Which clinical practice guidelines for depression? An overview for busy practitioners

PETER L CORNWALL

JAN SCOTT

SUMMARY

Background. *Many policy and research documents on the treatment of depression in primary care suggest that general practitioners (GPs) should make use of clinical guidelines.*

Aim. *To describe the content of peer-reviewed guidelines for the detection and treatment of depression in primary care and help GPs identify the one most useful to their own needs.*

Method. *Guidelines were evaluated by an explicit method using the Institute of Medicine assessment instrument and according to six key clinical management questions identified as important by GPs and psychiatrists.*

Results. *Only five (30%) of the published guidelines identified met all the pre-defined inclusion criteria. Total scores for development process and content ranged from 54% to 82%. Validity scores ranged from 52% to 88%. No guideline answered all the key questions identified by clinicians.*

Conclusions. *Only two guidelines conform to the quality standard of a clinical practice guideline. One covers all aspects of detection and management of depression in primary care but gives no advice on first-line choice of antidepressant, while the other focuses only on medication and fails to explore problems of case detection or to consider non-pharmacological treatments. However, taken together they do cover most of the key clinical issues in a reliable and valid manner. The identified guidelines vary considerably in both utility and clinical applicability.*

Keywords: depression; primary care; treatment; guidelines.

Introduction

CLINICAL practice guidelines have been advocated as a method of promoting effective clinical practice and reducing inappropriate variations in health care.[1-3] However, concerns have been expressed about the quality of some guidelines and their effectiveness in changing practice.[4] Others suggest that guidelines have been used to promote the views of narrow interest groups.[5]

Despite such reservations, many professional bodies, including the Royal College of General Practitioners (RCGP), have supported the production of guidelines and quality standards.[1] In primary care and in psychiatry, depression has been targeted as a disorder where clinical guidelines may be useful. It is one of the five most prevalent disorders seen in general practice and one in eight individuals may require treatment for depression in their lifetime. However, only 50% of cases of major depressive disorder presenting to primary care or other physicians are detected.[6] Even when detected, 30% to 50% of cases are undertreated.[7] The prevalence of chronicity in depression treated in primary and secondary care is about 20%.

We performed a survey of peer-reviewed clinical practice guidelines on the treatment of depressive disorders. We used a structured assessment instrument[8] to describe the content of the guidelines, to assess their adequacy, and to explore variations in content. Our specific aim was to determine whether existing peer-reviewed publications that meet criteria for a practice guideline achieve the appropriate quality standard, are valid, and, above all, are useful to clinicians treating adults presenting with depression in primary care.

Method

A practice guideline was defined as a 'systematically developed statement to assist practitioner and patient decision about appropriate health care for specific clinical circumstances'.[9] Guidelines were searched for using MEDLINE, EMBASE, and PYSCHLIT with the keywords 'depression/depressive disorder' and 'guideline'. Although many apparently relevant titles were found, papers were only included if the document was written in English, had been published after 1988 (to ensure information on SSRIs was included), and was directed for use in the primary care treatment of adult patients with major depressive disorder. Guidelines that had not been published or subjected to peer review were excluded, as were reports from conferences and workshops discussing the management of depression and guidelines developed only for use in particular localities or with more restricted patient populations.

Each guideline was initially evaluated using the explicit method described by Field and Lohr.[8] They developed an assessment instrument that is made up of 46 questions rated on a five-point scale from satisfactory (two) to unsatisfactory with major omissions (-2). The total quality standard score possible ranges from -92 to 92. The questionnaire allows judgements to be made both on the process of development of the guideline and the content of the resulting document. Four attributes concern the development process: clarity, multidisciplinary input, scheduled review, and documentation. Four others concern the substance of the guideline: clinical applicability, clinical flexibility, reliability, and validity. The instrument puts major emphasis on the validity of the guidelines (22 questions, score range = -44 to 44). Validity is assessed in five ways: the strength of the scientific evidence, qualitative and quantitative statements about the health benefits and harms or risks, qualitative and quantitative statements about expected health costs or expenditures, the extent to which the guideline recommendations are supported by the evidence, and potential conflicts with other guidelines. The rating scale is easy to follow and robust. However, the raters initially familiarised themselves with the questionnaire and practised its use on guidelines not included in the final study. Each guideline was then independently rated, first by PLC then (blind to PLC's rating) by JS. Very few problems occurred and total ratings were identical for three guidelines and within one or two points for the others. Differences were discussed and final totals represent an agreed mark.

To assess whether the guidelines provided information that

P L Cornwall, MRCPsych, senior lecturer, University Department of Psychiatry, Royal Victoria Infirmary, Newcastle upon Tyne. J Scott, MD, FRCPsych, professor of psychiatry, Department of Psychological Medicine, Gartnavel Royal Hospital, Glasgow.

Submitted: 27 August 1999; Editor's response: 28 October 1999; final acceptance: 9 August 2000.

was relevant to practising clinicians we surveyed 40 doctors (20 general practitioners [GPs] and 20 psychiatrists). To make both groups of doctors reasonably representative of those treating people with depressive disorders we identified 10 GPs with academic links (e.g. undergraduate teachers or academics in a university department of primary care) and 10 other GPs working at different practices in the same catchment area. We included GPs with an interest in primary mental health care and about 50% without such an interest. Likewise, we identified 10 psychiatrists with academic links and 10 others working in the same catchment areas as the GPs. Some of the psychiatrists had a special interest in the treatment of depression and others were general adult psychiatrists. Ages of the individuals surveyed ranged from 29 years to 51 years, and 24 were male. These clinicians were sent a questionnaire by post asking them to identify key clinical questions on the primary care management of depression that they would want to be answered by a clinical practice guideline. The clinicians were offered a list of eight possible issues but were also asked to identify and record any omissions. Thirty-two responses were received (17 GPs and 15 psychiatrists). The responders then placed their key questions in rank order according to importance. Where the researchers were unclear about any aspects of the responses or comments, the responder was contacted again and asked to clarify their contribution. A number of common themes emerged form the GPs' and psychiatrists' responses. These were formulated into six key questions on the clinical management of depression:

1. Threshold: What is the threshold for treatment of depressive symptoms?
2. First-line: What is the first-line treatment (when to use medication or psychological approaches)?
3. Drug of choice: Which is the first line antidepressant treatment — tricyclic (or a related medication such as lofepramine) or SSRI antidepressant?
4. Effectiveness: How does the clinician evaluate if treatment is effective (dose, duration of treatment, change in symptoms)?
5. Continuation: How long should an effective treatment be continued?
6. Second-line: When should treatment be deemed ineffective and what are the next steps in the clinical management of a patient who fails to respond to a first-line treatment?

Items identified by some clinicians (less than 30%) but not the majority included issues related to physical investigations (two GPs and two psychiatrists), the management of comorbidity (two GPs and three psychiatrists), and which model of psychological treatments (e.g. counselling, interpersonal therapy) should be offered (three GPs and one psychiatrist).

Results

The search yielded 15 documents but only five fulfilled all the inclusion criteria of the study.[10-14] Four documents were excluded because they did not refer specifically to the management of adults with depression in primary care[15-18] and a further six were excluded because they did not match the definition of a guideline.[19-24] Table 1 presents the total score and the validity subscale scores for the five guidelines that were evaluated in detail.

As can be seen, the Depression Guideline Panel (AHCPR)[10] guidelines have the highest score on all attributes but the North of England (NoE)[11] guidelines have the highest validity score. The British Association for Psychopharmacology (BAP)[14] guidelines scored lowest on both assessments but were highly comparable with the joint Royal College of Psychiatrists (RCPsych) and RCGP consensus statement.[13]

The assessment of the guidelines' specific recommendations on all six key clinical questions are shown in Table 2. No guideline addressed the six management issues identified most frequently by the clinicians. The AHCPR guideline offers recommendations on all topics except first-line antidepressant treatment, whereas this is the only issue addressed by the NoE guideline.

Finally, strengths, weaknesses, and general comments on the utility of each guideline were recorded (Table 3). Again, the AHCPR[10] and the NoE[11] guidelines appear to provide the most clinically relevant, evidence-based information. However, both are long and detailed documents, whereas the other three guidelines are considerably more accessible to a busy GP. The key strengths of the other guidelines include a greater emphasis on primary care research,[12] a consensus between key professionals (GPs and psychiatrists) on United Kingdom (UK) practice,[13] and an emphasis on the need for adequate doses of antidepressant medication for an adequate period of time.[14]

Discussion

This study has shown that although many papers described as guidelines for the detection and treatment of major depression have been published, very few conform to the quality standard for clinical practice guidelines.[1,2] We may have excluded other important documents by not undertaking a systematic review and by using a narrow definition of a guideline but these concerns can be addressed in two ways. First, several systematic reviews are already available (e.g. Freemantle *et al*[12]). Secondly, by carefully selecting guidelines that included information on the most up-to-date approaches to treatment and those published in peer-reviewed journals, the documents we assessed are more, rather than less, likely to represent the higher end of the quality spectrum. We believe that this approach most closely approximates to our explicit aim of identifying publications that a busy clinician would be likely to access and to give that individual key information on the reliability, validity, and utility of that document.

Reliance on one tool[1] to assess quality and validity is another potential weakness of this project. However, this is the most comprehensive and objective assessment tool currently available. We also recognise that researchers may argue that our sample of GPs and psychiatrists cannot truly represent their other colleagues. However, the key issues identified were remarkably consistent and have face validity as some of the most important 'decision points' in the primary care management of depression.

Our review suggests that the ideal guideline on the primary care management of depression is yet to be written. Only two of the guidelines could be classified as evidence-based; that is, incorporating explicit links between recommendations and the quality of the supporting evidence.[10,11] These two guidelines differ in that the NoE guideline has a narrower focus (on medication) and makes fewer recommendations than the AHCPR guideline. The only recommendation in the NoE guideline not supported in the AHCPR guideline is that tricyclic antidepressants should be used as the routine first-line drug treatment in primary care. The reason for this is straightforward but controversial: the NoE guideline uses economic analyses to determine the most cost-effective option; the AHCPR guideline (written primarily in, and for use in, the United States of America [USA]) explicitly avoids discussion of the cost of treatment. Similarly, the NoE guideline restricts itself to the choice of antidepressants once the patient and the GP have agreed that management plan. The AHCPR guideline is more comprehensive and looks at detection of depression and psychological interventions as well. Unfortunately, neither guide-

Table 1. Did the guidelines meet the quality standard and was the content valid?

	Total quality standard score (-92 to 92) (%)[a]	Validity subscale score (-44 to 44) (%)[b]
Agency for Health Care Policy and Research	59 (82)	23 (76)
North of England	51 (78)	33 (88)
Effective Health Care Bulletin	25 (64)	14 (66)
RCPsych and RCGP consensus statement	11 (56)	1 (52)
British Association of Psychopharmacology	7 (54)	1 (52)

[a]Percentages were calculated using the formula: (raw score + 92) divided by 184; [b]percentages were calculated using the formula: (raw score + 44) divided by 88.

Table 2. Did the guidelines answer the key questions identified by clinicians?

	Threshold	First-line treatment	Drug of choice	Effectiveness	Continuation	Second-line treatment
AHCPR[10]	✓	✓	✗	✓	✓	✓
NoE[11]	✗	✗	✓	✗	✗	✗
EHCB[a,12]	✓	✗	✓	✗	✗	✗
RCPsych and RCGP[13]	✓	✗	✗	✗	✓	✓
BAP[14]	✓	✗	✓	✗	✓	✓

[a]Effective Health Care Bulletin.

Table 3. What are the strengths and weaknesses of each of the guidelines?

Guideline	Strengths	Weaknesses	General comments
AHCPR	A high quality and valid evidence-based guideline. Deals with both detection and management. The only truly multi-disciplinary perspective and the only guideline to detail how to determine response and when and how to employ psychological therapies.	Large and detailed text (extends to two volumes). Fails to recommend a first-line antidepressant treatment and avoids all discussion of economic issues. Primarily written with the USA health system in mind.	The quick reference guide[25] and the clinical algorithms are very useful. The full volumes are excellent reference texts. It is clearly written and currently is the best of the guidelines available if you can spare the time.
NoE	Evidence-based and includes detailed economic analyses. Prepared to give clear advice on which medications to use and why.	It assumes the disorder has been detected and that the treatment is going to be medication. It fails to consider patients who do not want medication. The economic analysis inevitably includes subjective judgements that not everyone will hold to.	Thorough analysis of prescribing issues written by experts from around the UK who are knowledgeable about depression and about the development of guidelines. Answers some of the gaps left by the AHCPR but not exactly 'bed-time reading'.
EHCB[a]	Focuses on UK depression studies undertaken in primary care. The only document that does not assume secondary care research applies to primary care.	The stated aim is to influence decision makers and clinicians so it does not provide as much clinical advice as may be required by GPs.	A useful systematic review of the literature rather than a detailed clinical guideline on how or when to undertake different treatments.
RCPsych and RCGP	Outlines how recognition of depression can be improved as well as offering advice on standard therapeutic doses of medication.	Specific recommendations are not summarised or highlighted. Less clear about psychological management	Developed during the Defeat Depression campaign, this is a concise and readable consensus of the views of GPs and psychiatrists from across the UK.
BAP	Focuses on the choice of antidepressant and gives sound advice about dose and duration (particularly continuation phase treatment).	It is written by psychiatrists and psychopharmacologists with a clear preference for SSRIs Fails to include data from meta-analyses that contradict some of the expressed views.	It is easy to read and includes useful summaries of key information on pharmacology. This guideline scored lowest on quality and validity ratings but the BAP is in the process of drafting a new document.

[a]Effective Health Care Bulletin.

line answers all the key clinical management questions but together they do cover all the issues in detail.

The other three guidelines scored lower on the quality standard assessment and also failed to answer all the key management questions despite their stated aim to be useful in clinical practice. It might be argued that vagueness on some of the questions reflects our current knowledge base about who responds to what treatment in what setting. There is still a great deal of debate about symptom thresholds for prescription of treatment and the dosage and duration of use of antidepressants in primary, as compared with secondary and tertiary, care settings. However, the lack of consensus on the appropriate first choice of antidepressant is disappointing and the failure to comment on how to determine the effectiveness of treatment is also surprising. Only the AHCPR guideline makes the explicit statement that the aim of treatment is full remission of symptoms.

Evidence from the USA has suggested that depression guidelines can be implemented and produce improvements in practice in primary care.[26-28] However, recent UK research has been less convincing.[29] This study highlights the need for future guidelines on the treatment of depression, not only to summarise the best available evidence but also to adhere more closely to the quality standards for guidelines. It is untenable to constantly demand that GPs treat depression in primary care more effectively if guidelines vary so widely in the quality of their assessment of the available evidence and there is no consistency in the recommendations of what constitutes effective treatment.

Clinically, the next generation of guidelines should place greater emphasis on the key patient management questions and decision points and have more flexibility in treatment regimens, including more detailed advice on alternatives to medication.[30-33] Only then are such documents likely to be seen as supporting GPs in trying to facilitate improved outcomes for depressed patients in their care.

References

1. Royal College of General Practitioners. *The development and implementation of clinical guidelines*. [Report from General Practice Number 26.] London: RCGP, 1995.
2. Davies J, Freemantle N, Grimshaw J, *et al. Implementing clinical practice guidelines.* [Effective Health Care Bulletin Number 8.] York: NHS Centre for Reviews and Dissemination, 1994.
3. Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 1993; **342:** 1317-1322.
4. Grimshaw JM, Hutchinson A. Clinical practice guidelines — do they enhance value for money in health care? *Br Med Bull* 1995; **51:** 927-940.
5. Haycox A, Bagust A, Walley B. Clinical guidelines — the hidden cost. *BMJ* 1999; **318:** 391-393.
6. Freeling P, Rao BM, Paykel ES, *et al*. Unrecognised depression in general practice. *BMJ* 1985; **290:** 1180-1183.
7. Donoghue JM, Tylee A. The treatment of depression: prescribing patterns of antidepressants in primary care in the UK. *Br J Psychiatry* 1996; **168:** 164-168.
8. Field MJ, Lohr KN (eds). *Institute of Medicine: Clinical Practice Guidelines. Directions for a New Program*. Washington DC: National Academy Press, 1990.
9. Lohr KN, Field MJ. A provisional instrument for assessing clinical practice guidelines. In: Field MJ, Lohr KN (eds). *Guidelines for Clinical Practice: From Development to Use*. Washington DC: National Academy Press, 1992; 346-410.
10. Depression Guideline Panel. *Depression in Primary Care: Volume 1. Detection and Diagnosis: Volume 2. Treatment of Major Depression*. [Clinical Practice Guideline Number 5.] Rockville, MD: USDHHS, Public Health Service, Agency for Health Care Policy and Research, 1993.
11. North of England Evidence-based Guideline Development Project. *The choice of antidepressants for depression in primary care*. [CHSR Report Number 91.] Newcastle: Centre for Health Services Research, University of Newcastle upon Tyne, 1998.
12. Freemantle N, Long A, Mason J, *et al*. *The treatment of depression in primary care*. [Effective Health Care Bulletin No. 5.] York: NHS Centre for Reviews and Dissemination, 1993.
13. Paykel ES, Priest RG. Recognition and management of depression in general practice: consensus statement. *BMJ* 1992; **305:** 1198-1202.
14. British Association for Psychopharmacology. Guidelines for treating depressive illness with antidepressants. *J Psychopharmacol* 1993; **7:** 19-23.
15. Anonymous. Practice guideline for major depressive disorder in adults. *Am J Psychiatry* 1993; **150(suppl 4):** 1-26.
16. Friedhoff AJ, Ballenger J, Bellack AS, *et al*. Diagnosis and treatment of depression in late life. The NIH Consensus Development Conference Statement. *Psychopharmacol Bull* 1993; **29:** 87-100.
17. Hirschfeld RMA, Clayton PJ, Cohen I, *et al*. Practice guideline for the treatment of patients with bipolar disorder. *Am J Psychiatry* 1994; **151(suppl 12):** 1-36.
18. Kemerow B. Screening for Depression. In: **[Editors?]** *Guide to clinical preventive services: report of the US Preventive Services Task Force.* Baltimore, MD: Williams and Wilkins, 1996; 149-189.
19. Anonymous. Pharmacotherapy of depressive disorder. A consensus statement. WHO Mental Health Collaborating Centres. *J Affect Disord* 1989; **17:** 197-198.
20. Finlay-Jones R, Parker G. A consensus conference on psychotic depression. *Aust N Z J Psychiatry* 1993; **27:** 581-589.
21. Hirschfeld RM. Guidelines for the long-term treatment of depression. *J Clin Psychiatry* 1994; **55:** S61-S69.
22. Ustun TB, Goldberg D, Cooper J, *et al*. New classification for mental disorders with management guidelines for use in primary care: ICD-10 PHC chapter five. *Br J Gen Pract* 1995; **45:** 211-215.
23. Thompson C, Wilkinson G, Angst J, *et al*. Effective management of depression today: report from an interactive workshop. *Int J Clin Psychopharmacol* 1996; **11(suppl 1):** 45-50.
24. Hirschfeld RMA, Keller MB, Panico S, *et al*. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. *JAMA* 1997; **277:** 333-340.
25. Depression Guideline Panel. *Depression in Primary Care: Detection, Diagnosis and Treatment.* [Quick Reference Guide for Clinicians Number 5.] Rockville, MD: USDHHS, Public Health Service, Agency for Health Care Policy and Research, 1993.
26. Brown JB, Shye D, McFarland B. The paradox of guideline implementation: how AHCPR's depression guideline was adapted at Kaiser Permente Northwest Region Joint Commission. *J Qual Improvement* 1995; **21:** 5-21.
27. Katon W, Von Korff M, Lin E, *et al*. Collaborative management to achieve treatment guidelines. *JAMA* 1995; **273:** 1026-1032.
28. Schulberg HC, Block MR, Madonia MJ, *et al*. Treating major depression in primary care practice. Eight month clinical outcomes. *Arch Gen Psychiatry* 1996; **53:** 913-919.
29. Upton M, Evans M, Goldberg D, Sharp D. Evaluation of ICD-10 PHC mental health guidelines in detecting and managing depression within primary care. *Br J Psychiatry* 1999; **175:** 476-482.
30. Cornwall PL, Scott J. Partial remission in depressive disorders. *Acta Psychiatrica Scandinavica* 1997; **95:** 265-271.
31. Macaskill A, Macaskill N, Nicol A. The Defeat Depression Campaign. *Psychiatric Bull* 1997; **21:** 148-150.
32. Persons JB, Thase ME, Crits-Christoph P. The role of psychotherapy in the treatment of depression: review of two practice guidelines. *Arch Gen Psychiatry* 1996; **53:** 283-290.
33. Schulberg HC, Block MR, Madonia MJ, *et al*. Applicability of clinical pharmacotherapy guidelines for major depression in primary care settings. *Arch Fam Med* 1995; **4:** 106-112.

Address for correspondence

Professor Jan Scott, Department of Psychological Medicine, Gartnavel Royal Hospital, Glasgow G12 0XH.