

Review Article

# The Primary Care Treatment System for Severe Depression: Perspectives of Patients, Doctors, Treatment Guidelines and Treatment System Failures

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## Abstract

There are a number of key issues that matter to patients and General Physicians (GPs) in the primary care treatment system for severe depression. Patient and doctor narratives can contribute by highlighting these key issues. Various systems are employed in treating severe depression. However, there needs to be an investigation using systems failure methodology and how this methodology is applied which can help identify how and why the NHS treatment system for severe depression can fail patients in terms of provision of effective care.

## Introduction

There are rapidly increasing numbers of people suffering from severe depression seeking treatment and advice. The effects of severe depression are not only a financial and social burden in the UK, but it is also a global concern [1].

For this reason, it is desirable to have an effective treatment system in place to cope with this increase in demand which is certain to put serious strain on healthcare providers [2].

The need to identify treatment failures is crucial, particularly in the primary care setting. Misdiagnosing and the failure to initially provide adequate treatment and meaningful advice carry the risk of the patient deteriorating further to the point that they become treatment-resistant [3].

One issue is that patients and their carers often have little insight into the processes involved in these events. One of the root causes of a system failure at this stage of treatment may be due to a lack of effective communication between doctor and patient. Improved communication might benefit both patients and carers in terms of providing a more meaningful understanding of the nature of the illness and the treatment options but it is not always clear how to achieve this.

### The nature and experience of severe depression

Severe depression differs from mild and moderate depression in terms of causes and effects. The causes of mild to moderate depression can generally be easily identified as a direct result of personal difficulties such as the loss of a loved one, bankruptcy, or divorce, and also a result of serious

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physical illness such as heart attack or suffering from cancer. Severe depression on the other hand may at times have roots that stem from what is perceived to be a singular catastrophic life event, but it is also a case of increasing negativity in how one's whole world is perceived [4]. This insidious build-up of increasingly negative and irrational thinking begins to undermine and adversely affect the patient's normal character and personality which finally culminates in an ever-escalating and unstoppable descent into severe depression. The patient's happiness, sense of purpose, personality, and character are suddenly swept away leaving the sufferer frightened, bewildered, and feeling isolated. Patients suddenly find themselves suffering from severe depression and cannot understand what is happening to them and why. The patient's family is suddenly thrust into the role of caring for a person suffering from an illness they barely understand which becomes a constant source of upset for them. There is almost a complete disruption of memory. Sufferers of severe depression become suspended in time; there is no past, there is no future, just a minute-by-minute experience of a miserable and almost unbearable existence. For many sufferers, this locked-in pattern of misery cannot be changed by such things as going on a short holiday, or the efforts of friends and family to encourage any sort of effort that might make a difference. Nothing highlights the profoundness of the suffering more than the fact that almost without exception, severely depressed individuals often think of suicide as a way



out. Episodes of severe depression can last for up to a year and longer if the illness becomes resistant to treatment. Such is the severity of the illness; that whilst there may be evidence of symptomatic improvement and improved social function post-recovery, deficits in cognitive functioning apparent during the course of the illness have been found to be still evident for up to three years after recovery [5].

### The role of anxiety

It has been widely accepted that anxiety and severe depression go hand in hand. High levels of anxiety are an important feature of severe depression in that it is the overwhelming biological factor that accompanies the descent into severe depression, and persists during the course of the illness making it a physically debilitating and distressing experience in addition to the adverse psychological symptoms. Symptoms of anxiety are more likely to precede severe depression than the reverse [6]. In addition, anxiety disorder is the single biggest clinical risk for the development of severe depression. Although symptoms of both disorders frequently overlap, there is strong evidence that anxiety disorders occur independently of severe depression. This leads to the conclusion that anxiety and severe depression are different conditions that can be treated separately [7].

### Diurnal variations

Diurnal variation in mood has been recognized as a characteristic feature of severe depression. Beck notes that diurnal variations are more common in cases of severe depression and rarely in mild to moderate depression [8].

The severely depressed patient who experiences diurnal variations typically experiences low mood in the morning but mood improves towards the evening. Conversely, there are cases where the mood is better in the morning becoming worse in the evening. When experiencing positive diurnal variations, there may be a perception that this signals the permanent end of the suffering and the future looks bright. Invariably, the symptoms return.

### Classifying severe depression

The World Health Organization ICD-10 classification distinguishes three different categories for a depressive episode: mild, moderate, and severe. Differentiation between mild, moderate, and severe depressive episodes rests on the severity of symptoms present.

In all three categories, the patient suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are:

- (a) reduced concentration and attention;
- (b) reduced self-esteem and self-confidence;

- (c) ideas of guilt and unworthiness (even in a mild type of episode);
- (d) bleak and pessimistic views of the future;
- (e) ideas or acts of self-harm or suicide;
- (f) disturbed sleep;
- (g) diminished appetite.

The lowered mood varies little from day to day and is often unresponsive to circumstances.

### Severe depressive episode without psychotic symptoms

In a severe depressive episode, the sufferer usually shows considerable distress. Loss of self-esteem or feelings of uselessness or guilt are likely to be prominent, and suicide is a distinct danger in particularly severe cases. It is presumed here that the somatic syndrome will almost always be present in a severe depressive episode manifested by high levels of anxiety. All three of the typical symptoms noted for mild and moderate depressive episodes should be present, plus at least four other symptoms, some of which should be of severe intensity. Symptoms are particularly severe and of very rapid onset. During a severe depressive episode, it is very unlikely that the sufferer will be able to continue with social, work, or domestic activities, except to a very limited extent [9].

The other major diagnostic classification in clinical use is the American DSM1V [10]. Both classification systems list explicit diagnostic criteria. There are some conceptual differences but they could be considered minor. Using either DSM1V or ICD-10 diagnostic systems, patients who present with severe depression are likely to be suffering from symptoms that would fit the descriptions indicated in both of the diagnostic systems [11].

### The medical model of severe depression

There is a large body of opinion that maintains that severe depression is a product of a biochemical imbalance within the brain. Consequently, the treatment objectives are to restore this balance. It is generally believed that lowered levels of the neurotransmitter serotonin underpin the state of severe depression. Antidepressants are designed to restore levels of serotonin in the brain. Evidence via positive results claimed by scientific experiments demonstrating the efficacy of antidepressants and clinical guidelines such as NICE conclude that antidepressants should be the first choice treatment for severe depression. However, there is a view that serotonin has nothing to do with severe depression and that the serotonin theory is basically flawed [12].

If treatment by the first prescribed antidepressant fails to achieve the desired results, there can be a switch to another brand. Other drugs may also be used as adjuncts such as antipsychotics and in some cases, mood stabilizers.



Electroconvulsive therapy (ECT) is seen as a last resort treatment where the patient is considered to be treatment-resistant or at risk of suicide. The procedure is considered safe but can have side effects such as short-term memory loss. Short-term memory function generally returns a few weeks after treatment but problems such as the extended loss of forms of long-term memory as a result of ECT treatment have been widely described by patients [13].

### The psychological model

This model views severe depression as essentially reactive and a product of events and experiences that may be externally imposed or internally generated. To treat depression adequately it must be understood within a person's total life situation. To this end, various forms of psychotherapy have been adopted as treatment. The most prevalent of these therapies is cognitive behaviour therapy (CBT) which concentrates on training new patterns of positive thinking and understanding. Another form of therapy is interpersonal therapy (IPT) which concentrates on improving relationships with others. Not all patients benefit from these therapies but in any event, success is likely to hinge on the quality and skill of the therapist. Roth and Fongay emphasize this particular point by stating:

*'The ability of the individual practitioner to deliver a specific therapeutic intervention tailored to the needs of the individual client is as important, if not more important, as matching the type of therapy to the presenting mental health problems of the client' [14].*

Psychotherapies are also considered to be of importance in preventing relapse after recovery. Whilst some arguments remain between the medical model and the psychological model, a greater level of understanding between the two views would be more fruitful.

### Patient narratives: Their perceptions and experience of the treatment for severe depression in primary care

Narratives are a way for a patient affected by an illness to make sense of his or her experiences. Narratives are considered to be a basis for developing an understanding that cannot be arrived at by any other means. Narratives aid understanding of an otherwise perplexing world and can gain insight into the experience of severe depression. First-hand experience is imperative to understanding illness and narratives lead to the acknowledgement that depression is a complex condition where meaning can be made by experience through words [15]. Patient narratives are also considered to be of some importance because they can considerably improve an understanding by those treating them and a method of providing a history of the patient's journey through their illness from onset to remission. However, patient's narratives may not be telling the whole story. The reason for this is that it has been well established that autobiographical

memory function is a major casualty in severe depression; patient's memories tend to be too general and lacking in detail [16]. Because of this, there will be times when patients may not always provide a wholly accurate story relating to their experience of the illness.

There are a number of resources where patient narratives can be found and examined. There are professional writers who have published books on their experience of severe depression. There are published papers whose subject is the patient narrative in terms of their experience of the illness and how they were treated by healthcare workers. Finally, there are specialist websites devoted to providing information on depression and also allow patients to publish their experiences online.

### Professional writers' narratives

Narratives of patients who happen to be professional writers would be expected to offer a more lucid account of their experiences of severe depression.

Perhaps one of the more celebrated works on the experience of suffering from severe depression is William Styron's book *Darkness Visible* [17]. Styron was an accomplished professional author and as such was able to narrate the experience of his illness in a style that is likely to strike a chord with almost every reader who has suffered the same fate. In common with most severely depressed people, thoughts of suicide are never far away in his account. Styron admits that medication, psychotherapy, and hospitalization were really of no value in the lifting of his depression. However, because of the adverse effect of severe depression on autobiographical memory, some of Styron's accounts are not as accurate as supposed. Styron's work along with other professional author's accounts are retrospective; severely depressed people generally lack the will or the concentration levels needed to write a book whilst suffering from the illness. After his death, Styron's widow Rose published her experiences of caring for him [18]. In his book, Styron describes a moment where he is sitting downstairs listening to some music whilst Rose is asleep in bed. But Rose recalls that this never happened – she never slept if he was not in bed beside her. It also emerged that before writing his book, Styron suffered a relapse but does not mention this in his book. Another celebrated book on the personal experience of severe depression is Andrew Solomon's *The Noonday Demon* [19]. This book is a large and comprehensive assessment of the nature and experience of severe depression. Despite this, Solomon fails to identify the deeper issues that underpin the illness. He misses the clues. He describes lying in bed unable to go and take a shower as he had done every day before the onset of his illness. Solomon recognizes that not being able to take a shower is irrational but does not take the opportunity to explore why it is irrational. Solomon appears to dismiss the importance of psychotherapy in favour of psychopharmacology and declares that it was Prozac that saved him; that "medication has set us free."





Zimmerman [20] argues that although the texts of both Styron and Solomon's books purport to imply insightful knowledge and the assumption that these books are useful may at the same time 'reproduce depression's central dilemma – symptomatically re-enacting the failure of meaning at depression's centre.' Zimmerman further argues that these accounts fail to grapple with the fact that severe depression is a psychic experience; they miss the crucial aspect of just how terrible severe depression is for the sufferer.

Perhaps the major value of books of this type is that they offer hope to others that severe depression can be overcome.

### Patient narratives

It has been generally recognized that patient narratives can provide some insight into the experience and understanding of severe depression both in terms of how individual patients try to cope with their illness and how they communicate their problems to healthcare professionals. Listening to patient's first-hand experiences is imperative to understanding the illness. However, there may be cases where it may be almost impossible for patients to explain what they are going through because severe depression is a mystery to oneself [21]. As previously mentioned, aspects of memory are one of the casualties of severe depression. However, memories of specific events can be reasonably accurate – usually experiences with the GP, the treatments they received, and how they reacted to them. But the generalities of the day-to-day existence during the course of the illness are less likely to be recalled with any great accuracy. This particular fact highlights the need and importance for the patient's carers to be actively involved in the treatment system. This involvement is not only to support the patient but also to provide the GP and other healthcare workers with a more detailed background that fills in the gaps that the patient either forgets or chooses not to mention.

### The key issues identified in patient narratives

There have been a number of studies where ex - depressed patients have been interviewed to discover their perceptions of what the illness meant to them and their experience of the treatment system. Most studies describe depression as the subject for the study but some do not make the distinction between mild/moderate and severe depression. However, the basic principles of the patient's experience can be drawn from these accounts. What patient narratives can achieve is identifying key issues that matter to them.

One of the major issues for patients at the primary care level was the interaction with their GPs. Patients frequently had concerns with taking up the doctor's time. A significant number of patients tended to have a fear of wasting a GPs time [22]. One study found that the mean consulting time averaged around 8 minutes. However, other research showed a wider range of consultation time particularly when dealing with illnesses such as depression [24]. Another study found that a number of patients reported that GPs took the initiative

and extended the consultation time. Patients were very appreciative of this action [25]. Being listened to by the GP is naturally of importance to the patient but the GP also needs to send a clear message to the patient that they are valued as a person and as such, the patient is encouraged to provide sufficient information in order for the GP to make a proper assessment of the patient's condition and come to a decision on what form of treatment is appropriate. Many patients also express concerns regarding medication. Side effects such as weight gain and daytime drowsiness are of concern plus there may be a misunderstanding that antidepressants are habit-forming. Even if patients elect to take medication, there are cases where patients stop taking their medication because they find the side effects intolerable. Those patients who are suspicious of medication may prefer psychological treatment. However, a study investigated those patients who preferred psychological therapy alone at the outset and compared with those who chose antidepressant treatment found that the antidepressant group was much more satisfied than those who had psychological treatment [26].

Another significant issue for patients is the fear of the stigma attached to severe depression. There can be personal embarrassment about suffering from a mental illness; feeling excluded or misunderstood by family and friends. There may be worries that their illness may prejudice their career. It is for this reason that some sufferers may choose not to see their doctor and try and get through their illness as best they can.

How a patient copes with severe depression is another issue. At the outset, patients generally do not understand what is happening to them and why. Due to the sheer complexity of the illness and its treatments, this lack of meaningful understanding is not surprising. Some may see the illness as something that a pill from the doctor will return them to full health. Some patients see relief from alcohol or illicit drugs. Some resign themselves to their fate and spend time ruminating and feeling sorry for themselves. Others seek strategies that may help them cope better with the illness such as exercise. The more resourceful will do some research in order to understand what is happening to them and why from books or on the internet. The websites devoted to comprehensive information on severe depression always offer patients hope by stating that the illness is treatable. Depression Alliance published a report on the theme of improving treatment choices for people affected by depression and anxiety. The report included a response to the question 'What was the best thing about your treatment?' One answer was: "Becoming involved in a service user group. Everything I have found out has either been from them or through my own research" [27]. But this appears to be the narrative of someone who was determined to be a successful patient and comparing this view with the overwhelmingly negative experiences of the other interviewees suggest that this patient is in the minority of people who are prepared to



take on severe depression in an active and meaningful way. It has been argued that 'the successful patient is always the one who transcends patienthood' [28].

Studies that include patient narratives on various aspects of severe depression such as treatments and the attitudes of those treating them do highlight common themes of complaints and concerns and as such, the results of these narratives tend to be more or less replicated across other studies even taking into account the individual variables of different patients' experiences. In order to elicit a patient narrative that may gain a more original insight into the individual experience, perhaps a more Socratic form of questioning could be introduced. For example, 'What do you know now that you didn't know then?' This is the sort of question that could encourage a more insightful and thoughtful response leading to an improved conceptualization of the major issues to the benefit of both the researcher and the patient.

It should be borne in mind by researchers that not all patients are innocent victims of a failing treatment system. There will be patients who do not comply with the medications given to them and perhaps persist in a lifestyle that is not conducive to recovery and fail to employ any means of self-help strategies. These details can at times be conveniently forgotten.

Another issue not commonly mentioned in patient narratives is their thoughts on the longevity of the illness. What would be the possible devastating psychological effect on a patient who is told or discovers that severe depression can often last up to 12 months? Patients usually remember how long they were ill for but what would their reactions been had they been told from the start by their GP that they would likely be ill for a considerable period of time? Would it have made them feel worse and even more suicidal or would it have galvanized them into declaring all-out war on the illness rather than helplessly succumbing to their misfortune? However, the GP who withholds this particular truth from the patient maintains the patient's hope and hope is often the thing that helps patients survive the tortures of severe depression and recover.

However, declaring an all-out war on the illness means that patients need to know the necessary strategic tools from those treating them and how to accomplish this task. This does not seem to be adequately addressed by GPs in the existing treatment system.

### GP's narratives

GP's narratives can help identify a number of issues that are of concern to them when faced with treating patients presenting with severe depression. Good & Good point out that:

*Physicians talk in stories, whether discussing patients anecdotally or analyzing "cases" in formal settings such as*

*morbidity and mortality conferences or grand rounds. They teach through stories....Physicians practice in stories. They carry out their work by developing narrative accounts of patients and formulating therapeutic activities in relation to these anecdotes. They reason and make decisions in narrative terms [29].*

### The key issues identified in GP's narratives

One of the more common problems identified by studies publishing results of GP interviews is associated with correctly diagnosing depression in terms of its severity particularly mild/moderate depression. There are several reasons for this. Patients may turn up for an appointment to do with a physical illness but they may in passing admit to also feeling a bit down. It is likely that these patients are suffering from mild to moderate depression and that the source of the depression can usually be detected as being an identifiable reactive condition such as the break up of a relationship or the death of a loved one. However, GPs failing to recognize these milder forms of depression have been widely reported [30]. Not diagnosing milder forms of depression carries a risk that if not treated in time, patients could go on to suffer severe depression [31].

However, it appears that cases of severe depression are more reliably detected via the use of the hospital anxiety and depression scale [32]. Using the Patient Health Questionnaire, this level of reliability was also reported [33]. In another study, the recognition rates of depression by GPs in primary care was undertaken [34]. In this study, GPs used the Hamilton Depression Rating Scale to assess the severity of the patient's depression. The authors found that the GP recognition rate was greater in cases of severe depression. These results are not surprising as severely depressed patients are more likely to 'tick more of the right boxes' making a diagnosis of severe depression a relatively simpler task. In addition, physical clues may also be evident; the distressed state of the patient, evidence of abnormal levels of anxiety, lack of eye contact, a monotonous tone of voice and so on. It has also been noted that patients with severe depression consulted with their GP three times as often compared to non-depressed patients. The reason for the higher rate of consultations is likely to be due to the patient's high level of discomfort and the desperation and impatience due to their condition not improving quickly enough.

As with patient narratives, evidence also points to a major issue for GPs which is the length of consultation time. Some GPs prefer to stick to the mean average consultation time but where there are cases that clearly need a longer period of time to get the whole story from the patient. GPs seem willing to arrange another appointment where sufficient time is allocated. There appears to be an agreement with most GPs that clinical need supersedes consultation time. GPs also recognized that longer consultations are a form of investment. It is believed that a deeper understanding of the patient's problems can elicit a higher degree of trust from the patient



which translates into a more effective response to treatment, and that would save time in following consultations [35]. At least that is the theory. But what is of equal importance and arguably more so is the quality of care in the consultation. But what is meant by quality of care? Perhaps the quality of care means that the GP is conversant with all the complexities of severe depression and is confident in his clinical skills and that the GP is fully aware of the social and psychological background that is very much part of severe depression [36].

### GP training

Continual medical training is considered to be important in improving such things as interviewing skills and developing clinical skills in order to select the best therapeutic options [37]. However, training programmes do not appear to be as effective as was hoped. Koning, et al. [2009], found that 10 hours of training over 2 weeks was not cost-effective and did not improve patient outcomes compared to care as usual in the primary care setting. The authors concluded that the main stumbling blocks to effective care were the processes of care, organizational leadership, and patient behaviour all of which are only partly within the control of the GP. Thompson et al. [38]. led a study into the possible effectiveness of an educational training programme in part based on treatment guidelines adopted by The Hampshire Depression Project on detecting and treating mild/moderate and severe depression for GPs in order to improve the outcome in primary care and that it is possible to change the existing attitudes of GPs through education. The study reported that the training programme was well received by 80% of the participants who thought that their attitude to treating depression was definitely improved. Unfortunately, on follow up it was discovered that the training did not improve the GP's perceptions in treating depression. The authors attributed this failure to the possible shortcomings of the treatment guidelines. In addition, the authors suspected that the GPs' reliance on their positive feedback on the benefits of the educational course may have led to complacency.

In another study that incorporated a training course for GPs on the treatment of depression, the results also failed to raise the levels of confidence in GPs in treating depression [39]. The authors suggested possible reasons why the training did not work. The amount of good quality training in matters of psychiatry may have been lacking in the course of doctors' medical training. However, a more significant reason for failure was the recognition that educational training was perhaps insufficient when it comes down to the realities of everyday practice. This particular point emphasizes that there can be a distinction between educational programmes and continuous learning derived from real-life practice. One point not raised by these studies is the issue of job satisfaction. Treating severe depression is not the exact science of treating most physical illnesses where most drugs do the work they are designed for and are generally successful. In treating

most physical illnesses, GPs are more likely to feel they are doing the job they have been trained for whereas attempts to treat severe depression could undermine GPs' confidence in their competence. Perhaps learning from experience also means not being too isolated from other GPs in the practice or elsewhere who may have other perspectives on treating severe depression in terms of what they have experienced to be more effective forms of treatment. It is understood that GPs do meet with their practice partners from time to time and there may be the odd discussion on cases they have dealt with. As treating severe depression appears to be an ongoing problem for GPs, perhaps a continuous learning process could be enhanced by each GP discussing with their colleagues how they approach treatment and what seems to work better. When physicians do talk and practice with stories to their colleagues, it could prove to be beneficial for all parties.

### The National Institute for Clinical Excellence (NICE): The CG90 treatment guidelines for depression in primary care

**Do NICE CG90 treatment guidelines reflect the realities of practice?:** NICE is a special health authority of the NHS in England and Wales. Set up in 1999, its purpose was to improve the ability of the NHS to deliver effective health care. Originally published in 2004, NICE published its updated version of Clinical Guideline 90 (CG90) for the treatment and management of depression in adults in 2009 [40]. NICE continually updates these guidelines in light of current advances in treatment. The guidelines are rigorous and are underpinned by extensive research of current evidence. But do the treatment guidelines consider the realities of everyday practice? Hegarty, et al. [41] emphasize the point that assessments of current national guidelines on depression management in general practice suggest significant limitations in their relevance to general practice. The authors cite a number of issues such as NICE failure to appreciate risk factors in individual patients and patients' views about preferred treatments. Another criticism suggests that the contributors comprise those whose experience is 'more academic than practical and others who believe they have a monopoly of wisdom' [42]. NICE appears to have left no stone unturned in all aspects of treatment and the people involved in the treatment system including the role of patients and carers. Of the 35 guideline development group members, only 8 appear to be working healthcare professionals and there are only two GPs.

Doctors may decide to adopt these guidelines as insurance against being accused of not following official instructions in order to deliver the best care for their patients. Issues concerning difficulties for GPs in treating severe depression are highlighted by patient narratives and the findings of various studies commentating on the role of the GP. There are no GP narratives of personal experience published in the guidelines so it must be presumed that the GP perspective is





represented by the only two GPs involved in designing the guidance. It is perhaps due to this that NICE guidelines do not appear to fully take into account the realities of practice where individual patients almost invariably differ in their personal circumstances and attitudes to treatment. NICE does state that their guidelines do not replace the knowledge and skills of individual health professionals who treat patients; it is still up to them to make decisions about a particular patient in consultation with the patient and/or their guardian or carer when appropriate' in stating this, NICE presumably hopes to avoid being accused of stifling innovation and adaptation in treating individual patients.

But this implies that NICE is playing it safe in guarding its reputation against doctors who choose to stick rigidly to the guidelines and who may prefer not to be inconvenienced by taking into account individual patients' needs and circumstances and initially prescribe antidepressants in accordance with the guidelines simply because it is the easiest course of action. In order to highlight the differences between patients, NICE published a full and detailed account of 7 patients recounting their experiences of depression and the treatments (CG90 pp53-68). These are articulate and well-written accounts suggesting that the authors are clearly intelligent and have the ability to express themselves in a clear and coherent manner. However, not all patients have this ability. One interesting account is where the patient in secondary care describes that their GP 'had a go' with the consultant psychiatrist about the cocktail of drugs being taken (CG90 p54). This is unusual as consultants' opinions are rarely challenged. It also emerges that 5 of the patients stated that their medication was not successful. Again NICE covers its back by stating that these accounts are not representative of the experiences of people with depression and therefore can only ever be illustrative (CG90 p52).

NICE reference to the phenomenon of diurnal variations is restricted to two sentences. One study noted that after the onset of depressive symptoms, patients who experienced positive diurnal variations tended to wait longer before seeking treatment (Carpenter & Ellen 1986). Consequently, diurnal variation is a feature that both GPs and carers should be aware of.

Overall, the NICE guidelines are indeed comprehensive and thorough – perhaps too thorough. The NICE CG90- 91 Quick reference guidelines are more likely to be used by healthcare professionals who may not be inclined to wade through the full 700-page long CG90.

The question remains as to whether NICE guidelines will help people with depression. It was concluded by one study that they would not. What needed to happen was that support in primary care needed to be considerably extended. To achieve this, the authors suggest that consultant psychiatrists should be integrated into primary care [Whitty & Gilbody

2005]. But this suggestion ignores the reality of actual practice as consultants are normally bound by contract to operate purely on a secondary care basis [42]. It is also likely that case-laden consultants may be unwilling to take on extra duties and responsibilities.

In the end, NICE guidelines do not seem to fully recognize the realities of everyday practice problems in dealing with a very complex illness and the individual needs of different patients.

### **NICE CG90 and antidepressants**

Anti-depressants are usually the only drugs prescribed in primary care and are promoted by NICE as first-line treatment for cases of severe depression (CG90 p571). NICE claims that as a result of an analysis of a large qualitative study, the conclusion was that the majority of patients had positive experiences with medication (CG90 p78). However, in the published patients' personal accounts regarding medication (CG90 p78-79); NICE does not specify what the severity of the depression was in each patient making it difficult to determine the effects of antidepressants in the individual patient accounts.

However, antidepressants vary to some degree in effectiveness and severity of side effects but in reality, there is probably greater variation between people than between drugs. But do NICE guidelines go some way in improving the GP's understanding of these drugs to the benefit of their patients?

NICE appears to be reasonably clear on the treatment guidelines for severe depression in highlighting associations between severe depression and response to antidepressants.

However, there is evidence that the number of patients achieving symptom remission to initial antidepressant treatment is no more than 35% among all patients treated [43]. In addition, if the patient does not respond to first-line antidepressant treatment, the likelihood of improvement with subsequent changes lessens. Less than half of patients do not respond to a second antidepressant [44].

NICE guidelines rely on evidence from random control trials (RCT) on the efficacy of antidepressants but it is argued that 'RCTs are simply experimental tools used to test hypotheses—they are not well designed to assess clinical effectiveness' [45]. The very nature of RCT means that they are somewhat artificial. RCTs are conducted in a controlled clinical setting which does not necessarily translate into the best possible evidence that would translate into real practice [46]. However, NICE does acknowledge the limitations of the literature on RCT. For example, NICE states that participants who are recruited by newspaper adverts and paid for their contribution mean that these trials may not be representative of patients seen in clinical practice (CG90 p301). Despite acknowledging some of the objections to RCT, NICE does not



significantly differ from guidelines published in other English-speaking countries in promoting the use of antidepressants as first-line treatment. However, there are a range of issues concerned with the use of antidepressants; their supposed efficacy, and issues of possible adverse side effects. In terms of the efficacy of the different antidepressants, NICE concludes that all have largely equal efficacy (CG90 p328). Choices therefore may be based on side effects, patient preference and previous experience of treatments, propensity to cause discontinuation symptoms and safety in overdose, as well as cost. Potential interactions with concomitant medications or physical illness are also important to consider when choosing an antidepressant (CG90 p 412). Questions as to the efficacy of antidepressants have been published. Moncrieff [47], claimed that there is little evidence to support the NICE conclusions that antidepressants are more effective in more severe conditions [47]. This particular article did attract significant response from other readers. One of the more revealing responses posted by a GP from Poole in Dorset was titled: 'Give me an alternative'

*'When the next patient sits down & tells me they are depressed [almost certainly Monday morning], what will I do? I could offer them nothing, or referral to a psychologist – which amounts to the same thing, with a waiting list of over a year, access to which is screened by a psychiatrist. I could offer referral to a counselor – only 2-3 months wait, screened by the psychologists, with rejections involving more delay & tricky explanations.*

*Or I can treat them with an SSRI, & whether it works via a placebo effect or by altering brain biochemistry, I don't care. No delay, & it works. Patient happy, me happy. Patient still unhappy sent to a psychiatrist' [48].*

Could it be that the opinions of this particular GP are essentially his practical and pragmatic approach to the initial treatment of severe depression in the setting of a busy primary care practice or is he a GP who does not feel confident in treating patients beyond merely issuing a prescription for antidepressants?

### NICE and psychotherapy

NICE promotes the important role of psychotherapy as integral to the treatment of depression. The efficacy of psychotherapy is drawn from evidence-based research. In cases of severe depression, NICE advocates the combined therapies of antidepressants plus CBT or IPT (CG90 p297). NICE also recommends CBT alone as a treatment for moderate depression (CG90 p291).

Although NICE bases its recommendations on published trials, it appears not to have taken account of the findings of studies that conclude that CBT is ineffective in cases of severe depression [49,50]. However, other studies conclude that CBT or other therapies can be effective in the initial treatment

of severe depression. NICE fails to make this crucial point regarding treating severe depression with psychotherapy as early as possible. However, there is the question as to what level of illness severity gets psychotherapy treatment priority. It could be argued that cases of severe depression need to be as soon as possible because they are the most poor. It could also be argued that moderately depressed patients also need a quick appointment to prevent a slide into severe depression.

On February 2<sup>nd</sup>, 2011, the Department of Health indicated it would be investing over £3 million pounds in order to provide more psychotherapists. At first sight, this would seem that policy was heading in the right direction. However, increasing investment may not have the desired consequences. Despite there being more psychotherapists, there is a potential for infinitely expandable demand. The greater the provision made, the more likely it is that the increase in provision will itself create an expanding demand.

### Are NICE guidelines written in the best interests of the patient?

It could be argued that NICE provides the necessary comprehensive and detailed guidance for those treating patients. Patients should therefore benefit from being treated by healthcare workers who are better informed and directed. But is this always the case? How can evidence be gained from real-life experience and whether the guidelines do indeed provide the necessary information in order to maximize the best possible care for patients? Leaman [51] argues that: 'guidelines always attempt to be "watertight", and in order not to miss anything there is generally an element of overkill. This usually takes the form of over-investigation, or over-treatment, which is often not in the patient's interests.'

There is an increasing trend towards seeking evidence from the service user's experience of the treatment system. This is seen as an important contribution to improving the quality of care which should translate to patients' best interests. It has been suggested that service users often provide a different perspective which can result in imaginative and innovative solutions [52].

NICE devotes only a few pages to the role of the patient's carers and emphasizes their role as being one of patient support. But NICE fails to recognize that carers have a more important role to play that is in the best interests of a patient.

In terms of quality and effectiveness of primary care, evidence of the patient's carers can be crucial. The nature of severe depression can mean that the patient's thought processes may not be functioning properly. It is the carers who can a more detailed account of the patient's problems into perspective and thus contribute to a greater understanding in aiding the GP to assess the patient more accurately. The Royal College of Psychiatrists recognizes the full value of carers. The college's leaflet on depression and working in partnership with





doctors and carers carries advice on what to do if the doctor is unwilling to involve you as a carer [53]. This clearly implies that not all doctors are willing to invite the patient's carer to the consultation. It could be argued that not involving carers as part of the treatment 'team' could be a missed opportunity to deliver a better quality of care.

The basic interests of a patient are often very simple: to get better as quickly as possible. NICE guidelines are not likely to lead to this objective. NICE carefully ensures that they appear to be promoting the best interests of patients. But perhaps where the NICE guidelines do fail patients and healthcare workers, they do so because they do not add anything new to what is already known. NICE merely recommends areas for new research into various aspects of treatment.

### System failures, system failures methodology, systemic learning, and systems thinking

**Systems failure methodology:** In order to arrive at a useful understanding of a failure in the treatment system, there needs to be an understanding of its systemic background.

A systems failure methodology provides a useful framework for identifying the key areas of failure within the existing system.

It is, or it provides, the means for the doer of the study to achieve a complete plan for studying a situation, which encourages all and any important avenues to be explored and considered.

It is not a simple checklist that when worked through gives the right answer. Instead, it poses open-ended questions with many possible answers.

It contains a statement of the objectives of the study which are open to review and modification.

The systems failure methodology follows a sequence of steps.

Step 1 Create a list of all the actors and components involved in the treatment system for severe depression for example: patients, patient carers, consultants, GPs, mental health nurses, psychotherapists, and so on.

Step 2 Develop a systems model/hypothesis of the failure situation, in order to understand what happened and how it usually works.

This step begins with a description of the failure and the systems involved. At the end of this step, it should be possible to identify various failure areas and the system(s) involved.

#### (a) Describe the failure

What kind of failure is it?

Why are we interested in studying it?

What objectives were not met?

#### (b) Define and examine the systems involved

Use system questions to identify relevant systems and components and examine components, responsibilities, goals, processes, interactions, and constraints.

Try to look at the systems in different ways.

Step 3 Define a hypothetical system(s) and its activities which is relevant to the failure situation and which satisfies the necessary set of objectives.

Step 4 Compare the actual and hypothetical systems to ascertain where and why the system failed

Step 5 Select areas for further research.

This step should be based on the problem areas arising from Step 4

Step 6 Select, design, and implement feasible, desirable solutions, i.e., decide what actions are required.

Step 7 Appraisal – in other words, never close the books - the job is never done!

### System failures

Failures can happen at any point in primary care treatment systems which can affect its efficiency. System failures are not just random happenings; they are likely to be a result of the output of any particular element of the treatment system. A system failure can be simply expressed as a shortfall between actual performance and required standards and may also generate undesirable outcomes.

### Why study failures?

It is generally accepted that more can be learnt from a system failure because it can not only enable the investigator to discern patterns and find coherent explanations in order to discover why and how a system fails but also predict where future failures are likely to happen. Brearly [54] identified some common themes of system failures:

- Failure to maintain change
- Communication failures
- Performance monitoring failures
- Failure to act on feedback information
- Failure to learn past lessons
- Complacency
- Violations of procedures

But learning from successes can at times be just as important; not doing so could itself be classified as a system



failure. One example is the work of the Regional Mood Disorders Service in Newcastle which provides tertiary care for patients with complex and treatment-resistant conditions. This center claims to provide informative feedback to others concerned with the treatment of severely depressed patients in cases of how and why treatment has been successful.

System failure methodology can highlight not only shortcomings but also identify gaps in the system where more beneficial and cost-effective approaches could be implemented. Feedback is an important feature of systems design. For example, it is claimed that doctors are poor at reporting adverse and serious effects of drugs [55]. Having a feedback system in place to report these problems could avoid cases where patients feel very much worse due to side effects and could risk suicide ideation. No national feedback system exists whereby healthcare professionals can report and publish when they have presided over what they consider to be treatment failures and successes. Such a feedback system may prove to be just as helpful if not more so than the results of scientific studies simply because it involves the experiences and realities of everyday practice.

### Systems thinking and systemic learning

Systems thinking can be defined as being a process of understanding how things influence one another as a whole. It provides insights and understanding into complex situations and problems. It can be used to investigate problems in a holistic way that takes into account all the system's actors at all levels. It recognizes that humans are involved and with this and as such, there will be many variables and complexities in different people at every level of the system in both the giving and the receiving of treatment. Systems thinking and approach are also designed to provide a framework where healthcare workers can agree on an agenda for improvement or a process for moving forward. A systems perspective could be considered as 'more like history or philosophy: it is an intellectual approach to issues that can apply to a wide range of human experience [56].

One example of examining a problem area where the treatment system could fail at an early stage in the primary care system may be GPs attitudes towards changing practice habits and existing beliefs.

There is the concept of systemic learning. The word systemic means pertaining to a system and how it affects the system as a whole. Systemic learning is the process by which an organization or individual responds and adapts to change. It could perhaps identify why external GP training programmes often fail as Chapman [56] points out:

*'Systemic learning involves practice and reflection on one's own experience; as such it is often an essential complement to acquiring new skills and knowledge. Systemic learning requires people to be willing to work jointly with those who have other*

*perspectives, but most importantly it requires those involved to reflect on the outcomes of their actions and modify their behaviours, beliefs, and interventions on the basis of that reflection. This type of learning is a continuous, on-the-job process and is distinct from the skills and knowledge learning that require instructors and attendance at relevant courses.'*

### Defining a hypothetical system and comparing it with the actual system: an example of how system failure methodology is applied

This is a short example of how step 4 of the systems failure methodology is applied. The first thing is to define a hypothetical treatment system. This is usually one sentence. For example, a hypothetical system for a primary care treatment system for severe depression could be:

*A treatment system to achieve remission of symptoms of severe depression as quickly as possible.*

The next step is to compare the actual system with the hypothetical system to identify problem areas, research alternative ideas, and develop these ideas into a coherent set of activities that is an effective system. Comparing the hypothetical to the actual system provides a more detailed understanding of why and how the system fails and is a basis for researching areas for feasible changes.

It is possible that the objectives of the original hypothetical system definition may not be feasible. The bar may need to be lowered to something that can be realistically achieved. For example, a modified definition could be:

*A treatment system to stabilize the patient in order to prevent further deterioration and improve quality of life.*

This definition would consider the possibility that full remission may not be achievable. It may be the case of getting the patient to an acceptable level of functioning and improved quality of life until a more advanced reduction of symptoms is achieved. It could be argued that this redefining of the original hypothetical objective is something of a 'fail-safe' mechanism.

### Primary care treatment systems for severe depression

There are a number of proposed primary care treatment systems published which are designed to increase the chances of recovery from severe depression. Two systems that appear to be studied more than others are the stepped care system and the collaborative care system.

A system is defined as something that is an assembly of components connected together in an organized way. Both treatment systems qualify as systems in this respect but do these proposed treatment systems employ a systems thinking approach in order to provide sufficient insight that would take into account all the variables and the problem areas that exist in what is essentially a human activity system?



## The stepped-care system

The stepped care system comprises different treatment steps arranged in order of increasing intensity of treatment. NICE published details of the stepped care system in their 2009 CG90 quick reference guide. The steps are:

Step 1: Recognition in primary care and general hospital settings

Step 2: Treatment of mild depression in primary care

Step 3: Treatment of moderate to severe depression in primary care

Step 4: Treatment of depression by mental health specialists

Step 5: Inpatient treatment for depression

In cases where severe depression is diagnosed in primary care but has not responded to treatment the patient is elevated to step 3. This step includes issues of medication advice such as dangers of non-compliance plus high-intensity psychological interventions, combined treatments, and referral for further assessment and interventions. Step 3 marks the extent of treatment that can be offered in primary care. The step 3 team consists of mental health workers and family support teams. Primary care mental health workers may come from a range of professional disciplines (for example, nursing, psychology, allied health professions, social work) but who have a relevant mental health professional background. Should patients fail to respond to the treatment options, they are then referred to secondary care with a consultant psychiatrist. However, the basis for step 3 to be effectively implemented, an accurate history is required from the referring GP. Here there is a potential for an early system failure.

Belgamwar, et al. [57] assessed GP referrals to the step care system as recommended by the NICE guidelines. They found instances where the GP was not clear on such matters as medication and if other interventions had been tried and the condition of the patient which could have allowed for a better assessment by the stepped care team. It was also suggested that some GPs may be unaware of the NICE guidelines and so did not refer the patient. This particular study excluded severely depressed patients but it highlights an important issue concerning the shortcomings of some GPs irrespective of the severity of their patient's condition. Chew-Graham [58], also points out the dangers of the poor communication skills of some GPs in the stepped care system. It appears that the designers of the stepped care system had not employed elements of systems thinking that would have identified the following issues:

- The potential of a blame culture such as identified by the Belgamwar study

- Whether local trusts have sufficient resources to meet the demands of a fully operational and effective system
- Recognizing the different and changing needs of individual patients
- The provision of an effective feedback system so healthcare workers are fully informed of the patient's progress

## The collaborative care system

This system proposes the use of a multi-professional collaborative approach to patient care. One American study pertaining to primary care required the patient to visit the GP at regular intervals during the first 4-6 weeks of treatment. The system also required the services of a psychiatrist who oversaw the education of the patient about the biology of depression, and the mechanisms of antidepressants and monitored the data on antidepressant repeat prescriptions to monitor patient compliance. Although the study claimed that their collaborative care system did improve patient outcomes, the authors admitted that it was difficult to identify which components of the intervention were effective [59]. Furthermore, the healthcare professional participants may have signed up for the trial for however long it took but who is to say whether they maintained this system of treatment much beyond the end of the trial?

A UK-based study set up a randomized controlled trial to test the effectiveness of a collaborative care system. The treatment system consists of a GP and a case manager who are a mix of professionals such as nurses, counselors, and occupational therapists working with the GP under weekly telephone supervision from specialist mental health medical and psychological therapies clinicians. There was a structured management plan of medication support and access to a depression-specific psychological intervention. In addition, there was a patient follow-up system and an enhanced inter-professional communication system consisting of feedback to the GP via email or personal contact. Compared to controls receiving care as usual, the authors of the study concluded that their collaborative care system produced encouraging results that were considered to be clinically significant. Unlike the American collaborative care system, the UK system did not employ the services of a consultant psychiatrist. However, it has been proposed that this could be a possibility in the future where consultants could act in an advisory role in more complex and treatment-resistant cases [60]. Despite the reported success of this particular collaborative care system, there is the issue of whether this system is generalizable. A follow-up study for say a year later would demonstrate whether the system is still functioning effectively; whether there were any new factors that had affected the system in some way.

Although the Richards, et al. study is a collaborative care





system, it misses taking into consideration how the system is likely to behave in terms of the individual members of the care team. There is the question of team dynamics and from this, recognition that individual healthcare workers will differ in terms of relationships, perspectives, conflicts, and motivations that can affect team performance.

A collaborative care system clearly relies on good teamwork. Good teamwork begins with the recognition that each member of the team has their own special skills and that therefore it should be accepted that there is no overriding importance of any of these individual skills. Inevitably, there will be treatment successes and there will be treatment failures. There will be opportunities to look at case failures to see if something can be learned from them. Perhaps one extra way of minimizing failure would be if possible, to ensure that team members are specialists. For example, CBT therapists can be people with not only basic training but also trained in the specific application of CBT to cases of depression. It has been demonstrated that patients treated by a specialist had better post-therapy outcomes [61]. Then there is the concept of systemic learning which encourages the team to adopt a continuous on-the-job learning process and the ability to adapt to the individual patient's needs. It can also provide insight into these individual problems. Insight cannot be taught, it can only be learned.

It would seem that collaborative care has a number of advantages over the stepped care system. Unlike stepped care, collaborative care has a functional feedback system and seems to encourage a more team-orientated approach. It is a system that is more likely to consider innovation in the light of experience and be flexible enough to meet individual patient's needs.

### How can GPs improve the treatment of depression in their practice?

In 2003, the Lundbeck Award for Best Practice in Depression was awarded to the Leicester Terrace Healthcare Centre, Northampton Primary Care Trust. The practice demonstrated the progress that general practices can make through a comprehensive and extensive mental health service, and the impact that involving nurses can make in improving the management of depression [61]. Research suggests that, with only brief special training, practice nurses can achieve excellent patient outcomes when working alongside GPs in assessing and managing depression. The principle aim of the mental health nurse is to provide practices with a nurse who can dedicate time to managing patients with depression, aiding the work of the whole practice team. Very positive patient outcomes are achieved through meeting the aims of the nurse. The impact of employing a trained practice nurse meant patients expressed a high level of satisfaction. GPs also had high levels of satisfaction regarding the progress of the nurse and the effect on their patients and that the service was beneficial to both patients and GPs.

Perhaps this could be the way forward in the primary care treatment of depression.

## Conclusion

Treating patients with severe depression can be challenging and treatment failures are commonplace. There are a number of studies that promote what is considered to be the optimum treatment system for severe depression. However, these studies do not apply systems thinking. Due to this, there is a failure to recognize that where there is a human activity system, there is always going to be the potential for failure. Treatment systems need to take into account that inevitably, there will be varying degrees of competency among healthcare workers.

Ultimately, the only effective judge of whether a treatment system succeeds is the patient.

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