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Research Article

Levels of Shared Decision Making During Antidepressant Treatment – Pilot Findings from an Australian Qualitative Patient Feedback Survey

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Abstract

Objective: To investigate rates of shared decision-making experienced by patients treated for major depression in Australia, examining impacts of side effect profiles, efficacy profiles, and cost on agent selection.

Methods: An anonymized online structured survey was administered to patients self-reporting being diagnosed with major depression during the two-year period prior to survey.

Results: 13% of the 207 patients surveyed felt they played an active role in treatment selection. Some 40% of patients reported that their doctor had not discussed treatment options with them, and that their doctor had selected their treatment without the patient feeling they had an active role.

Conclusions: This qualitative retrospective patient survey suggests the majority of patients in the study sample did not feel they were actively involved in making decisions about their antidepressant medication. This finding suggests low levels of shared decision making.

ABBREVIATIONS

MD: Major Depression; SSRIS: Selective Serotonin Re-Uptake Inhibitors; SNRIS: Selective Serotonin Noradrenaline Re-Uptake Inhibitors

INTRODUCTION

International guidelines encourage shared decision making by doctor and patient during antidepressant prescribing to enhance compliance and engagement [1]. Such has also been referred to as 'patient centered care' in the literature, to highlight the need to better balance clinical decision making between doctor and patient [2]. But shared decision-making is perhaps a preferable term given its focus on an alliance between doctor and patient. The basic premise is that better shared decision making will enhance patient engagement, compliance, and overall treatment outcomes. Yet empirical data on patient experience of shared decision making is lacking.

Major Depression (MD) is projected to be the lead cause of disability globally by 203 [3]. Both the social and economic costs are large, estimated to cost 210 billion per year in the United States alone [4]. With this growing burden of disease, better outcomes in the management of MD are a public health priority. For more severe cases of MD, and cases refractory to lifestyle and psychological counselling approaches, antidepressant medication remains a cornerstone of treatment [1].

Unfortunately remission rates with antidepressants are low – only around 40% of patients remit [5]. When intention to treat analysis is included – to capture those who drop out of treatment– efficacy rates are even lower. While improved efficacy of antidepressants in compliant patients remains an issue, enhancing effectiveness through better compliance is also a key factor to overall outcomes [5]. While much research has focused on improved antidepressant efficacy, ways to improve real world engagement, compliance, and effectiveness of treatment has been relatively under researched.

Several factors have been investigated in regard to differential patient compliance. Beyond side effects and tolerability profile, cost, stigma, and patient engagement through shared decision making also appear to be factors influencing compliance and treatment effectiveness. Shared decision making appears to improve compliance and outcomes, but to date relatively little research has been conducted [6].

A study was conducted to investigate the rate of shared decision-making subjectively experienced by patients treated for MD in Australia. Impacts of treatment side effects, costs, and patient satisfaction with care were assayed as secondary outcome measures.

METHODS

A quantitative market research study was undertaken in September 2014.The market research was conducted by a health care research company, Metis Healthcare. The study was not approved by a human ethics committee. Patients self-reporting being diagnosed with depression by a general practitioner (GP) or psychiatrist in the previous two years were identified from an Australian consumer research panel which sourced patients in a variety of ways including online recruitment, referrals and offline sources. The patient recruitment process was managed by the market research company. Patients were invited to complete an on-line survey about their experiences of treatment. Concession cardholders (patients who receive medicines at a government subsidised rate) were excluded from the research based on the assumption that non-government subsidised antidepressants are not a viable option for patients to be offered. Exclusion of concession cardholders also enabled cost of medication to patient to be an operant factor for analysis in the study.

Patients were asked to complete an online survey consisting of 29 questions; eleven questions focused on respondent demographics and eighteen questions covered treatment history, patient treatment preferences and involvement in treatment decision making. The questions were developed by the research company in conjunction with Servier Australia Pty Ltd. A copy of the survey is included in the Supplementary Material. As part of the survey, respondents were provided with a table of three antidepressant types; selective serotonin re-uptake inhibitors (SSRIs), selective serotonin noradrenaline re-uptake inhibitors (SNRIs) and the melatonergic antidepressant agomelatine. Responses were anonymous. The frequency of responses was counted and means calculated. Study questions and information about the different medications were designed with input from a senior psychiatrist and in line with manufacturer prescribing information about the medication classes. Responses were anonymous and no patient identifiable data was collected.

RESULTS

Description of sample

A total of 207 patients participated in the study. Of these, 104 (50.2%) were currently taking an antidepressant whilst the remaining 103 (49.8%) were not currently taking an antidepressant. Of the respondents not currently taking an antidepressant, 62 (60.2%) had previously been taking an antidepressant whilst the remaining 41 (39.8%) had never taken an antidepressant. Patient demographics are provided in Table (1).

A total of 150 patients (72.5%) were seeking treatment for their depression at the time of the survey. Of these, most patients (n=97; 65%) consulted a GP, whilst a smaller number consulted a Psychologist (n=27; 18%) or a Psychiatrist (n=24; 16%). Fifty-seven respondents (27.5%) were not currently seeing any clinician.

SSRIs were the most commonly prescribed antidepressant, with 61 (59%) patients indicating they were either taking, or had taken an SSRI. SNRIs were the second most commonly prescribed agents, used at some point by 35 (34%) of patients. The rate of SSRI use was higher (n=49; 79%) in those patients who had previously been on an antidepressant but were not on treatment at the time of the survey. The antidepressants mirtazipine, amitriptyline, and agomelatine were prescribed less frequently among studied patients.

Treatment selection

Regarding treatment selection, only 13% of patients felt they

Table 1: Patient demographic features (N=207).

		n (%)
Age (years) (n=207) (Mean 44 years; SD: 12.15)	18-24	8 (4%)
	25-34	44 (21%)
	35-44	50 (24%)
	45-54	56 (27%)
	55-64	43 (21%)
	65 and over	6 (3%)
Gender (n=207)	Male	115 (56%)
	Female	92 (44%)
Geographic Location (n=207)	QLD	29 (14%)
	NSW	77 (37%)
	ACT	2 (1%)
	VIC	50 (24%)
	TAS	2 (1%)
	SA	19 (9%)
	WA	25 (12%)
Income (n=207) Pre-tax, yearly household income (Mean $95,000; SD: 50.89)	≤ $60,000	44 (21%)
	$60,001 - $100,000	75 (36%)
	$100,001 - $150,000	47 (23%)
	$150,001 - $200,000	10 (5%)
	> $200,000	12 (6%)
	Not disclosed	19 (9%)
Private health insurance (n=207)	Yes	139 (67%)
	No	68 (33%)
Non-PBS extras cover (n=139)	Yes	67 (48%)
	Unsure	72 (52%)
Year of depression diagnosis (n=207) (Mean 2005)	1990 or prior	13 (6%)
	1991-1995	12 (6%)
	1996-2000	26 (13%)
	2001-2005	41 (20%)
	2006-2010	52 (25%)
	Since 2010	63 (30%)
Year antidepressant treatment commenced (n=166) (Mean 2005)	1990 or prior	6 (3%)
	1991-1995	11 (7%)
	1996-2000	23 (14%)
	2001-2005	34 (20%)
	2006-2010	44 (27%)
	Since 2010	48 (29%)
Current principal treating clinician (n=207)	GP	134 (65%)
	Psychologist	37 (18%)
	Psychiatrist	32 (16%)

	Other[a]	3 (1%)
	Not currently seeing any doctor for the depression	57 (27.5)%
Current antidepressant (Patients currently on antidepressant treatment, n=104)	SSRI[b]	61 (59%)
	SNRI[c]	35 (34%)
	Other[d]	8 (7%)
Previous antidepressant (Patients not currently on antidepressant treatment, n=62)	SSRI[b]	49 (79%)
	SNRI[c]	6 (10%)
	Other[d]	7 (11%)

SD: Standard Deviation; SSRIs: selective serotonin re-uptake inhibitors; SNRIs: selective serotonin noradrenaline re-uptake inhibitors

[a] Includes two mentions of a neurologist and one mention of a rheumatologist.

[b] SSRI's included sertraline, paroxetine, fluoxetine, escitalopram, citalopram, fluvoxamine

[c] SNRIs listed included venlafaxine, duloxetine, desvenlafaxine

[d] Included mirtazipine, amitriptyline, agomelatine

played an active role in selecting a treatment that best suit them. Although an additional 47% of patients said their doctor had discussed the treatment options available with them, the treating doctor made the final decision for them according to surveyed patients. The remaining 40% of patients reported not being given any medication choice and were only told about the treatment that was prescribed for them.

Interestingly, 100% of patients that felt they played an active role in selecting their treatment were either 'extremely satisfied' or 'satisfied' with their treatment. This compares with only 72% of patients who were provided with treatment options but had their treatment selected for them.

When asked about their willingness to trial an SSRI, SNRI or melatonergic antidepressant, 67% of all respondents said they would prefer to trial the melatonergic antidepressant based on the side effect profile provided. Seventy three percent of previously untreated respondents also said they would be willing to try the melatonergic agent based on the side effect profile.

Once patients were notified that the melatonergic antidepressant was a private prescription, with out of pocket costs (A$22.10-$26.06 per month), 46% of all respondents stated they would still be willing to try it. Of these respondents, 32% stated they would be extremely likely to trial the melatonergic agent if their doctor offered it to them. Respondents reported lack of discontinuation symptoms, sexual dysfunction, mode of action and weight gain as well as the limited impact on blood pressure and cardiovascular health as key reasons for considering the melatonergic agent. The ability of the melatonergic agent to potentially improve sleep and help restore hedonic drive without affective blunting was also rated highly. Liver function testing and treatment cost were listed as negative attributes by 63% and 50% of respondents respectively. The other two classes of antidepressant (SSRIs and SNRIs) lacked these added cost issues, thus were not subjected to the same sub-analysis.

DISCUSSION

Shared decision making is an essential aspect of good psychiatric care. It is a consultative process between the clinician and patient about a patient's management. This can only occur by discussing the benefits and harms of treatment options, whilst also considering a patient's values, preferences and circumstances [7]. Shared decision-making is both part of informed consent and part of optimal patient engagement [6].

Despite several international initiatives to advance shared decision making, relatively little has occurred in Australia [6]. This is reinforced by the current study, with only 13% of patients feeling they played an active role in selecting their treatment. This is somewhat alarming given shared decision making is considered a hallmark of good clinical practice, advocated for in both clinical practice guidelines and health care policies [8-11]. Shared decision making may enhance patient engagement with care, compliance to medication, and overall medication effectiveness – the combination of efficacy and compliance rates [7,12-16]. The importance of a "patient centred approach" (including shared decision making) was emphasised repeatedly in the most recent report by the Federal Mental Health Commission in Australia [17].

A plethora of effective antidepressant treatment options exist for clinicians to choose from. The current study suggests that SSRIs and SNRIs continue to be the most commonly prescribed antidepressants in Australia, but the current study is of modest size. There has been less use of the melatonergic antidepressant agomelatine, possibly in part due to cost and limited shared decision making of its differential side effects profile to SSRIs and SNRIs (Supplementary Table).

Prescribers may consider price as an overarching determinant of a patient's willingness to trial non-subsidised medications – such as agomelatine. The current data suggest many patients are in fact willing to pay added out of pocket amounts if given the option of medications with preferable tolerability and symptom efficacy profile. Some 46% of patients indicated they would select agomelatine despite added cost – suggesting that perhaps clinician concerns about such are greater than that of patients. Of those surveyed, a third stated they would be extremely likely to trial it if their doctor offered it to them.

There were a number of important limitations with this study. Firstly, patients were selected from a panel that sourced patients in a variety of ways including online recruitment, referrals and offline sources. Additionally, concession cardholders were excluded from the research – limiting generalizability of findings, especially on ability to pay issues. This selection process may therefore have led to a bias in favor of willingness to trial agomelatine among higher socioeconomic groups. The rationale for excluding concession cardholders was based on an assumption that the price differential between a product subsidised by the Pharmaceutical Benefit Scheme (PBS) and a private item would be much greater for concession cardholders, and that this price differential would outweigh a product's attributes for the majority of these subjects with limited use of the melatonergic agent underpinning study power.

Secondly, patients were only provided with three medication class profiles: SSRIs as a class, SNRIs as a class and a melatonergic antidepressant (agomelatine), preventing intra-class comparisons.

Finally, inclusion in the study was based on self-report of a diagnosis of depression. No formal clinical or rating scale operationalised method to clarify diagnosis or severity for depression was employed given the design of the study. This is a further limitation of the current study.

CONCLUSION

In this cohort it appears rates of shared decision making in the treatment of depression in Australia are low. Patient treatment preferences vary between patients and do not seem limited to any one specific factor such as cost, but larger studies are need for robust conclusions on all relevant mediating factors. Shared decision-making should become a more routine practice to better ensure more optimal outcomes are achieved for patients with depression. Shared decision making and better patient centered care will likely enhance engagement, compliance, effectiveness of medications and overall outcomes.

CONFLICT OF INTEREST

Ajeet Singh has received speaking honoraria from Servier Australia Pty Ltd.

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REFERENCES

1. Malhi GS, Bassett D, Boyce P, Bryant R, Fitzgerald PB, Fritz K, et al. Royal Australian and New Zealand College of psychiatrists clinical practice guidelines for mood disorders. Aust N Z J Psychiatry. 2015; 49: 1087-1206.
2. Souliotis K. Patient participation: are we far from fulfilling the vision of patient-centred care? Health Expect. 2016; 19: 787-789
3. Murray CJ, Voss T, Lozano R, Naghavi M, Flaxman AD, Michaud C, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2012; 380: 2197-2223.
4. Greenberg PE, Fournier AA, Sisitsky T, Pike CT, Kessler RC. The economic burden of adults with major depressive disorder in the Unites States (2005 and 2010). J Clin Psychiatry 2015; 76: 155-162.
5. Pigott, HE, Leventhal AM, Alter GS, Boren JJ. Efficacy and effectiveness of antidepressants: current status of research. Psychother Psychosom. 2010; 79: 267-279.
6. Deegan PE, Drake RE. Shared decision making and medication management in the recovery process. Psychiatr Serv 2006; 57: 1636-1639.
7. Hoffmann TC, Légaré F, Simmons MB, McNamara K, McCaffery K, Trevena LJ, et al. Shared decision-making: what do clinicians need to know and why should they bother? Med J Aust. 2014; 7; 201: 35-39.
8. Elwyn G, Tilburt J, Montori VM. The ethical imperative for shared decision-making. Eur J Person Centered Healthcare 2013; 1: 129-131.
9. 111th United States Congress. Patient Protection and Affordable Care Act. Public Law. 2010;111-148.
10. Australian Commission on Safety and Quality in Health Care. Australian Safety and Quality Framework for Health Care. Sydney: ACSQHC, 2010.
11. NHS England. Shared decision-making.
12. Bauer AM, Parker MM, Schillinger D, Katon W, Adler N, Adams AS, et al. Associations between antidepressant adherence and shared decision-making, patient-provider trust, and communication among adults with diabetes: diabetes study of Northern California (DISTANCE). J Gen Intern Med. 2014; 29: 1139-1147.
13. Elwyn G, Dehlendorf C, Epstein RM, Marrin K, White J, Frosch DL. Shared decision-making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. Ann Fam Med. 2014; 12: 270-275.
14. Loh A, Simon D, Wills CE, Kriston L, Niebling W, Härter M. The effects of a shared decision-making intervention in primary care of depression: a cluster-randomized controlled trial. Patient Educ Couns. 2007; 67: 324-332.
15. Loh A, Leonhart R, Wills CE, Simon D, Härter M. The impact of patient participation on adherence and clinical outcome in primary care of depression. Patient Educ Couns. 2007; 65: 69-78.
16. Van Geffen EC, Hermsen JH, Heerdink ER, Egberts AC, Verbeek-Heida PM, van Hulten R. The decision to continue or discontinue treatment: experiences and beliefs of users of selective serotonin-reuptake inhibitors in the initial months-a qualitative study. Res Social Adm Pharm. 2011; 7: 134-150.
17. National Mental Health Commission: The National Review of Mental Health Programmes and Services. Sydney: NMHC. Published by: National Mental Health Commission, Sydney. 2014.

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