Depression in general practice

Consultation duration and problem solving therapy

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Background
General practitioners have expressed concern that consultations offering psychological therapy approaches will take up too much time. However, problem solving therapy (PST) for depression may be able to be used within the time constraints of general practice. This study investigates whether GPs' concerns that PST would result in unacceptably long consultations are justified.

Method
General practitioners were observed providing PST in simulated consultations before and after PST training – PST skill and duration of consultations were measured.

Results
Twenty-four GPs participated. Problem solving therapy skill increased markedly, but mean consultation duration changed minimally: 17.3 minutes and 17.9 minutes.

Discussion
This research suggests that GPs can provide an evidence supported psychological treatment for depression within the time constraints of routine practice. The structured nature of PST may allow GPs to provide additional mental healthcare for depression, without significantly increasing consultation duration. It suggests GPs' concerns about the time PST may take up in practice may be unjustified and that further research into the use of PST in routine general practice should be undertaken.

Keywords: general practice; depression; problem solving; consultation; time factors

Each year 700 000 Australians experience depression.[1] Most patients who seek professional help for depression visit a general practitioner, with more Australians receiving clinical care from a GP than all other health professionals combined.[2] It is estimated that GPs in Australia deliver more than 3 500 000 services for depression each year.[3] General practice consultations for psychological problems have been reported to take longer than consultations that address nonpsychological issues.[4,5] Many GPs report concern that time is a limiting factor in their capacity to address psychological issues, including depression.[4,6] A range of solutions to address this difficulty, including opting to adjust consultation duration to respond to psychological needs by 'running over time' have been reported.[7]

General practitioners provide antidepressant medication and a range of nonpharmacological treatments for mental health presentations. Psychological treatments for depression are favourably regarded by patients, with many expressing a strong preference for such treatments rather than antidepressant medication.[8] Although a number of evidence based psychological treatments for depression are available to GPs, including cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and problem solving therapy (PST), when GPs provide nonpharmacological treatments for depression, the approaches they use are often not evidence based.[9]

Problem solving therapy, sometimes known as 'structured problem solving', is a structured psychological treatment for depression that involves a series of sequential stages (*Table 1*).

Table 1. Stages of problem solving therapy

- Define the problem/s
- Set specific, achievable goal/s
- Brainstorm possible solutions – pros and cons
- Decide on a solution
- Implement the solution
- Review progress

General practitioners may use elements of PST in consultations, without using the structured approach of PST.[6] The GP facilitates the patient to clarify the symptoms that are causing life problems, to set goals and to identify and implement solutions.[10] Problem solving therapy requires less training than CBT or IPT and is suitable for use by GPs.[11] It has been described as 'the most accessible form of psychological intervention for primary care practitioners'.[12]

A number of barriers that may limit GPs' use of PST for depression have been identified, including that providing PST in routine general practice would result in unacceptably long consultations.[6] Time concerns about PST are similar to GPs' concerns about managing psychological issues in general.

This article investigates whether GPs' concerns that PST would result in unacceptably long consultations are justified.

Method

Participants in this study were GPs recruited as volunteers through an information flyer circulated by four Victorian divisions of general practice.

Data was collected from GPs who received 5 hours of small group interactive workshop training in the use of PST for depression, conducted by an experienced GP (one of the authors).[13] These GPs were then asked to

Table 2. Clinical scenario used in simulated consultations

- Woman, 52 years of age, long standing patient at practice
- PH: hypothyroidism (on thyroxine, recent TSH normal). No previous depressive illness
- For some months has been tired, depressed mood, anhedonia, frequently tearful, poor sleep
- K10 score 35. Self harm risk assessed as low
- Following discussion about treatment options declines antidepressant medication. Decides to try PST with you as her usual GP

undertake a simulated consultation with a patient (actor), playing the role of an adult experiencing mild/moderate depression. The patient presentation and depression severity was typical of routine general practice, as indicated in *Table 2*.

The simulated consultations were directly observed by a researcher who recorded consultation duration and GPs' PST skill using a previously established tool – the Problem Solving Treatment Adherence and Competence (PST-PAC) scale.[14] The PST-PAC scale provides a combined score from each PST stage, as well as a rating for communication and process skills and a global PST skill rating: a score of ≥27 is regarded as satisfactory.[14] General practitioners were asked to provide PST as they would during a consultation in their own practice. They were not given time constraints. Each GP undertook two observed consultations 6 weeks apart, one at the beginning, and the other at the end of a total of 5 hours of PST training. Between these formal training sessions the GPs were encouraged to provide PST for depression to their own patients during routine clinical sessions.

Data did not justify parametric analysis. Wilcoxon Signed Rank test was used for matched pair data, Spearman rho test for continuous variables, and Mann-Whitney U test for a categorical and a continuous variable. SPSS Version 18 was used; statistical significance was set at 0.05.

Ethics approval was granted from The University of Melbourne.

Results

Twenty-four GPs (10 males and 14 females) participated in the study. Their mean age was 49 years (SD: 9). Most (20/24, 83%) had practised as a GP for more than 10 years. None had undertaken specific PST training previously. A number were aware of the principles of PST, especially those (9/24, 37%) who had undertaken previous mental health training and were accredited by the General Practice Mental Health Standards Collaboration to deliver Medicare funded focused psychological strategies.

Most PST consultations were less than 20 minutes in duration (35/48, 73%). The variation in consultation duration is indicated in *Table 3*.

The mean consultation time for GPs during their first and second PST consultations was 17.3 (SD: 3.5) and 17.9 (SD: 3.1) minutes respectively. However, more change occurred than is suggested by mean consultation times. Nine GPs took longer in their first simulated consultation than in their second consultation and 12 GPs took longer in the second consultation. Only four GPs changed their consultation duration by more than 5 minutes.

Most GPs' PST skill measured by the PST-PAC scale (Cronbach alpha 0.75) increased markedly between the first and second consultation with an effect size of 0.60 (*Table 4*). However, a significant association was not found between consultation duration and PST skill or between consultation duration and existing mental health skill as measured by eligibility to provide Medicare funded focused psychological strategies.

Discussion

Most GPs, when providing PST to a simulated patient experiencing depression, completed the consultation within 20 minutes. Even though half of the GPs spent more time in their second consultation (after training) than their first consultation, for most this difference was small. The 17.6 minute (SD: 3.3) PST mean consultation time reported in this study compares favourably with recent Australian data,[15] which reported a 15.1 minute mean GP consultation time for all consultations. Considering that this study focused on addressing psychological problems, the addition of just over 2 minutes to the average consultation length is likely to be acceptable to GPs. The limited change recorded in consultation duration between first and second consultations occurred despite significant improvement in PST skill for most GPs, suggesting that experienced GPs may be able to incorporate effective psychological therapy, in the form of PST, into their routine consultation pattern. The absence of correlation between consultation duration and either existing level of mental health skill or measured level of PST skill, may suggest

Table 3. Number of GP consultations with depressed simulated patient in time categories

Consultation time (minutes)	First consultation n (%)	Second consultation (6 weeks later) n (%)
12–15	10 (42)	5 (21)
16–19	8 (33)	12 (50)
20–23	5 (21)	6 (25)
24–27	1 (4)	1 (4)
Total	24	24

Table 4. Problem solving therapy skill demonstrated during consultations with depressed simulated patient

	First consultation	Second consultation (6 weeks later)
PST-PAC score	26.2 (SD 3.4)	31.1 (SD 3.8) (p=0.002)

that consultation duration is independent of developing and applying new PST skills and is related to other factors, such as established clinical practice patterns. General practitioners' concern that providing PST in clinical practice would result in unacceptably long consultations appears unfounded.

Using PST in mental health management may add greater structure to the consultation. This in turn may have a positive impact on consultation duration.[6] In this study, GPs in the second consultation may have been providing additional mental healthcare (as a result of greater PST skill) in the same consultation time – the potential extra time required to provide mental healthcare may have been balanced by the positive time impact of a more structured consultation associated with PST. This suggests that GPs may be using their consultation time more efficiently. In addition, with a mean PST consultation time of only 2.5 minutes longer than the average Australian GP consultation, this study suggests that PST may be a viable psychological treatment approach in routine practice and should reassure GPs who are concerned that using PST will lead to prolonged consultations.

This study has strengths as well as some limitations. A strength is that consultation duration was measured using a standardised simulated patient encounter, limiting the natural variation in real patient presentation and consultation duration, ie. patient rather than doctor derived.

However, the study is limited by its small sample size. In addition, participants were GP volunteers recruited through divisions of general practice and therefore may have been more positive about the management of mental health issues in general practice than the wider GP population. The consultations in this study were simulated, aiming to replicate real world conditions. However, replication of these findings in routine general practice cannot be assumed.

Conclusion

The finding that fewer than one in five GP consultations providing PST exceeded 20 minutes should allay the concern of GPs that providing PST in routine general practice will take too long. It supports further investigation of PST as a routine treatment option for depression in general practice.

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