that patients were often reluctant to take antidepressants and quite commonly refused a prescription, at least initially.

*--because there is still a stigma attached to depression and mental illness and that feeling that is a failure so erm---I think that most patients will have some sort of reluctance towards them initially. (Dr 605)*

The reasons that GPs gave for patients showing reluctance was fear that antidepressants were addictive, concerns about safety of the drugs with long term use and stigma associated with the drugs. On the other hand the GPs also felt that there was less resistance these days and patients even came into the surgery asking for an antidepressant to be prescribed.

*Well I think in general people are very accepting and it (antidepressant) is not a problem. But there are some who when you suggest medication a barrier comes up. ---But there are probably three quarters of people if you say well I think you will benefit from antidepressants they seem to accept that quite readily in my experience. (Dr 508)*

GPs expressed understanding of patients' misgivings about medication. They cited cases where they had respected patient's wishes not to be treated with them even though the GP thought they would benefit from doing so. With mild to moderate depression GPs felt there was less urgency to get patients to accept antidepressants since they were quite likely to get better without any treatment: antidepressants merely speeded up this process and reduced the duration and intensity of patients' distress. A number of doctors described how they were prepared to let patients take their time in deciding whether or not to accept antidepressants, but assumed that they would be led to accept them eventually. However, the GPs also acknowledged that they were inclined to persuade reluctant patients to take antidepressants: some used the word 'sell' rather than 'persuade' in this context. This strategy was justified by the doctors' confidence in the efficacy of antidepressants, and their assumption that patients' initial reservations would quickly be overcome by their experience of treatment.

*And things like Prozac have got themselves a bad press, although it's pretty good stuff on the whole, but they (patients) need selling the idea and I usually use – "Look, you know if you've got a broken leg then you have a crutch and so as far as I'm concerned if you've got a broken brain then you'll need a crutch there as well and this is what these chemicals are." (Doctor 608)*

As this extract illustrates, the GPs often explained the underlying pathology of depression and the therapeutic action of antidepressants in terms of disordered brain chemistry. This model addressed the stigma concern since it presented depression as a physical illness – resulting from insufficient levels of serotonin in the brain – rather than a psychological weakness.

The doctors anticipated that patients' main concerns about taking antidepressants focused on side effects and the risk of addiction. Even when patients did not raise these issues explicitly, the doctors often pre-empted their concerns and took the initiative in providing reassurance.

*Go over about the fact that antidepressants aren't addictive and that you can always stop them if you don't like them, you don't have to be stuck on them. (Doctor 507)*

Most GPs also mentioned the severity and duration of likely side effects, although a few downplayed these so as not to encourage patients to expect them.

Antidepressants were recognised to be problematic in that they took time to become effective. The actual number of weeks that GPs specified varied. Mostly it was two weeks but a few warned patients that it could be as many as three to six before the benefits of treatment started to become apparent. Initially then, patients would feel no better, and possibly worse, after starting antidepressants.

*I get the feeling that when I see them at the two week and sometimes at the near four week review that they feel slightly unsure about taking them because they, although we have discussed it they--they don't see an obvious benefit. (Dr 601)*

Many GPs set the date of the second consultation for two or three weeks after the first. By this time they hoped that any side effects would be declining even if the benefit of the antidepressant was not yet evident to the patient. This provided an opportunity for the doctor to reinforce the initial message that antidepressants take some weeks to take effect. However, the doctors were aware that patients quite often did not return for even the first follow up consultation. In two practices the significant extent of this early drop out had been confirmed by a practice audit.

Some GPs set the scene for long term compliance by telling their patients at the outset that they would need to stay on the antidepressant for six to nine months to achieve a stable recovery. Others gave this information later in case it put patients off starting treatment. One GP described how he prescribed Prozac generically to patients he suspected to be anti-Prozac in order to conceal its identity. Once again, the justification was that once the patient had worked through the side effects to experience the benefits of treatment, he would come to share the doctor's viewpoint.

While overtly accepting and tolerant of patients' reservations, many of the doctors admitted deliberately giving patients a steer towards antidepressants, and at least covertly influencing treatment decisions. One GP acknowledged that this might be considered paternalistic but when patients first consulted with depression they wanted to be accepted as patients in urgent need of care rather than fully autonomous individuals with a view on how they should be treated. That was what he wanted when he switched role to being a patient. Indeed, it was widely assumed that patients came to the consultation in search of advice and direction, rather than be faced with difficult decisions about how to manage their problems. One GP who was personally committed to patients making their own choice of treatment recognised that they were sometimes thrown by this approach, having come expecting answers rather than questions from the doctor.

*I sometimes find when I say, "Well what do you think would be most beneficial?" and list the things that we could, could do erm... And they find that unusual but I think that perhaps that is because with depression we do that more readily than we would with say (antibiotics).....Would you wouldn't you want some antibiotics? And I think that doctors on the whole now are keen to withhold antibiotics for all the right reasons and so patients, so they don't really always come expecting to be given a lot of options. (Doctor 601)*

This doctor saw the irony of expecting patients with a mental illness to decide which treatment would be best, when those with a physical illness needing antibiotics would not be given such a choice.

#### *Patients' views*

Patients came to the consultation with a range of views and impressions of antidepressants. These were shaped by their own past experience, or that of friends and family, as well as by the media. Three respondents described their apprehension at being prescribed an antidepressant, although all had accepted their prescription.

*No, she (GP) wanted to put me on Prozac straight away because basically I broke down within the ... during the consultation if you like, I was very upset even during when she was talking to me and she wanted to put me on Prozac straight away because we (spouse present in consultation)... You hear different rumours about antidepressants; we weren't too sure about whether that was the right way to go. (Patient 409)*

A major concern of patients was that they would not be able to stop taking the tablets, and the fear of becoming addicted to them. This derived mainly



from other people's experience or media coverage of antidepressants, but sometimes patients could not attribute the fear of addiction to any specific source.

*A: -The consultant assured me that Prozac wasn't addictive but you get a conflict of opinions on that don't you ?*

*Q: Yes that - yes and had somebody, had you just been worried about it yourself or had someone suggested that they might be?*

*A: No, no, it was just something I thought well I want to get better but I don't want to get better and end up addicted to a certain tablet.*

(Patient 314)

Most patients said they wanted to know about side effects. Having negative expectations about antidepressants did not necessarily result in patients' refusing treatment, but it did help prepare them for the experience.

Fifteen of the 32 patients described feeling positive about antidepressants at the point of prescribing, though this does not mean that they did not have concerns about taking these drugs. Nine were reluctant or actually resistant and five had mixed views. The remaining three patients had never been prescribed antidepressants. Several respondents described how the decision to accept treatment developed over time.

*A: No, I didn't ask her (GP). She gave me all the options and said, "This is what we can do if", erm you know, "You can also have this option." And then I went back and, erm, it was either a week, or two weeks later and things were just getting worse and worse and she was still reluctant but she said that it (antidepressant) might be the only option that we had at the time.*

*Q: And how did you feel about that?*

*A: I didn't want to, but I knew that I couldn't do it on my own. (Patient 308)*

Four other patients showed a similar qualified acceptance of antidepressants. It was not so much that they were especially positive about taking these drugs but that any treatment that held out the prospect of alleviating their symptoms was to be welcomed. It just happened to be antidepressants that were offered. While some patients' resistance or qualified acceptance of antidepressants was influenced by prior knowledge, the uncertainty of whether or not to take antidepressants was often expressed as part of a general reluctance to take medicines. In this sense antidepressants were no different from other medicines.

The diagnosis of depression was a big factor in determining patients' attitude to antidepressants. Five patients rejected the suggestion that they were depressed and others struggled with the idea initially though later came to accept it. While these patients questioned in their own minds the appropriateness of being prescribed antidepressants some did go on to take them.

*--because of the way it was done like, I was in with him (doctor in hospital out patient clinic for physical problem.) for ten minutes and in that ten minutes he did that full assessment that I needed Prozac and I suppose if I'd been more with it I would have said, "What the hell are you talking about?" I thought, "Oh let me get out of here the quickest way?" (Patient 403)*

*The prescription was there (in the house) thinking you are depressed, I think that it was, I didn't want to accept that I was maybe*

*erm.....and I was(laugh).....it is difficult to describe how I felt but yes, I held on to it for a couple of weeks before I decided to go (to the pharmacy) (Patient 404)*

For these patients the diagnosis was unexpected, particularly in the case of Patient 403 where she was unexpectedly and as she thought inappropriately diagnosed as suffering from depression during an outpatient appointment for an unrelated physical condition. She took one of the Prozac tablets that had been prescribed by the hospital doctor but used the experience of side effects as a reason not to take any more. This respondent felt aggrieved that that the label of depression had been forced on her, and that she had not had the opportunity to challenge the diagnosis. Three patients were unable to react to the diagnosis since depression had not been discussed, or even mentioned as a diagnosis during the consultation. One of these only realised that the medicine prescribed was an antidepressant when he got home and read the patient information leaflet inside the packaging.

Four patients went to the GP actively wanting an antidepressant, although only one of these felt able to ask the doctor outright for this. The others either hinted at their preference, or found their desired outcome was in line with the GP's decision about treatment.

*I didn't ask for Prozac, I didn't go in and say I think I need Prozac, I wouldn't have dared do that, but the fact that that was the one that came out was -- (R pleased with this outcome) (Patient 301)*

Three of these patients were prescribed antidepressants (including the one who took a more direct line with the GP) but not the fourth. She felt that her doctor had told her to 'sort herself out' and would have liked an explanation as to why antidepressants were not appropriate in her case.

Several patients commented on the approach taken by their GP during the consultation(s) that led up to antidepressants being prescribed. Three described their awareness of the tactics that the GP employed to bring about patients' acceptance of antidepressant treatment. These were a variation on the 'go away and think carefully' approach. One doctor encouraged the patient to discuss the matter with her husband before the next consultation. Another was given the prescription to hold during the thinking phase.

*He gave me the prescription in my hand and he said, "I want you to go away and think about it over the weekend, and either get the prescription on Monday or bring it me back." (Laughs) (Patient 313)*

These patients reported their doctors' approaches in a positive way and had decided to take the antidepressants offered. Sometimes, however, such tactics could backfire. Another patient was less positive in her perception of her doctor's attempt to manipulate her response to treatment. She observed her GP's reluctance to tell her about any side effects from the medicine. When she asked him directly he referred her to the leaflet in the packaging. She concluded that her doctor did this in order not to encourage her to expect side effects. Some patients had past experience of depression and could compare the way different GPs had approached antidepressant prescribing.

*So really it was a case of trusting him (second doctor) because I felt that he would be completely open with me. You know if he had said to me, "Oh come on we'll just give you these for six weeks or eight weeks and then you can come off". He didn't do that at all. He did say that these could take a little while, but these do tend to respond more quickly than some do. He said, "I have no idea how long I will be asking you to take them but we can discuss it and if at any stage you have got concerns then you make an appointment and come in and see me and we'll talk about it." But if he had said to me, as had been*

*said to me some years before by another doctor in the practice, "Well, I know how you feel about antidepressants and I can understand that on the one hand but I am only asking you to take this for three months." So I agreed that. At the end of the three months, "What happens now, are they reduced or can I stop them." "No, no, no you have got to take them, you are looking at a good six months from the time you start." And I did say, "Look you did say three (months)." "Yes, but it was more important to get you onto them. But in actual fact I am sure you will get much more benefit if you stay on them for another three months." So on that premise I thought, "Well ok he's being reasonable", but then it became very obvious that it wasn't going to be that at all. It was almost saying you are going to be on these forever and a day, and I thought but I don't want to be dependent on medication forever and a day. (Patient 401)*

This patient felt that her first GP had been deliberately dishonest in order to get her to accept the treatment. She contrasts this with the second occasion where antidepressants were suggested by a different doctor with whom she feels she has an open and trusting relationship. Despite a bad experience with side effects during her first experience of treatment, she is prepared to accept the antidepressants from the second doctor. In this case, openness and honesty were valued above pragmatism in the relationship between patient and GP. Respondents described a range of responses in presenting their concerns during consultations. Few reported being as direct as this last case, while some trusted their doctor to the extent that they felt it was unnecessary or inappropriate to question his judgement. Most respondents fell in between these two extremes. It was evident, however, as has been illustrated above, that patients often found it difficult to state their preferences or express open disagreement with their GPs. Respondents' accounts refer to concerns being withheld, and issues merely hinted at, rather than made explicit, in the effort to observe the implicit norms governing interaction between doctors and

patients. Patients also describe their awareness of their doctor's attitude and responses to the consultation. Concern about annoying the doctor, and losing his sympathy as a consequence, resulted in patients consciously modifying their presentation in order to 'please' him, and to appear co-operative. These constraints on patients' behaviour in the consultation, and their wider implications for concordance are taken up for further discussion in Chapter 6.

### *Patients' experience of taking antidepressants*

Whatever their response to antidepressants when these were first prescribed, patients were likely to modify their position vis a vis antidepressants during the following weeks in the light of changing knowledge and experience. Most patients reported having side effects in the early weeks and some patients found them difficult to cope with at a time when they were feeling little benefit from antidepressants.

*--because they were making me feel dreadfully sick and er--sort of tired erm-- but that I think it must have taken another three weeks (before R felt the benefit) and I went back again and I did feel much more in control, that I was coping. (Patient 312)*

Some patients found it more difficult to cope with side effects.

*Well I'd read about this Prozac and he talked to me about antidepressant tablets for quite some time and suggested that there is different tablets of course and I'll try you on them. And what he said to me was you're going to be on them for at least six months and it'll be fourteen days before you start to feel better. Well I thought after fourteen days I was going to start and feel better and things like that and after six months I thought I was going to be a new man, but after nine days of taking them and I just knew that I couldn't manage to take them for a fourteen day period you know. So I thought I cannot*

*stand that, I never ate anything for about five days and I mean I am only skin and bone as it is. (Patient 402)*

Despite feeling very positive about taking antidepressants initially, the respondent found the experience of taking the drug intolerable, and rapidly reassessed the treatment. This was an unusual case in that the side effects of the antidepressant had a direct impact on a coexisting physical condition. The respondent found that even getting through the initial two to three weeks before the benefit outweighed the side effects became an impossibility. Nevertheless, the general response was one of stoicism, and of soldiering on.

*Yes, yes it was sort of explained how it worked and erm like I say the length of time it would probably take to have effect. I think I thought it was something that I would (take) for a month and that was it. But I didn't think at all that it was going to work to start with and then they said that it does take a while to get into your system. And I think I thought when it didn't start to work to start with I suppose I did start to feel a bit desperate really, thinking well this is not working, what is going to, you know. (Patient 309)*

Here some uncertainty about the effectiveness of the medicine begins to creep in. There were other cases where patients had accepted what their doctor had told them during the consultation but later re-appraised this in the light of additional information gleaned from a variety of sources.

*I did ask him (GP) specifically are they addictive and he said, "No." But I'm not entirely convinced of that I'm afraid. I don't know whether you have heard of (names horse trainer)? He trains horses, his wife I read in the papers suffers from depression and she's now, it said in the paper she's addicted to Prozac. (Patient 405)*

Reading about someone else's experience led this patient to query the information that the GP gave. The reaction of others to the knowledge that the patient is on antidepressants (and therefore depressed) is a further factor influencing patients' ongoing commitment to antidepressant treatment.

Even where patients started off accepting the doctor as expert and were happy to leave the decision to him second thoughts about the appropriateness of the treatment could subsequently emerge. Doubts about the costs and benefits of antidepressants could be complex and finely balanced. For example, one older patient had not been very happy to accept medicine that affected the mind. Part of his rationale for continuing to take antidepressants had been that since he had noticed no effects on his mood it was reasonable to conclude that the drug was probably not very strong. He saw a new relationship as being very important in his present and future improvement. However he had noticed that impotency was listed as a side effect of the antidepressant he was taking and was concerned that this might affect him and damage his new relationship and prospects for recovery. He had not felt able to express his concerns to his GP, even by the time of the follow up interview, and was scheduled to be on antidepressants for a year or so.

Within a short period of time after the consultation in which the patient had accepted the GP's authoritative on diagnosis and treatment, new learning and experience leads to further questions, different understanding and continuing testing and reappraisal of antidepressants. We will return to the significance of this finding below in relation to patients' accounts of stopping antidepressants.



## *Stopping Treatment Early*

### *GPs' views*

Most of the GPs operated with a general rule, in accordance with current guidelines<sup>1;20;91;92</sup> that patients should take antidepressants for at least six months and continue with the medication for three to four months after symptoms subsided. As was noted above, the doctors were aware that patients quite commonly did not return for follow up following their first appointment, and so either did not start their prescribed antidepressant, or did not continue taking it after the months supply they would initially have been given. They varied in their assessment of how often patients who were established on a course of treatment stopped taking the medicine early. Some thought that with an accurate diagnosis, good explanations and support of the patient in the early weeks, compliance was high. Others gave compliance at about 50% or even less. Doctors gave feeling better as the main reason for patients stopping treating early.

*Frequently the medication is stopped by patients. They will try alternate days etc ...or they come back feeling better and just stop them. So yes I think probably, I suspect half of the time or two thirds of the time people don't take medication as prescribed. I am no exception I do the same erm...and I think you know you might have left the pills on the table and not taken them to work or...who knows there are all sorts of reasons why people don't comply. People think well I am better and I don't want to take the tablets. (Dr 511)*

GPs might pick up non-compliance from the computer (more usually not) but with mild to moderate depression it was unlikely that any further action would be taken or contact with the patient made. Stopping early was accepted as a foible of human nature that the doctors generally accepted without exasperation. They expected that some of these patients would relapse and return for a further consultation.

*I suppose they begin to feel not too bad and then they forget to take them and then you might see them about a year later when they get into trouble again. (Doctor 507)*

The relapse could then be used as a lever to persuade the patient of the need to stay the course with a subsequent prescription.

### *Patients' views*

Nearly a half of the patients had stopped taking their antidepressant ahead of the date set by their GP. There was no consistent relationship between their initial attitudes toward antidepressants and whether they stopped early. A third of those who felt positive about taking antidepressants stopped prematurely as well as a half of those who were negative or had mixed views.

As we have seen patients began to reappraise the information they had been given about antidepressants very soon after the consultation in which it had been prescribed. A major factor that led to a reappraisal was the experience of taking the drug. A few patients felt better even after the first tablet and recognised that this was likely to be a placebo effect. Some felt no different and others gradually came to realise they had improved. It was not a sudden breakthrough and this gave rise to uncertainty as to whether the improvement was anything to do with the antidepressants at all. One way to find out was to experiment by stopping to see if the symptoms returned. Sometimes this was a natural experiment where the patient simply forgot to take the tablet and discovered that nothing untoward happened.

*A:.) No, I stopped taking those (ADs) not long after your visit (first interview) I think, yes. (So had taken antidepressants for less than a month.)*

*Q: And what were the circumstances around deciding to stop taking them?*

*A: Well after a while ... because as I said I was often out, mmm.... I roughly started taking them I was just thinking get through the day. I would take one of these tablets and the pain will go away and I won't feel like this. But after I started going out I was forgetting to take them on the times when I normally would take them. I used to take them dead on the dot at a certain time you know and I thought perhaps if that's the case then perhaps I don't need them any more because I was forgetting I needed to take them. So I just stopped. And a lot of my friends were concerned about it (being on antidepressants) as well and my parents as well I think. Although when I was first very depressed and very distressed you know they wanted anything really I think to make me feel better so I was prepared to try it. But you know I pulled through a bit on my own as well, without having tablets.*

(Patient 407)

This respondent reassessed her need for antidepressants in the light of her experience, and after starting to feel better. She was also influenced by her perceptions of how her family and friends reacted to her taking this medicine. Sometimes stopping was more deliberately engineered as patients experimented to calibrate the extent to which they had recovered from depression, or evaluate the extent of their continuing need for antidepressants. Other patients anticipated the date they had been given for coming off antidepressants and stopped ahead of time. This was reported as a dry run to test that they were sufficiently recovered and could manage without further treatment. These respondents were keen to demonstrate that they had regained their health ahead of schedule. The decision to stop taking antidepressants was usually a private and independent one. Patients did not

usually share these plans with their GP, nor did they consult close family and friends. Some respondents feared that by divulging their intention to stop taking antidepressants they risked their GP's disapproval, and also that if they raised the issue they would be discouraged from experimenting and persuaded to carry on with the medicine.

A number of respondents remained unsure about the extent to which their recovery could be attributed to antidepressants or other factors such as improvements in their personal circumstances, or even the simple passage of time. Uncertainty about the effectiveness of antidepressants was also a factor for patients who did not feel they were very much better even after several months of treatment.

*I am going to see the doctor on Friday this week so I don't know what the long term plan is or the short term plan really, I just don't really know because I am now beginning to wonder well are the tablets having any effect or they must be erm I am not too sure any more about it. (Patient 409 Follow up interview so been on antidepressants over six months)*

This uncertainty led to a fear of coming off antidepressants in case doing so might exacerbate the symptoms of depression. Lacking any objective means to assess the effectiveness of treatment, some patients continued to take their antidepressants, albeit ambivalently, because they felt more averse to the risks of stopping than the continuing uncertainty of carrying on.

Patients' understanding of addiction also gradually changed as time went on. Initially their concern was articulated as a fear of not being able to come off drugs and becoming physically dependent on chemicals to function. This apprehension was similar to the GPs' perception of patient concerns about dependency. Part of the patients' uncertainty about antidepressants was their

anticipation that that if it was the drug that was responsible for their improvement then each time they had to confront a stressful situation in future, they would end up using antidepressants as a crutch to help them manage. They considered they were at risk of coming to rely on antidepressants as a means of coping. Thus their concept of addiction shifted to one of psychological dependency and their concern focused on the profound ontological shift that this entailed. The individual's sense of integrity and personal competence, his valued self, could be undermined by these doubts about the need for antidepressants and the loss of autonomy their extended use implied.

*A: Well, he (GP) was insistent that it was discussed, it's insisted on the packet, you know, they're not addictive-*

*Q: They're not?*

*A: But how you become addicted to something is an interesting one in itself isn't it?*

*Q: Yes?*

*A: You know, nicotine is but it becomes it doesn't it, I would not, I hope I will have the strength and the emotional support around me and wherever I get it eventually to not need these things. (Patient 301)*

Patients' symptoms may have improved but it was hard to see themselves as recovered or as being their normal self if they still needed to take a tablet.

*I just feel it is not really you, is it, if you have to get through each day by taking pills really. It is not really me. Whereas if I had a physical*

*thing I had got to take it for, I would need to take those to live sort of thing just to keep the symptoms at bay or whatever.*

*I know it is the same, but I cannot think about it the same. (Patient 312)*

This patient knew about the physical model of depression that was favoured by the GPs but it now no longer fitted her experience. The only way these patients feel they will be able to be themselves again is when they are coping without antidepressants. The next patient expressed this dilemma of antidepressants being part of the problem as well as the solution.

*I think, I mean tomorrow I am going to sort of talk to him (GP) about it again, but when I started saying that to him, he said, "You haven't given it time to work for you yet." I think that he was thinking, "She wants to come off these and she has not given herself enough time to be feeling better and she is going to be back here within weeks wanting them again." But I don't feel that I have been able to talk to him enough to say, "Look, okay I am going to have to accept that I do get these lows and I know that once I start taking the tablets I start to feel better but I don't want to suddenly think yes, there is going to be a crisis coming up in my life and I can't cope so I had better go and get these." You know, I just want to.... And I don't know why I can't, I get so frustrated with myself that I can't, that I know that if I, if I start weaning myself off these how I wanted to now, that I would feel so horrible again that I would have to up them again if you like and would be on them until like next year and I know that that is coming and I don't want that to happen. (Patient 410)*

This respondent had tried to explain her concerns to her GP but felt that he did not understand the core of her dilemma and saw antidepressants only as a solution.

The factors influencing individual decisions to stop or continue with antidepressant treatment were often complex. Some patients gave up taking antidepressants earlier than their doctor recommended because they were feeling better and were confident in their recovery. Others stopped because they preferred to engage in the struggle to be, and to remain themselves, rather than accept support from a chemical crutch. Some patients continued to take antidepressants reluctantly and with ambivalence, uncertain of the extent of the drug's effectiveness, or their continuing need for them, but apprehensive, nevertheless, that they might not be able to cope without them.

### *Stopping treatment according to plan*

#### *Patients' views*

Some patients had clearly defined treatment plans from the outset, whereas others were more open ended or even non-existent. However, whether they had a plan or not some patients said they were fearful about stopping at quite an early stage because of concerns about dependency. GPs responding to such concerns by sanctioning a trial stopping or providing reassurance that prevention of dependency was on the doctor's agenda could inadvertently reinforce patients' fear of becoming dependent.

*---but the only fear I do have is am I going to get addicted to these tablets, because what she has told me to do is to take them for six months and then if I feel I want to come off them, to come off them and she said that you'll know in four to five days if you're going to manage without them and that was what ... I thought, the bells went off and I thought, "Am I going to be on these for the rest of my life sort of thing", so ... (Patient 404)*

*She (GP) did say not to rely on them, she doesn't want me to become dependent on them, it feels like --- I don't think like in an addiction sense, but it's like the fear of coming off them and what I am going to face when I do because I mean you can't feel them working in a sense. I've not experienced any euphoria or anything like that, so I don't really know if they are working. I just know that I'm getting better and I'm wondering what's causing it. The fear of coming off them in case it all sinks back again, I just don't want to go through that again I really don't. (Patient 407, first interview after taking antidepressants for less than a month)*

As we have already seen it was this dilemma that led patients (including P407) to stop early.

Four patients described how their concern intensified as they came to the point of a planned stopping of antidepressants.

*Because I was worried that by stopping taking them I might start to feel like I did before. I mean, I sort of changed the way I was thinking about it, because I didn't want to take them initially, and I wanted to stop taking them as soon as I started to feel better. But then I think I was feeling so much better, was feeling so good and I was coping and every thing. I am thinking this is fine and if I stop taking them I might not feel like this and that was the quandary really. (Patient 312)*

Three of these patients who expressed a fear of stopping as well as a fear about being on tablets long term were perched on the horns of a very uncomfortable dilemma.

*I suppose I didn't feel happy taking them really, you know perhaps I thought I didn't know how much control they were having over me,*



*you know how effective were the other (self help) things that I was doing or whether it was the tablets that were sort of making me feel better. (Patient 309)*

On balance, however, these patients did want to stop antidepressant treatment, and had received professional advice about how to do this. The fourth respondent had found an article in a magazine that explained how to come off antidepressants and had not involved her GP very much once he had sanctioned her stopping. Three of these cases had successfully stopped (though one said she had a few tablets put by) and one was in the process of stopping her antidepressant.

#### *GPs' views*

Most GPs expected patients to remain on antidepressants for at least six months after which the process of stopping should be accomplished through negotiation between doctor and patient. If the patient felt ready then the GP would support the decision to stop, although some doctors would advise patients not to give up antidepressants if they anticipated that a particularly stressful time lay immediately ahead.

*And more often I won't stop someone's drug until they say they're happy to stop it. I think that's important and they're usually twisting my arm and sometimes I'll have to persuade them to stay on a bit longer. I had someone the other day who wanted to stop and I said "Oh I never stop anti-depressants before Christmas, it's not a good time to stop anti-depressants, let's see you again in the new year when you've got over the stresses of Christmas." And then I would tell them how to fade it out and what to look for and they will remember their symptoms and I will say "If they start coming back, you come back and see me, not if it's an odd bad day, because we all get those, but if you're getting those symptoms back, if you're waking up early etc.*

*come and see me or give me a ring. Don't wait for an appointment."*

(Doctor 604)

Advice given to patients about the process of stopping varied between doctors. A few GPs considered that the half life of the antidepressant they were prescribing was sufficiently great for patients to stop treatment quite suddenly. Others, as above, advised a gradual withdrawal. One GP recognised that patients did experiment with antidepressants and was prepared to authorise (but not encourage) patients to stop for a few days to see if symptoms returned. Patients were advised to return to the GP if symptoms recurred and/or save a few tablets for such an eventuality.

*This is why when you actually stop treatment you have to make it clear to them that you are just testing the water and if they stop treatment, you do it gradually anyway, but if they stop the treatment and they start to go bad again not to worry it just means that in their case they needed treatment for a little bit longer. (Dr 508)*

Although most GPs said that they had only a few patients on antidepressants long term, they were generally relaxed about this as a possibility and recognised that some individuals needed to stay on treatment indefinitely in order to remain well. Several of the patients in the study accepted that they would probably need to take antidepressants indefinitely and were quite happy to do so, but this response was quite unusual.

A few GPs expressed an understanding of the difficulty that patients could face over stopping antidepressants, and recognised that psychological dependency was a key issue.

*There is no doubt that there is some sort of psychological dependence. I mean, I think that if you have been unwell and having anxiety*

*symptoms and not functioning, not coping with life for several months and then you have felt back to normal then they often have that ' is it the drugs or is it me.' And they often have that dilemma as to saying well is it me that is living my life now or is it the drug me that is living my life now. Which is often to giving them that confidence to sort of support them through that period can be important as well. (Dr 606)*

However, this kind of awareness was not common. Most of the doctors seemed unaware of the extent and ongoing nature of the difficulties patients experienced as a result of taking antidepressants. Their support to patients trying to stop the treatment centred on reassurance that if it did not work out they could always return to antidepressants. In general, however, the doctors were not aware of the extent to which many patients regarded such a prospect with fear and apprehension, because of the doubts that relapse and return to treatment would raise about the possibility of ever being able to achieve recovery. The wider significance of the different assessments of antidepressants between doctors and patients, and their implications for concordance, are taken up for discussion in chapter 6.

**Chapter 5**  
**Community Pharmacists and Depression**  
**Mary Landers**

Background

In 1999 the National Service Framework for Mental Health set standards to ensure quality and consistency in the provision of mental health services in the UK but made no mention of the role of the community pharmacist. The Royal Pharmaceutical Society of Great Britain responded to the lack of recognition outside the profession of the role of pharmacists with the publication of its Practice Guidance on the Care of People with Mental Health Problems in 2000. This paper identified potential roles for community pharmacists in the recognition of symptoms, management of treatment and support of families and carers of patients with mental health problems. Particularly with regard to depression, there appears to be much support pharmacists can offer in a community setting. Little research has looked at what support community pharmacists are currently offering to people with depression, what affects the support they offer and how pharmacists would like to see their role develop. These were the aims of this study.

Description

This study was a qualitative interview-based investigation of community pharmacists' experiences supporting patients with depression, their opinions on the nature of their current role, and views on how they would like to see their role develop. Informal face-to-face interviews were completed with twenty community pharmacists selected to ensure a mix of age, gender, ethnic origin, experience, postgraduate experience, working environments and roles within a community pharmacy setting. Data gained from these interviews revealed a wide range of pharmacists' experience in dealing with depression, and very differing views of the role of the pharmacist in

supporting patients with depression. These results are discussed under the headings of the study questions.

#### Do patients discuss depression and its treatment with pharmacists?

Pharmacists' responses indicated patients do discuss depression with pharmacists but not to the same extent as other illnesses. Reported frequency of these discussions varied from once or twice a month to two or three times a week. Patients were thought to be more reluctant to initiate discussion of depression because of the persistence of a stigma associated with depression. Despite this, pharmacists reported a wide range of questions they were asked by patients regarding depression and its treatment. Most queries involved the use of prescribed antidepressant medication or St John's Wort. Some respondents felt patients found community pharmacists more accessible and approachable than GPs for discussing subjects such as depression.

Not all pharmacists were as comfortable discussing depression as discussing other illnesses either because they were not confident in their knowledge of depression, its treatment or how best to approach an already vulnerable patient, or they felt lack of time and privacy in a busy pharmacy setting was inappropriate for such discussions. Fifteen percent of pharmacists said they never initiated discussion of depression, seeing their role as involving simply the supply of prescribed medication and response to patient queries.

Pharmacists who did approach patients with depression did so in response to a request for an over-the-counter treatment for possible symptoms of depression, or at various stages of prescribed antidepressant treatment of depression.

These results indicated a need for pharmacists to update their knowledge on depression and its treatment, and for pharmacist training to focus more on communication and counselling skills. More open discussion of depression with patients would help to dispel any stigma associated with depression.

*How do community pharmacists perceive their role in the recognition of depression?*

Pharmacists were generally confident recognizing signs of depression and reported instances where they had identified depression in vulnerable patients, as an adverse effect of medication, associated with co-existing illness, or as a result of excessive or repeated requests for over-the-counter medicines such as sedative antihistamines. These patients were generally referred on to the GP without the word 'depression' being mentioned. Where patients with undiagnosed depression were reluctant to consult their GP, pharmacists were less confident in their approach and were generally reluctant to disclose a diagnosis of depression to these patients. This was partly because of apprehension as to how the patient would react, partly because some pharmacists were not sure of their diagnosis, and partly because diagnosis was seen as encroaching on the role of the GP. Where patients were keen to self-diagnose and self-treat or were reticent to visit their GP, forty percent of pharmacists felt they could assess whether alternatives to prescription treatment were appropriate. Five pharmacists said they would recommend St John's Wort in mild to moderate depression, while a further seven said they would only recommend it if asked about it. Although unsure of the different types of psychotherapies, most pharmacists felt counselling would be effective in depression, especially where the patient was keen to try it. Only one pharmacist was aware of any local availability.

Pharmacists could develop their role in the recognition of depression by giving the needs of the patient priority over concerns of professional encroachment in areas such as diagnosis. By considering patient concerns with their illness and its treatment, assessing the severity of symptoms and advising on the appropriateness of various drug and non-drug treatments, pharmacists could help to avoid the medicalisation of depression when the symptoms are less

severe and less likely to respond to prescription treatments. An improved understanding of the different psychotherapies and knowledge of their local availability would assist pharmacists in this role.

#### How do pharmacists perceive their role in the management of depression?

Of the seventeen pharmacists interviewed who reported they initiated discussion of depression, all felt it was important to do so with the first prescription for an antidepressant as patients needed to be aware of the delay in therapeutic effect. Most of these pharmacists felt it was important to monitor patients with repeat prescriptions for effectiveness of therapy, adverse effects and/or compliance. Some pharmacists also attempted to speak to patients when there was a change in medication or dosage, or with a repeat prescription request. Although these pharmacists recognized the value of this role in ensuring the safe, effective use of antidepressants, only three of the 20 pharmacists interviewed said they ensured they approached all such patients. Lack of time was the most common reason giving for not fulfilling this role.

There were conflicting views as to whether patients should be advised of possible adverse effects. Although information on adverse effects was the most common reason for patients requesting advice on their prescribed medicines, some pharmacists felt it was not appropriate to mention adverse effects. This was because they felt it could further distress patients, deter patients from taking their medication, or encourage them to inappropriately or incorrectly report these effects, an effect which has not been supported by research in this area. Other pharmacists believed the patient should be advised of the more common adverse effects, especially those that could affect lifestyle, and that these effects were often transient but could appear before any benefits from the medication were experienced.

One area where most pharmacists reported difficulties was where the patient prescribed antidepressants appeared to be unaware of their diagnosis. Pharmacists were then in a difficult position of deciding whether or not to reveal the probable diagnosis against the apparent wishes of the prescriber, or to limit the extent of any patient counselling provided and reduce the patient's chances of complying with their medication.

These responses revealed pharmacists are not the only health professionals who are reluctant to discuss depression with patients. It appears patients can be diagnosed and treated for depression without having the opportunity to discuss their illness or its treatment with a health professional. More open discussion of the illness with patients by all health professionals would enable more patient participation and therefore more positive outcomes for patients. Initiatives such as Pharmaceutical Care and repeat dispensing will facilitate greater involvement of pharmacists.

#### What is the pharmacist's role in concordance?

Although most pharmacists were unfamiliar with the term concordance, some were aware of its value in ensuring a patient-focussed approach to the treatment of depression. These pharmacists addressed the needs of the patient by responding to patient concerns over their illness or its treatment, and acknowledging these concerns in any advice provided. Other pharmacists however perceived their role as more of a regulatory role aimed at reinforcing the wishes of the prescriber. These pharmacists had difficulty responding to patients who chose not to discuss their depression with a GP or comply with prescribed medication. This indicates a need for a change in focus to a more patient-centred approach to the support offered to patients with depression, where healthcare is more of a partnership between the patient and their health professionals. This role could be developed further with the community pharmacist as the patient's advocate, liaising with the prescriber where necessary on behalf of the patient. The negative reactions of prescribers



reported by some pharmacists to their efforts to extend this role suggest a need for pharmacists to promote themselves more in this role to patients and other health professionals.

*How do pharmacists perceive their role in supporting families and carers of patients with depression?*

There were few reports of interactions between community pharmacists and informal carers of patients with depression. There was some awareness amongst pharmacists interviewed of the contribution pharmacists could make towards dispelling the stigma of depression amongst families of patients, but otherwise little awareness of the needs of carers. This highlighted the need for pharmacists to develop their understanding of the needs of those caring for patients with depression, and how pharmacists could respond to these needs. Pharmacists would need to then promote themselves as a source of support to carers.

How do inter-professional relationships affect the pharmacist's role in depression?

Although most pharmacists reported a good relationship with other health professionals there was little evidence of any interaction. Most pharmacists interviewed appeared to work in isolation from other health professionals, the main form of communication involving brief telephone prescription queries to GPs. Many pharmacists had quite strong views on the prescribing of antidepressants, views often in conflict with local prescribing practices. However most had little understanding of the rationale behind local GP prescribing and generally very little input into prescribing decisions.

Where issues were raised with individual prescriptions, most pharmacists felt able to ensure the safety of the prescriptions they dispensed with regard to dosage and drug interactions. However some pharmacists were deferential towards the prescriber, assuming superiority of the prescriber's knowledge

and experience in the use of apparently unsafe dosages. This attitude was also evident with the prescribing of sub-therapeutic doses of antidepressants.

Pharmacists who rely on the prescriber to be sufficiently knowledgeable and experienced to prescribe without any input from a pharmacist take away the need for a pharmacist. If pharmacists want to achieve full professional standing they need to prevent the interests of their patients from being adversely affected by subservience to doctors and fears of professional encroachment. Further initiatives for collaboration between community pharmacists and other health professionals are needed to develop inter-professional communication and cooperation. Such initiatives will also promote a greater understanding of the working practices of others.

#### Are community pharmacists equipped for these roles?

Pharmacists were generally satisfied their level of clinical knowledge was sufficient for answering most patient queries, although some admitted their knowledge was not sufficiently up-to-date to enable them to have an input into prescribing decisions. Pharmacists' experiences with depressed patients indicated a need for further training in counselling and communication skills required for patients with depression. Two pharmacists had responded to this need by taking on informal training in psychotherapy to enable them to meet the needs of these patients. With further training, many pharmacists expressed an interest in becoming involved in problem-solving clinics. Further studies are needed to investigate the feasibility of these clinics in a community pharmacy setting.

#### Is the community pharmacy an appropriate setting?

Respondents in this study recognized discussion of depression with patients required more time and privacy and one pharmacist felt this made a busy pharmacy setting inappropriate for any such discussions. Other pharmacists felt a quiet area could usually be found in the pharmacy for such discussions,

examples given including 'near the shampoos' or 'in the doorway to the staff room'. Where consultation rooms were available, little use was made of them. Reasons given for this included the need for the pharmacist to be available for dispensing checks and supervision of counter medicine sales and a feeling that the depressed patient would be intimidated in a closed setting. These pharmacists felt an advantage pharmacists had over GPs was that some patients preferred such consultations in an open setting at the pharmacy counter.

Most pharmacists interviewed felt frustrated in their attempts to fulfil their current professional role. Lack of time was the most often quoted barrier to pharmacists fulfilling their professional role. This was seen as being due to lack of support staff, employer expectations of the pharmacist taking on administrative and other non-pharmacist duties, or a heavy dispensing workload. Any extension to the pharmacist's role in this area would require means to be found of releasing the pharmacist from non-pharmacist duties, and possibly from current roles in dispensing and medicine sales supervision, as well as promoting the availability of the pharmacist for patient counselling. Even if patients appear content for consultations to be held in quiet areas of the pharmacy, without an appropriate consultation area, pharmacists are missing the opportunity of promoting this aspect of their professional role. If pharmacists are serious in wanting to be recognized as more than glorified dispensers by those outside the profession, pharmacists and their employers need to acknowledge this role in the way we promote ourselves in the community pharmacy setting. A change in the remuneration structure would also be required which rewards the pharmacy proprietor more for the professional service on offer rather than the volume of prescriptions dispensed. This could take the form of remuneration for extra professional services provided or an increase in dispensing fees with recognition of the limits of a single pharmacist in providing a dispensing service.

## Conclusion

The main findings of this study were that some pharmacists have taken on a variety of roles in supporting patients with depression, but could not carry out these roles consistently with current workloads. For other pharmacists lack of confidence dealing with depression and training needs restricted the role they currently provided. The nature of the relationship with GPs also needs to change to enable pharmacists to operate as independent professionals, particularly if pharmacists want to extend their role in areas such as recognition of depression and acting as the patient's advocate. The majority of pharmacists were keen to develop their role further, but realized this would require changes to their current working practices. Until this happens, community pharmacists may continue to be an underused resource within the NHS. It is hoped that these results will assist in further studies to define expanded roles for the pharmacist in the provision of a more patient-focused service for patients with mild to moderate depression, as envisaged in the NHS Plan. Comparison with the results of other studies currently underway into patient and GP perceptions of depression and its treatment will assist in the development of teamwork between patients, pharmacists and GPs to meet the needs of patients with depression.

## Chapter 6

### Concordance

The commitment to concordance between patients and health professionals in the prescribing and taking of medicines has emerged after several decades of research and policy aiming to promote patient centred medicine as a means of delivering higher quality and more accountable health services. Despite this long history of anticipation and encouragement, our findings accord with many other studies in showing that the principles of concordance and patient centred medicine have not been widely translated into practice<sup>54</sup>. In spite of growing evidence linking concordance and better healthcare outcomes<sup>44;93</sup>, the traditional forms of professional and patient interaction remain remarkably entrenched. In this chapter we consider the significance of our findings for an understanding of the cultural and organisational barriers to the realisation of genuine concordance between patients and health professionals in medical consultations.

#### *Patient and GP perspectives of antidepressant treatment*

Concordant consultations involve the achievement of shared understandings between doctors and patients about the nature of the problem and how best to deal with it. For shared decision making to occur it is necessary for each party to know what the other knows, and to use this knowledge as the basis for negotiation and, ideally, consensus about treatment. Our analysis highlights the extent of the distance between patients' and doctors' evaluation of antidepressants, as well as the adverse consequences which follow from doctors' lack of awareness of patient concerns about taking antidepressants and patient inhibitions about sharing these with their doctors.

Our findings support the analysis of Rogers, May and Oliver<sup>26</sup> that the general practice consultation is not a good setting for dealing with depression and the associated problems and distress that patients bring to their doctors.

Consultations for depression routinise the presentation of deeply subjective personal distress as *work* within a bureaucratic format governed by the norms of conventional medical knowledge and organisational practice. It is difficult, though as our data shows, not impossible, for patients and doctors to transcend this format in their discussion of depression. A number of patients in our study, as well as that of Rogers et al were explicit in regarding general practice consultations as unsuitable settings for meaningful communication about depression. A more general sense of inhibition and constraint, of the need to withhold issues and frame the information that was presented to GPs was commonly expressed in patients' accounts.

In contrast, the doctors in our study were more positive about the scope for dealing with depression successfully, and the effectiveness of antidepressants as a major tool of therapy. While recognising the importance of adverse social, economic and personal circumstances in causing people to experience distress, the diagnosis of depression was usually incorporated within a conventional biomedical framework in which pathology is represented as a disorder of brain biochemistry and treatment logically involves the restoration of chemical balance with antidepressants. The fundamental disparity between the medical model of depression and the inchoate nature of patients' experienced distress proved problematic for patients in formulating an illness identity and coming to terms with treatment. Most of the doctors we talked to presented as being reasonably open to patients preferences and concerns, and willing to discuss issues relating to treatment and care. However, they rarely expressed awareness of the ongoing doubts and uncertainties about diagnosis and treatment which patients disclosed. The parameters of the biomedical model of depression and the constraints of the consultation do not make it easy for doctors and patients to communicate freely and effectively about the complex problems raised in the treatment of depression. It is difficult for GPs to be aware of patient concerns when these are not fully disclosed. Some of the doctors acknowledged that they knew very little about

what their patients thought about their illness and treatment. Their interest in finding out had been one reason for participating in the research.

In the absence of accurate knowledge, GPs tend to make assumptions about patient views and what concerns them. For example, in acknowledging patients' reluctance to take antidepressants, most GPs depicted their specific concerns as concern about side effects and dependency. They then moved to pre-emptively to resolve patient anxieties in providing information about side effects and therapeutic delay and reassuring patients that antidepressants were not addictive. The doctors' accounts conveyed the impression that this intervention should be sufficient to resolve patient uncertainties about taking antidepressants. However, it is evident from the data we presented in Chapter 4 that patient misgivings and ambivalence about antidepressants were often much greater and longer lasting than many of the doctors supposed. In particular, the GPs seemed to lack awareness of the ontological challenge that a diagnosis of depression and acceptance of antidepressants posed for many patients, and the continuing struggle to retain a sense of personal integrity and competence that these unleashed. Such conflicts often developed gradually, in the weeks and months following diagnosis, long after the patient had left the consulting room. As we have seen, whatever patients' initial reaction to treatment their attitudes were liable to change in the light of experience, further information and introspective reflection and reappraisal.

Doctors mentioned reassuring patients about to come off antidepressants by telling them that it would always be possible to reinstate treatment if the attempt failed. Some patients found this heartening, as intended. Others found the prospect of such failure intensified their existing anxieties about dependency and the altered sense of self this invoked.

Our findings indicate that the range of patient responses to antidepressant treatment is wider, more complex, and sometimes more problematic than the

doctors generally realised. Patients often came to their doctors feeling desperate for help, and the GPs were understandably willing to provide this in the form of what they saw as a safe and effective therapy. Some patients accepted the biomedical model of depression as a constructive way of interpreting their distress, and were positive in their assessment of the effectiveness of antidepressants in contributing to their recovery. More often, however, patients' responses were uncertain and equivocal, sometimes to the extent that treatment itself was considered to constitute a problem rather than a solution to their illness. Moreover, regardless of the duration of depression or antidepressant therapy their damage to the individual's sense of self and personal autonomy was likely to be permanent: a diagnosis of depression could not be retracted.

For these reasons, it is important that health professionals develop a much greater awareness of the range of patient responses and concerns regarding the diagnosis of depression and treatment with antidepressants. Professional understanding and acceptance of the legitimacy of such concerns is a prerequisite for the development of more concordant consultations and a different kind of discussion about the choice of treatment for depression. Given that a substantial number of patients regard antidepressants to be of no or limited efficacy and experience a sense of lasting damage as a result of taking them, it is essential that the decision to accept treatment should be well considered, fully informed, and made with the active involvement of the patient. Information about a wider range of treatment options, and knowledge of other patients' experience of antidepressants should be incorporated in information routinely given to patients consulting for depression and related disorders. While individual responses to treatment cannot be anticipated in advance, it is essential that patients should be informed about the potential disadvantages of antidepressant therapy for a condition which many doctors - and subsequently also a number of patients



– felt was likely to be self limiting or could potentially be resolved by other methods, and without recourse to treatment with drugs <sup>1;2;4;5;26;36;38-40;92</sup>.

The provision of information – even across a range of media – to both patients and professionals is not sufficient to produce concordant consultations for depression. However, it can play an important part in widening participants' awareness of the issues that it is legitimate and productive to discuss, and so can be an important catalyst for change. Apart from the information leaflet inside their prescription packs, patients rarely reported receiving information materials from their GP during the course of their treatment. There is clearly considerable scope for extending provision in this area. Depression may be a particularly appropriate subject for the development of decision aids to assist both patients and doctors assess patients' preferred options. Dowell and Hudson <sup>44</sup> have suggested a potentially powerful way of encouraging concordance between patients and GPs. Doctors could deliberately authorise the experiments in taking antidepressants they know that patients undertake and so embark on a collaborative venture in which important feedback could be shared and evaluated. The patient could be allocated a much greater degree of involvement and control of treatment than is currently usual, while still receiving his doctors' support. There is a great deal of scope for pharmacists to become more involved in supporting patients, and monitoring their experience of such experiments, especially as they become responsible for administering repeat prescriptions. This could be a potent way of engineering a shared understanding of different (professional and patient) points of view.

#### Managing time in consultations for depression

Although the debate about the relationship between the length and quality of a consultation continues unresolved, the study findings point to the importance of patients' sense of time shortage, rather than absolute lack of time, as a critical factor constraining the development of concordance. Even

where doctors were prepared to offer time, and were positive about patient involvement in the consultation, patients often felt unable to take up the opportunity. The messages conveyed by professionals in their handling of time could have a powerful impact on patients' sense of entitlement. Difficulty in accessing help, having to wait for appointments, feeling hurried in the consultation, all impact negatively on patients' sense of self worth and inhibit disclosure of problems and optimal use of time in the consultation. Professionals need to facilitate an extension of patients' sense of time entitlement, though it will not be easy to alter such a deeply engrained aspect of the culture of the consultation, particularly in view of the absolute limits on time available.

Innovative ways of using time are increasingly coming into operation. Some practices allow patients to select the time option (long, standard, short) they feel they will need. This alerts patients to the availability of longer consultation times, and reinforces their entitlement to this resource. The use of telephone consultations is being extended, and there is considerable scope for exploiting email and the internet in exchanging information and contact between patients and practice staff. There is a planned extension of counselling support for patients within general practice and a great deal more use could be made of support services within the voluntary sector. Nevertheless, the face to face consultation between doctor and patient will remain the standard clinical encounter for the foreseeable future. In view of this it is important for professionals to develop an understanding of the dynamics of the consultation as a means of extending skills in communicating and time management that will facilitate concordance. Good intentions and an in principle acceptance of patient centred medicine will not achieve this without an awareness and conscious manipulation of the established norms governing interaction with patients. In particular, more attention should be paid to the organisation of talk.

### *Barriers to concordance in the consultation*

The organisation of time is bound up with the structured asymmetry of the traditional consultation which reinforces professional authority and patient deference. Power in social interaction is manifested through the propensity to interrupt, ask questions, and control speech turns. These are all behaviours associated with professionals rather than patients, and there is a considerable amount of evidence that these remain normative to the present day<sup>85;94-103</sup>. Martin et al<sup>67</sup> found that short and medium consultations were dominated by the doctor's input and control of talk. It was not until consultations extended to 20 minutes or more that patients began to play an active part in the encounter. The consequences of early interruptions to patients' initial presenting statements have been reported by Beckman et al<sup>104</sup> and more recently replicated by Marvel et al<sup>105</sup>. Allowing patients to complete their statements added very little time (an average of six seconds) to the consultation). However, when, as usually happened, doctors intervened quickly to cut patients off and take over control of the consultation patients were unlikely to return to complete their agenda or consider unvoiced issues later in the meeting. These features might provide a partial explanation for the often reported failure of GPs to detect depression in their patients. However, it is likely that doctors, like patients, exert a degree of choice about whether indications of psychological distress are given or acknowledged and taken up for discussion<sup>82</sup>.

In the depression interviews patients' accounts showed their sensitivity to the dynamics of the consultation, their awareness of the balance of power, the degree of control and direction being exerted by the doctor and their own responses and leverage in this situation. They also were also aware of areas where their views conflicted with those of their doctor, or where they felt that their doctor had become 'fed up' with them, or was likely to do so if they did not consciously modify their preferences in order to 'please' him. Patients were clearly sensitive to the implicit rules that governed the consultation and

modified their behaviour accordingly. For example, asking too many questions, or displaying specialist knowledge risked challenging the doctor's authority, and was avoided.

Earlier work by Tuckett et al <sup>106</sup> and Stimson and Webb <sup>107</sup> highlighted the extent to which patients and doctors strive to protect their relationship and avoid overt expression of disagreement. Strong <sup>108</sup> attends to the organisational constraints which govern medical consultations rather than the skill and aptitude of individual patients and practitioners. Strong characterised the 'bureaucratic' format of the consultation in terms of its routinization, brevity, impersonality and politeness. The patient role is one of passive deference to professional expertise, with little scope for active intervention. Such encounters are not conducive to the discussion of patients' fears and concerns about their condition, and patients are generally reluctant to raise such issues. The surface manifestation of routinised detachment and civility frequently overlays the experience of tension and unease. Much more recent research confirms the continuing professional domination of most medical encounters. These studies have consistently described the limited extent of patient participation in the consultation and the lack of professional awareness and elicitation of patient concerns and understandings of illness which underly the decision to consult. <sup>81;85;94;96;97;99-103;109</sup>

The traditional model of the consultation is deeply engrained in the culture of health care and has proved remarkably difficult to change. By and large patients and professionals perpetuate the patterns of interaction into which they have been socialised and to which they have become accustomed. Concordance places greater demands on all participants in going beyond the traditional model of the consultation and encouraging the open disclosure of conflicting views and differing goals and values which would previously have remained hidden and unsaid. Participants are asked to engage in a

potentially risky strategy that could jeopardise the consultation, and perhaps threaten the therapeutic relationship, if it does not succeed in achieving resolution through negotiated agreement. Dowell et al<sup>53</sup> refer to a 'zone of discomfort' through which patients and doctors pass in the course of realising concordance and making the transition from a 'diagnostic' to a 'therapeutic' encounter. They reported positive outcomes for such an approach in a study exploring patients' reasons for non-adherence through concordant consultations. Evidence is increasing that patient centred consultations can produce tangible benefits for health care<sup>110-113</sup><sup>53</sup>. However, this may not always be the case. A recent study involving patients presenting with persistent but non-specific psychological distress suggests that doctors may still feel vulnerable if they consider that patients are putting them under pressure by undermining their opinion, or implying a lack of confidence and trust in the doctors' abilities<sup>114</sup>. The doctors responded to what they felt to be pressure of time and demands from these patients by reverting to a more authoritarian response in the effort to regain control of the encounter. The patient centred model of the consultation was not considered helpful in managing this group of patients.

Concordance entails a major shift in orientation for both patients and professionals. It requires both groups to accept a different view of the goals and outcome of the consultation and to develop new skills and communicative techniques to achieve these. The traditional model of the consultation has demonstrated a remarkable resistance to change, but there is evidence that concordance is achievable, and that it produces tangible gains and improved healthcare outcomes. In a particularly interesting study, Dowell et al<sup>53</sup> comment on the challenges and conflicts that arose in attempts to practice and evaluate the outcome of concordant consultations with previously non-compliant patients and develop a model to assist concordant prescribing. However, the outcomes of the study were positive. Three months after intervention 14 out of 22 patients showed improved clinical control of their

condition and all participants had found the exercise valuable. The investigators considered that the improved relationship between the doctors and patients was also a tangible benefit of the research. This study is one of the few attempts to date to 'practice' concordance. Its results are extremely promising, both in providing a model of how concordance can be achieved and in documenting the improved outcomes that followed from the intervention.

*Concordance in the relationship between patients, community pharmacists and other health professionals*

In the preceding discussion we have focused on concordance between the core dyad of patient and general practitioner. However, concordance is clearly applicable in a much wider range of clinical contexts<sup>115</sup>. These involve both individual relationships between patients and other types of health professional (e.g. pharmacist, consultant, physiotherapist, nurse) as well as the more complex series of contacts between individual patients and a range or network of different health professionals contributing to their care. One aim of the research was to extend the analysis of concordance to patient contacts with community pharmacists. This group of professionals is obviously a potentially important source for patients of expert knowledge about treatment for depressive illness, and recent proposals have called for an extension of the role of community pharmacists in providing support for patients in their use of antidepressants<sup>116;117</sup>.

The pharmacists were not familiar with the concept of concordance, though some recognised the value of including patients in treatment decisions and the majority expressed an interest in extending their current role in supporting patients suffering from depression. Most pharmacists reported routinely giving patients advice about antidepressants at the point of dispensing their first prescription. However, they did not usually become involved in monitoring the patient's subsequent response to treatment, which

they considered to be the GP's responsibility. A number of practical obstacles (lack of time, privacy and remuneration) were cited as reasons for pharmacists' inability to extend their role in providing support for depression. It was evident also that pharmacists were reluctant to extend their involvement because they anticipated resistance from GPs and patients. Some also doubted their own competence or were disinclined to engage in discussion of difficult and sensitive issues with patients.

The type and extent of support pharmacists provided to patients was constrained by their reluctance to risk conflict in their relationship with other professionals. Where patients had been diagnosed or prescribed treatment by their GP, pharmacists seemed to adopt a traditional 'compliance' model of care, and saw their role as reinforcing the doctor's advice and prescribing decision. They tended to refer patients back to their GP if they had queries about diagnosis and treatment, rather than risk giving conflicting advice and transgressing professional boundaries. Professional solidarity and a concern to avoid damaging their relationship with the GPs were significant influences shaping the pharmacists' responses to patients. Respondents were inclined to defer to the authority of individual GPs, though in giving a more general appraisal many were critical of current prescribing of antidepressants which they considered to be frequently overprescribed. More than half believed that counselling and herbal remedies were more effective than antidepressants in cases of mild to moderate depression. Pharmacists were more willing to exercise autonomy in giving advice to patients who were looking for help outside the formal healthcare system about alternative and OTC remedies such as St John's Wort.

The relationship with GPs and the negotiated boundaries between professionals will substantially determine the scope for extending the pharmacist's future role beyond the dispensing and supply of drugs. The pharmacist currently occupies an uncomfortable role as intermediary in which

the patient's needs for full and open information and the disclosure of the pharmacists' own judgements are often subordinated to the exigencies of interprofessional relationships and the professional hierarchy. Once again, however it is apparent that it is not enough for health professionals simply to be exposed to information or learning programmes about concordance, or even to develop a personal commitment to patient centred medical practice. Substantial organisational and environmental changes must also take place for concordance to become truly integrated into the structure of the health service.

Achieving concordance in the tripartite relationship between patient, GP and pharmacist poses a considerable challenge. The extension of the pharmacist's role in repeat dispensing<sup>118</sup> will expand involvement in monitoring patients taking antidepressants, and offers a route for closer working with GPs. The situation becomes increasingly complex in the care of patients involving input from range of different specialities. Concordance requires a greater transparency of information exchanged between health professionals from different disciplines as well as between professionals and patients. Different specialities work with different models of pathology and treatment of depression (e.g. psychiatry and psychology), and individual practitioners within a single discipline may operate with a wide range of explanatory schemes and treatment preferences<sup>119</sup>. Further research is required to understand how such epistemological differences are handled between professionals, and how patients detect and respond to such diversity.

The pharmacists in this study tended to defer to the greater status and authority of the GP in withholding information from the patient that might have conflicted with the doctor's judgement. Some also indicated they would limit the information they gave patients (concerning side effects for example) that they felt might encourage non-compliance. Such rationing of information is widespread, and was reported by some of the GPs in the study.



It is linked to an ingrained assumption about the authority of clinical judgement, and a commitment to the achievement of patient compliance as a determinant of successful health care outcomes<sup>54</sup>. However, this kind of professional paternalism is inimical to the achievement of genuinely concordant relationships with patients. Greater openness about the range of options and attendant uncertainty that often apply in decisions about treatment, as well as the diverse and conflicting nature of medical knowledge and expertise, will prove challenging to laymen as well as professionals. The move towards more active involvement and greater responsibility in treatment decisions may provoke anxiety and disenchantment among patients accustomed to rely on the security of accepting professional expertise as unequivocally authoritative. Many professionals may find it difficult to accept the revision of professional expertise, along with the need to accommodate the perspective of the patient in accepting treatment choices which may conflict with conventional medical rationality.

### *Conclusion*

Concordance requires a reconceptualisation of the professional role from that of expert to guide in supporting patients in achieving health care outcomes which optimise their overall quality of life rather than maximise compliance. It is asking a lot of health care workers who remain to be convinced of the necessity of change or the gains to be realised through such a major exercise in revision. They may regard concordance as a form of deskilling and a threat to their professional status. Patient centred consultations make greater demands on the communicative skills of all participants, especially professionals. However, the evidence is increasing that concordance produces real gains in increasing patient satisfaction, improving relationships between patients and professionals, and improving health care outcomes. Professional knowledge of the patient perspective and willingness to take this on board as the cornerstone of the consultation is at the core of concordance. The present research has contributed to an understanding of patient and

professional understandings of depression. It has highlighted key areas where discrepancies between patient and professional viewpoints hinder the best use of healthcare resources and so compromise the quality of care and related outcomes. We hope it has made a contribution to an understanding of how concordance can be realised in future between patients and health professionals involved in the management of depression.

## Appendix 1

Summary Data of recruitment and respondent characteristics.

Table 1 The Study Practices

| Practice | No of doctors* | List size<br>(to nearest<br>1000) | Location/population |
|----------|----------------|-----------------------------------|---------------------|
| A        | 3              | 4,000                             | Urban/Mixed         |
| B        | 2              | 4,000                             | Semi-rural/mixed    |
| C        | 3              | 6,000                             | Rural/mixed         |
| D        | 6              | 10,000                            | Urban/deprived      |
| E        | 6              | 10,000                            | Urban/affluent      |
| F        | 1              | 2,000                             | Rural/mixed         |
| G        | 6              | 12,000                            | Urban/deprived      |
| H        | 4              | 5,000                             | Rural/affluent      |

\*This column refers to the number of doctors actually working at each practice at the time of the study ( including two registrars). Nineteen of the total of 31 doctors agreed to take part in the research.

Table 2. GP and Counsellor respondents: Age and Sex

|        | 20 – 29 | 30 – 39 | 40 – 49 | 50 – 59 | Total |
|--------|---------|---------|---------|---------|-------|
| Male   | 0       | 1       | 5       | 7       | 13    |
| Female | 1       | 2       | 4       | 1       | 8     |
| Total  | 1       | 3       | 9       | 8       | 21    |

Table 3: GPs: Length of time with practice

|                   | Male | Female | Total |
|-------------------|------|--------|-------|
| Less than 3 years | 0    | 2      | 2     |
| 3 –9 years        | 3    | 1      | 4     |
| 10 – 19 years     | 5    | 3      | 8     |
| 20 – 29 years     | 5    | 0      | 5     |
| Total             | 13   | 6      | 19    |

Table 4. Illness duration among patient and DA respondents

| Time since onset/diagnosis   | Depression Alliance | Patient Group | Total |
|------------------------------|---------------------|---------------|-------|
| Last 6 months                | 0                   | 15            | 15    |
| 7 – 12 months                | 3                   | 4             | 7     |
| 1 – 2 years                  | 2                   | 2             | 4     |
| More than 2 years            | 23                  | 3             | 26    |
| No clear onset               | 2                   | 3             | 5     |
| Other ( diagnosis contested) | 0                   | 5             | 5     |
| Total                        | 30                  | 32            | 62    |

5. a. Patient respondents: Age and sex

| Age    | <19 | 20–29 | 30–39 | 40–49 | 50–59 | 60–69 | >70 | Total |
|--------|-----|-------|-------|-------|-------|-------|-----|-------|
| Male   | 0   | 1     | 2     | 2     | 1     | 3     | 0   | 9     |
| Female | 2   | 3     | 3     | 8     | 5     | 2     | 0   | 23    |
| Total  | 2   | 4     | 5     | 10    | 6     | 5     | 0   | 32    |

5.b. Depression Alliance respondents : Age and Sex

| Age    | <19 | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 | >70 | Total |
|--------|-----|-------|-------|-------|-------|-------|-----|-------|
| Male   | 0   | 0     | 1     | 5     | 1     | 0     | 0   | 7     |
| Female | 1   | 2     | 4     | 5     | 8     | 2     | 1   | 23    |
| Total  | 1   | 2     | 5     | 10    | 9     | 2     | 1   | 30    |

Table 6. Patient and Depression Alliance respondents: Social Class

| Social class | 1 | 2  | 3  | 4  | Student | Total |
|--------------|---|----|----|----|---------|-------|
| Patient      | 2 | 12 | 10 | 6  | 2       | 32    |
| DA           | 3 | 11 | 12 | 4  | 0       | 30    |
| Total        | 5 | 23 | 22 | 10 | 2       | 62    |

Table 7. Patient and DA respondents: Current occupational status

| COS     | Full time | Part time | Retired | Housewife | Sick/unable to work | Unemployed | Other (student/training/between jobs) | Total |
|---------|-----------|-----------|---------|-----------|---------------------|------------|---------------------------------------|-------|
| Patient | 11        | 7         | 6       | 2         | 2                   | 0          | 4                                     | 32    |
| DA      | 13        | 4         | 5       | 1         | 5                   | 1          | 1                                     | 30    |
| Total   | 24        | 11        | 11      | 3         | 7                   | 1          | 5                                     | 62    |

Table 8. Patient and DA respondents: Marital Status

| Group   | Married/partnership | Single | Widowed | Divorced/separated | Total |
|---------|---------------------|--------|---------|--------------------|-------|
| Patient | 19                  | 5      | 3       | 5                  | 32    |
| DA      | 19                  | 4      | 0       | 7                  | 30    |
| Total   | 38                  | 9      | 3       | 12                 | 62    |

Table 9. Patient and DA respondents taking antidepressants at time of interview.

| Group   | First interview | Follow up Interview* |
|---------|-----------------|----------------------|
| Patient | 25/32           | 16/30*               |
| DA (30) | 19              | N/A                  |

\* Two FU interviews were not completed because one patient died and another was not contactable after moving out of the area.

Table 10: Demographic data for community pharmacists

| Category                                   | Type        | Number |
|--|-------------|--------|
| Gender                                     | Female      | 12     |
|  | Male        | 8      |
| Age  | 21-30       | 4      |
|  | 31-40       | 4      |
|  | 41-50       | 9      |
|  | 51-60       | 2      |
|  | 61-70       | 1      |
| Ethnic origin                              | White       | 7      |
|  | Black       | 1      |
|  | American    | 1      |
|  | Black other | 7      |
|  | Indian      | 1      |
|  | Chinese     | 3      |
|  | Other       |        |
| Number of years registered as a pharmacist | 0-5         | 3      |
|  | 6-10        | 3      |
|  | 11-20       | 8      |
|  | 21-30       | 4      |
|  | 31-40       | 1      |
|  | 41-50       | 1      |
| Postgraduate qualifications                | Yes         | 3      |
|  | No          | 17     |
| Current role                               | Proprietor  | 4      |
|  | Manager     | 7      |
|  | Support     | 3      |
|  | Locum       | 5      |
|  | Other       | 1      |
| Hours worked                               | 21-30       | 4      |
|  | 31-40       | 6      |

|  |               |    |
|--|---------------|----|
|  | 41-50         | 9  |
|  | varies        | 1  |
| Pharmacy location  | High Street   | 5  |
|  | Suburban      | 6  |
|  | In-store      | 2  |
|  | Rural/village | 2  |
|  | Various       | 5  |
| Reported having undertaken continuing education on mental health | Yes           | 9  |
|  | No            | 11 |



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