

Patient Choice in Depression: Are We Failing to Implement NICE Guidelines?

Journal of Patient Experience
Volume 12: 1-4
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DOI: 10.1177/23743735251325132
journals.sagepub.com/home/jpx



Susan McPherson, PhD¹ , Claire Wicks, PhD² ,
and Peter Beresford, PhD³

Abstract

In 2022, the National Institute of Health and Care Excellence (NICE) introduced “patient choice” as a major new principle in the guideline “Depression in adults: treatment and management.” In 2024, NICE launched a “patient decision aid” to provide practical support for this principle. We explore data on the treatment of depression from the United Kingdom’s National Health Service before and after the guideline was published to consider whether patient choice has been enabled by these developments. The types of treatment most commonly delivered prior to the new guideline (Guided Self-Help books, Counseling for Depression, Cognitive Behavior Therapy, and antidepressant prescriptions) are now more common than before. This suggests that the inclusion of patient choice in the guidelines has not yet translated into patients making a wider range of choices. We consider how patient choice came to be prioritized over patient experience in the guideline development process; whether the patient decision aid is likely to support patient choice and shared decision making; and whether there may be underlying ideological barriers which mean a more straightforward emphasis on patient experience would be a more logical route to enhancing patient choice.

Plain Language Summary

In the United Kingdom, the National Institute for Health and Care Excellence (NICE) provides guidelines for different conditions. In 2022, NICE published a new guideline for depression in adults. Between 2017 and 2022, professional and patient organisations engaged with NICE around how the guideline was being developed. They expressed concerns that *patient experience* was not being properly included. To address this, NICE included a review of research on *patient choice*. The patient choice review mainly summarised perspectives of healthcare professionals as well as identified some barriers to patient choice. The 2022 guideline subsequently emphasised the importance of offering *patient choice*. In 2024, an accompanying ‘patient decision aid’ was published to support patients to make informed choices about treatment.

We consider published data from England’s Talking Therapies services and antidepressant prescriptions. We discuss whether there is evidence of increased patient choice since the guideline was released. The most common therapies delivered before and after the 2022 guideline were guided self-help books, counselling and cognitive behavioural therapy. Furthermore, the frequency of delivery of these therapies increased in comparison to other treatment types. Antidepressant prescriptions also increased over the same time period. It therefore seems that choice decreased rather than increased. It could be that patients prefer these treatments. It seems more likely that these treatments are more available and that professionals guide patients to accept these limited options.

We discuss how the decision to review patient choice instead of patient experience when developing the guideline may have a role in preventing patient choice being implemented. We argue that patient experience remains a crucial element that needs to be better incorporated into guideline development.

Keywords

health policy, public health, depression, patient choice, patient experience

¹ Institute of Public Health and Wellbeing, University of Essex, Colchester, UK

² School of Health and Social Care, University of Essex, Colchester, UK

³ Shaping Our Lives, London, UK

Corresponding Author:

Susan McPherson, Institute of Public Health and Wellbeing, University of Essex, Colchester, CO4 3SQ, UK.
Email: smpher@essex.ac.uk



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Introduction

The National Institute for Health and Care Excellence (NICE) guideline on “Depression in adults: treatment and management”¹ prioritized patient choice through an explicit recommendation to provide information about treatment options, discuss treatment preferences and for commissioners to make preferred treatments available. We discuss the lack of patient choice evident in practice data across England and consider whether a new patient decision aid for depression released in September 2024 will be adequate to address this implementation deficit.

It appears the emphasis on patient choice was introduced to address stakeholder concerns.² A stakeholder position statement signed by 50 organizations stated:

A full systematic review of primary studies of service user experience is required, employing formal methodology for qualitative synthesis; AND findings from such a review must be incorporated into the broader approach to quantitative review and treatment recommendations rather than being left as a stand-alone section.³

Stakeholders were subsequently concerned that a proposed new review on “patient choice” would not adequately address their concerns about patient experience.⁴

Nevertheless, a review of “patient choice” went ahead and underpinned the patient choice component of the 2022 guideline. The review, published separately,⁵ represents a large volume of detailed work and generated useful insights. However, we consider whether the decision not to review research on “patient experience” may have limited the potential for implementing true patient choice.

Systematic identification of evidence is an essential step in developing guideline recommendations.⁶ In this case, the “patient choice” review aimed “to synthesize the qualitative literature on facilitators and barriers to treatment choice, from the perspective of people with depression and health-care practitioners.”

Although the inclusion criteria were precise, the 56 studies reviewed were diverse and included patient experiences of treatments, illness, choice, or shared decision making and professional (mainly GP) experiences of managing depression. The review is dominated by professional perspectives and in many of the studies of patient perspectives, there was no means of knowing that participants had a confirmed diagnosis of depression, which would normally be an exclusion criterion in a systematic review for a specific condition.

The review identified numerous barriers and facilitators to patient choice as per the expressed aim. Barriers included patient distrust of authority; patient concerns about the availability of preferred treatments; patients feeling unable to contribute to the decision-making process; GPs feeling obliged to prescribe antidepressants; and GP concerns that only short-term psychological therapies are available.

The guideline recommendations that followed were generic: to provide patients information about options and to offer choice. No recommendations directly address barriers identified in the review or harness facilitators identified.

Actionable Insights

Table 1 shows descriptive data⁷ from National Health Service (NHS) Talking Therapies organized by type of therapy for 2019/20 and 2023/24 (before and after publication of the 2022 guideline). We narrowed down the data to “depression” and selected courses of therapy delivered and converted the raw numbers into percentages of all courses delivered to people accessing NHS Talking Therapies across England.

These data show that the most common treatments delivered by NHS Talking Therapies prior to and after the 2022 guideline were Guided Self-Help books, Counseling for Depression and CBT. In fact, the delivery of these treatments (as a proportion of all treatments) has increased by several percent. Meanwhile most other treatments have reduced in terms of their share of delivery with a few exceptions (eg, interpersonal psychotherapy increased from 1.55% to 2.02%).

Patients may prefer guided self-help, counseling and CBT whether or not offered a choice. Alternatively, it is possible that NHS Talking Therapy services have a historically greater capacity for these treatments and are either guiding patient choice in this direction to match resource or not offering choice at all.

In addition to the therapies detailed in Table 1, antidepressant medication remains a common treatment for depression. NHS data indicate a 9% rise in the number of patients receiving antidepressant medication and 14% rise in the number

Table 1. NHS Talking Therapies Descriptive Data: 2019/20 and 2023/24 Financial Years.

Therapy type	Courses of therapy (%)	
	2019/20	2023/24
Cognitive behavior therapy	30.55%	34.00%
Guided self help (book)	25.22%	30.29%
Counseling for depression	18.74%	20.04%
Guided self help (computer)	7.18%	4.01%
Psychoeducational peer support	6.66%	6.54%
Nonguided self help (computer)	2.67%	0.21%
Behavioral activation (low intensity)	2.67%	0.00%
Nonguided self help (book)	2.13%	0.88%
Interpersonal psychotherapy (IPT)	1.55%	2.02%
Couples therapy for depression	0.57%	0.59%
Mindfulness	0.43%	0.18%
Behavioral activation (high intensity)	0.42%	NA
Eye movement desensitization reprocessing	0.41%	0.38%
Collaborative care	0.36%	0.40%
Brief psychodynamic psychotherapy	0.33%	0.41%
Applied relaxation	0.04%	0.06%
Structured physical activity	0.03%	0.00%
Ante/postnatal counseling	0.02%	0.00%

Note: shaded cells indicate an increase from 2019/20 to 2023/24.

of antidepressant items prescribed between 2019/20 and 2022/23.⁸ Considering findings in the NICE review of patient choice which suggested that patients felt “dismissed by prescriptions,” were fearful of addiction and pessimistic about their efficacy,⁵ this increase in prescriptions does not seem likely to be a sign of patient choice being implemented at scale.

Practical Recommendations

The new patient decision aid⁹ designed to support the implementation of choice focusses on 6 treatment options, including talking therapies (individual and group), supported self-help options and medication. This is far from the full range of treatments that are listed in the guideline so it appears patients will still be encouraged to pick from a list of options that broadly match current provision, which ultimately limits their choice.

The NICE guideline states that offering patient choice is “likely to lead to improved adherence with therapy and better outcomes for people with depression, offsetting any costs associated with longer consultations.” We hope that the new patient decision aid will help tap into this potential, which is essential given that beyond the patient encounters that do occur, there are also growing waiting lists, high levels of untreated mental distress and significant inequalities in access to mental health care.^{10–12}

It may be difficult for the decision aid to achieve this, however, in part because the concept of patient choice seems to have been highlighted and prioritized in the NICE guideline without adequate recognition of its specific ideological relations. Yet these are of significance and seem to be rooted in the shift to more market-based approaches to health and other public services. This also connects with the limited attention that has been paid to patients’ and carers’ lived experience and resulting experiential knowledge, despite the increasing emphasis on public and patient involvement in health and social care policy and research. The replacement of lived experience views and perspectives with a focus on “choice” also obscures other issues emerging from these knowledge sources. This has recently been highlighted by the international development of the discipline of “Mad Studies”¹³ which challenges prevailing medicalized understandings of conditions identified as mental illness, including “depression.”

How might this ideological disconnect work in practice to hinder rather than facilitate patient choice? NICE recommended treatments for depression include a fairly narrow range of NHS psychotherapies along with psychotropic medications and exclude treatments without a very specific type of evidence base (randomized controlled trials [RCTs]). Most community-based or third sector approaches to prevention and treatment such as counseling services, social prescribing, green prescribing, peer support and other forms of mental health support are not suited to or do not have capacity to mount full scale RCTs and their potential benefits may be largely obscured by NICE evidence hierarchies.

Moreover the evidence hierarchy appears to operate selectively. Where there is a formal evidence base, there is acknowledgement that much of it is of limited quality or compromised by conflicts of interest. The 2022 guideline is therefore heavily influenced in certain places by “knowledge and experience” of the committee members. For example, “The committee made the recommendations on the use of lithium by informal consensus and based on their knowledge and experience”; “The committee were aware, based on their knowledge and experience, that informal exercise, and particularly exercise outdoors, may lead to an improved sense of well-being”; “The committee used their knowledge and experience to recommend follow-up arrangements for people on relapse prevention therapy.”

Yet other forms of knowledge and experience (such as patient and carer experience) are either omitted from the guideline or have no influence on recommendations, even where this experience has been extensively researched using rigorous qualitative methodology and reviewed using systematic review processes. A future guideline could benefit from centering patient expertise and knowledge further, for example, by including a review of patient experiences of treatments and using findings from these reviews to inform treatment recommendations. Moreover, if it is agreed that patient choice of treatments may lead to improved outcomes, it will be critical that barriers to patient choice and shared decision making identified in research literature are addressed in any ongoing work to implement the 2022 NICE guideline. The decision aid may be a first step toward implementing patient choice; but its impact may depend on the extent to which patient experience and patient involvement was centered in the design of the tool and the underpinning evidence that it was based on and it is so far unclear whether that was the case.

Conclusion

There is little evidence that the inclusion of patient choice in the 2022 NICE guideline “Depression in adults: treatment and management” has resulted in patients being more able to choose psychological over medical treatments; nor in a wider range of psychological therapies being delivered by NHS Talking Therapies services. This commentary highlights that the inclusion of patient choice in treatment guidelines for depression may have limited impact without more meaningful engagement with patient experience when developing guidelines.

Authors’ Contributions

SMP was primarily responsible for conceptualizing this comment. Otherwise, SMP and CW contributed equally to the manuscript. PB contributed to conceptualizing this comment and proof reading/editing of the manuscript.

Availability of Data and Materials

The datasets analyzed during the current study are available via NHS England at <https://digital.nhs.uk/data-and-information/>

data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set

Declaration of Conflicting Interest

Prof Susan McPherson was a coauthor of the stakeholder position statement on the NICE guideline for depression in adults.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Patient involvement

Peter Beresford (coauthor) is a service user, survivor researcher, and co-chair of the disabled people's organization Shaping Our Lives.

ORCID iDs

Susan McPherson  <https://orcid.org/0000-0002-9478-9932>

Claire Wicks  <https://orcid.org/0000-0002-8330-5373>

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