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GUIDELINES IN PSYCHIATRY

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SUMMARY

Introduction: *Guidelines are important to the effective implementation of modern psychiatry.*

Method: *Review Article, using various sources.*

Results: *The writer's own experience of drafting guidelines is drawn upon, while pubmed articles have been searched on how to implement guidelines.*

Discussion: *The utility of guidelines are discussed and the relationship of guidelines to audit is explained.*

Conclusion: *Guidelines need to be effectively researched in order to have credibility; they need to be properly implemented in order to achieve desired improvement in practice and their implementation needs to be audited.*

Key words: *guidelines – implementation - audit*

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Introduction

Time was when we all practiced individually. Each practiced in his own way, according to his own beliefs. So there was no need for doctors to compare each other's practice with the other's.

However, now, most of us practice in a system which is, in one way or another, run by the state for the citizens of a country. Hence it is reasonable that each citizen should be enabled to receive equivalent treatment, so that all should receive the best treatment for the condition he/she has and at a reasonable cost-effective price.

Reasons for Drafting Guidelines

This immediately raises a serious problem. This problem is; What, then, is the best and most cost-effective treatment for a person with Mental health problems?

In answering this problem, various issues arise;

- How do we evaluate different treatments to decide which one is the best?
- How do we decide whether different treatments should be combined?
- Should we rely on consensus views of different groups of individuals? (will psychologists and psychiatrists ever agree?)
- Should we rely on experimental evidence/research?
- Who will collate the evidence and on what basis will judgements be made?

For most of us 'hard pressed clinicians' such collation of the evidence is a daunting task. Hence we turn to groups of persons who are willing to get together to draw up guidelines.

Guideline development is a sort of secondary science, derived from the knowledge acquired by primary research. It depends on people collecting information and putting it together in a readable, memorable and acceptable form in order to be able to promulgate it widely.

Biases in Guidelines

However, here there arises another problem; There is no hard and fast rule as to how the information is gathered and processed and used, and there can be an element of bias.

The bias may depend on who writes the guidelines

Guidelines may be being written in order to ensure that a certain treatment is given…so they may emphasize it.

Guidelines may be being written so that cost is reduced, so they might emphasize the cheapest treatment rather than the best.

Guidelines may be written so that a particular group of people, who have commissioned them, are favoured and their therapy is used.

However, even in such situations, there may very well be truth even in such guidelines.

In order to illustrate this, we could give some examples from treating Depression in the UK scene;

In the past, in order to manage costs, before SSRIs came off patent, Government officials used to try to persuade GPs not to prescribe SSRIs, but instead to use tricyclics. A hospital which wishes for one particular treatment or group of treatments be used jointly with the local GPs will commission a group to write local consensus guidelines which will then be promulgated across the area. However, the evidence is that SSRIs and CBT are a very useful treatment for depression (NICE 2009).

It is also true that there is no one standard way of writing guidelines thus;

One group of guideline writers may simply produce a consensus document based on their experience, while another group will organise a meticulous literature search, critically review many papers, and then produce evidence based guidelines, quoting their evidence.

Development of Independent Bodies for Guideline Writing

This is why the UK Government Decided that for our National Health Service, guidelines would be drawn up by an INDEPENDENT body, the National Institute of Health and Clinical Excellence, who would develop guidelines based on the best, independently gathered and analysed clinical evidence (Nice 2009). Hence in this way, Government could, when controversial issues arose, avoid the bias described above.

However, NICE, in its analysis, also considers cost effectiveness, and the tests it uses can become controversial, (being based on quality of life years-QALYS), and when a treatment is rejected by NICE on the grounds of cost effectiveness, this may lead to controversy as with new expensive Chemotherapeutic Agents for Cancer, or, in mental health, with anti-dementia drugs.

In fact, NICE, when developing guidelines for a particular therapeutic area such as depression or schizophrenia,

- Looks at all available evidence for all available treatments.
- Carries out extensive metanalysis of all available data for an available treatment.
- Carries out cost efficacy/effectiveness analysis.
- Publishes all their data as accompanying data with the main documents (extensive forest plots on the treatment of depression).
- May publish care pathways based on the evidence (as in schizophrenia, and depression 'stepped care).

However, there is no guarantee that NICE will cover all options. Because treatment is developing all the time, and NICE guidelines are published in revision every about 5-10 years ago, it is possible that NICE guidelines may go out of date before they are replaced.

In fairness, NICE always consults widely before a new guideline is issued, both with individuals and with bodies such as the Royal College of Psychiatrists.

- Guidelines are important because
- They inform individual practice.
- They guarantee effective practice.
- They guarantee safe practice tolerability is as important as efficacy.

They provide a standard against which the care given in a particular unit can be audited.

It is very important that guidelines should be drawn up locally, for local groups of doctors. This will ensure that the local situation is kept in mind. In this context it is important that it is remembered that NICE guidelines refer to the context of the British National Health Service, and it should not be assumed that they are applicable in all countries and all situations, where the context may be entirely different.

How to develop Guidelines

When devising guidelines locally, the following stages should be followed.

- Carry out an extensive literature search to identify guidelines which already exist, such as the NICE guidelines –you can use these as a basis.
- Carry out an extensive literature search to identify new data, such as major new studies (e.g. CATIE (Lieberman et al. 2005), CUTLASS (Jones et al. 2006), CAFÉ (Perkins 2008), EUFEST (EUFEST 2008), SOHO (Haro et al. 2006), in Schizophrenia).
- Critically appraise both the existing guidelines and the new papers as a consensus group (see our recent papers on the status of Olanzapine, and the biases in CUTLASS and EUFEST, note what data has been left out of the NICE guidelines on depression).
- Then draw up guidelines which are relevant to your clinical situation and where you practice (Agius 2010).

Guidelines provide a standard against which the care given in a particular unit can be audited.

This means also the task of implementation needs to be properly resourced.

When using Guidelines to audit practice remember that treatment, while usually falling within guidelines, needs to be taylored to the individual patient and circumstance. Therefore do not expect 100% compliance with guidelines-you are doing well with 75%.

If a patient's treatment does not comply with well set guidelines there is usually a good reason; ask for it or look for it- this may help identify important considerations in your practice (cultural or genetic issues in your population perhaps), and could lead to important and interesting research questions (difficulty in applying psychosocial interventions to South Asian Patients in my first episode of psychosis service led to much research in transcultural psychiatry (Agius et al. 2008, Agius et al. 2010).

Implementation of Guidelines

It is known that we do not change practice by simply publishing guidelines.

When the ICD-10 Primary care guidelines were published, colleagues in Cambridge did a study to observe the outcomes of using them (Croudace et al. 2003).

They found that Attempts to influence clinician behaviour through a process of adaptation and extension of guidelines are unlikely to change detection rates or outcomes.

One reason for this is is Information Overload. Guidelines are often left to lie on shelves.

Forsner has studied the implementation of guidelines (Forsner et al. 2008, 2010, 2010). A number of other factors have been suggested which are barriers to

Guideline Implementation. These include concerns about control over professional practice, concerns and beliefs about evidence-based practice and suspicions that there might be financial motives for guideline introduction (Forsner et al. 2008, 2010, 2010). Other barriers to guideline implementation include a lack of organizational support, the reluctance of clinicians to change, concerns about the quality of the guidelines, concerns that a "cook book" approach to medicine is being introduced and that complex clinical questions may be being oversimplified, an actual lack of acceptance of guidelines' recommendations, possible practical barriers in how the service is set up, as well as an implied and perceived challenge to the clinician's autonomy (Forsner et al. 2008, 2010, 2010). All of these elements may lead to anxiety and resistance among clinicians.

There are, however certain factors which can be used to enable guideline implementation. Effective facilitation strategies emphasize the importance of effective feedback, while focus groups about the Guidelines, as well as adaptation of the guidelines to the local circumstances of the service have also been found to be valuable (Forsner et al. 2008, 2010, 2010).

Given that compliance with the guidelines will be considered particularly important by service managers, clinical leadership, as well as education of the whole team about the importance of the use of the guidelines to improve practice is important, and needs to be followed by an audit to establish that the implementation process has been successful (Forsner et al. 2008, 2010, 2010).

Experience of Guideline Development

The content of Guidelines may depend on the Context.

Guidelines for treating schizophrenia in a traditional long stay asylum might be very much about medication. On the other hand, guidelines for treating schizophrenia in a community service committed to a 'recovery model' might also contain much about psychosocial interventions. Sometimes guidelines might be used as a tool for change, so if one wishes to change your model of care from an asylum to a community service, one will put psychosocial interventions into your guidelines, however one will have to provide an adequate resource to implement the guidelines.

The present author has drafted different sets of guidelines which had different aims.

On one occasion this was as a result of a UK Government Grant called a Beacon Project in which I was required to develop how primary care worked with mental health problems within the practice itself. Thus the accent of the guidelines was about how to work within a general practice. The guidelines I developed were included and published within a primary care resource pack (Agius 2003).

The most recent time the present author developed guidelines was at the request of GAMIAN, a Europe – Wide patient organisation (Agius et al. 2005, Agius et al. 2005). The aim was to explain to patients what modern Community Mental Health Services should look like, so that they could lobby Government in their states to develop such services and so that they could monitor progress; again a different focus. The guidelines were published in Psychiatria Danubina in 2005. Since the aims and the target group of the two sets of guidelines were different, although the scientific content of the Guidelines was similar, their presentation, and orientation was different.

The use of Audit in Guideline Implementation

Often, Guidelines are used to establish the standards for audit. Audit is defined as *"The systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient'*

Working for Patients 1989

In order to carry out the Audit Cycle,

- Determine which aspects of current work are to be considered
- Describe and measure present performance
- Develop explicit standards (the guidelines)
- Decide what needs to be changed
- Negotiate change
- Mobilise resources for change
- Review and renew the process.

The use of audit is very useful in the implementation of guidelines which have been developed.

Conclusion

Guidelines are useful when used appropriately.

However they need to be drafted judiciously, implemented carefully, interpreted wisely, and practice needs to be assessed against the guidelines with understanding and acceptance that in the human condition, the guidelines, the clinicians and the patients are all potentially fallible.

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