'Watchful waiting' or 'active monitoring' in depression management in primary care: exploring the recalled content of general practitioner consultations.

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Abstract

Background

Current NICE depression guidelines recommend a period of 'active monitoring' prior to commencing treatment with antidepressants.. The content of consultations during active monitoring or supportive care has not been previously prescribed.

Methods.

As part of a randomised trial of supportive care vs supportive care plus SSRI consultation content was measured through patient recall for the purpose of testing equity in content between trial arms. An exploratory analysis of the consultation content measure is presented together with a measure of consultation satisfaction (MISS) and depression severity (HMRD). A score for 'psychoactive consultation content' (PSAC) was generated to enable comparison between groups.

Results

220 patients were randomised in the study. The majority of participants recalled a discussion of practical problems they faced and many reported some element of problem solving; a significant minority reported discussions about changing the way they thought, addressing relationships or talking to trusted friends or family Consultation content was unrelated to depression outcome although in multivariate analysis it was strongly related to consultation satisfaction.

Limitations This is a secondary analysis based on patient recall of consultation content.

Conclusions

Supportive care is not a passive process as patients report several potentially therapeutic discussions within the consultation and these occur regardless of whether antidepressants are prescribed. It is not known whether these discussions do have any therapeutic value in this context. Consultation content was unrelated to outcome in this study but did predict satisfaction with the consultation. Further work is required to validate the patient report of consultation content and to identify what if any consultation strategies have therapeutic effect.

Depression
Consultation
Primary Care

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Background

Depressive disorders have a community point prevalence of about 9%(McManus et al. 2009) and are present in 19% of screened patients attending UK general practices although not all are recognised at initial presentation(Brody et al. 1995;Thompson et al. 2000) . Depression can have a profound impact on personal and family life and tends to increase use of health care resources(Simon et al. 1995). NICE guidelines (3); recommended "watchful waiting" "for patients presenting in primary care with mild or moderate depression. The revised guidance (4)stresses general advice and shared decision making and "active monitoring, but does not mention therapeutic approaches within primary care consultations; on the contrary, by advocating supervised manualised therapy it implies that GPs should not use or develop micro-therapeutic skills. Patients on the other hand value being listened to and being offered solutions (Gask et al. 2003;Johnston et al. 2007). An understanding of current practice is a prerequisite for more definitive advice to primary care practitioners.

There are few studies of the content of consultations during 'watchful waiting' or the use of psychological approaches by GPs in the treatment of common mental health problems. Patients have reported lack of time, difficulty expressing themselves and a failure of some and a failure of some GPs to respond to emotions(Gask, Rogers, Oliver, May, & Roland 2003;Johnston, Kumar, Kendall, Peveler, Gabbay, & Kendrick 2007) they also describe variability in information sharing, shared decision making and other evidence based components of care(Byng et al. 2007). Cape et al reviewed the active approaches used by GPs which include listening, empathetic understanding, problem solving and cognitive techniques(Cape et al. 2000) (BJGP, 2000). The measurement of consultation skills and quality in primary care has received more attention. The Medical Interview Satisfaction Scale (MISS) (Meakin and Weinman 2002) for example is a generic scale which asks patients to rate how much doctors provided information, developed rapport in the consultation, and also whether the consultation resulted in relief from distress and intention to follow advice. Mavaddat has developed a scale, based on what people with depression want from their doctors, which also includes generic issues such as time to listen(Mavaddat et al. 2009). Although a number of instruments have been developed to assess patients' perceptions of what occurred in consultations we could identify no questionnaires which aim to measure components of the consultation which might in themselves be therapeutic.

We report a secondary analysis from a randomised controlled trial comparing two approaches to the management of those with mild to moderate depression presenting in primary care. The comparison treatments were supportive care from the general practitioner alone compared to supportive care plus the offer of an SSRI (Selective Serotonin Reuptake Inhibitor). By quantifying the specific components that make up 'watchful waiting' or 'good clinical care' (Andrews 1993) we aimed to measure and compare the supportive care in both groups for the main trial(Kendrick et al. 2009) and for this sub-study to gain an insight into the nature of consultations in primary care for recently identified depression. ,.

Methods

A cross sectional questionnaire design was used to quantify active consultation care by GPs, and to test the following hypothesis:

- Those in the supportive care alone arm, and SSRI plus supportive care arm, would have similar consultation experiences

- Frequency of depression specific consultation components would correlate with consultation satisfaction recorded using the validated MISS.

Participants were recruited through an open randomised controlled trial, the THREAD study, designed to test the clinical and cost-effectiveness of selective serotonin reuptake inhibitors (SSRIs) plus supportive care, versus supportive care alone, for mild to moderate depression in primary care(Kendrick et al 2009). General practitioners (GPs) in practices in three centres (Southampton, Liverpool, and London) referred patients diagnosed with new episodes of mild to moderate depression. Inclusion criteria included age 18 and over, symptoms for at least eight weeks, no antidepressant treatment within 12 months, no current counselling or psychological therapies, baseline score 12 to 19 (inclusive) on the 17 item HDRS(Hamilton 1960),. Exclusion criteria expressed suicidal intent, reported significant substance misuse, and a score of 13 or more on the Alcohol Use Disorders Identification Test (AUDIT) questionnaire, (Saunders et al. 1993). Follow-up assessments were undertaken at 12 and 26 weeks. Practitioners were asked to provide supportive care to both groups and consultation content was left to the GP and patient to agree and was not defined further. The intervention group were randomised to the offer of a prescription for an SSRI in addition to supportive care.

The care provided by GPs during consultations was measured by counting the total numbers of consultations and using two measures of consultation content. The first was a bespoke measure designed to describe the potentially psycho-active components of the consultation, which might make up "watchful waiting" or supportive care. Questions were derived from the literature together with the combined expert opinion of the study group. (See Box 1 and Appendix 1 for full questionnaire. This scale is known as the PSAC: (Psycho-Socially Active Consultation) Score. The second measure was the Medical Interview Satisfaction Scale (MISS) a validated generic measure of consultation content and impact.(See Box 2 and Appendix 2). The two measures were both self-completed at the 12 week follow-up time point and hence represent an aggregate opinion on consultation content in the follow period from 0-12 weeks.

Outcomes were entered blind to trial arm into SPSS and transferred to STATA. Descriptive analyses were carried out across data from both arms combined. Comparisons between the two trial arms were carried out using students' t test.

Box 1 Content of the Psycho-Socially Active Consultation Questionnaire - PSAC

Ten questions rated:
No *Yes, a little* *Yes, a lot*

- Did your doctor(s) discuss practical problems which have been facing you?
- Did the doctor(s) discuss with you ways in which you could work to solve the problems facing you?
- Did the doctor(s) discuss whether you should do more physical exercise?
- Changing work patterns
- Changing thinking patterns
- Relaxation

- Finding more leisure time
- Starting enjoyable activities
- Considering relationships
- Talking with trusted family or friends

Box 2 Content of the Medical Interview and Satisfaction Scale

MISS
29 items, 7 point scale – agree strongly to disagree strongly
Four recognized subscales (with examples)
Communication
The doctor gave me a poor explanation of my illness
The doctor told me all I wanted to know about my illness
Rapport
The doctor seemed interested in me as a person
The doctor seemed warm and friendly to me
Distress relief
After talking with the doctor I feel much better about my problems
The doctor has relieved my worries about my illness
Compliance Intent
I intend to follow the doctor's instructions
I expect that it will be easy for me to follow the doctor's advice

Results

A total of 177 GPs recruited patients with new episodes of depression and 220 patients were randomised in the study. Full baseline characteristics have been reported(Kendrick et al 2009) .In summary the mean age was 40 years, 70% were female, 89% were white, 54% were in relationships and 67% were in work; and 186 (85%) patients were followed up at 12 weeks.

The numbers of consultations were similar in both groups with no statistical differences (supportive care alone (SC) mean 3.8 contacts (sd 2.0); supportive care plus SSRI (SC+SSRI) mean 4.1 (sd 2.2)). Antidepressants were prescribed to 97 patients (87%) in the SC+SSRI arm and 22 patients (20%) in the SC arm.

The majority of participants recalled a discussion of practical problems they faced and many reported some element of problem solving; a significant minority of the participants reported discussions about changing the way they thought, addressing relationships, talking to trusted friends or family. Other potential activities were recalled less frequently (Table 1).

Table 1. Frequency of Individual items on the PSAC scale.

Numbers recalling discussion of different issues			
N=186	**A lot (%)**	**A little (%)**	**Not discussed (%)**
Discussion of practical problems	99 (54)	63 (34)	22 (12)
Problem solving	76 (42)	76 (42)	29 (16)
Advice to change negative thinking	40 (22)	76 (42)	65 (36)
Advice to talk with trusted friends and family	31 (17)	84 (46)	66 (36)
Advice to address Relationships	32 (18)	60 (43)	89 (49)
Recommendation of physical exercise	29 (16)	73 (40)	79 (44)
Recommendation to restart activities	29 (16)	61 (34)	91 (50)
Discussion of leisure time activities	25 (14)	64 (35)	92 (51)
Discussion of changes at work	21 (12)	56 (31)	103 (57)
Advice on relaxation techniques	16 (9)	39 (21)	126 (70)

In order to allow examine relationship of the PSAC to other constructs a total score was calculated by allocating a score of two for 'a lot' , one for 'a little' and zero for 'not mentioned'. A maximum score of twenty was possible. Scores were well distributed with some slight skew towards to the left (Figure 1). Four consultation sets (2.2%) scored zero and thirty-two (17.7%) scored three or less. The mean score was eight. Fifty-nine (21.6%) scored more than 10.

Figure 1 Distribution of PSAC scores for both study arms combined

Consultation satisfaction (MISS) scores across the sample showed considerable variation. Total scores ranged from 75 to 203 with an approximately normal distribution (Figure 2) and a mean of 147.51 (sd 25.0). MISS subscale scores showed similar variation.

Comparison of consultation content between trial arms

Psycho-socially active consultation (PSAC) scores were similar between arms at 12 weeks: PSAC scores (mean (SD): supportive care (SC) 7.8 (4.5), supportive care plus selective serotonin reuptake inhibitor (SC+SSRI) 8.3 (4.4); p= 0.52 (t-test). Whereas MISS scores were greater for those randomised to SSRI arm: SC 143.5 (25) SC+SSRI 151.3 (25) p= 0.035 We looked for evidence of univariate association of various baseline and outcome measures with the two consultation measures regardless of intervention group (Table 2 and Table 3). In addition to the study intervention, higher consultation satisfaction (MISS) scores were associated with receipt of an SSRI in either arm and depression severity at 12 weeks, but not depression severity at baseline. The consultation content score however was unrelated to the intervention allocated, receipt of an SSRI or severity measures at baseline or 12 weeks.

Table 2 **Differences in PSAC for subgroups (t test)**

		n	Mean score	Difference (95% confidence interval)	p-value
Intervention SC or SC+SSRI	**SC** **SC+ SSRI**	**89** **92**	**7.82** **8.25**	**0.66 (-1.73, 0.88)**	**0.4790**
SSRI at all	**No SSRI** **SSRI**	**99** **82**	**7.54** **8.64**	**-1.10 (-2.40, 0.20)**	**0.1089**
Baseline HDRS	**>median** **<median**	**81** **100**	**8.07** **8.06**	**0.01 (-1.31, 1.32)**	**0.9930**
HDRS at 12 weeks	**>10** **<10**	**84** **97**	**8.33** **7.83**	**0.51 (-0.81, 1.81)**	**0.4474**
Age	**>40** **<40**	**93** **87**	**8.11** **8.10**	**0.01 (-1.29, 1.32)**	**0.9859**

SC Supportive Care
SSRI selective serotonin reuptake inhibitor
HDRS Hamiltlon Depression Rating Scale.

Table 3 Differences in MISS for subgroups (t test)

		n	Mean score	Difference (95% Confidence Interval)	p-value
Intervention SC or SC+SSRI	**SC** **SC+ SSRI**	**89** **92**	**143.5** **151.3**	**-7.8 (-15.1, -0.57)**	**0.035**
SSRI at all	**No SSRI** **SSRI**	**99** **82**	**143.1** **152.9**	**-9.8 (-17.0, -2.6)**	**0.008**
Baseline HDRS	**>median** **<median**	**81** **100**	**150.9** **144.8**	**6.1 (-1.2, 13.42)**	**0.1046**
HDRS at 12 weeks	**>10** **<10**	**84** **97**	**152.3** **143.3**	**8.9 (1.7, 16.2)**	**0.0159**
Age	**>40** **<40**	**93** **87**	**144.5** **151.0**	**-6.5 (-13.8, 0.85)**	**0.083**

A multivariate analysis was completed to examine the predictors of perceived consultation satisfaction (MISS) (Table 4). Factors included in the model were significant in the univarate analysis PSAC was added into the model as a potential predictor of patient satisfaction. In addition to the depression rating at 12 weeks and

age, the PSAC contributed to the model for the MISS score. There was no effect of the intervention group after controlling for the other predictors. The variables included were able to account for 36% of the variation in MISS scores.

Table 4 Predictors of (MISS) (linear regression model)

	Change in MISS score (regression beta)	p-value
PSAC	**3.01**	**<0.001**
HDRS at 12 weeks	**-0.72**	**0.012**
Age	0.25	0.025
SSRI ever	5.62	0.130
Intervention group	2.42	0.521

SSRI selective serotonin reuptake inhibitor
HDRS Hamiltlon Depression Rating Scale
PSAC PsychoSocial Activity Consultation

Discussion

In this study the majority of participants recalled at least one potentially psychoactive component of the consultation such as; discussion of practical problems, problem solving, addressing negative thinking patterns and recommending talking to trusted friends and family. This shows that patients perceive many GPs as making some active interventions rather than just providing 'watchful waiting' or simply listening to narratives. Components included cognitive work, problem solving and advice to change behaviours or confide in others. These activities could be said to constitute a form of 'micro-therapy', but at present are not supported by evidence of effectiveness in this context and are not recommended by NICE guidance. Those scoring higher on the PSAC were more likely to score high on the MISS providing some evidence both for the construct validity of the new measure and that active consultations are potentially beneficial (the MISS incorporates perceived generic measures of consultation quality of relevance to depression such as empathy).

Psychoactive consultation content (PSAC) scores did not differ between the two arms in the THREAD study (SSRI treatment and supportive care versus supportive care alone). There is no suggestion that the consultation content varied by allocated treatment arm or contributed to the positive trial finding. In contrast the generic measure of satisfaction with consultation quality the Medical Interview Satisfaction Scale (MISS), had higher scores in the SSRI plus supportive care arm in the trial, where it was treated as a secondary outcome measure (ie a measure reflecting recovery from depression). This analysis indicates that the higher MISS score in the intervention arm does not appear to be mediated by a change in the consultation content itself. Rather the MISS scores improved more in the intervention arm, either because perceived quality and satisfaction are increased by receipt of antidepressants, or indirectly as a result of reduced levels of depression. While the

MISS measures perceptions of content such as empathy and immediate impact such as distress relief and adherence, the PSAC was designed to measure specific consultation processes of relevance to primary mental health care.

There was no evidence that potentially psycho-active components of the consultation were associated with better or worse depression outcomes (HDRS); this may be because they occurred infrequently, and the study was therefore not powered to show any difference. There was a weak but significant negative correlation between HDRS and MISS. For each point increase in the HDRS at 12 weeks the MISS reduced by 0.72 points even when controlling for baseline HDRS.

Strengths and weaknesses

We measured patient recall of consultation content soon after the episode of care, but not immediately. The study used consultation components derived from the literature to develop a new scale to measure active care rather than "passive watchful waiting". The elements of the scale were chosen to reflect processes which may have an active element ie contribute to patient recovery. We did not however record consultation content at the time of consultation.

The practitioners participating in the study were asked to continue with usual care and received no additional training or guidance in the consultation content. Whilst patients recalled consultation elements which may have an active component this was not assessed in a formal way so recall of an activity such as 'solving problems' can not be taken to indicate that this was delivered in a structured way with therapeutic consequences.

The population was well characterised within the context of a randomised controlled trial. The patients came from a wide range of UK settings. This is the largest quantitative study of consultations for depression with family physicians.
Although there was no direct interference in the consultation, its content may have been changed by the constraints of the trial. The population consenting to take part in the study may not be representative of typical patients in primary care given that they had to agree to the trial measures, be in equipoise regarding the two intervention arms and satisfy the trial entry criteria(Kendrick et al 2009). Equally practitioners who recruited to the trial may take a greater interest in depression management and may take a more active role in the consultation.

We are unable to provide full validation of the PSAC scale as no direct measures of the consultation content were made and the measure relies on patient recall and self report after some days or weeks. The Medical Interview Satisfaction Scale is designed to be use of immediately following a consultation but was also administered at 12 weeks after randomisation, thus both scales will represent an aggregate impression of a number of earlier consultations rather than a single consultation.

Implications

This study indicates that patients do recall specific potentially psychoactive components of consultations for depression and that a higher score correlates with a validated generic measure of consultation quality. Many patients and GPs believe that the consultation is more than a mechanistic "detect and treat" process. This study takes a small step in identifying specific components which might make up good quality consultations beyond the more researched areas of recognition, prescribing and onward referral. Whilst the study does not provide definitive evidence for advising GPs to incorporate the components of the PSAC into clinical practice, it does indicate that the more commonly reported components are associated with

higher scores in a scale measuring perceived consultation quality (MISS). In turn the MISS is weakly associated with improved outcome regardless of intervention group. Previous work has indicated that empathic communication is associated with improved outcomes from mental health consultations and that more formal brief interventions delivered in primary care are effective(Burns and Nolen-Hoeksema 1992;Cape 2000;Cape et al. 2010). More research is required to unpick which, if any, of the potentially active components are perceived to be and actually are effective for improving outcomes. More research would also be required to further develop the PSAC, utilised in this study to demonstrate consultation equivalence between arms of a trial, into a validated PROM; or alternatively to combine it with other measures of important processes in primary care mental health consultations.

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