NICE Guidelines on Depression: A full digest for Arts Therapists.

Malcolm Learmonth, Insider Art, May 2006.

Arts Therapies Services are increasingly threatened because we do not feature in NICE Guidelines, and therefore are not on managers 'tick boxes' for services. It is extremely damaging to the professions that, in the guideline in question, we do not exist at all. This review was undertaken at the request of the Council of the British Association of Arts Therapists, (BAAT), partly with a view to acting as a template as to how we might be able to approach other NICE Guidelines and influence their future development. The information should also be helpful to other Arts Therapies colleagues.

NICE Guidelines are extremely powerful documents. They 'should form part of the service development plans for each local health community in England and Wales.' (Shortened version, p40).

'Local health communities should review their existing practice in the treatment and management of depression against this guideline.' (ibid p39).

'Relevant local clinical Guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly' (ibid. p40)

'Health professionals are expected to take (the Guidelines) fully into account when exercising their clinical judgement' (ibid p2).

Some of this is potentially helpful, for instance the suggested audit criterion that:

'100% of patients with mild and moderate depression who have not responded to an alternative, less complex intervention (for example, guided self-help) should be considered for short-term psychological treatment.' (ibid p 53).

This document is an attempt to pull out of the NICE Guidelines the basis for a critique of their development and methodology, intended to help Arts Therapists question them as definitive statements of 'what works', to help us make the case for full participation in their review, (in this case, not due until December 2008), and to help make the case for more inclusive methodologies.

The professional bodies will need to consider this process in the light of '*The guideline development process – an overview for stakeholders, the public and the NHS'* available from NICE, as a matter of urgency. It is hoped that this review may be a start on this. It is particularly important that the full weight of research and publication in the Guidelines Therapies is brought to bear on this effort, and this should therefore be worked on in collaboration with educational institutions engaged in producing research.

This document is also intended to provide ready access to statements from the Guidelines that *do* help to make the case for the Guidelines Therapies and is accompanied by a collection of statements from the Guidelines which help build a case for Arts Therapies. ('Making A Case').

The full Guidelines are a 358, A4, page document, plus appendices. The process for this review included: 8 hours reading all the versions with a highlighter: 40 plus hours pulling out and analysing relevant passages from the downloaded PDFs and writing the document. The task has necessitated a relatively long document in itself.

It is clear from this that the major work needed on the NICE Guidelines issue is beyond the scope of working on an amateur basis, and requires a full professional investment and response. Doing other Guidelines might be quicker based on this experience, but is still a major and extremely time consuming undertaking.

This document is laid out mostly in the order of the Guidelines for ease of cross referencing to it.

Versions of the Guidelines.

The Guidelines are published in four versions. This document is based on the full version. The other versions are: The Quick Reference Guide (for professionals), (15 A4 pages), the information for service users, carers, advocates and the public, (56 A5 pages), and the reduced Guidelines (63 A4 pages).

It is important to realise that very few people, including decision makers, will have read the full Guidelines, and that most of the information useful both for making a critique, and for building a case for the Arts Therapies, do not appear in the shorter versions. All quotations and page numbers below are from the full Guidelines.

The Quick Reference Guide and shortened Guidelines are essentially synopses of the full Guidelines, but with all caveats and ambiguities removed. The effect of this is to make them read as hugely more 'authoritative' statements of fact, whereas the full Guidelines allow for far more questioning of both process and outcome.

It is worth noting some key aspects of the version primarily produced for service users, and I list these points in a separate section at the end of this document.

There are separate Guidelines on Depression in children and young people, which are not covered here, but need a similar review process by an Arts Therapist.

The Guidelines Development Group (GDG).

The Guidelines claim to 'have been developed by a multi disciplinary group of healthcare professionals'… (p7). In fact, there were only three disciplines involved in the Guideline development Group: Psychiatry (5), Psychology (3), Pharmacology (2). There was also 1 GP, 3 'patients', and a representative from NIMHE. There were no Allied Health Professionals (AHP's) whatsoever. There is nothing 'multi-disciplinary' about it as a group. The claim to have involved 'all relevant stakeholders' (p9) is not true, and the information given to service users ('The Guidelines produced by NICE are prepared by groups of healthcare professionals…', p3), is misleading.

The Guidelines were developed 'within the National Collaborating Centre for Mental Health' (NCCMH). Again this contains no AHP's. BAAT is listed as having responded to consultation draft. (p175). This is the sole mention of the Arts Therapies in the entire document.

The group formed sub groups 'covering identifiable treatment approaches': 'the Psychology topic group covered psychotherapies.' (p36) No rationale is offered for excluding AHPs from this. (p11). 'The clinical practice recommendations made by the GDG are…. derived from the most up-to-date and robust evidence base for the clinical and cost effectiveness of the treatments and services used in the management of depression' (p35). Again no rationale is offered for Arts Therapies exclusion, despite the specific aim of the Guidelines to 'evaluate the role of specific psychological interventions' (p12).

Revealingly, the Guidelines are 'for use by' list *does* include 'nurses, social workers, counsellors and occupational therapists'. (p11). The structure of the Guidelines development accurately reflects the power, status and hierarchy of health service professions, but in no way reflects which groups in fact do most of the front line work.

This makes a big impact when it comes to processes like 'Consensus statements'. 'Where evidence is lacking the Guidelines will incorporate statements and recommendations based on the 'consensus statements' developed by the ..group' (p7)

The Guidelines do state, that they are not 'a substitute for professional knowledge and clinical judgement' (p8), that they are limited by the availability and 'generalisability' of research available and 'by the uniqueness of individual patients' (p8). This point is emphasised several times: 'there will always be patients for whom Guidelines recommendations are not appropriate' (p8).

The Guidelines.

While the tenor of the Guidelines, certainly by the time they reach the shorter versions, is to represent themselves as definitive, the full version does acknowledge that just because there isn't evidence, (within a very rigid sense of what is 'evidence'), it doesn't mean an

approach it doesn't work: 'it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness' (p8)

Therapeutic relationship is critical: 'to support and encourage a good therapeutic relationship is at times more important than the specific treatments offered.' (p8). Arts Therapists can claim specific training and expertise in this area.

Research into depression that has 'failed to respond to treatment' often excludes 'whether the patient has had an adequate course of an appropriate psychotherapeutic treatment'. (p15.)

The Guidelines acknowledge that much of our understanding of depression is poor: 'our understanding of the aetiology and underlying mechanisms of depression remain putative and lacking in specificity.' (p 19)

They do acknowledge that 'premorbid difficulties (e.g. sexual abuse), psychological mindedness and current relational and social problems…. may significantly affect outcomes' (p19). Arts Therapists can claim expertise in working with these areas. 'Adverse childhood experiences' are identified as increasing vulnerability to depression, as is 'not having a confiding relationship' and 'separation or loss of a loved one'. (p20)

The discussion of aetiology, in terms of psychological thinking, cites Freud (1917). It is extraordinary to imply that there has been no development on this. Bowlby on his own provides a far better and more grounded psychological approach. The Guidelines do later acknowledge that there are 'numerous theories and methods of psychological treatment' (p28).

Professional communications skills make a big difference to detection: 'The communication skills of the GP make a vital contribution to determining their ability to detect emotional distress, and those with superior skills allow their patients to show more evidence of distress during their interviews, thus making detection easy' (p23)

Fascinatingly, 'Attempts to improve the rate of recognition of depression by GPs using Guidelines, lectures and discussion groups have not improved recognition or outcomes' (p23.) Arts Therapists can claim have these skills, and maybe to be able to train others in them, thus improving early detection.

The Guidelines acknowledge that 'factors like acknowledgement of distress, reinterpretation of symptoms, providing hope and social support were suggested to contribute to better patient outcomes', (p24), and that 'Psychological treatment for depression often reduces anxiety.' (p25)

Patient choice is emphasised: 'the healthcare professional should discuss alternatives with the patient' (p25)

The evidence for drug treatments is highly flawed: 'the placebo effect in trials of psychiatric drugs is often so large that specific pharmacological effects can be hard to identify'. 'when antidepressants are compared with placebo for this diagnostic group, the clinical improvements resulting from antidepressants over and above that for placebo is not clinically significant (Kirsch et al, 2002b). Given the recent focus upon publication bias, especially with regard to drug company funded trials (Lexchin et al, 2003; Melander et al, 2003) there is the possibility that some drug (or other) treatments for depression may offer no advantage, on average, over placebo, for patients with mild depression.' (p27).

This is an extraordinarily frank statement, and in the light of it, it is startling that the Guidelines go on to recommend drug treatments as the invariable first intervention beyond 'watchful waiting'. This raises serious questions about why drug companies were included as 'stakeholders' in the preparation of the Guidelines themselves, which we'll come back to.

Despite the fact that 'Psychological treatments have expanded rapidly in recent years and generally have more widespread acceptance from patients' (p29), psychotherapy is seen like this: 'Many, but not all, such therapies are derived from Freudian psychoanalysis, but address the difficulties of treating people with depression using a less rigid psychoanalytic approach (Fonagy, 2003). In any event, the emergence of cognitive and behavioural approaches to the treatment of mental health problems has led to a greater focus upon the evidence base and the development of psychological treatments specifically adapted for people with depression (for example, see Beck et al, 1979). (p29).

'Psychological treatments for depression currently claiming efficacy in the treatment of people with depressive illnesses and reviewed for this guideline in Chapter 6 include: cognitive behavioural therapy (CBT); behaviour therapy (BT); interpersonal psychotherapy (IPT); problem-solving therapy (PST); counselling; short-term psychodynamic psychotherapy; and couple-focused therapies'. (p29).

No rationale is attempted for excluding any other model beyond the singling out of 'psychological treatments specifically adapted for people with depression' (p29). This takes no account of the Guideline's own acknowledgement of the unsatisfactory nature of 'depression' as a diagnostic label, nor the complexity of its causes and outcomes.

'The view of the Guideline Development Group is that it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans. A focus on symptoms alone is not sufficient because a wide range of biological, psychological and social factors have a significant impact on response to treatment and are not captured by the current diagnostic systems'. (p54).

If this is the case, then why are only psychological therapies 'specifically adapted' to a category that has 'limited validity as a basis for effective treatment plans' included, and ones that take a more holistic approach to the 'biological, psychological and social

factors' (and, one might add, the existential, cultural, discriminatory, empowerment and disempowerment ones), as the Arts Therapies tend to do, excluded? This is one of several instances where the apparent logic and coherence of the Guideline's approach breaks down under scrutiny.

Later in the document it becomes clear that availability, what is 'seen' to be available, and extremely exclusive criteria for research evidence are also major factors in what is in, and ex-cluded.

The service user perspective is extremely token, taking up less than one page out of 358, despite claiming that 'For any guideline on the treatment of depression to be credible it has to be informed at every stage of its development by the perspective of patients' (p31). This is mere lip service, and there is no evidence of this having taken place beyond this statement. By its own account then, the Guideline is not credible.

The (sole) patient quoted clearly says that 'The provision of alternative therapies is paramount, instead of the reliance on medication as an ongoing first line defence.' (p32). Despite 'being informed at every stage by the perspective of patients', medication is *exactly* what the Guidelines recommend as a 'first line of defence'

Diversity also receives lip service: 'A number of different treatment approaches may be equally effective for patients who are depressed, especially for those with mild and moderate depression who are not considered to be at substantial risk of self-harm. Patient preference and the experience and outcome of previous treatment(s) should be considered when deciding on treatment.' And 'psychotherapies and information about medications in the patients own language', 'should be considered'. (p33). Culture, ethnicity, disability and social exclusion are nowhere considered in the Guidelines as factors, which seems extraordinary both in terms of the governments initiatives in these areas, and in the Guidelines own questioning of the usefulness of 'depression' as a universal diagnosis.

Methodology:

Six steps are identified: Defining the scope, defining the questions, developing the criteria for 'evidence', designing protocols for systematic reviews of evidence, synthesise and analyse data, and produce evidence statements related to the questions, and finally to 'answer clinical questions with evidence based recommendations for clinical practice' (p35).

It is claimed that the recommendations:

'are therefore derived from the most up-to-date and robust evidence base for the clinical and cost effectiveness of the treatments and services used in the management of depression. In addition, to ensure a patient and carer focus, the concerns of patients and carers regarding clinical practice have been highlighted and addressed by good practice points and recommendations agreed by the whole GDG'. (p35).

It is very hard to discern in what follows any evidence for 'a patient and carer focus'. Neither is it clear on what grounds 'treatments and services' offered by any AHP's are excluded from the Guidelines, nor on what basis were AHP's excluded from the GDG.

Within the GDG, 'topic groups' covered particular areas. Of particular interest to us is the 'Psychology Topic Group'. Membership of this group is not listed, though its chair is.

The GDG were assisted by 'special advisors', listed in Appendix 2. This list consists of *one* name, who is Head of a School of Health Science. Use of 'Special Adviser*s*' in the text is misleading.

The 'clinical questions' for the Psychology topic group were:

Are psychological interventions effective compared to: treatment as usual: other psychological interventions: medication?
Is there a benefit in combining psychological interventions with medication? (Appendix 6, p278).

It is hard to see how these questions can claim to have been fairly answered given the exclusion of many approaches, including the Arts Therapies.

The 'evidence base' was, fundamentally, Randomised Control Trials (RCT's).

'Since most of the clinical questions for this guideline concerned interventions, much of the evidence base was formed from high quality randomised controlled trials (RCT's). Although there are a number of difficulties with the use of RCT's in the evaluation of interventions in mental health, this research design remains the most important method for establishing treatment efficacy' (p38).

The first sentence of this statement appears to be a non sequiter: 'Since…' implies that there is an innate link between 'interventions' and 'RCT's'. This link is not obvious, and is not elaborated. Why should it be assumed that an 'intervention' is necessarily amenable to being isolated as a single factor? In fact, the Guidelines themselves acknowledge that the quality of the relationship with the practitioner significantly affects the outcome of any intervention. ('therapeutic relationship, is at times more important than the specific treatments offered'. p8).

Therefore, it is very hard to tease apart what is the result of the 'intervention' from *how* the intervention was made. The whole assumption of an RCT is that we *can* completely isolate single factors. This is something being made to look logical, when in fact it is very far from it. Both aetiology and psychological interventions are immensely complex in depression. There is no innate link between RCT's , interventions, and evidence, and it is misleading to imply, and even to state, that there is.

Nevertheless, and despite the acknowledged 'problem' with RCT's, the search for 'existing systematic reviews' was limited to 'RCT's published in English since 1995'.

This search was enhanced by approaching 'known experts in the field', but only for finding unpublished RCT's. (p39).

In assessing this extremely narrow view of 'evidence', a 'statement decision tree' was devised. (p45). This process begins with whether a study identifies a 'statistical difference'. If a study does not, the flow chart allows only two possible 'statements' to be made: either ' there is evidence suggesting that there is no clinically significant difference' or 'There is insufficient evidence to determine of there is a clinically significant difference'.

While this flowchart was 'designed to assist with, but not replace clinical judgement', (p44), these statements can only effectively damn any evidence that is not statistically based.

This is made explicit in the table on p46: 'Hierarchy of evidence and recommendations grading scheme':

'Grade A' evidence is: Evidence obtained from a single randomised controlled trial or a metaanalysis of randomised controlled trials

'Grade B' evidence, in descending order of value, are 'well designed controlled study without randomisation', 'well designed quasi-experimental study' and lastly 'well designed descriptive studies' (comparative, correlation and case studies).

'Grade C' evidence is expert opinion. This includes, as a special category, 'recommended good practice based on the clinical experience of the GDG, and evidence from other NICE Guidelines'.

It is very significant that this hierarchy completely excludes any evidence that is service user or carer based, and makes a nonsense of the previous claims that these perspectives are central. Hierarchy is absolutely the right word. It is extraordinary to claim that the Guidelines are based on the clinical experience of healthcare professionals, when only doctors and psychologists are members of the group, and defining who they regard as 'expert authorities' and what is 'evidence'.

The explanation of 'graded recommendations' (p47), makes it clear that the GDG 'extrapolated' from available evidence 'based on their' (own) 'combined clinical experience'. This allowed them to 'moderate recommendations based on factors other than the strength of evidence'

Answering clinical questions in the 'absence of appropriately designed high quality research' (i.e. RCT's), was achieved by 'informal consensus'. Given the selective nature of the GDG, it is not surprising that the 'clinical experience' and 'informal consensus' appear to have been extremely limited.

It is startling that it is the claimed that 'Professionals, patients and companies have contributed to and commented on the guideline at key stages in its development. Stakeholders for this guideline include: Professional stakeholders: the national organisations that represent healthcare professionals who are providing services to patients' (p49), given the apparent absence of any AHP input whatsoever.

It is equally startling that included are 'Commercial stakeholders: the companies that manufacture medicines used in the treatment of depression' when these stakeholders have a clear commercial interest in the promotion of their products, (as the Guidelines acknowledge) and produce unreliable evidence in order to do so. ('Most studies of the effects of drugs are sponsored by the drug industry, and these have been shown to be more than 4 times as likely to demonstrate positive effects of the sponsor's drug as independent studies' (p179).

Summary of Recommendations.

The relevant recommendations for a psychological therapies point of view are (pp52/52):

Short-term psychological treatment:

'In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered.'

Initial presentation of severe depression:

'When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own'.

Combined treatment for treatment-resistant depression

'For patients whose depression is treatment resistant, the combination of antidepressant medication with CBT should be considered.'

CBT for recurrent depression:

'CBT should be considered for patients with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions.'

What is obvious here is that only a very restricted range of psychological therapies options have made it into the Guidelines: CBT, problem solving, and brief counselling, even when a patient has expressed a preference for psychological interventions.

The guidance does however acknowledge that the evidence on which the recommendations are made, is in fact extremely weak, not least because the concept of depression itself is too broad. While it has been touched on before it is worth quoting the passage in full, because it considerably undermines the impact and validity of the whole document, but is in no way represented in the recommendations, and certainly not in the abbreviated forms. It is well worth Arts Therapists using this statement when confronted by the 'you're not in NICE' argument.

'The guideline draws on the best current available evidence for the treatment and management of depression. However, there are some significant limitations to the current evidence base, which have considerable implications for this guideline. These include very limited data on both long-term outcomes for most, if not all, interventions, and outcomes generally for the type of severe depression that often presents major challenges in secondary care mental health services. In parts, these limitations arise from the problems associated with the randomised control trial methodology for all interventions, but particularly for psychological and service interventions.

However, the most significant limitation is with the concept of depression itself. The view of the Guideline Development Group is that it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans. A focus on symptoms alone is not sufficient because a wide range of biological, psychological and social factors have a significant impact on response to treatment and are not captured by the current diagnostic systems.' (p54)

Given that virtually all of the RCT evidence is based on either the **HADS (**Hospital Anxiety and Depression Scale), **BDI** (Beck Depression Inventory) or **HRSD (**Hamilton Rating Scale for Depression) tools, all of which are symptom based, it is fascinating to read that 'a focus on symptoms alone is not sufficient', so not only is RCT methodology flawed because it cannot reduce trials to one discreet factor, but because it can only use measures that are 'not sufficient'.

The Stepped Care Model.

This model 'draws attention to the different needs that depressed people have – depending on the characteristics of their depression and their personal and social circumstances – and the responses that are required from services. It provides a framework in which to organise the provision of services supporting both patients and carers, and healthcare professionals in identifying and accessing the most effective interventions'

Of use to Arts Therapists are that at Step 3, Primary care mental health workers, working with moderate or severe depression are to offer 'psychological interventions' (without saying what), and at Step 4, specialist teams, working with 'treatment resistant, recurrent, atypical and psychotic depression', and 'significant risk' are to offer 'complex

psychological interventions' (the only mention of this), and that here and at Step 5, inpatient care and crisis teams should offer 'combined treatments'. (p58).

The expansion on step 2 (primary care), milder depression, states that 'structured therapies such as problem solving, CBT or counselling may be helpful' 'psychological therapies, such as longer term therapies such as longer term CBT or interpersonal therapy (IPT) are not recommended as an initial treatment' (p60).

Under 'psychological interventions' it is emphasised that 'the choice of treatment should reflect the patients preference based on informed discussion'. (p60). (This is a useful statement for Arts Therapists, despite the lack of any informed discussion in preparing the Guidelines, especially when combined with what follows): 'past experience of treatment and the fact that the patient may not have benefited from other brief interventions. For all treatments the strength of the therapeutic alliance is important in ensuring a good outcome.' (p61). Though this is then weakened by then claiming that 'problem solving is a brief treatment that can be readily learned by practice nurses and GPs' (despite the research evidence quoted earlier that training GP's in better interviewing didn't work!). Nevertheless, here it is in black and white that a) brief treatments don't always work, and b) that therapeutic relationship, which we can claim to have particular expertise in, does.

This is re-emphasised, alongside training and experience in relation to psychological interventions:

'Healthcare professionals providing psychological treatment should be experienced in the treatment of the disorder and competent in the delivery of the treatment provided'. (p61).

'In all psychological interventions, healthcare professionals should develop and maintain an appropriate therapeutic alliance, because this is associated with a positive outcome independent of the type of therapy provided.' (p61).

It is also important to note that where 'co-morbidity' features (i.e. complexity, for instance where there is also trauma, addiction or other problems, as there frequently are), that longer term work is often necessary. This helps build a case for more complex interventions like ours:

'In patients with depression who have significant co morbidity, consideration should be given to extending the duration of treatment for depression, making use, where appropriate, of treatments that focus specifically on the co morbid problems' (p61)

'Where depression is comorbid with another significant disorder, such as personality disorder, then treatment may need to be extended or varied' (p69).

And also that older people also qualify:

'The full range of psychological interventions should be made available to older adults with depression, because they may have the same response to psychological interventions as younger people'.(p61).

In the section on antidepressant drugs is this statement:

'Antidepressants are as effective as psychological interventions, widely available and cost less'.(p62).

It is worth inverting this statement: 'psychological interventions are as effective as antidepressants', and also well worth noting that slipped in here is some of the real agenda: psychological therapies are not widely available, and recommendations are being reached on a cost basis. And therefore 'In moderate depression, antidepressant medication should be routinely offered to all patients before psychological interventions.' (p63).

Psychological Treatments.

Here are the summary recommendations for psychological therapies in full. I will return to the 'evidence base' for these recommendations. What is obvious is that CBT has very effectively 'cornered the market'. This is presented as inevitable in that it has a 'robust evidence base'. I will consider this evidence base in detail later: it is not in fact all that robust.

'For moderate to severe depression, a number of structured psychological interventions of longer duration (usually of 16 to 20 sessions) from an appropriately trained member of the mental health team are effective. In addition to the evidence for their effectiveness, the choice of treatment will reflect patient preference and past experience of treatment. Most patients receiving these interventions will not have benefited from other interventions. The same principles underpinning the use of psychological therapies outlined for the treatment of mild depression (Step 2) also apply here. Where depression is comorbid with another significant disorder, such as personality disorder, then treatment may need to be extended or varied.' (p69)

Psychological Therapies: (Cognitive Behavioural Therapies and Interpersonal Therapy).

'The following recommendations focus on the provision of CBT. However, IPT can also be an effective treatment for depression. Where patient preference or clinician opinion favours the use of IPT, it may be appropriate to draw the patient's attention to the more limited evidence base for this therapy.' (p69) (We'll see just how slim later).

'When considering individual psychological treatments for moderate, severe and treatment-resistant depression, the treatment of choice is CBT. IPT should be considered

if the patient expresses a preference for it or if, in the view of the healthcare professional, the patient may benefit from it.'

'For moderate and severe depression, the duration of all psychological treatments should typically be in the range of 16 to 20 sessions over 6 to 9 months.'

'CBT should be offered to patients with moderate or severe depression who do not take or who refuse antidepressant treatment.'

'CBT should be considered for patients who have not had an adequate response to a range of other treatments for depression (for example, antidepressants and brief psychological interventions).

'CBT should be considered for patients with severe depression in whom the avoidance of side effects often associated with antidepressants is a clinical priority or personal preference.' (pp69-70)

The only rider to this, but a useful one, is that

'Psychodynamic psychotherapy may be considered for the treatment of the complex comorbidities that may be present along with depression.' (p69)

Couple focussed therapies also gets a mention:

'Couple-focused therapy should be considered for patients with depression who have a regular partner and who have not benefited from a brief individual intervention. An adequate course of couple-focused therapy should be 15 to 20 sessions over 5 to 6 months.' (p70),

It is emphasised that CBT should be offered in conjunction with medication. When we come to the evidence itself, it will be seen that in fact the only really convincing evidence for CBT is that this combination works better than either intervention on their own.

Psychological Therapies are particularly recommended when other approaches fail:

'Patients whose depression is treatment-resistant may benefit from psychological interventions' (p72).

Patient preference for psychological therapies is acknowledged, but tellingly is hidden on a consideration of computerised CBT! (An approach which by definition excludes the therapeutic relationship aspects of psychological therapies previously acknowledged as core.) The Guidelines also consider guided self help: 'It has been suggested that this can be done by para professional or administrative staff' (p95). (It also points out that US based research work on self help books reveals that one problem is that '22% of the USA population is functionally illiterate, and 44% will not read a book in any year' p89).

Nevertheless, it is there, and usable:

'Whilst many patients generally prefer psychological therapies over other interventions for depression (Angermeyer & Matschinger, 1996; Tylee, 2001), and the National Service Framework for Mental Health (Department of Health, 1999b) has called for increased availability of such treatments for common mental health problems, such treatments are often not available. This limited access arises from the shortage of trained therapists, expense, waiting lists (Goldberg & Gournay, 1997), and the reluctance of some patients to enter therapy.' p95

Psychological therapies have a role in relapse prevention:

'Mindfulness-based CBT, usually delivered in a group format, should be considered for people who are currently well but have experienced three or more previous episodes of depression, because this may significantly reduce the likelihood of future relapse.' (p76).

Research Recommendations.

Extraordinarily, given the ways in which approaches such as our own have been 'written out' on the basis of lack of 'high quality' research, the recommendations for future research break down as: 5/15 organisational/ social areas (screening, guided self help, exercise etc.), 7/15 pharmacological, and 3/15 psychological. These 3 are: to compare CBT, IPT and behaviour therapy outcomes related to initial severity: problem solving therapy in primary care, and

'An adequately powered RCT reporting all relevant outcomes to assess the efficacy of short-term psychodynamic therapy for depression should be undertaken' (p79)

This last is potentially useful to Arts Therapists wanting to take this sort of work on, and could be very useful to us.

The Health Economics research recommendations contain one relevant to psychotherapy:

'Investigate the comparative cost-effectiveness of IPT versus CBT for the secondary care treatment of depression with regard to the nondisease specific nature and the lower training needs of IPT.' (p80).

It is fascinating here that having earlier limited the range to approaches that are specific to depression, that here it is the *non*-specific nature of IPT that is seen as necessitating further research. In which case, why not the Arts Therapies? Presumably because they do not have the attraction of 'lower training needs'. On this issue, it is interesting to note that the costings on CBT are based on 'CBT …provided by a suitably qualified and trained clinical psychologist.' (p302), which implies a parallel level of training needs to Arts Therapists.

Mental Health Workers.

It is well worth noting that the agenda for 'de-professionalisation' is articulated on the Guidelines:

'In the UK, there are not sufficient mental health professionals to provide enhanced input and care coordination for all primary care patients with depression…..A major NHS staffing initiative for primary care mental health is the appointment of new graduate primary care mental health workers (Department of Health, 2000; Department of Health, 2003) who may potentially and significantly affect this situation.' (p82).

Review of Psychological Therapies for Depression.

We come now to the real meat of the document from an Arts Therapies point of view.

'It has long been recognised that focusing on their psychology can help people with depression' p127

This is followed by the criteria for exclusion:

'More recent has been the development of psychological therapies designed specifically for depression, linked to specific theories, and the use of randomised control trials for assessing efficacy… The focus of this guideline is on those approaches for which there is some evidence of efficacy and which are routinely used in the NHS.'

There is no question that the Guidelines Therapies *are* routinely, if inadequately, used in the NHS, and there *is* evidence of efficacy, if little in the RCT format.

Research is cited which demonstrates that:

'In their systematic review of a large number of studies, Roth and Fonagy (1996) concluded that there was good evidence for some psychological interventions for a range of psychological disorders, including depression. Many reviews have found that psychological treatments specifically designed for depression (e.g. cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT)) are equivalent to drugs in terms of efficacy (DeRubeis et al, 1999; Hollon et al, 2002). Recently, the Health Technology Assessment Group published a 'Systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression' (Churchill et al, 2001). Their general finding was that psychological therapies were effective, with 50% or more of those taking part having recovered by the end of treatment. However, they caution that a sizeable proportion of this may be due to non-specific factors, such as the therapeutic relationship and natural time course of depression. No significant differences were found between treatments that were specifically designed for depression, such as cognitive therapy, behavioural therapy and interpersonal therapy'(p127).

It is very important to note the phrase that approaches designed for depression specifically are not more effective on current evidence. Therefore there was no effective rationale for excluding them from the Guidelines. Yet in the next paragraph we read that 'non specific therapies tend to perform less well than specific therapies' (p128). No evidence is offered for this statement.

It is also acknowledged that:

'Leichsenring's (2001) meta-analytic study on the comparative effects of short-term cognitive behavioural therapy and psychodynamic therapy found little evidence of difference. This may be a result of large numbers of patients who respond in trials independent of the nature of the intervention as a result of non-specific therapeutic factors' (p128)

Having acknowledged the centrality of therapeutic relationship, this appears to be an attempt to dismiss it as a 'non specific factor'. (It is also added that since these were not RCT's 'caution should be exercised'.). Despite this 'it is now recognised that specifying the active ingredients in effective outcomes on therapy is difficult' (p128).

Some of what Arts Therapists would recognise as the effective factors are acknowledged:

'in practice most psychological treatments for depression share common features.
Indeed, there has been long debate about the 'specificity versus the nonspecificity'
of treatment (Karasu, 1986). Many of these common features relate to the therapeutic relationship such as providing an accepting, open and active listening relationship that helps to de-shame and remoralise people. In addition, however, there have been many suggestions for psychotherapy integration (Norcross & Goldfried, 1992). Even without a deliberate attempt to integrate therapies many approaches have evolved overlapping features in focus and intervention' (p128)

And the need to develop services is acknowledged:

'In 1999 the Clinical Standards Advisory Group acknowledged the effectiveness of some psychological interventions for depression and advised on the need for localities to develop resources for providing such interventions. The Department of Health's Treatment Choice in Psychological Therapies and Counselling Evidence-Based Clinical Practice Guideline (2001a) made similar recommendations. Indeed, in other countries such as the USA (Beutler et al, 2000), and Canada (Segal et al, 2001a; Segal, et al, 2001b), guideline development groups are consistent in noting the effectiveness of psychological therapies.' (p128)

It is acknowledged 'treatment manuals are necessary to clarify exactly what was done in a trial'. (p129) Only 'manualised' therapies are really testable by RCT's, since RCT's depend on isolating discrete factors. (Manualised therapies which are inevitably formulaic, delivered by rote, and unresponsive either to therapeutic relationship or to individual uniqueness, both of which the Guidelines themselves identify as key factors).

This is problematic given the nature of psychotherapy. This acknowledgement critically undermines the use of the RCT as the 'gold standard' on which the whole Guidelines are based, and which have been used to discount the Guidelines Therapies. For this reason, it is well worth quoting the passage in full:

'Therapies are also constantly evolving. For example, while the early trials of cognitive therapy focused primarily on automatic thoughts and assumptions, more recently some cognitive therapists have advocated additional elements of schema focus (e.g., Young et al, 2001). Salkovskis (2002) has argued that, 'In most incidences, CBT for any particular psychological problem is quite different now to CBT as practised ten or even five years ago. This process is evolutionary and interactive, and pragmatic outcome trials play relatively minor part in this development'. Of course, the same will apply to other forms of psychological treatment. This means that treatment manuals are necessary to clarify exactly what was done in a trial. It will also direct people to specific skills needed to engage that therapy as was conducted in the trial. However, treatment manuals also have a number of disadvantages in routine practice. First, they may restrict innovation because therapies are often in a constant process of development and change in line with new findings (Elliott, 1998). Secondly, as therapies become more complex and combine different elements in new packages, this can lead to a proliferation and an increasingly large number of different treatment manuals requiring validation. Although RCT's using manualised treatments can be one of a number of research endeavours that lead to the evolution of therapeutic understanding and techniques, it is unclear how an uncritical use of this approach will avoid stifling innovative practice.' (p129).

Other variables are also acknowledged: primarily the level of training is seen as critical. This leads to a very useful 'Good Practice Point' for us:

'Healthcare professionals providing psychological treatment should be experienced in the treatment of the disorder and competent in the delivery of the treatment provided' (p130)

There is a recommendation emphasising therapeutic relationship:

'Relationship factors'

'Many approaches advocate a therapeutic stance of genuineness, empathy and positive regard as derived from early counselling models of change (Rogers, 1957). Indeed, there have been important developments in understanding the role of the therapeutic relationship and alliance (Safran & Muran, 2000) and therapeutic 'universals' such as remoralisation, social support and reassurance are also regarded as important factors for treatments (Norcross, 2002; Schaap et al, 1993). The quality of the alliance/relationship may account for a significant percentage of variance in outcome (Norcross, 2002; Roth & Fonagy, 1996). Despite this, few research trials offer data on therapist characteristics or capacity to create a good therapeutic relationship.' (p130).

'In all psychological interventions, healthcare professionals should develop and maintain an appropriate therapeutic alliance, because this is associated with a positive outcome independent of the type of therapy provided.' (p130).

Comorbidity is again acknowledged as a big factor (i.e. a simple diagnosis of 'depression' is often an over simplification of a complex situation.)

'it is common for depressed patients to have different comorbid diagnoses, such as social phobia, panic and various personality disorders (Brown et al, 2001), which can affect outcome. Pre-existing disorders such as social anxiety disorders may, for example, increase vulnerability to depression, influence treatment seeking, the therapeutic relationship, and staying in treatment.' (p131).

In addition, there are complex factors affecting length of therapy, and a recommendation that this is recognised:

'In patients with depression who have significant comorbidity consideration should be given to extending the duration of treatment for depression, making use where appropriate of treatments that focus specifically on the comorbid problems' p132.

(In passing, it is worth noting that to shift a therapeutic focus 'specifically on the comorbid problems' may be repeat the error of responding to people entirely within symptom based and diagnostic categories, neglecting complexity and an holistic approach).

Nevertheless:

'different symptoms, e.g. those of distress versus those of self-criticism, appear to have a different time course. Key issues relating to the ability to form a therapeutic relationship will have an impact on time course and responses to time limited therapies (Hardy et al, 2001)…. historical factors such as sexual abuse may significantly impact upon speed of engagement and recovery. With this in mind the GDG undertook a separate analysis of short-term psychotherapies'(p130).

The logic here is hard to follow: having acknowledged that a factor like sexual abuse make engagement harder, and therefore the therapy longer, why then just look at *short* term therapies? It is also questionable to what extent 'distress' and 'self criticism' can be satisfactorily identified as differentiated 'symptoms', further illustrating the pitfalls of a purely allopathic approach.

The Trouble with 'Depression', Psychological Therapies and RCT's

The Guidelines do note that there is a fundamental problem with the concept of depression itself, and the concept that it is one 'thing' or symptom that be considered separately from the huge numbers of variables at work.

‘Typically, the symptom-focused diagnostic approach distinguishes between types of depression (e.g. psychotic versus non-psychotic), severity (mild, moderate and severe), chronicity, and treatment resistance. As this is the approach adopted in much contemporary research, and underpins the evidence base, it is adopted for this guideline’ (p130)

In other words, the Guidelines take ‘evidence’ produced within this frame because it is there, not necessarily because it tells us anything useful, and despite

‘Growing concerns as to adequacy of the current diagnostic system for efficacy research and the relationship between different diagnoses and different psychological and physiological processes (and indeed pharmacological interventions). For example, it is common for depressed patients to have different comorbid diagnoses, such as social phobia, panic and various personality disorders (Brown et al, 2001), which can affect outcome. Pre-existing disorders such as social anxiety disorders may, for example, increase vulnerability to depression, influence treatment seeking, the therapeutic relationship, and staying in treatment.’(p131).

This last statement is very important for making the case for Guidelines psychotherapies: both complexity, therapeutic relationship and length of psychological intervention have all been correlated in the Guidelines with these common factors. The ‘evidence’ as such relates to:

‘….trials that treat depression as a single disorder. However, depression is a highly heterogeneous disorder with many variables affecting outcome, including history (e.g. of child abuse) personality (e.g. perfectionism and self-criticalness) and life events.’ P132.

In other words, the fundamental relevance of the evidence to the common correlates of depression are fundamentally questionable.

The ‘evidence’ is further undermined by questions about the appropriateness of the RCT model to psychological therapies: the Guideline’s thinking about this issue is again hard to follow:

‘RCT’s for psychotherapy have been adopted from the methods of drug studies and this can raise a number of difficulties (Elliott, 1998; Roth & Fonagy, 1996). They have some disadvantages: for example, they may have unrepresentative patient populations, limited outcome measures, and significant problems with truly blinding assessors to the intervention.’ (P132).

The problems of standardising and ‘manualising’ psychological therapies have already been noted, as have the centrality of the ‘non- specific’ therapeutic alliance. Despite all this:

‘RCT’s have a key role in developing evidence-based practice but are best seen as only one element of a complex chain, which moves from initial case series through

controlled trials (development studies) on to randomised control trials (efficacy studies) and beyond to their application to routine care in 'ordinary' clinical settings (effectiveness studies). These issues were borne in mind by the GDG when assessing the evidence' (p132)

Despite this 'bearing in mind' in the next paragraph RCT's are still held as the definition of 'high quality', in line with the 'hierarchy of evidence' imposed earlier, even though

'trial results can be hard to interpret because of poor description of the trial participants, poor control for adherence to the therapy, uncertainty about therapist training and experience and, in some cases, participants having adjunct therapy, including antidepressants, during a trial.' (p132).

What this boils down to is that the standard of any evidence on psychological therapies, including CBT, is in fact acknowledged to be extremely poor, even within the Guidelines' own definitions of what constitutes 'quality', which they have also acknowledged to be dubious.

The bias for the Guidelines becomes even more questionable given the subjectivity of the therapies that were considered:

'The following therapies are considered as they were *seen as* (my emphasis) available in the NHS and there was initial evidence of a sufficient evidence base to warrant further investigation:
• Cognitive behavioural therapies (CBT) (for individuals and groups)
• Behaviour therapy (BT)
• Interpersonal psychotherapy (IPT)
• Problem-solving therapy
• Non-directive counselling.
• Short-term psychodynamic psychotherapy
• Couple-focused therapies.'(P133.)

That *'seen as'* is a frank declaration of subjectivity in the selection of the therapies that were considered. Seen as by whom? On what criteria? It would be fascinating to compare the list with the areas of interest of the psychological therapies group members. Since the group members are not identified, it is unfortunately not possible to do this.

It is hard to understand how the Guidelines therapies can not be *'seen as'* 'available in the NHS', when they most certainly are, or, given the process of HPC registration, the work of the Art Therapies Practice Research Network (ATPRN), and the extent of published research *'seen as'* not 'having a sufficient evidence base to warrant further investigation'. It is significant that the Guidelines themselves have a double standard about what constitutes 'evidence': on the one hand only statistical and RCT based approaches are 'quality', and on the other they have 'difficulties' and 'disadvantages' that make them an inappropriate tool for investigating psychological therapies.

It is very important to repeat that these passages, which between them undermine the RCT methodology in relation to psychotherapy, and appear to acknowledge a highly subjective bias in terms of what is '*seen as'* available and evidenced in the NHS, raise serious doubts about the credibility of the Guidelines as reliable bases for effective service development. However, *no hint of these caveats is to be found in the shorter and more accessible documents.*

CBT.

There is an interesting assumption made in the definitions offered of how CBT differs from psychodynamic therapy. CBT's original focus

' was on the styles of conscious thinking and reasoning of depressed people. For example, when depressed, people focus on negative views of themselves, the world and the future. A key aspect of the therapy is to take an educative approach where, through collaboration and guided discovery, the depressed person learns to recognise his or her negative thinking patterns and how to re-evaluate his or her thinking. This approach also requires people to practise re-evaluating their thoughts and new behaviours (called homework). The approach does not focus on unconscious conflicts, transference or offer interpretation as in psychodynamic therapy. As with any psychological treatment, cognitive behavioural therapy is not static and has been evolving and changing. For example, as noted, some cognitive therapies for depression may now focus on a schema-based approach' (p133)

If the process is one of discovery, learning, and recognition, then what is discovered, learned or recognised was, by definition previously not conscious. It is hard then to see how definitively separate from other psychotherapeutic approaches this really is. Any psychotherapist is working through 'collaboration and guided discovery' towards changes that include changes in how people think (cognition), and what people do (behaviour), by learning and discovering patterns of which we were previously unaware (schema). Schema thinking comes directly from attachment theory, and the early creation of 'working models' based on early experience.

There is important work to be done by the Arts Therapies developing this point, and emphasising that much of the work is done through the therapeutic alliance. (On which there is extremely strong evidence which does not seem to be used in the Guidelines). There is an urgent need to re articulate what we do in language other than that of early C20th psychoanalysis, which sounds arcane and is easily dismissed. Remembering that the initial reference to psychological therapies was referenced to Freud, (1917), and the claim that 'most' psychological therapies are psychoanalytically based, the language of 'unconscious conflict', 'transference', and 'interpretation', while they sometimes have real therapeutic explanatory power, are here being used to subtly imply that psychodynamic approaches are still somehow '1917'.

In reality of course, the appeal of CBT is at least as much to do with its 'discrete, time limited' approach. (p134). (And therefore 'cheap'. Although the costings are not in fact that cheap). However, the Guidelines definition of CBT is certainly congruent with aspects of the practice of Art Psychotherapy, but omits other key areas: therapeutic relationship, imagination, non-verbal thinking, dealing with emotions, 'autobiographical competence and affective processing', cultural context, emotional intelligence, creativity, empowerment and self esteem, all of which are key areas in depression.

Evidence.

It is worth noting the extent of the CBT evidence base used (which includes one study because its researcher was 'known to' the GDG (p135). It consists of 30 trials, with 2,940 participants. Interestingly,

'Since so many comparisons were possible from the available data, some were combined in an attempt to increase statistical power (for example, behaviour therapy and IPT were combined as 'therapies designed for depression').' (p137).

Given that the IPT evidence base is much smaller, this presumably had the effect of 'lending' some of CBT's credibility to IPT.

These are the evidence statements on CBT in full. This is dull, but it is very worthwhile pulling out what this evidence actually amounts to. *On the basis of these, it is not valid to in any way claim that the efficacy of CBT is 'proven', and many of these findings can be quoted verbatim to make that point. This is essential as CBT as 'treatment of choice' in the NICE Guidelines for psychological therapies is currently invariably securing resources over other approaches.*

There is insufficient evidence to determine:

'if there is a clinically significant difference between CBT and wait list control on increasing the likelihood of achieving remission' (p137)

'whether there is a clinically significant difference between CBT and placebo plus clinical management either on increasing the likelihood of achieving remission or on reducing depression symptoms by the end of treatment' (p137)

'whether there is a clinically significant difference between CBT and placebo plus clinical management on reducing the likelihood of leaving treatment early for any reason'.(p138)

'whether there is a clinically significant difference between CBT and other psychotherapies on either increasing the likelihood of achieving remission or on reducing depression symptoms'. (p138)

‘there is a clinically significant difference between CBT and other psychotherapies on reducing the likelihood of leaving treatment early for any reason’. (p138)

‘there is a clinically significant difference between CBT provided in primary care and GP care (with antidepressant treatment) on reducing depression symptoms as measured by the BDI or the HRSD at the end of treatment or at 5-months follow-up’. (p138)

‘there is a clinically significant difference between group CBT and other treatments on reducing the likelihood of leaving treatment early’.(p139)

‘there is a clinically significant difference between CBT and antidepressants on reducing the likelihood of relapse’.(p140)

‘there is a clinically significant difference between CBT and antidepressants on reducing the likelihood of leaving treatment early for any reason in people with moderate, moderate/severe depression or severe depression’. (p141)

‘there is a clinically significant difference between CBT plus antidepressants over antidepressants alone (with/without clinical management) on increasing the likelihood of achieving remission’ (p141)

‘there is a clinically significant difference between CBT plus antidepressants compared with antidepressants alone (without clinical management) on reducing depression symptoms’ (p141)

‘there is a clinically significant difference between CBT combined with antidepressants and antidepressants alone on reducing relapse rates’. (P141)

‘there is a clinically significant difference between CBT plus antidepressants and antidepressants alone on reducing depression symptoms in those with severe depression’ (p142).

‘there is a clinically significant difference between CBT plus antidepressants when compared to antidepressants (with/without CM) on reducing the likelihood of leaving treatment early for any reason’ (p143).

‘there is a clinically significant difference between CBT plus antidepressants and CBT alone on reducing the likelihood of leaving treatment early for any reason’ (p143).

‘there is a clinically significant difference between CBT and other treatments for patients with residual symptoms on reducing the likelihood of leaving treatment early for any reason’. (p143)

'there is a clinically significant difference between CBT and clinical management in people with residual depression on reducing relapse rates 2 and 6 years after treatment'. (p144)

There is *some* evidence suggesting that:

'that there is a clinically significant difference favouring CBT over antidepressants on reducing the likelihood of leaving treatment early' (p140)

'that there is a clinically significant difference favouring CBT over antidepressants on reducing the likelihood of leaving treatment early for any reason in people with severe to very severe depression' (p141)

'that there is a clinically significant difference favouring CBT plus antidepressants over antidepressants alone (with/without clinical management) on reducing depression symptoms at the end of treatment' (p142)

'that there is a clinically significant difference favouring CBT plus antidepressants over antidepressants alone on increasing the likelihood of achieving remission by the end of treatment in chronic and severe depression'. (p142)

'that there is a clinically significant difference favouring CBT plus antidepressants over antidepressants alone on reducing depression symptoms by the end of treatment in those with moderate or moderate/severe depression and severe or very severe depression'. (p142)

'that there is a clinically significant difference favouring CBT plus antidepressants over antidepressants (with clinical management) in people with residual depression on reducing relapse rates at1 year' (p143)

'that there is a clinically significant difference favouring CBT over clinical management in people with residual depression on reducing relapse rates 4 years after treatment' (p144)

'that there is no clinically significant difference between CBT and antidepressants on: reducing depression symptoms by the end of treatment and increasing the likelihood of achieving remission' (p140)

'that there is no clinically significant difference between CBT + antidepressants and antidepressants (with clinical management) in people with residual depression on reducing depression symptoms at the end of treatment (p143)

'that there is no clinically significant difference between CBT plus antidepressants and antidepressants (with clinical management) in people with residual depression on reducing depression symptoms 17 months after the end of treatment' (p143).

There is *some* evidence that:

'there is a clinically significant difference favouring CBT over antidepressants on reducing depression symptoms 12 months after treatment' (p140)

'there is **no** clinically significant difference between CBT and antidepressants on reducing depression symptoms by the end of treatment in moderate, severe, very severe or chronic depression'. (p140)

There is *strong* evidence *suggesting*:

'that there is a clinically significant difference favouring group CBT over other group therapies on increasing the likelihood of achieving remission' (p139)

'that there is a clinically significant difference favouring CBT plus antidepressants over antidepressants alone on increasing the likelihood of achieving remission in people with moderate and moderate/severe depression by the end of treatment' (p140

There is *strong* evidence that:

'The effectiveness of CBT plus antidepressants over antidepressants alone was particularly marked for those with moderate and moderate/severe depression or severe/very severe depression' (p140)

'Trends':

'Although it was not possible to detect a statistically significant difference between CBT plus antidepressants and antidepressants alone on reducing the likelihood of patient's leaving treatment early for any reason, there was a trend favouring combination treatment' (p142)

It can be seen from this that the CBT evidence, even within the Guidelines own definitions of 'quality' is that: CBT is not more effective than antidepressants in moderate to sever depression and that CBT combined with antidepressants tends to work better than either on their own. (Which in itself might well be because some appears to be paying the sufferer some attention and trying to help, rather than the specific technique they are using to do so).

CBT Summary:

This statement would appear to make it extremely hard to justify just how CBT has been represented as the 'proven' 'treatment of choice':

‘there was insufficient evidence to determine the efficacy of individual CBT for depression compared to either pill placebo (plus clinical management) or other psychotherapies’. p144

What evidence there is however presented very positively, given the number of statements in the ‘insufficient evidence’ list above.

‘CBT is as effective as antidepressants in reducing depression symptoms by the end of treatment.’ (This appears to contradict one of the statements above). ‘These effects are maintained a year after treatment in those treated with CBT whereas this may not be the case in those treated with antidepressants. CBT appears to be better tolerated than antidepressants, particularly in patients with severe to very severe depression. There is a trend suggesting that CBT is more effective than antidepressants on achieving remission in moderate depression, but not for severe depression. There was also evidence of greater maintenance of a benefit of treatment for CBT compared with antidepressants. We recognise that this is a different finding to that of Elkin et al (1989).’

'Adding CBT to antidepressants is more effective than treatment with antidepressants alone, particularly in those with severe symptoms’.

‘There is no evidence that adding an antidepressant to CBT is generally helpful’ (pp144/5).

Other Therapies and evidence.

I have not been as exhaustive with the evidence statements for other psychological therapies included in the Guidelines, since CBT is what Arts Therapies will be measured against. What is worth noting is how slender the evidence base for them is, emphasising the question over what was, and was not, included in the Guidelines.

Behaviour Therapy.

Behaviour Therapy is included, despite the absence of any systematic review, and only two RCT’s. Outcome is that there is ‘insufficient evidence’ for comparison with other therapies on leaving treatment, and ‘no evidence’ on efficacy compared with other psychotherapies. (p148).

It is hard to see why this has been included.

Interpersonal Therapy (IPT).

There was no systematic review, and 7 RCT’s. The evidence statements which are on pp150/1.

The clinical summary for IPT:

'There is some evidence to suggest that IPT is more effective than placebo and usual GP care and that its effectiveness may be increased when combined with an antidepressant. There was insufficient evidence to compare IPT with other psychological interventions' (p151).

Problem Solving Therapy

There was no strategic review, and 3 RCT's

The clinical summary:

'Problem-solving provides direct and practical support for patients with mild depression with their current life difficulties. The evidence is that this can be helpful for patients with mild depression and may be as useful to them as antidepressants. Both appropriately trained GPs and practice nurses can deliver this treatment effectively. However, all the studies of problem-solving therapy have been carried out in primary care; we do not know about its value in secondary care (for example, how it compares with active drugs or with CBT) and for depression other than in its mild form'. (p155)

Counselling.

It is acknowledged that Counselling is a vague term. The clinical summary (p158) states that 'it appears to be effective'. Of 1027 references the GDG found, 9 were RCT's, of which 3 met the evidence criteria.

Short Term Psychodynamic Psychotherapy.

3 suitable RCT's were identified. The clinical summary is that:

'Despite the fact that psychodynamic psychotherapy is the longest established psychotherapy, good quality research studies are rare. Comparisons between short-term psychodynamic therapy and CBT or antidepressants demonstrate a clear but not definitive trend towards increasing effectiveness for drugs and CBT at end of treatment. The potential superior efficacy of antidepressants and CBT is not maintained at follow up. However, psychodynamic psychotherapy may be of value in the treatment of the complex comorbidities that may be present along with depression'. (p161).

Couples Therapy.

5 RCT's were identified. The clinical summary is:

'There is some evidence for couple-focused therapies as effective treatments for depression when compared with wait list control, and they appear to be more acceptable than antidepressants. They appear to be as acceptable as individual therapy (CBT and

IPT). Unfortunately, there was no evidence to determine their efficacy compared with antidepressants'.(p164).

Older Adults.

4 Studies were identified, 3 of IPT, and one of CBT.

The clinical summary:

'There are few RCT's of psychotherapies undertaken on exclusively older populations. Therefore, there is largely insufficient evidence for the efficacy of psychological therapies in this patient group. There is some evidence, however, for the addition of antidepressants to IPT compared to IPT alone on achieving remission by the end of treatment and on reducing the likelihood of relapse after three years' maintenance treatment'. (p167).

Short term Psychological treatments.

It is worth quoting the Introduction in full, because it identifies the major assumption behind short term approaches, which are often contradicted in clinical practice, and what drives this, which is economics versus clinical realties.

'In primary care, there is a clear desire to find effective and rapid treatments for depression, particularly milder disorders. This has led to the development of short-term cognitive behavioural and other structured psychological therapies with 6 to 8 sessions. Most short-term interventions cover the same material as long-term therapies, but introduce it at a faster rate. In addition, therapists aim to establish a therapeutic relationship with clients much more quickly. Clients are expected to be able to articulate their problems clearly, not to have difficult interpersonal problems that would interfere with the establishing of a good therapeutic alliance, to be able to understand and appreciate the rationale of the therapy, and to be able to engage in independent work outside the therapy sessions'. (p168)

The clinical summary is:

'Short-term psychological therapies (counselling, problem-solving therapy or CBT) are more effective and more acceptable to patients than either placebo or wait list control. There is evidence that there is no difference in efficacy between short-term psychological therapies and other treatments (mostly antidepressants and GP care), although psychological therapy appears to be more tolerable' (p171)

Clinical recommendations.

In the light of the above, it is hard to understand in this section why:

‘When considering individual psychological treatments for moderate, severe and treatment-resistant depression, the treatment of choice is CBT. IPT should be considered if the patient expresses a preference for it or if, in the view of the healthcare professional, the patient may benefit from it.’ (p171)

nor why:

‘For moderate and severe depression, the duration of all psychological treatments should typically be in the range of 16 to 20 sessions over 6 to 9 months’. (p171)

No clinical evidence is offered, and the implication is that this recommendation is based entirely on economic, rather then efficacy criteria.

Of the 20 recommendations, 15 specifically relate to CBT. One relates to psychodynamic therapy:

‘Psychodynamic psychotherapy may be considered for the treatment of the complex comorbidities that may be present along with depression.’ (p173)

Of the research recommendations, there is one advocating:

‘An adequately powered RCT reporting all relevant outcomes to assess the efficacy of short-term psychodynamic therapy for depression should be undertaken. (p173).

Health Economics Evidence.

The economic evidence makes it clear why antidepressants are favoured: costs per patient were between £70 and £196. However ‘The number of prescriptions for antidepressant drugs dispensed in England has been increasing steadily since 1992 and reached £23.3 million in 2002. Spend on antidepressant drugs reached £380.9 million in 2002’ . (p177).

It is also

‘likely that the additional costs, if any, of brief psychological interventions provided in primary care are offset by savings on other healthcare costs. Hence, other factors such as clinical benefits, patient preferences and staff availability should be taken into consideration when choosing between these alternatives’ (p297)

and

‘The study by Guthrie et al (1999) compared brief psychodynamic interpersonal therapy with usual psychiatrist care. They found psychotherapy to be both more effective and cost saving’. (p298)

This is not surprising given that the cost of Psychiatrist care per hour of patient contact, is £207. (p305).

For comparison, a 16 week course of CBT:

'The cost of a full course of CBT was estimated at £867 when provided by a suitably qualified and trained clinical psychologist.' (p307.)

That's £54 a session: a top of Band 8 Arts Psychotherapist's time is valued at around £19per hour and at the bottom at around £16 per hour. Even allowing for planning, notes and admin around sessions, that is considerable cheaper. The cost of antidepressant prescribing would pay for around 19 million hours of Arts Psychotherapies. Taking a long therapy of say 80 hours per client, that is 2.3 million treatments.

'Based on the overall results, CBT alone is unlikely to be a cost-effective first line therapy for patients with moderate/severe depression treated in secondary care. Combination therapy however has been shown to be a cost-effective routine treatment for patients with severe depression'. (p311).

A useful counterpoint to the economic argument is the the quality of life issue.

'People with moderate to severe depression had QWB' (Quality of Well Being) 'scores similar to ambulatory AIDS patients and patients with moderate to severe chronic obstructive pulmonary disease'.

'A considerable proportion (25%) of the patients with Major Depressive Disorder valued the state of severe depression worse than death or equal to death'(p299.)

It is worth noting that QWB's and 'QALY's' (Quality Adjusted Life Years) may have some promise as measures of therapeutic effectiveness against medical symptom measures.

It is in this section that it becomes clear that the emphasis on CBT in the Guidelines is 'based on expert advice', and on what is available, (or '*seen as'* available). Which would seem rather circular, given both the 'experts' involved, and that availability is partly determined by what the experts recommend, and where the professional power blocs sit.

'Current evidence shows that a course of cognitive behavioural therapy (CBT) or interpersonal therapy (IPT) is effective in treating acute depression and also significantly reduces the risk of relapse. Based on expert advice, CBT was chosen as the form of psychological therapy for this (Health Economics) analysis since currently it has the best clinical evidence and it is more widely available than IPT in the UK'. (p300)

Despite the fact that:

'the clinical evidence review showed no overall superiority for CBT alone on treatment outcomes over antidepressants.' (p300).

Research recommendations: Health economics.

There is no proposal to research any psychological interventions, except, very significantly,

'Investigate the comparative cost-effectiveness of IPT versus CBT for the secondary care treatment of depression with regard to the non-disease specific nature and the lower training needs of IPT' (p312)

Pharmacology.

I have not attempted to review this section of the document in detail. It is however worth noting that

'Differences in outcome between antidepressant drug treated and untreated major depression are difficult to demonstrate in naturalistic studies' (p174)

'The number of prescriptions for antidepressant drugs dispensed in England has been increasing steadily since 1992 and reached 23.3 in 2002. Spend on antidepressant drugs reached £380.9 million in 2002'. (p177).

And that the viability of the RCT's promoting the validity of antidepressants are flawed, firstly because 'placebo effect' is distorted by what in effect is therapeutic relationship:

'In RCT's, patients assigned to the 'placebo' arm receive regular visits to their doctor, supportive help, and a kindly interest in their welfare. In some trials the participants are allowed to contact the therapist at any time to report problems. In short, they receive everything except the pharmacological help from the tablet in the 'active drug' arm of the trial. This constitutes a treatment in itself, and almost 30% of patients assigned to placebo respond within 6 weeks (Walsh et al, 2002). This recovery has two components: the spontaneous recovery of the disorder itself; and the additional recovery due to supportive care'. (p178)

It is clear from this that what is called 'placebo' is fact the first stages of therapeutic relationship. There is a famous phenomenon in social sciences research called the 'Hawthorne Effect'. Researchers trying to improve efficiency in an electrical plant were startled to discover that productivity rose, whatever variables they changed. They deduced that the variable producing the effect was *the presence and interest of the researchers.* People liked and responded to the importance and attention, and in this case the 'kindly interest in their welfare'.

Secondly,

'Most studies of the effects of drugs are sponsored by the drug industry, and these have been shown to be more than 4 times as likely to demonstrate positive effects of the sponsor's drug as independent studies (Lexchin et al, 2003). Finally, the tendency of journal editors to publish only studies with positive results (Kirsch & Scoboria 2001; Melander et al, 2003), and the fact that the same patients may appear in several publications (op. cit.), introduces a severe bias'. (p179)

Other problems with the drug RCT's are listed as: high drop out rates (20-35%), recruitment of participants (often through advertising, and paying participants), the smaller likely numbers of seriously depressed participants as a result, the fact that recovery is sometimes spontaneous anyway, the fact that seriously depressed people are seen as less suitable for RCT's because of risk factors, are all itemised (pp178/9).

'Despite the limitations of RCT's described above, the bulk of our recommendations are based on RCT evidence'. (p179).

In the light of this, it is even more disturbing that drug companies were included as 'stakeholders' in the preparation of these Guidelines when many mental health professionals were not.

The 'Information for people with depression, their advocates and carers, and the public'.

This document is produced 'mainly of people with depression'. (p3).

Like the other abbreviated versions, the processes and questions about the validity of the methods and evidence is concealed. There are some useful points:

The claim that the NICE Guidelines are produced 'by groups of healthcare professionals' is repeated (p3).

It is made clear that the Guidelines do no cover 'comorbidity', dual diagnosis or complexity. The Guidelines 'do not specifically look at' 'people with depression who have a separate physical or mental illness' (p5). Therefore anxiety as a diagnosis for instance, or other problems like substance abuse, PTSD or trauma put service users outside the scope of these Guidelines, and they are in a position to argue for different treatments.

It is acknowledged that 'depression can be set off for a variety of reasons (such as serious physical illness, dementia. Difficult things that have happened in childhood or are happening now, bereavement, family problems or unemployment') (p 9). Since the psychological therapies on offer are 'specifically designed' for depression in ways that exclude these biographical, complex, and social factors in favour of addressing only symptomology, then there is a case for services which do address these issues.

Service users are encouraged to feel 'that it is very important that you are involved in any decision about your treatment, and feel that the healthcare professional is always listening to what you have to say and that your views really do influence the type of treatment that you receive' (pp11-12). Given that professionals are obliged to implement the NICE Guideline, which contains no information about the Arts Therapies as an option, there is a case that service user choice is severely diminished by them.

This reinforced by the list of other possible referrals: 'Your GP may suggest that you see a specialist such as a psychiatrist, psychologist or mental health nurse' (p14). AHP's of any sort are not mentioned as an option. This list is repeated on p17, with the sole mention of 'counsellors'.

Despite this 'each person with depression is treated as an individual'. (p17). 'Psychological treatments' as such are mentioned on p18, where it is explicit that 'the aims of all psychological treatments is to reduce symptoms', as opposed, presumably, to addressing the potential causes identified on p9.

It is emphasised that treatment should be 'healthcare professionals who have experience of people with depression, and are skilled in giving treatment. In all psychological therapies, your therapists should work with you on what is helpful in overcoming depression'.

The range of psychological therapies is once again limited to those 'specifically designed to help people with depression' (p32), because 'these can be effective'. (p38). 'Psychodynamic therapy should not be offered ordinarily, but it maybe of some benefit if you have a number of complicated personal problems'. (As most will!)

CBT is defined as 'based on the idea that the way we feel ifs affected by our thoughts (or 'cognitions') and beliefs, and how we behave'. (p49). The definition of psychodynamic therapy is quite useful:

'Psychodynamic psychotherapy: a kind of psychological treatment, which is called dynamic because it focuses on the different forces (or dynamics) that are present in a person's relationships and everyday life, and may be causing them difficulties. The patient explores those thoughts and feelings of which he or she is aware (conscious) or not aware (unconscious), The aim is to examine understand and work through the forces and difficulties, which may have begun in childhood' (p54).

Conclusions.

- There are numerous grounds to question the validity of the NICE Guidelines.
- Specifically, the make up of the Guideline Development Group, the exclusion of any AHP's from the process, the view of stakeholders that includes drug companies but excludes AHP's, the use of research methodologies that mitigate against 'non manualised' psychotherapies, and give unreliable information about even manualised ones, the poverty of the evidence for CBT and the caveats about

methodologies which are not reflected in the shortened documents, the utter lack of any evidence that user or carer perspectives have in fact been considered, the neglect of social inclusion and equalities issues…

- These Guidelines are however extremely powerful documents, which remain as a fait accompli having a major impact on service development in England and Wales, and pose a major threat to the Arts Therapies.
- It is essential that the professional bodies commission more work like this review on the other mental health related Guidelines, and work on having a voice on the review process.
- There is a case to be made for the Arts Therapies from this document. It is a lamentably thin one. Such as it is, I point to the key elements in the 'Making a Case' document.

Malcolm Learmonth, May 2006.