

Editorial

The NICE guideline on depression: research recommendations for primary care

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The eagerly awaited National Institute for Clinical Excellence (NICE) guideline for management of depression in adults is to be welcomed as a further contribution to the current emphasis on evidence as a basis for improving clinical care and outcomes.¹ However, despite the authors' comprehensive review of the evidence, the guideline will be a disappointment for many in primary care who had hoped for definitive help in improving the services they provide. How does so much evidence tell us so little about what to do in primary care? What new opportunities are created in the wake of the NICE guideline to identify relevant strategies for primary care research that will help bring about service improvements founded on suitable evidence?

Today, almost a quarter of the population describe having some form of mental ill health, the vast majority reporting depression and anxiety.² 'Depression' in primary care accounts for over a half of cases presented to the general practitioner (GP).³ GPs have been criticised for poor detection of

depression, missing up to half the cases presenting to them, inadequate treatment with ineffective doses of antidepressant drugs for insufficient duration, failure to refer for effective psychological techniques such as cognitive-behavioural therapy in favour of unproductive types of counselling, and unacceptable variations in care.^{4,5} Depression seen in primary care is less severe than that seen in psychiatric out-patient clinics, yet patients treated by psychiatrists have better outcomes.⁶⁻⁸

This conventional story of failings in primary care management of depression is seductively simple yet unconvincing. There is an emerging alternative narrative in which depression is a socially constructed phenomenon resulting from individual responses to unresolved distress and adversity.⁹ Medicalisation has led to excessive reliance on drugs and formalised psychological interventions, which are of limited benefit, potentially harmful and costly.¹⁰ The alternative account sees GPs as good at identifying depression, whereas educational interventions for

GPs targeted at detection and prescribing or cognitive behavioural therapy have limited impact on outcome.^{11–13} Screening tools, questionnaires and feedback add little to the diagnosis or management of depression, resulting in greater use of drugs, but doing little to improve health status or prognosis.^{14–16} Usual GP care is as effective and cost-effective over one year as non-directive counselling or cognitive-behavioural therapy.^{17–19} This alternative narrative, rather than being an excuse for complacency, suggests that the conventional narrative is flawed.

During consultation for this guideline other voices from primary care have expressed reservations about the content of earlier drafts, arguing that the main weakness of the NICE guideline lies in the fact that the evidence is not presented in a format that is user friendly to primary care, and that there are important omissions and inconsistencies.²⁰ However, a more fundamental problem exists with content rather than presentation. It is on this basis that we advocate a more radical and long overdue challenge to orthodoxy and it is on this basis that truly novel research priorities for depression should be developed.

Most compromising to the guideline is the failure to root its recommendations in a consistent view of the nature of depression.²¹ Since the guideline offers no unifying definition of depression, there are powerful *a priori* reasons to be sceptical about the authority it claims for management and recommendations for future research. Patients' accounts of feeling depressed consist as much of idiosyncratic characteristics as those that may be considered typical. So it is that the reality of management consists of helping and supporting those who feel depressed and rather than clinicians trying to make sense of patients' presentations, by focusing on 'symptom' characteristics, they should focus on patients narratives as an expression of need for help to overcome practical difficulties that impair their day-to-day functioning.

Having failed to address the core consideration of the nature of depressed feelings, the NICE guideline weaves a strange path through a minefield largely of its own making. It acknowledges variations in presentation but declares, without sensible rationale, that recommendations apply to patients who can be categorised by diagnostic criteria cited in ICD-10.²² What proportions of patients in primary care conform to these criteria? A cardinal shortcoming of the reviewed evidence base is that it has nothing to offer considerations of treatment for conditions other than ICD-10 moderate-severe depression, and these are a small minority of all cases seen in primary care.²² Thus, the NICE guideline fails in not providing guidance with the treatment of the majority of cases. Constructions of depression found to be useful for researchers conducting randomised

controlled trials of drug regimes or psychological therapies, are not necessarily apposite for assessing, planning or providing primary care help and support in real world settings.

The impression consolidated by the NICE guideline is that its presumed power and assumed authority derives from a view of evidence-based practice with origins from academic rather than clinical practice imperatives, and an allegiance to methodologies far removed from day-to-day primary care. In order to improve care of patients who feel depressed, primary care practitioners might do well to start developing services that are informed by practice-based evidence rather than adhering to uncertain prescriptions of evidence-based practice.

It would seem that an appropriate agenda for primary care research in this area involves more than methodologically refined versions of previous studies. It makes little sense for primary care to opt for more of the same, when the main achievement of orthodoxy appears to have been criticism of primary care for not treating patients radically enough with drugs and psychological therapies of doubtful effectiveness and efficacy. To reclaim research relevance for primary care, the main concern should be to develop an appropriate model. A useful starting point might be to systematically describe patient's views of their depressed feelings, the nature of these feelings, the changes that occur over time, the precipitating circumstances and the support that patients have found helpful towards recovery.²³ We have argued for research to establish the veracity of considering expressions of fear (anxiety) and despair (depression) as adaptive, in so far they signal a need for help and support from others to overcome adversity.⁹ It is anticipated that exploring patient accounts of their experience of depression will begin to contribute to an understanding of wider social circumstances, leading the individual to present to primary care in the first instance. This may also lead to appropriate methods of managing distress in a conceptual framework that is helpful for both patients and professionals.²⁴ Such qualitative studies into patient experiences of assessment and care can be expected to lead to testable theories and models of depression, which in time will inform larger scale quantitative studies, clinical trials, and service evaluations, supporting a true and relevant evidence base for primary care.

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