The quantity and quality of clinical practice guidelines for the management of depression in primary care in the UK

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SUMMARY

Background. *Despite research evidence that guidelines can improve patient care, concerns remain over their cost-effectiveness. This is particularly so when there is a proliferation of guidelines for the same condition. Faced with differing recommendations, users will wish to make informed decisions on which guideline to follow. In creating a guideline appraisal instrument we have assessed guidelines developed in the United Kingdom (UK) for the management of a range of disorders including depression in primary care.*

Aim. *To identify the number of UK clinical guidelines for the management of depression in primary care and to describe their quality and clinical content.*

Method. *A survey was undertaken to identify all depression guidelines developed in the UK between January 1991 and January 1996. All guidelines produced by national organizations and a random sample of local guidelines were appraised using a validated instrument by six assessors: a national expert in the disease area, a general practitioner, a public health physician, a hospital consultant, a nurse specializing in the disease area, and a researcher on guideline methodology. The clinical content of each guideline was then assessed by one of the researchers (RB) according to a defined framework.*

Results. *Forty-five depression guidelines were identified. While there was a considerable range in the quality of the six national and three local guidelines appraised, at a group level their performance was similar to guidelines for other diseases. Clinical recommendations tended to reflect the joint consensus statement produced by the Royal College of General Practitioners and Royal College of Psychiatrists in 1992. The most obvious difference was in the style in which the guidelines were written and presented.*

Conclusion. *A 'national template' was the starting place for most guidelines. Steps need to be taken to ensure that these templates are based on the best possible research evidence and professional opinion. Local clinicians should concentrate on effective dissemination and implementation strategies, rather than creating new guidelines.*

Keywords: depression; clinical guidelines; primary care.

Introduction

THE management of depression in primary care has been under considerable scrutiny in recent years. This has been the result of an increased recognition of the high levels (often undiagnosed)[1] of morbidity and mortality,[2] variation in the quality of care,[3] and the size of direct and indirect costs to the health service.[4] Initiatives responding to these concerns have come from the Department of Health (DoH)[5] as well as from professional organizations. In 1992, the Royal College of Psychiatrists and the Royal College of General Practitioners embarked on a joint 'Defeat Depression' programme.[6] As part of this campaign, two consensus conferences were convened to create guidelines for the diagnosis and management of depression.[7]

In 1993, the National Health Service (NHS) Centre for Dissemination and Reviews published an 'Effective Health Care Bulletin' on the treatment of depression in primary care.[8] This summarized the results of a systematic review of which treatments were effective in the management of depression in primary care. It concluded that there was a range of effective interventions but more research was required to provide evidence on the effectiveness of a variety of management strategies. Their main recommendation for 'decision makers' was that: 'Clinical guidelines for the detection and management of depression in primary care should be developed with the participation of a wide range of health service organizations, professions, voluntary groups, and consumers.' They went on to describe what they considered should be included in these guidelines, while acknowledging that guidelines would be influenced by the available services.

Clinical guidelines continue to generate controversy. Despite research evidence to suggest that if introduced by appropriate dissemination and implementation strategies they can lead to changes in practice and improved outcomes for patients,[9] concerns remain that these conditions will rarely be achievable in routine practice.[10] In order to increase the likelihood that clinical guidelines are cost-effective, we are undertaking a programme of research that includes developing a methodology to assess guideline quality. Our approach is based on the premise that guidelines need to be rigorously produced and also address the issues surrounding effective dissemination and implementation. This work is aimed at assisting guideline producers as well as those who potentially would be using the guidelines. In creating a guidelines critical appraisal instrument, we have assessed the quantity

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and quality of guidelines developed in the UK between January 1991 and January 1996 for the management of a range of disorders including depression in primary care.[11] This paper explores the clinical recommendations of the depression guidelines, and identifies the differences and their relevance to clinical practice.

Method

Assessing the quantity of guidelines

A national postal survey to identify guidelines was undertaken between March and June 1995. All individuals and organizations that might have produced guidelines were targeted. Electronic searches were also undertaken. A detailed description of the survey has been published elsewhere.[12]

Assessing the quality of the guidelines

All national guidelines and a random sample of local guidelines were selected for appraisal. Background information was obtained from the authors and each guideline was assessed by six appraisers who assessed three guidelines each. These included a national expert in the disease area, a general practitioner, a public health physician, a hospital consultant, a nurse who specialized in diseases, and a researcher on guideline methodology.

The critical appraisal instrument[11] contains 37 items divided into three dimensions. The first, 'rigour of development', reflects the attributes necessary to enhance guideline validity, reproducibility, and includes the multidisciplinary process and scheduled review. It contains 20 items and assesses the responsibility and endorsement of the guidelines, the composition of the development group, identification and interpretation of evidence, the link between evidence and main recommendation, and peer review and updating. The second, 'context and content', contains 12 items addressing the attributes of guideline reliability, applicability, flexibility, and clarity. It assesses the aims of the guidelines, the target population, circumstances for applying the recommendations, presentation and format of the guidelines, and estimated outcome–benefits–harms and costs. The third dimension, 'application', contains five items addressing the dissemination and monitoring strategies. All three dimensions assess the adequacy of documentation. Each guideline is given a standardized dimensional score ranging from 0 to 100. A score of a hundred means that all reviewers considered that a guideline had fulfilled all the criteria within that dimension. A full explanation of the method of creating the scores is provided elsewhere.[11]

Assessing the clinical content

The clinical content of the guidelines was then assessed by one of the researchers (RB) according to a defined framework. This included issues of diagnosis (incidence/prevalence, at-risk groups, interview style, diagnostic criteria, severity and assessment of risk) and management (drug treatment, psychological interventions, risks/benefits of treatment, monitoring, length of treatment, prognosis, prophylaxis, criteria for referral to specialist services). To allow meaningful clinical comparison, only those guidelines that explicitly addressed the management of depression in a general adult population were assessed; for example, guidelines referring to specific sub-groups such as the elderly or those restricted to drug prescribing were excluded.

Results

Quantity

The survey identified 45 guidelines concerned with the primary care management of depression. Initially, nine of these were attributed to national organizations; the remaining 36 were produced by a variety of local groups and organizations. There was at least one local guideline in every region in England and Wales, the maximum being eight in the North West Region. One guideline was identified in Scotland and none in Northern Ireland. When the nine national guidelines were retrieved, only six were guidelines specifically aimed at clinical management of patients and therefore included in the appraisal process. In addition, nine randomly chosen local guidelines were retrieved to make the total up to 15. This was the number of guidelines required to assess the validity and reliability of the critical appraisal instrument.[11] Only three of these fulfilled the entry criteria for the assessment of clinical content (see method). Therefore, in this paper, only the critical appraisal results of those guidelines that also had their content assessed is presented. These guidelines were:

- Berkshire guidelines for the recognition and management of depression in primary care, Berkshire Health Commission;
- Depression, sharing the load, Bolton FHSA;
- Depressive illness, a critical review of current practice and the way ahead, Consensus statement, Clinical resources and Audit Group, Scottish office;
- Management of depression in general practice, Eli Lily Clinical Audit Centre;
- New classification for mental disorders with management guidelines for use in primary care ICD 10 PHC chapter 5 [Discussion paper], *British Journal of General Practice*;
- Recognition and management of depression in general practice, consensus statement, RCPsych and RCGP;
- Shared care guidelines: management of depression, North Staffordshire District Medical Committee;
- Shared guidelines for the management of depression, West Glamorgan drug strategy group;
- Treatment of depression — adults under 65 years, consultant psychiatrist.

Quality

The dimensional scores of the nine guidelines are presented in Table 1. While there is a considerable range of individual guide-

Table 1. Quality of nine depression guidelines as assessed by the Critical Appraisal Instrument.[11,a]

Guideline	Rigor of development	Context and content	Applicability
1	28.33	47.22	20.83
2	18.33	41.67	20.83
3	35.83	16.67	25.00
4	56.67	61.11	72.00
5	25.00	38.33	30.00
6	25.00	30.56	20.83
7	40.83	69.44	36.67
8	40.00	75.00	26.67
9	47.50	50.00	30.00
Mean	35.28	47.78	31.43
	95% CI = 25.8–44.7	95% CI = 33.4–62.1	95% CI = 20.9–40.5
All guidelines[b]	34.0	46.2	29.0
	95% CI = 29.6–38.3	95% CI = 41.8–50.7	95% CI = 22.9–35.1

[a]Standardized score: maximum = 100. Guidelines would score 100 if all referees thought guideline had fulfilled all criteria. [b]In main study, guidelines for management of asthma, coronary artery disease, and breast cancer were also assessed.

Table 2. The diagnosis of depression: features referred to in the guidelines.

	Guidelines								
	1	2	3	4	5	6	7	8	9
Interview Style									
Unhurried	yes		yes		yes		yes	yes	
Eye contact	yes	yes	yes		yes		yes	yes	
Questions with psychological/social content	yes		yes		yes			yes	
Empathy	yes	yes	yes		yes		yes	yes	
Open to closed questions		yes					yes	yes	
Non-verbal behaviour			yes				yes	yes	
Flexible consultation time	yes						yes	yes	
Indicators of severity									
Mild	yes			yes	yes			yes	
Moderate	yes			yes	yes			yes	
Severe (major)	yes			yes	yes		yes	yes	
Dysthymia	yes			yes			yes	yes	
Mixed anxiety/depression				yes			yes	yes	
Assessment of risk of suicide									
Need to assess	yes	yes	yes	yes	yes		yes	yes	yes
Those to assess	yes	yes	yes	yes				yes	

line scores, the mean scores for each dimension differ little from those of guidelines for other diseases in the main study.[11] A full description of how guidelines performed against each criteria, together with assessors' comments, is available.[13]

Comparison of clinical content

The clinical content of the nine guidelines was assessed according to the framework. The epidemiology of depression was referred to in six guidelines, with agreement that 5% to 6% of the general population suffered with major depression at any one time. Four guidelines gave a similar value (5%) for minor depression, with one giving a lower figure of 4%. Four guidelines mention high-risk groups for depression, which included the elderly, the unemployed, women with young children, life events, the recently bereaved, and those with chronic illness and alcohol problems.

Diagnosis (Table 2)

Six guidelines described the type of interview needed; eight outlined the diagnostic criteria for severe depression. The consensus statement gave a definition of depression based on modified published criteria and references to ICD10 and DSM3R. Four guidelines gave criteria for a diagnosis that are the same as the consensus statement. The remaining three refer directly to ICD 10/DSM3R. Five guidelines gave an indication of severity, and eight mention assessment of suicide risk: this ranged from a reminder to ask the patient directly, to in-depth assessment and description of risk groups.

Management (Tables 3 and 4)

Drug treatment was described by all guidelines but no definite drug of first choice was offered. Selective serotonin re-uptake inhibitors (SSRI) tended to be suggested for the elderly and the physically ill or suicidal patients. All stressed the need for therapeutic dosage and adequate trials of therapy. Eight guidelines mentioned psychological interventions but in variable detail. Most guidelines mentioned the risks and benefits but few in any detail. The majority proposed that the length of treatment should be four to six months after remission, but some guidelines recommended as short a period as three months and others up to 12 months. Many guidelines did not present information on relapse; those that did suggested 50%, some 70%. There were many criteria for referral and few had mentioned them all (Table 5). Three guidelines mentioned that 10% of general practice patients were referred on to secondary care services.

Discussion

Most guidelines covered broadly similar areas and tended to reflect the contents and recommendations of the consensus statement developed by the Royal College of Psychiatrists and the Royal College of General Practitioners. This is reassuring as the campaign aimed to increase the 'knowledge of health care professionals in the recognition and effective treatment of depressive illness'.[6] The results of this survey suggest that the information produced as part of the campaign has been widely and successfully disseminated. It also supports the view that the most cost-effective way to create guidelines is to concentrate on producing a national template, which can then be adapted to reflect local priorities and circumstances.[11]

However, this approach places considerable responsibility on the national guideline truly reflecting the available research evidence and balance of professional opinion in their recommendations. In this respect, depression guidelines were no better or worse than guidelines for the management of asthma, breast cancer, and coronary artery disease. This is perhaps surprising, as it may have been assumed that the research basis for primary care management of depression would not be as great as for other diseases. In general, the reviewers were not convinced that the guideline producers had demonstrated the research basis for their recommendations. Appreciation of the necessity of explicitly linking recommendations to the underlying research is now increasing and should be reflected in future guidelines. However, this requires research to be undertaken in primary care rather than relying on the extrapolation of results from secondary care studies. A research priority is to identify appropriate steps in adapting national guidelines. Achieving local acceptance should not mean altering the recommendations merely to fit in with local practice.[14] Advice on creating evidence-based guidelines emphasizes the need to highlight key recommendations that should not be altered.[15] An important point to remember when creating guidelines is that they are intended to be a practical guide for clinicians managing real patients and should not detract from the need to

Table 3. Treatment of depression: intervention referred to in nine individual guidelines.

	Guidelines								
	1	2	3	4	5	6	7	8	9
Drug treatment	Discusses different groups	Discusses TCAs unless contra-indicated	Choice depends on clinical picture	Discusses different groups	TCAs unless contra-indicated	TCAs unless contra-indicated	Discusses all drug types, choice depends on clinical picture	Discusses old and new drugs in brief	Use drugs responded to in past, newer drugs in older/ mentally ill, sedating drugs for anxiousness or sleeplessness
Costs referred to	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
Psychosocial interventions	Yes in detail	In brief		In brief	In brief	Refers to consensus statement	Yes in detail	In detail	In brief
BCP	Yes in detail	In brief		In brief			Yes in detail	In brief	
Psychodynamic psychotherapy	Yes in detail			In brief			Yes in detail	In brief	
Interpersonal and family therapy	Yes in detail			In brief			Yes in detail	In brief	
Risks/benefits of treatment	Mentions but no details	Described in details	Mentions but no details	Mentions but no details	Mentions but no details	Mentions but no details	Described in detail	Toxicity of TCA in OD	Mentions but no details
Length of treatment	4-6 months (12/12 in severe episodes) after admission	6 months	6 months after remission	4/12 after episode has resolved	6 months after remission	6/12 (unless recurring or BPAD)	6 months after remission (3 years if recurrent)	4-6 months after depression has resolved	3 months after remission
Prognosis	50% relapse if treatment inadequate	70%	No comment	No comment	No comment	No comment	60-70% respond to anti-depressant	50% relapse if treatment inadequate	No comment
Prophylaxis	If recurrent or BPAD (anti-depressants or Lithium)	No comment	No comment	No comment	No comment	If severe recurrent (refer to specialist)	3 years in severe recurrent	If recurrent or BPAD (anti-depressants or Lithium)	No comment

TCA = tricyclic antidepressants.

Table 4. Criteria for referral to secondary services.

	Guidelines								
	1	2	3	4	5	6	7	8	9
Diagnostic uncertainty	yes	yes	yes	yes		yes	yes	yes	
Treatment failure	yes	yes	yes	yes	yes	yes	yes	yes	yes
Disturbed behaviour			yes	yes			yes	yes	
Suicidal	yes	yes	yes	yes	yes	yes	yes	yes	yes
Sharing burden				yes			yes	yes	
Need for services	yes			yes		yes		yes	yes
Self neglect		yes		yes				yes	
Organic illness				yes				yes	
Severe illness					yes			yes	
Patient demand		yes							
Recurrence		yes							
Physical complications			yes						
Treatment refusal			yes						
Intolerance/side effects			yes					yes	
Psychotic	yes		yes	yes		yes		yes	
Co-morbidity	yes			yes		yes		yes	

tailor the care to individual patient needs. They are unlikely to be successful if the underlying motive is perceived to be cost-containment rather than quality improvement.[16,17]

Most guidelines covered the areas highlighted by the effectiveness bulletin, but all were reluctant to be specific in identifying drug regimens, particularly not being specific in recommending tricyclic antidepressants (TCAs) in preference to SSRI. There remains considerable scope for individual clinicians to prescribe what they want, although there were strong assertions that these drugs should be at therapeutic levels and for appropriate lengths of time. It is likely that if guidelines are to offer cost-effective advice, recommendations in this area will need to be more specific. This can only be achieved with more information on the cost-effectiveness as well as the efficacy of different drug regimens.[18] Since our survey, evidence-based guidelines for 'the choice of antidepressants for depression in primary care' have been published,[19] but they will have to be actively implemented if they are to be more successful than previous guidance at changing current trends in GP prescribing patterns.[20.]

There were no major variations in recommendations apart from one set of guidelines advising treatment for three months while all others were for a minimum of four months. The groups considered most at risk of depression varied slightly, but only four sets refer to risk groups at all. The risk of suicide and the need for this to be assessed in this group of patients was given little attention in most guidelines, which is surprising given successive government commitments to reduce target rates of suicide.[21,22]

The most obvious difference was in the style in which the guidelines were written and presented. Some are in-depth discussions of the latest research from which the guidelines are subsequently drawn, others are simple bullet points to aid the clinician, with little information on their background. The guidelines that are more rigorously produced tend to be more detailed but also easier to follow.

Like many other initiatives seeking to ensure that clinical practice is based on sound research findings, guidelines have their antagonists and protagonists. However, arguing whether advocating guidelines is a 'good' or 'bad' policy is a sterile exercise.[23] Guidelines are already being produced in vast numbers;[11] a trend that shows no signs of abating. Furthermore, guidelines are expected to play a key role in ensuring that the new Institute of Clinical Excellence improves the quality of patient care.[24] What is needed is careful research addressing each stage of their development, dissemination, and implementation in order that they make an appropriate and cost-effective contribution to improving the care of patients with depressive illness.

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