Malcolm Learmonth believes that the NICE guideline on depression is deeply flawed

What evidence?

According to the recent Layard report, 'Crippling depression and chronic anxiety are the biggest causes of misery in Britain today.'[1] Both this report and the National Institute for Health and Clinical Excellence (NICE) clinical guideline on depression[2] are shaping policy and having a major impact on what help is available to people. And both claim that cognitive behaviour therapy (CBT) is *the* 'evidence based' psychological treatment.

I came to the NICE guideline from the point of view of analysing it to help approaches such as the arts therapies make a case for their continued existence.[3] The task turned out to be one of the most depressing I have ever undertaken professionally.

The full NICE guideline runs to 358 pages, but it is also available in three shortened versions for the public and professionals. Unsurprisingly, few people – including those who implement the guideline – read the full version. Yet it is only in the full version that the flaws show themselves. The shortened versions simply remove all the complexities, caveats and doubts. What is presented to the world as 'Now we know the facts we can tell you what's good for you' turns out to be highly questionable, even within its own terms.

Let's start with service user participation. The guideline claims 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' (p.31). Yet the service user perspective takes up less than one page out of 358. This is mere lip service: there is no evidence of service user participation having taken place beyond this statement.

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' (p.32). Yet medication (and CBT) are *exactly* what the guideline recommends as a 'first line of defence'.

Then there's the question of whether 'depression' is valid at all as a catch-all description for hugely variable experiences of distress. The guideline's development group themselves don't believe that it is. Their view 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' (p.54).

If, as the guideline suggests, depression as a category doesn't mean very much, why are only psychological therapies 'specifically adapted' to this chimera included? And why are holistic approaches like the arts therapies excluded?

The apparent logic and coherence of the guideline's approach breaks down under scrutiny.

Then there is the question of what constitutes 'evidence'. NICE works with what they call a 'hierarchy' of evidence. Grade A evidence is obtained from randomised controlled trials (RCTs). 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.

It is extraordinary to claim that the guideline is based on the clinical experience of healthcare professionals, when only doctors and psychologists are members of the professional group and it is they who define who they regard as expert authorities (other doctors and psychologists) and what constitutes evidence. As we have seen, evidence that is service user or carer narrative based doesn't count, making a nonsense of previous claims that these perspectives are central.

RCTs (Grade A evidence) assume that a single variable can be isolated and measured against another single factor. That's how they work. But trying to apply this psychological approach is about as sophisticated as trying to dismantle a watch with a meat cleaver. As the guideline puts it, 'there are a number of difficulties with the use of RCTs in the evaluation of interventions in mental health' (p.38).

We know that with psychological approaches, relationship is key: 'One of the most robust findings in psychotherapy research is that a good therapeutic alliance is the best predictor of outcome in psychotherapy'.[2] NICE knows this too. The guideline itself acknowledges 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' (p.8). So how can factors as subtle as the relationship between two people be illuminated by the RCT? How can you 'isolate' kindness, listening, understanding, validation and being alongside a person?

Having suffered from depression myself, I have found nothing in the guideline that relates to the complexity or depth of my experience or that of the sufferers I work with every day in my NHS practice

And then there are the vested interests of those who manufacture evidence. 'Stakeholders who have contributed to and commented on the guideline at key stages in its development ' (p.49) include 'Commercial stakeholders: the companies that manufacture medicines used in the treatment of depression'. These stakeholders have a clear commercial interest in the promotion of their products and, as the guideline acknowledges, may 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' (p.179).)

So the stakeholders who stand to make money out of depression manufacture not just drugs but also evidence. The writers of the guideline know that this evidence is distorted, and say so. And yet it is still presented as Grade A evidence. Even this evidence for drugs and CBT is a lot weaker than the abbreviated guideline would have us believe. Read the shortened guideline and you could believe that antidepressants and CBT are the 'facts' of what 'works'. Read the full version or try talking with a few people and you get a different picture.

Having suffered from depression myself, I have found nothing in the guideline that relates to the complexity or the depth of my experience or that of the sufferers that I work with every day in my NHS practice. I conclude that the guideline is a logically flawed mouthpiece for the professional and commercial vested interests that have created it.

The process for its review has started. If we want humane and effective mental health services to survive we must challenge NICE's approach to mental health, root and branch.

Cartoon by Fran Orford

1. *The depression report: a new deal for depression and anxiety disorders*, The Centre for Economic Performance's Mental Health Policy Group, June 2006.
2. All page numbers cited in the text are from the full version of *Depression: management of depression in primary and secondary care*, National Clinical Practice Guideline 23, National Institute for Health and Clinical Excellence.
3. The full text of this critique, and a shorter document with suggestions for arts therapists about how to make a case based on the guideline, are available to members of the British Association of Art Therapists from the BAAT website www.baat.org.uk and to anyone from the documents page of the Insider Art website www.insiderart.org.uk
3. Jeremy Holmes (2002) 'All you need is CBT?', *British Medical Journal* 324: 288–94.