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# '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 versus 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.


## 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 GPs to respond to emotions (Gask et al., 2003; Johnston et al., 2007) they also describe variability in information sharing, shared decision making and other evidence based components of care (Byng

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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). 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 was 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). 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.

## 3. 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).

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 (Fig. 1). Four consultation sets (2.2%) scored zero and 32 (17.7%) scored

**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.