Patients’ perspectives on depression case management in general practice – A qualitative study

Jochen Gensichen a,b,⁎, Corina Guethlin b, Nilab Sarmand b, Dharshini Sivakumaran b, Cornelia Jäger b, Karola Mergenthal b, Ferdinand M. Gerlach b, Juliana J. Petersen b

a Institute of General Practice, Friedrich-Schiller-University Hospital, Jena, Germany
b Institute of General Practice, Goethe-University Frankfurt am Main, Frankfurt am Main, Germany

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ABSTRACT

Objective: General practice-based case management is effective in improving symptoms, adherence, and the perceived process of care of patients living with major depression. The aim was to explore the patients’ perceptions of practice-based depression case management, their satisfaction with it and how living with depression contextualizes case management.

Methods: This qualitative study was nested in a large cluster-randomized controlled trial on the effectiveness of case management for patients living with major depression. Case management was provided over 12 months by practice-based health care assistants, who monitored symptoms. We undertook semi-structured interviews with 41 patients, then transcribed and analysed them using qualitative content analysis.

Results: Patients described depression as the unfortunate situation, where loneliness and lack of energy lead to being unable to actively seek help. Case management was appreciated because of regular, proactive contact and support by health care assistants. It was crucial to patients that they could trust the health care assistant. Some patients complained that case management was undertaken too mechanically and lacked empathy.

Conclusion: Patients living with depression may perceive practice-based case management as beneficial if carried out in a trustworthy and empathetic manner.

Practice implications: General practices should ensure that depression case management is patient-centered and non-mechanical.

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1. Introduction

1.1. Depression in general practice

Depression is a common mental disorder in primary care, with a prevalence of about 10% [1]. It is associated with morbidity AND mortality and causes a substantial disease burden [2].

The majority of patients living with depression are treated in primary care, and general practitioners (GPs) are more often the first point of contact [3,4] than psychiatrists [5]. An adequate
diagnosis and treatment of depression is complicated by the fact that patients more often complain about somatic than depressive symptoms, and general practitioners tend to focus on somatic diseases [6]. Nowadays, more and more concepts for depression management in primary care are being established, e.g. case management.

1.2. Case management for patients with depression

Collaborative care improves depression outcomes by providing decision support and clinical information for physicians, as well as self-management support and follow-up for patients [7]. Most of the evidence on collaborative depression care stems from managed care settings in the United States [7–10]. In small, isolated primary care settings, resources are often limited [11]. In the United States, 26% of primary care practices are solo or two-person partnerships, where extensive collaborative models would be difficult to implement, and 22% are located in rural areas with limited access to mental health specialists [12]. Case management is an essential, patient-centered element of collaborative care that is effective in
improving symptoms and adherence to medication in primary care patients [7,8,13]. It has been defined as “taking responsibility for following up patients, determining whether patients were continuing the prescribed treatment as intended, assessing whether depressive symptoms were improving, and taking action when patients were not adhering to guideline-based treatment or when they were not showing expected improvement” [14]. It may also support patients’ self-management—activities, facilitate behavioral changes and empower patients to undertake pleasant activities [15].

Case management involves the whole practice team in a collaborative approach and emphasizes proactive support for the patient [16]. Various health professionals are able to provide depression case management [4], such as practice nurses [17,18] or less well qualified staff such as health care assistants [19]. In Europe, health care assistants are well established in various primary care systems. In the United Kingdom, for instance, about 50% of family practices employ health care assistants [20], who increasingly deliver basic medical tasks traditionally performed by practice nurses [21]. In Germany, health care assistants are also well established in family practices, and mainly responsible for administrative tasks and simple medical procedures, such as measuring blood pressure [22]. They receive less training (they are not college graduates) than U.S. physician assistants or nurse practitioners, who provide first-contact care [21]. Health care assistants are a potentially important resource for enhancing patient care in primary care settings [21].

In general, patients living with depression miss the feeling of being listened to by their GPs [23]. Qualitative research has shown that regular monitoring of patients’ symptoms is regarded as helpful by patients living with depression as it provides feedback on their current situation [24]. However, listening alone is not perceived as being sufficient [25]. Being monitored by telephone has been shown to be appreciated by patients as it provides some control over the situation. Patients living with depression value adequate information and counselling by their GPs, while receiving a prescription of anti-depressive medication is viewed as less important [26]. Patients are able to trust and rely on case managers, who are seen as people they can speak to, who assist them in understanding the meaning of mental illness, who motivate and encourage them and who help them to believe in themselves [27]. However, comprehensive knowledge of what exactly patients living with depression experience in a case management program is still lacking.

The aim was to explore the patients’ perceptions of practice-based depression case management, their satisfaction with it and how living with depression contextualizes case management.

2. Methods

2.1. The trial

This qualitative study was nested in a large cluster-randomized controlled trial conducted between 2005 and 2007 on the effectiveness of case management provided by practice-based health care assistants for patients living with major depression in primary care [28]. We used written consent procedures. The institutional review board of Goethe University Frankfurt/Main approved the study protocol on 25 April, 2005 [29].

2.2. The intervention in the main trial

The intervention consisted of 1-year of case management designed in accordance with the Chronic Care Model [30]. One health care assistant from each practice assigned to the intervention group received interactive training including information on depression, communication skills, and behavioral activation for the patient [28]. The health care assistants contacted patients by telephone twice a week in the first month and then once a month for the following 11 months. They monitored depression symptoms and adherence to medication by using a depression monitoring checklist, which includes structured questions on depression symptoms [31]. The assistants were extensively trained to monitor symptoms and to report their findings to the family doctor in a structured way. The “traffic light” scheme facilitates the easy categorization and visualization of how urgently the results need to be reported to the family doctor. For instance, if the patient reported suicidal ideation (red box ticked), the call was immediately redirected to the doctor in charge. Health care assistants also encouraged patients to pursue self-management activities, such as medication adherence and participation in pleasant or social activities (behavioral activation). This intervention was in addition to the regular treatment provided by the family doctor. In case treatment changes were necessary, the family doctor provided this information to the health care assistant.

On average, patients were contacted 14 times over 1 year, and the mean length of each telephone contact was 12 min.

2.3. Participants

In the main trial, we enrolled 626 patients from 74 small general practices in central Germany. Inclusion criteria were confirmed diagnosis of major depression with an indication for antidepressive treatment (at baseline), aged 18–80 years, and access to a private telephone. Exclusion criteria were confirmed pregnancy, severe alcohol or illicit drug consumption, or acute suicidal ideation, as assessed by the GP.

To prevent the qualitative interviews from being experienced as part of the intervention, the participants in this qualitative study were recruited and interviewed at the end of the intervention phase of the main trial, i.e. 12 months after baseline assessment. Patients from the intervention group were contacted by the general practice team and invited to take part in the additional qualitative interviews. Practice members were explicitly asked to address patients who may have benefited from the intervention as well as those who may not have.

2.4. Interview procedure

The interviews were conducted by telephone by a trained interviewer (DS) using a semi-standardized interview guide. The interview guide was developed on the basis of the Chronic Care Model [16] and an extensive literature research. The guide contained questions on how patients perceived their disease and usual care, the case management they had received in the previous 12 months, and the interaction with the family doctor and the health care assistant. After a pilot test with 4 patients (data not shown), we made minor revisions to the interview guide (Table 1). The interviews were audio-taped, and verbatim transcripts were written.

2.5. Analysis

We carried out computer-assisted content analysis in accordance with Mayring [32] using Atlas.ti version 5.2 software. The methodological approach proposed by Mayring is shown in Fig. 1. Compared to other qualitative analysis methods, content analysis is most similar to the thematic framework approach [33], as it also develops a matrix of themes, concepts and emergent categories. First we used tentative overarching concepts to code the data on the patients’ perspectives regarding: (1) their illness, (2) the case management they had received and (3) the interaction
with the family doctor and the health care assistant. Following the inductive approach of Mayring, this preliminary classification was used for the stepwise creation of new codes and emerging themes. As requested a total of 10% of the data was used to refine and revise the preliminary categories [34]. The resulting categories and typical patient statements were approved by the research team (GPs, psychologists, health care assistant, PhD students). In case of differing opinions, mutual consensus was sought. After a final consensus on all categories was achieved, JC, CG and NS completed the analysis on all the data. Content analysis looks for typical as well as atypical statements. We have included quotes indicating both the benefits and limitations of depression case management. We are reporting our results in line with the standards for reporting qualitative research [35].

3. Results

3.1. Participants

The basic socio-demographic characteristics of the 41 patients enrolled in this study (Table 2) did not differ from the sample in the main trial [28]. The high percentage of women (78%) is consistent with epidemiological findings, which indicate that about twice as many women as men are diagnosed with depression [36].

3.2. Emergent themes

The main themes that arose from the interview analyses are presented in the following sections. When exploring experiences with case management it became clear that these were not only influenced by current depressive symptoms, but also by prior experiences with depression care. We will therefore report on the main themes: (1) patients’ experiences of living with depression: helplessness, barriers to seeking help, isolation and chronicity, which contextualize case management; (2) patients’ experiences with depression case management: receiving active support, increasing awareness, and having confidence in the relationship; and (3) patients’ perspectives on the limitations of case management.

3.2.1. Patients’ experiences of living with depression, which contextualize case management: helplessness, barriers to seeking help, isolation and chronicity

The experience of living with depression was characterized by a sense of helplessness and other more specific problems that were also tackled by case management. One patient gave a telling summary as follows:

“[…] but there are things you just have to live with and that you can live with, once you’ve worked on it for a bit and cleared up a few things for yourself. But that’s the problem with this stuff. It’s really difficult to break out of your bad habit because you don’t talk about it, and anyway who can you talk to. Who’s going to understand you and if you need help, where are you going to get it?” (Pat.1)

Another salient theme was guilt which intermingles with helplessness and thus leads to a reluctance to seek help. Patients blamed themselves for not being able to break out of the depressive circle. They reported that both lack of energy and the feeling that nobody could help defined the attitude towards their (in-)activity. However, patients also talked about accepting the disease and how this enabled them to fight their depressive symptoms. Another recurrent theme was isolation which certainly adds to the feeling of guilt and to the reluctance to seek help. Case management on the other hand helped to overcome inactivity and helplessness according to the account of the patients.

Most patients assumed that in the long run their depression could not be cured at all, and there was always the risk of recurrence, despite the possibility of controlling some of the symptoms.

### Table 2

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>(n=41)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women, n (%)</strong></td>
<td>32 (78.0)</td>
</tr>
<tr>
<td><strong>Mean age in years (SD)</strong></td>
<td>55.2 (12.6)</td>
</tr>
<tr>
<td><strong>Education, n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>9 (22)</td>
</tr>
<tr>
<td>&lt;College</td>
<td>32 (78)</td>
</tr>
<tr>
<td><strong>Employed, n (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15 (36)</td>
</tr>
<tr>
<td>No</td>
<td>26 (64)</td>
</tr>
<tr>
<td><strong>Depression severity at baseline</strong></td>
<td></td>
</tr>
<tr>
<td>Mean PHQ-9 (SD)</td>
<td>16.5 (3.7)</td>
</tr>
<tr>
<td>Depression severity at the end of study</td>
<td></td>
</tr>
<tr>
<td>Mean PHQ-9 (SD)</td>
<td>10.1 (5.4)</td>
</tr>
</tbody>
</table>
3.2.2. Patients’ experiences with depression case management: receiving active support, increasing awareness, and having confidence in the relationship

Patients appreciated the regular contact with the practice most, and felt in particular that being contacted rather than having to get in contact with the GP by themselves helped overcome the barriers they described when talking about living with depression:

“It may well have provided me with stability at a difficult time because it ensured regular contact and because it meant to some extent dealing with my mood.” (Pat. 31) and “On the other hand, if you’re incapable of even moving, then you’re probably not going to manage to make your way there. Then it’s definitely a good thing if someone gives you a call. In my situation, I felt. I was feeling really lonely and didn’t want to live any longer and then it was good that someone called.” (Pat. 38)

Besides actively approaching patients living with a depressive illness, it was part of the intervention that case managers ask patients about their current state every month (using the depression monitoring checklist) and set small targets for the next 4 weeks. Patients explained that it particularly helped them to get feedback on their current state regularly, as it increased their “awareness” (Pat. 19).

Awareness was also increased through target-setting, and target setting even helped to fight depressive symptoms by bringing about positive emotions like pride:

“Err, I would say I have. I have had to face the problems more directly. It was possible to find out where, more or less, the problems lie and how to do something about them. Things were put into words and the problem was identified.” (Pat. 35) and “Setting these targets, yes. In autumn, I actually managed to go for a regular walk, alone to start with, then with a friend. I even did it two or three times a week and was pretty proud of myself.” (Pat. 12)

Patients perceived case management as supportive, and felt that someone “accompanied” them during the disease and took them seriously:

“[…] simply feeling someone else is there: Not being completely alone and before things start to get worse, to be asked. ‘How are you at the moment and do you need anything?’ It’s possible that something might actually happen again, something that makes me glad to have support. […]to have regular company, that makes you feel differently than if you had to rely on your own motivation to stay in contact and keep things under control a bit.” (Pat. 26) and “[…] I felt I was being taken seriously, that someone was there that really went to the trouble of working on the problem […] I had the feeling that a bit more attention was being paid to the subject. And that the situation wasn’t just being seen as ‘oh well, if she could just think a bit differently, everything would be ok’. What you’re always being told, namely to stop making such a fuss”. (Pat. 4)

Clearly it was important for patients that the person who provides this kind of support (i.e. the case manager) was “on a par with them” (Pat. 41) and that she could be trusted:

“Yes, because I really … Well, I’ve been going to the practice for a good 15 years now, and over the years, particularly in my, in the practice, I have developed a trusting relationship with the health care assistant, and there are really moments, I reckon, when you confide a bit more in people or … what does different mean?” (Pat. 18)

Patients started to talk about “the communication barriers” which “became fewer and fewer” (Pat. 27) throughout the study, both towards the GP and the health care assistant. But not only did communication improve as a result of a more trusting relationship, trust was also mentioned as a necessary prerequisite:

“I don’t know what it’s usually like with health care assistants, but this one’s really discreet and you can trust her. When that’s the case then for me it’s, for me the title is not important”. (Pat. 40)

3.2.3. Patients’ perspectives on the limitations of case management

Not all patients were satisfied with the case management approach, and some perceived the procedure as rather “mechanical”, and lacking in empathy. It became obvious that not only the regular contact is crucial but also the perceived quality of the contact. The following three citations all refer to a slightly different aspect of this quality. One refers to the standardized approach, one to the absence of any personal contact (as it was mostly regular phone calls) and one describes the brevity that is a result of the standardization.

“No, the phone call, it was so, it all went so mechanically. The woman answers, finished, all over. That’s why I wasn’t so keen on it.” (Pat. 17)

“I would have liked to have spoken to a doctor and had the chance to have a longer conversation for a change, a more intensive talk. Yes, you have to be a bit more responsive to people, not just write something down. How are you today? How are you going to be tomorrow? How were you yesterday? etc. etc. You really have to give people a bit more time and attention. […] you were able to discuss the pros and cons, or, or, or, well I really missed that. What was on the sheet of paper was read out, yes, no, yes, no”. (Pat. 15)

4. Discussion and conclusion

4.1. Discussion

This qualitative study sheds light on the perception of practice-based depression case management of patients living with depression in Germany. While most of the evidence on collaborative depression care stems from managed care settings in the United States [7–10], this study adds value by exploring the benefits of case management in settings outside of America.

4.1.1. Living with depression: helplessness, barriers to seeking help, isolation, chronicity as context for depression case management

According to the patients’ accounts, depression is associated with feelings of loneliness and with a reluctance to burden others with problems. Previous research shows that this even extends to feeling guilty at taking up the general practitioner’s limited time [37]. It is a challenge for patients to talk to the family doctor about their depression symptoms. Patients may hesitate due to feelings of guilt and shame [38], which are recurring burdens in depression [39]. Patients living with depression appreciated case management as offering help in this situation of reluctance and inactivity. This supports previous research that identifies information and counselling as unmet needs of patients living with depression in primary care [26]. According to the patients’ accounts, case management represents timely support, in contrast to their prior experiences of long periods without adequate help. Patients living with depression are often known to suffer from long-time chronic depression and inadequate support [40].

All this clearly is the context of the broad implementation of case management in general practices in which, independently of
the case management approach, patients are seen on a regular basis.

4.1.2. What case management can add according to the patients’ experiences

Patients appreciated case management as a tool which relieved them from actively seeking help, whereby the health care assistant was seen as accompanying them during the course of the disease. Patients felt they were being taken care of and were grateful that their symptoms were taken seriously and mattered to the health care team. Patients explained that in the end both aspects may have increased their awareness and have led to a better control of the disease. Patients may value the heightened sense of control over and above other therapeutic content such as medication [26]. However, although patients felt that some active fighting against the disease was helpful, they understood depression to be a disease that never disappears.

In communication with the health care assistant, a feeling of trust was important to patients. Either they recognized that trust was enhanced during the year the study lasted, or they felt that trust was a precondition for case management. Enhanced trust probably helps make relationships to the practice team more stable. The aspect of “trust” also played a role in the perceived limitation of case management, with some patients describing the process as being too mechanical, lacking empathy, and robbing them of the chance to talk to the doctor in more depth. A study by Richards and colleagues on patients’ perceptions of collaborative depression care yields similar findings, with patients criticizing telephone contacts as being too anonymous [41].

Overall, our results show two things: Patients living with depression appreciate being contacted and being supported. But the way case management is provided should be “non-mechanical” and individualized. This implies that the case management approach requires the case manager be appropriately trained, including on how to psychologically deal with their own fear of how to act towards patients presenting depressive symptoms, and on how to logistically incorporate the extra task in a full work day [42].

This qualitative study supports findings which indicate that patients recognize depression case management as helpful [27], but also demonstrates that it is able to overcome the barriers to communication that are associated with depression. Case management provides an essential basis for communication, which contrasts with an often perceived lack of time and effort on the part of the medical profession [43].

Finally, this study supports “trust IN the provider” as an important factor in case management in primary care, both as a pre-condition for and as a result of regular monitoring by the health care assistant.

4.1.3. Limitations

We acknowledge that a potential patient selection bias may have resulted from the selection of patients for this qualitative study by the practices. As in other cluster-randomized studies [44], it was important that patients were approached by the practice which recruited them in first place.

However, we tried to ensure that enrolled patients were not only those who were likely to speak overenthusiastically about case management. Interviewees may have adapted their reports to increase their social desirability, but it has to be noted that we also looked at negative accounts (which were present).

Since patients did not comment explicitly on developments in the doctor–patient-relationship, we were not able to address this point as originally intended. In our opinion, patients may feel uncomfortable assessing the quality of their relationship to their doctor due to the often close and trusting nature of such doctor–patient-relationships [45].

We ensured investigator triangulation [46] by discussing and re-discussing categories in the interdisciplinary team of psychologists, medical doctors and students involved in the study. Although content analysis is established in primary care research [47–49] and we developed categories for analysis as an interdisciplinary team, it is, of course, possible that we have failed to notice important angles. Our aim was to analyze the perceptions of case management with regard to their context, subjective benefits and limitations.

4.2. Conclusion

This qualitative study explored the perspectives on case management of patients living with depression in general practice. Case management was perceived to be beneficial because it supports the patient and facilitates access to continuous care. A trusting relationship with the health care assistant was either seen as an essential pre-condition, or as something which developed over time as a consequence of receiving case management on a regular basis.

4.3. Practice implications

Family practice-based case management appears to be beneficial for patients living with depression, as it increases their awareness of the disease and facilitates support in a vulnerable real-life situation. However, since a trusting relationship to the health care assistant is crucial, the practice team should ensure that depression case management is patient-centered and not implemented mechanically.

We confirm that all patient/personal identifiers have been removed or disguised so the patients/people described are not identifiable and cannot be identified through the details of the story.

Contributions

J. Gensichen, C. Guethlin, C. Jäger, D. Sivakumaran, N. Sarmand, and F.M. Gerlach contributed to the conception and design. J. Gensichen, C. Jäger, D. Sivakumaran, and K. Mengenthal contributed to the data collection. J. Gensichen, J.J. Petersen, N. Sarmand, C. Guethlin, C. Jäger, F.M. Gerlach analysis and interpretation. J. Gensichen, C. Guethlin, J.J. Petersen, N. Sarmand provided drafting of the article. All authors contributed to the critical revision of the article for important intellectual content and final approval of the article. J. Gensichen and F.M. Gerlach obtained a funding source.

Conflict of interest

We declare that we have no conflict of interest.

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