

Naughty not N.I.C.E.: Implications for therapy and services

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Are we deceiving service users in an attempt to provide good services? The current climate does not encourage innovation within psychological therapy. This article will examine what is currently happening in mental health services, identify problems and explore potential solutions.

We may be deceiving service users in an attempt to provide good services! The National Institute of Health and Clinical Excellence (NICE) have produced guidelines for clinicians regarding the management of major mental health disorders. They include evidence-based treatments that are proven to be effective for those conditions. One of the treatments commonly recommended is known as Cognitive Behaviour Therapy (CBT).

The NICE guidelines are based on the principle that a good quality service should offer therapy that has been clinically proven to be effective. However, in my opinion there are problems with the existing system. Service users may be at risk of being misled and assume that the therapy they are receiving has had extensive research proving its effectiveness, which may not be true. NICE also have not provided a framework for the development of new theories and treatments.

Problem 1: Misrepresenting facts to Service Users

Recently, there has been a significant growth in the second generation types of CBT that are available. These include Schema-Focussed CBT, Mindfulness CBT, Compassion-Based CBT, Trauma-Focussed CBT, Family-Focussed CBT, and Solution-Focussed CBT. There are other types of therapy, such as Rational Emotive Therapy, Rational Living Therapy, and Dialectic Behaviour Therapy, which have even been described by some practitioners as CBT, but are clearly not what NICE originally intended when it developed the original guidelines. The generic use of the term CBT has led to an acceptance and endorsement of a wide range of disparate therapies as a result of the NICE guidelines.

Some of the new CBT treatments are very different from the original studies on which many of the NICE guidelines are based. These studies were based on a form of CBT that focussed primarily on behavioural strategies and changing the content of negative thoughts (see Roth and Pilling, 2007). Many of the newer forms of CBT are using very different techniques. These include a shift in emphasis from making changes to the content of negative cognitions to observing and accepting negative thoughts as well as using imagery and our senses. That is not to say that these newer treatments are not effective, just that they have not all been evaluated in large-scale studies. The use of the term 'CBT' in these circumstances may be misleading, encouraging service users to make assumptions about their treatment that are incorrect.

Thus, when CBT services are commissioned and service users request CBT based on NICE recommendations, they will assume the treatment has not only been vigorously evaluated and clinically proven to be effective but is also endorsed by the government. In reality, however, this may be far from being the case. Some of the second generation types of therapy on offer have undergone

little research and would not meet the strict NICE guidelines. Service users may not be aware that they are being treated with techniques that have not been vigorously evaluated, and if they were made aware, they might not give informed consent. Thus, using the term ‘CBT’ in the current climate may lead to assumptions about the therapy that may be untrue. This is misleading and disingenuous.

Nonetheless, it is important for CBT to develop and evolve. The originators of these innovations are probably not intentionally using the term CBT just as a means of gaining recognition and approval. However, the danger in the system lies in the context in which the term CBT is used; the assumptions and implications that accompany the use of the term ‘CBT’.

Problem 2: Innovation will happen

Innovation to therapy will happen! Further clinical observations and small scale studies continue to inform our understanding of treatment techniques. New advances in technology have increased our understanding of how the brain works, such as the use of functional MRI scans, which may also have implications for treatment. Without innovation in therapy, gradually treatment techniques become more outdated and not reflect current knowledge in the field. Following the existing NICE framework, only using evidence from large clinical trials, will not allow for the development of new and more effective psychological techniques, and will eventually lead to widespread use of archaic treatments.

Therapists have been involved in developing innovative practices, such as Human Givens (HG) therapy, mindfulness CBT, compassion-based CBT, narrative therapy... the list could go on. For each of these therapies, there will have been service users on whom the treatments were initially tried and refined. Once the treatments became more established, there may have been even more service users who would have been used in the small trials to demonstrate effectiveness. Thus, in the development of all of these innovative treatments, there are many service users who have been treated with therapies that do not comply with the NICE guidelines for evidence-based practice.

Problem 3: Narrow definition of evidence-based practice

One of the problems in the existing system is that the NICE guidelines are based on large clinical treatment trials. This is perhaps because they were partly designed to validate drug treatments, which do require large-scale studies to demonstrate their effectiveness and lack of dangerous side-effects before they can be recommended. However, the development of psychological treatments is different to the development of drug treatments. Innovative psychological treatments are often based on practice-based evidence and do not have the backing of large pharmaceutical companies that can fund the large-scale studies or who could financially recoup money that was invested in the research.

While large-scale studies can be a strength in helping to ensure the robustness of results, it also produces a weakness in the system. It is very difficult for innovative therapies, even if they are based on the latest evidence, to get recognised. Indeed we have seen that by having the name ‘CBT’ in the description, some therapies have inadvertently gained recognition without completing the rigorous research. A colleague was told by the NICE department that it would cost approximately £300,000 to pay for trials to get a therapy recognised. Clearly, this is not possible for most emerging therapies. A therapy needs to be well established, and have many trained therapists who are able to participate in large treatment trials in order to get the NICE stamp of approval. In the current system, there is no other recognised and approved way that developing innovative therapies can be seen as good practice.

Possible solution: Innovative Practice

One solution is to acknowledge the use of new therapeutic techniques to service users and to formalise good practice in innovative treatment. Acknowledging **Innovative Practice (IP)** as being beneficial is important because NICE 'evidence-based' practice is currently seen by many to be the only benchmark of good practice. Service users could benefit from the latest research, observations and techniques, often more specifically tailored to their individual treatment needs. IP acknowledges that these techniques are in the process of being continuously evaluated and improved. Finally, IP acknowledges that these treatment techniques do not have a large body of research to demonstrate their effectiveness, as they are still relatively new.

Services or individual therapists could describe themselves as being innovative therapists or services, if they adhere to recognised standards for IP. IP could be seen as evidence-based practice, providing good practice and service. If good practice in using new treatments is formalised, innovative therapies could be encouraged while informing and protecting service users. We, as clinical psychologists, are in a position to take a lead on this issue.

Broader use of 'evidence-based practice'

Firstly, we need to consider how new treatment techniques are created. One method is use of **practice-based evidence** and clinicians make clinical observations about what is therapeutic for clients. Research producing new knowledge of how the brain and body work, or studies observing behaviour or thoughts may also lead to new treatment techniques. An example of this is how evidence from dream research informed the theory and practice of HG therapy. New strategies could be elicited through researching what works in the general population, and then testing these strategies or techniques in clinical populations. These methods could be described as **evidence-based treatments**, as techniques are developed from different types of evidence. Both of these could be seen to be evidence-based practice in a broader sense of the meaning.

Use of micro-evidence

All of these pathways to new treatment techniques need to be tested out using micro-evidence. This would involve evaluating their effectiveness for individual service users, and would involve using pre and post treatment measures, such as Clinical Outcomes in Routine Evaluation (CORE), Beck Depression Inventory (BDI), or BAI.

General questionnaires, such as the ORS or SRS, could be used in each session to monitor progress. Specialised measures could also be used to measure specific changes that the treatment is expected to improve. These could then be reported in individual case studies. Ongoing evaluation and supervision would be crucial for IP.

Once there is a body of evidence using individual case studies, a small scale research study could be done, again to demonstrate the effectiveness of the therapy. As more of these studies are done, the treatment is likely to be taught to other therapists (note this happens before an innovative therapy can be recognised by NICE). These should also be reported in the scientific journals. It is only when a

therapy is well established that it might be possible for it to undergo the rigorous studies required by NICE.

These processes are not new, but are merely descriptions of what currently happens with the development of innovative therapies. However, there is no formalised guidelines from NICE to allow for the development and acceptable use of IP.

Benefits of formalising Innovative Practice

Formalising innovative practice would benefit both services and therapy in general, and well as protecting service users.

With formalised good practice for IP, new advances in treatment using the latest knowledge would be encouraged. Centres for developing innovative therapies could be acknowledged as following NICE guidelines, which may include Improving Access to Psychological Therapies (IAPT) sites. Services and therapists would be free to use both evidence-based treatments and use IP and still be adhering to guidelines for good practice.

Services or therapists could describe themselves as using IP, which would bring transparency to the process and give service users a more accurate understanding of the innovative and possibly untested aspects of the treatment they will receive. They would then be able to give informed consent to participating in innovative treatments. Service users would be protected by the use of good practice, supervision and continual evaluation that would be involved in good practice of IP.

Conclusion

While the NICE guidelines can be very useful, they are limiting and will eventually have a detrimental effect on treatments, either by limiting the development of innovative therapies or by inadvertently misleading service users. The narrow use of the term 'evidence-based' has minimised other types of evidence-based treatments, and made it difficult for newer treatments to be recognised. The current processes in developing innovative treatment needs to be formalised and a standard of good practice developed to encourage new developments and to protect and inform service users.

Roth A.D. and Pilling, S. (2007) Identifying the competences needed to deliver Cognitive and Behavioural Psychotherapies: A methodology and a model. www.ucl.ac.uk/CORE

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