UK Council for Psychotherapy

Looking at the evidence:

A DISCUSSION ON HOW NICE ASSESSES TALKING THERAPIES

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Introduction

In the summer of 2011 UKCP campaigned to highlight areas of concern in the way NICE assesses talking therapies for provision on the NHS. UKCP followed up on this, in conjunction with the New Savoy Partnership, by inviting a range of interested parties to attend a roundtable discussion. The event provided an opportunity for open and productive discussion about the methodologies used by NICE and the range of evidence it uses to assess the cost effectiveness of different talking therapies. Twelve people with substantial and diverse experience in psychotherapy and counselling research, theory and practice as well as those from NICE's National Collaborating Centre for Mental Health and from the wider mental health and health fields participated.

The roundtable discussion

Those present were: Nancy Cartwright, Jeremy Clarke (co-chair), Sophie Corlett (co-chair), Angela Coulter, Peter Fonagy, Tim Kendall, Peter Kinderman, Michael King, Sue Mizen, Nancy Rowland, Stephen Pilling and David Pink. Andrew Samuels attended drinks prior to the discussion only. More information about the delegates is located in Appendix 1.

In advance of the roundtable discussion, all participants received a copy of a discussion paper written by Sue Mizen and Nancy Rowland – "Can NICE guideline development procedures - and thus the commissioning of mental health services - be improved?"

The report

So that participants could talk more openly and freely, participants agreed to the Chatham House Rule which states that "When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed".

This report has been divided into 5 sections to reflect the major themes of the discussion:

(1) the current context: NICE guidelines and guideline development processes;

(2) embracing sound scientific evidence: study design and outcomes;

(3) the role of routine outcome monitoring data;

(4) meeting the needs of clients and;

(5) additional points.

1. The current context: NICE guidelines and guideline development processes

It was acknowledged that NICE had achieved many things over the last ten years, comparing well internationally. Guideline development processes had also improved with a greater capacity for responsiveness as evidence amasses – for example, in relation to schizophrenia and dementia. It was said that the evidence base does not have to be large for a treatment to be recognised within NICE (for example, family therapy). Despite this, it was agreed that there was still room for improvement and there was a pragmatic desire to get things working for clients in a changing mental health context where there is both a need and potential to get effective therapies to clients earlier. It was noted that NICE guidelines are designed for use in clinical contexts rather than to guide public policy however the emphasis is changing and it was said that NICE can be drawn into commenting on issues downstream of their remit. It was also noted that evidence does not necessarily drive policy decisions; rather the opposite may also occur. Questions were asked about how NICE could influence central government decisions about health services commissioning groups but it was also pointed out that this is outside the remit of NICE.

It was stated that NICE's achievements are intrinsically linked to the evidence that they rely on. NICE's role is to guide the commissioning of services and clinical practice rather than their implementation. It has since been added that NICE guidance is intended to inform both commissioning and implementation in clinical practice. It has also been added that NICE has no funds for primary research; it does, of course, commission a great deal of secondary research such as systematic reviews. It was noted that NICE guidelines have a differential impact according to clinician's or commissioner's level of experience and the guidelines are not followed by everyone. It was unclear exactly how much service commissioners rely on NICE guidelines, but it was of concern that those with less experience who follow the guidelines may be relying on a restricted evidence base. It was said that NICE has no money to fund or undertake research. Two facts at the heart of NICE rationales were: (a) that government cannot pay for every psychological or other treatment, and (b) those that are funded must be linked to a robust evidence base.

It was noted by some that the NICE Guideline Development Groups (GDGs) must read and understand complex evidence (not only relating to Randomised Controlled Trials (RCTs)) and that although they bring expertise, members do not always have the benefit of a 'meta' view of evidence/evidence debates or a capacity to analyse data. NICE and GDGs are also confronted by a rapidly amassing evidence base (though not all of this has been analysed). Despite this, it was said that psychological therapies get a very good hearing within GDGs and supplementary evidence to RCTs such as client experiences and routine outcome monitoring were taken into account. It was observed by some that not all RCT evidence is taken into account in the guidelines. Participants were pointed to the NICE manuals for clarification on some of the issues raised in this part of the discussion.

2. Embracing sound scientific evidence: study design and outcomes

The majority of the evening's discussion focussed on the issue of study design and outcomes - ie what kinds of research design create data that would be considered as evidence within the context of NICE guidelines? Underlying this key question were broader issues around who should take the initiative in providing evidence to NICE and how would people know if the evidence would be acceptable?

Study Design

Albeit to varying degrees, there was agreement that RCTs are based on good logic and can remove some of the complexities when predicting the outcomes of different treatments/interventions. Some people thought that RCTs still needed to be at the core of NICE guidelines and others were more critical of this model and/or wanted to see other study designs having equal or greater weight. Useful questions arose as to the gaps RCTs leave in our understanding of the outcomes of psychological therapies and how best those gaps in knowledge could be filled. A spectrum rather than hierarchical approach to evidence in which different approaches worked synergistically was suggested. It has since been suggested that 'spectra' are just like hierarchies only they are continuous not discrete but there is a definite order. It has also been suggested that given many people in the discussion did not feel a definite order of evidence could be upheld, that another term such as a 'cobweb' – rather than 'spectrum' - may better reflect the tone of the discussion.

It was argued by some that RCTs are good at predicting what works in a particular place but less good at predicting whether something would work for other people in other places because of both known and unknown factors. Other identified limitations of RCTs were their small size and expense relative to their external reliability. Another issue raised was that because treatments can interact not only with each different separate confounder but also interact differently with different combinations of confounders, far larger RCT study populations can be required than is often supposed. It was also stated that many RCTs (on which NICE predominantly rely) use diagnostic categories and that in natural settings clients do not necessarily present to services with clear diagnoses and may instead present with a problem such as "I can't work". In real life settings, practitioners may be using psychological therapies as a means to get clients back to work, rather than to reduce particular diagnostic symptoms. It has since been added that there was a strong point made that one of the benefits of RCTs is that they can also control for some of the complexity of human variance, which observational trials can't do so well (because they are randomised and you can identify where a variance leads to a difference in outcome). So RCTs therefore have a complementary role to observational studies which can be used to pursue some of these differences further.

It was further said that studies needed to focus much more on how treatments work (mechanisms of change) and the factors that support or hinder them in different social, cultural and physical

contexts. Structural equation modelling was mentioned as a potential (future) way of dealing with known confounders. Econometric analysis was also mentioned, both for help with dealing with confounders in population data and for helping with problems of selection bias into the study population.

It was suggested that RCTs may not be the study design of choice in years to come. The use of observational studies (where the possible effects of interventions are observed but the researcher does not randomly assign people to groups) was discussed and linked to the idea that observational data can help with the question: "Will it work for me?" The idea that observational data could be fed back into guidelines more quickly was debated as was the potential interplay/synergy between observation studies and RCTs. It was argued that large observational studies pick up harm to clients more effectively and observational data can provide the basis of modelling individual trajectories and identifying potential sub samples. Observational data can provide the markers to do intelligent RCTs and there is a potential role for econometric analysis here. It was said that new research should build on findings from RCTs but also that studies could explore multiple outcomes in varied ways. GPs and other clinical databases were suggested as good sources of observational data. It was also noted that confounding variables are problematic in observational data.

What outcomes should be measured, when and how?

Moving forward from a discussion of broad study design issues - but still related to these concerns - is the question of what should be measured in research into psychological therapies. Fundamental questions about the meaning of effectiveness and efficacy still require debate and potentially agreement. People asked questions about the purposes of different psychological therapies and at what point in time they should be measured given the effects of therapy may not be recognised or understood until years later. It was asked, how and whether we should account for the spin-off benefits of therapy, beyond diagnostic change? The possibility of having a wellbeing outcome measure was raised.

Some people thought it would be more useful to focus on service or therapist level data (for example, around rates of treatment relapse or treatment failure or success). It was acknowledged by some that clients have different goals in therapy and though challenging in terms of statistical analysis, this is a valid approach to measuring the success of any psychological therapy. The importance of capturing harm caused by therapy/therapists was also discussed within the context of outcomes.

3. The role of routine outcome monitoring data

It was said that in principle good quality routine outcome monitoring data could be included as evidence within NICE guidelines, though issues of case mix and quality of data were important to control for. It was noted that there is a large quantity of adult IAPT (Improving Access to Psychological Therapies) data available for use as evidence within NICE guidelines. People wondered about what could be agreed in terms of routine outcome monitoring data and how this could be taken forward. Issues around data quality were of concern but this was not seen as an insurmountable problem. Engaging practitioners in the collection of systematic and robust data about their practice was seen as useful. Agreement about the characteristics of good quality, usable (in terms of evidence) outcome data is required. It has since been added that it was agreed that there was plenty of excellent data, but research and analysis of the data was still required before it would be directly useful.

4. Meeting the needs of clients

It was said that clients require information about treatment options (for example, decision aids that rely on unbiased evidence). Harms and benefits of different treatment options need to be outlined clearly with key information reduced into usable packages for clients (and therapists). Clients also need to have a range of treatment options available to them acknowledging that clients do not always see their problems in the same way nor do they want the same type of treatments necessarily. It was said that it is important to research and document client experience of different treatments in a systematic way. The possibilities for client-defined outcomes was noted (as above) as well as the fact that people were already working in this area. It has since been added that the point was made that what was needed was more patient-centred outcomes research, including the use of PROMs (patient reported outcome measures) in both RCTs and in observational studies.

5. Additional points made in the discussion

- There was agreement that more research is needed that produces robust evidence. However it was also acknowledged that there is already a lot of data in existence (though not in relation to children) which could be analysed as well as already analysed data.

- It was acknowledged that RCTs have a much better chance of funding than other types of research and therefore other study designs have less opportunity to contribute to the evidence base.

- There was a potential to offset the costs of research against the cost savings in service delivery by finding out more about what works for whom.

- It was also said that psychological science is only just escaping from the biomedical model and that in 10 years there will be more sophisticated ways of looking at data and at people (e.g. it was observed that the DSM in the US was under threat).

- Cost off-setting was mentioned as another approach to delivering psychological therapies in which the benefits of receiving treatment now is offset against future treatment costs.

- It was noted that psychological therapies are increasingly important in a world sceptical of drugs.

Final attendance list

Roundtable discussion - Thursday 29 September 2011, London

Name	Organisation	Position
David Pink	UKCP	Chief Executive of the UK Council for Psychotherapy
Nancy Rowland	BACP	Director of Research, Policy and Professional Practice at the British Association of Counselling and Psychotherapy
Jeremy Clarke	New Savoy Partnership	Chair of New Savoy Partnership and member of Ministerial Advisory Group for No Health without Mental Health
Tim Kendall	NICE	Director at the National Collaborating Centre for Mental Health, Royal College of Psychiatrists Foundation Trust Visiting Professor at University College, London Medical Director and Consultant Psychiatrist at Sheffield Health and Social Care NHS.
Stephen Pilling	NICE	Director of National Collaborating Centre for Mental Health. Consultant clinical psychologist in adult mental health for Camden and Islington Foundation Trust Director of CORE (Centre for Outcomes Research & Effectiveness), University College London
Sophie Corlett	Mind	Director of External Relations at Mind
Nancy Cartwright	LSE	Professor of Philosophy at the Department of Philosophy, Logic and Scientific Method at the London School of Economics and Political Science (LSE)
Peter Fonagy	UCL	Freud Memorial Professor of Psychoanalysis and Head of the Research Department of Clinical, Educational and Health Psychology at University College London Chief Executive, Anna Freud Centre, London.

Name	Organisation	Position
Peter Kinderman	DCP, PBS	Professor of Clinical Psychology, University of Liverpool
Sue Mizen	RCPsych	Consultant Psychiatrist in Psychotherapy at Devon Partnership NHS Trust Deputy Chair of the Psychotherapy Faculty at the Royal College of Psychiatrists
Michael King	UCL	Psychiatric Epidemiologist. Particular interest in the design and conduct of cohort studies and randomised trials of complex mental health interventions in primary and secondary care
Angela Coulter	Independent consultant and expert in patient and public involvement in healthcare	Independent healthcare analyst/consultant. From 2000 to 2008 she was chief executive of Picker Institute Europe, a UK-based research charity specialising in measuring and improving patients' experience. She is currently working with the Foundation for Informed Medical Decision Making and a number of other organisations to promote improvements in patient and public information and involvement

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