# The Tour de NICE and the art of deception

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*Though originally a reflection on the direction of the profession of clinical psychology*, its message of systemic complicity in the corporate world of mental healthcare is relevant to mental health practitioners of all disciplines.*

In October 2012, it was confirmed to a lot of cycling fans all over the world that they had been tricked and that Lance Armstrong's seven Tour-de-France wins were actually a bit dirty. There had been plenty of evidence over the years to suggest this, but it was somehow sidelined. There had also been a fair amount of infighting in the cycling world about 'lean teams' and 'clean teams'. Different agendas, competing interests and money were all at play, with high stakes. Team-mates were expected to get with the program and those who refused to join in were marginalised. And, whilst Armstrong has been identified as the culprit and a bully, undoubtedly this was not just a team effort but also a cycling-community effort; the prizes cannot sensibly be re-awarded to anyone else because *they were all doing it*.

Does riding a grand tour have some similarities with modern mental healthcare? Do we sometimes have a similar relationship with the evidence? Do we experience pressures to work in particular ways even though there may be good arguments not to? Do we find ourselves caught between different agendas and competing interests where decisions are driven by financial imperatives? Is it hard or potentially damaging to our careers to challenge the status quo? Are we in danger of losing sight of the reasons we came to be doing this in the first place? I think so.

## The evidence game

In 2002, *Cycle Sport* magazine was targeted by Lance Armstrong, who took exception to the fact that journalist, David Walsh, had tried to expose his doping practices – further expanded on in the book, LA Confidentiel (Ballester & Walsh, 2004). Even at that time, the evidence against Armstrong was beginning to grow, but this was apparently either ignored or covered up.

Evidence is a concept of fundamental importance to mental health professionals. Numerous documents, from the British Psychological Society, briefing on clinical governance (Hall & Firth-Cozens, 2000) to the National Institute for Health and Clinical Excellence (NICE) guidelines, emphasise the importance of evidence. Yet, pick apart the processes by which this evidence is generated, and scrutinise the ways in which evidence undergoes metamorphosis, and the evidence we end up with would not stand up in court. Other evidence, the hard evidence, seems to get lost in a sea of information where facts are indistinguishable from claims. NICE guidelines are a good case in point:

1. Across various conditions, NICE guidelines, in their full versions, acknowledge conceptual and methodological problems, which fundamentally threaten their validity, whereas the quick reference guides ignore these problems and make recommendations which conflict with their statements about the evidence base. This is likely to be the case with the majority of NICE guidelines for mental health difficulties, due to epistemological problems with all diagnoses, and is certainly the case for the guidelines for depression, chronic fatigue syndrome/myalgic encephalomyelitis and borderline personality disorder. For a fuller account of these problems see Midlands Psychology Group (2010).
2. We might assume those organisations with an interest in promoting and ensuring a robust evidence-base would devote proper attention to this task. We would be wrong. My own experience of being involved in the British Psychological Society contribution to the consultation on the NICE guidelines for borderline personality disorder left me astonished. I was initially surprised at having the opportunity to submit my own response, not being someone recognised in the profession for particular expertise associated with this diagnosis. Yet, I was also pleased at such an open process. I completed the response form and returned it to the society before the deadline, interested to see what the collated submission would look like. I received an email thanking me and the other five contributors, with the overall society's submission attached. A covering letter stated that they aimed *"to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge"*. Yet, the submission was far from demonstrating a high standard of professional knowledge; rather, it was an incoherent statement that had been collated by copying and pasting the individual submissions from the six contributors. Not only did these submissions include quite widely differing views, for example, from those embracing diagnosis to those challenging it, but also the copying and pasting process meant that the points made did not actually correspond with the page and section numbers in the document. Furthermore, I had expected the task would at least be overseen by someone in the profession with a track record of specialising in this area. I did not recognise any of the names of the other five contributors, nor, I suspect would they have recognised mine.
3. As NICE guidelines have become the cornerstone in decision making about mental healthcare in the UK, it would seem appropriate for our professional organisation to be interested in commenting on the validity of NICE guidelines and the work of the Institute as whole. In September 2012, the House of Commons Health Committee launched an inquiry into the way in which NICE was conducting itself. This was in anticipation of the extension of its remit to include evaluating social-care interventions. The

opportunity for the Society or Division of Clinical Psychology to make a submission to this inquiry would have been one way of trying to ensure a high standard of psychological knowledge in the workings of NICE. However, the deadline for submissions came and went without it ever being taken up by the division. The Association for Family Therapy, incidentally, was much more organised, and submitted a detailed and thoughtful response.

## The corporate machine

Within the profession of clinical psychology, views about how we should conduct our business successfully are by no means shared. Kinderman & Tai (2008) argue that, *"Psychological specialists should lead on the development of individual formulations based on need and functional outcome; these formulations should in time become as universally incorporated in care planning as diagnostic categories ... at present, care is often uniformly driven by an understanding of illness as represented by patterned clusters of symptoms which risks ignoring or subordinating psychological and psychosocial stressors"* (p. 5). If clinical psychologists, of whatever persuasion, are interested in the analysis of the individual and environmental characteristics of each person's problems, rather than allocating people's experiences to predetermined categories, then it is hard to see how clinical psychology fits with a model of 'payment by results', which is due to be implemented in mental healthcare in 2014.

However, it would appear that the dominant view is one that is neither interested in scrutinising the role of NICE, nor highlighting problems with corporate moves to packages of care in mental health. Instead, we are encouraged to use the opportunities afforded by NICE guidelines and the introduction of 'payment by results' to grow the psychological workforce, to increase our business. The focus is, if you like, on competing with our opponents and staying in the race using all necessary means, as opposed to reliance on our natural strengths. The focus is, if you like, on the interests of psychologists and the profession of clinical psychology and less on the needs of people who are referred to us.

This position is clearly apparent in a recent document explaining the opportunities and risks associated with 'payment by results' (Cohen-Tovée, 2012). On page 6, there is a diagram illustrating a hypothetical caseload. It looks alarmingly like a piece of machinery. We are warned that, *"Psychological Services need to approach the implementation and evaluation of CPP* [Care Packages and Pathways] *& PbR* ['payment by results'] *strategically in order to maximise the opportunities and pre-empt or manage risks"* (p. 1). With its templates and components and high-quality processes, the paper makes the business case for our psychological machine, which, apart from being so counter to the science of psychology, is highly contradictory. For example, it is argued that Care Packages and Pathways is *"not diagnostically driven"*, yet arguably care clustering is simply another way of grouping people. And, even if care clusters are not diagnostic, there are *"template care packages for the mandated clusters"*, which are inherently bound up with NICE guidelines, and hence, diagnosis: *"Each component of each care package will be linked to the underpinning NICE guidance and standards"* (p.9). These template care packages *"are available (but not compulsory)"*. NICE guidelines aren't compulsory either but our organisations now have to prove that they are complying with them.

## What a tangled web we weave

In the early days of the Tour de France, there were no teams. It was each man for himself. It has been said that the modern Tour cannot be won by the efforts of one individual. Doping also tends to require the efforts of more than one individual. It takes a network of individuals and organisations to support these kinds of practices, each with their own role in perpetuating the deception in order to protect their own interests.

In a similar way, there is a tangled web of networks of individuals and organisations involved in the control of mental healthcare, some of which may have different and competing interests. For example, CSE Healthcare designs and markets the RiO patient information management system, which supports the move from paper to electronic records. RiO software is also key to the implementation of 'payment by

results'. CSE Healthcare describes how RiO is a web-based system, *"favouring mobile operation, which is becoming an increasing requirement in the NHS as its estate reduces and care becomes more focused in the home"*. Whilst, on the face of it, this might sound like a case of using technology to improve healthcare, information technology companies have a shocking history with the NHS; in 2011, the £12.7bn programme to create a computerised patients record system across the entire NHS was scrapped. As one Department of Health spokesperson put it: *"It was too ambitious, the technology kept changing, and loads and loads of money has been put into it. It's wasted a lot of money that should have been spent on nurses and improving patient care, and not on big international IT companies"* (Campbell, 2011). One of those big international companies, Computer Sciences Corporation, was contracted to provide the Lorenzo patient software system. When they struggled to deliver this system, the government was not able simply to cancel the contract. In order to avoid a costly legal battle, the Department of Health was reported to have forced a number of trusts to commit to taking the Lorenzo system and is, in effect, left paying for a system nobody wants with money which could have been spent on real patient care (Simons, 2012).

The Care Packages and Pathways Project forms another strand of the 'payment by results' web. This project is driving the work to develop national currencies and local tariffs for mental health 'payment by results'. They claim this work is, *"innovative and groundbreaking as on an international basis there are no comprehensive and effective examples of this type of approach"*. In other words, there is no evidence base for this type of approach. At the time of writing (July 2013), their research and development page, which had until recently been empty, had disappeared altogether (*www.cppconsortium.nhs.uk*). Perhaps, like the latest performance enhancing drugs, people will blindly climb on board if the idea is sold successfully.

And for anyone who still maintains that Care Packages and Pathways is not diagnostically driven, just take a tour through the care cluster pathway guides (*www.mednetconsult.co.uk/imhsec/*). Click on the care cluster tab. Choose a care cluster, say number eight. Scroll down to therapeutic interventions. Click on the psychological tab. Scroll down and there you will be taken to the NICE guidelines for borderline personality disorder, antisocial personality disorder and self-harm. Mednet Consult Ltd, by the way, is a UK Healthcare consultancy and service provider. One of its services is a model to increase *"patient adherence and compliance to medication"*. Its director previously worked in the pharmaceutical industry.

Just as a number of individuals and organisations involved in Armstrong's winning efforts were possibly not that interested in cycling, some organisations involved in mental healthcare may not be really that interested in psychology, the reasons why people experience distress and what is really going to help alleviate that distress.

## So long, Mr Clean?

People often get annoyed when they are challenged, and perhaps even more so when the veracity of their claims is challenged. Facts and evidence that challenge certain ideas and practices are liable to threaten the interests of people who have invested in such ideas and practices.

When the French cycling team, Festina, were found to have been doping in 1998, it emerged that Christophe Bassons was the only member who had refused to take performance-enhancing drugs. This earned him the nickname, Mr Clean. During the following year's Tour, he wrote a newspaper article, effectively exposing Lance Armstrong. The Texan responded by telling him to go home, later saying that Bassons' claims were not good for his team, for anybody or for cycling. It wasn't just Armstrong who shunned him; Bassons' future team-mates refused to share their winnings with him. (In a move where the irony was clearly lost, someone within the profession of clinical psychology also told me that the language in this article was *"offensive and unwarranted"*). Following events in October last year, Bassons was magnanimous towards Armstrong, pointing out there were lots of people in the cycling world just like Armstrong. Not only that, everyone had known for some time. Armstrong is now facing a pile of legal actions. Bassons enjoys a career as a sports professor: he said, *"If I had wanted to continue, to shut up and continue as others did, I could have done so, but I didn't. A career like that didn't please me"* (Willsher, 2012). Bassons survives with his integrity intact. Can we say the same?

Meanwhile, on the eve of the 2013 Tour, Lance Armstrong was still making headlines, insisting it is not possible to win the Tour de France without doping. *"I didn't invent doping"*, he said, *"and it didn't stop when I stopped. I simply participated in a system. I am a human being. Doping has existed since antiquity and will always carry on"* (Ingle, 2013). What for the future of mental health care?

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