Running head: *BELIEFS ABOUT, AND USE OF NICE GUIDELINES*

# They're NICE and Neat, but Are They Useful? A Grounded Theory of Clinical Psychologists' Beliefs About, and Use of NICE Guidelines.

Alex John Court[1], Anne Cooke[2] and Amanda Scrivener[3]

[1] Salomons Centre for Applied Psychology, Canterbury Christ Church University, Tunbridge Wells, Kent, UK

[2] Salomons Centre for Applied Psychology, Canterbury Christ Church University, Tunbridge Wells, Kent, UK

[3] Kent and Medway NHS and Social Care Partnership Trust, Canterbury, Kent, UK

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*Requests for reprints should be addressed to Dr Alex Court, Salomons Centre for Applied Psychology, Canterbury Christ Church University, Runcie Court, David Salomons Estate, Broomhill Road, Tunbridge Wells, Kent, TN3 0TF, UK (e-mail: alexcourt@nhs.net).

Abstract

Guidelines are ubiquitous but inconsistently used in UK mental health services. Clinical psychologists are often influential in guideline development and implementation, but opinion within the profession is divided. This study utilised grounded theory methodology to examine clinical psychologists' beliefs about, and use of NICE guidelines. Eleven clinical psychologists working in the NHS were interviewed. The overall emerging theme was; NICE guidelines are considered to have benefits but to be fraught with dangers. Participants were concerned that guidelines can create an unhelpful illusion of neatness. They managed the tension between the helpful and unhelpful aspects of guidelines by relating to them in a flexible manner. The participants reported drawing on specialist skills such as idiosyncratic formulation and integration. However, due to the pressures and dominant discourses within services they tended to practice in ways that prevent these skills from being recognised. This led to fears that their professional identity was threatened, which impacted upon perceptions of the guidelines. To our knowledge, the theoretical framework presented in this paper is the first that attempts to explain why NICE guidelines are not consistently utilised in UK mental health services. The current need for services to demonstrate 'NICE compliance' may be leading to a perverse incentive for clinical psychologists in particular to do one thing but say another and for specialist skills to be obscured. If borne out by future studies, this represents a threat to continued quality improvement and also to the profession.

**Key Practitioner Message**

- Guidelines have many benefits but the current pressure for services to be 'NICE compliant' may be having unintended negative as well as positive effects.

- Lack of implementation may be partly the result of active choice by clinicians concerned to use the full range of professional skills and to offer flexibility and choice to service users.
- The current context is creating a perverse incentive for clinicians to say one thing but do another. This is problematic for services and a potential threat to the profession of clinical psychology.

*Keywords:* NICE, clinical guidelines, decision making, clinical psychologists, mental health.

Numerous authors have highlighted the increasing role of clinical practice guidelines in both physical and mental healthcare over the last two decades (e.g. Franx, 2012; Girlanda, Fiedler, Ay, Barbui, & Koesters, 2013; Grimshaw et al., 2004; Nathan, 1998; Parry, Cape, & Pilling, 2003; Pilling, 2008; Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999). Parry et al. (2003) suggested that 'health care professionals are living in the age of evidence-based guidance' (p. 337), highlighting a 'remarkable proliferation of clinical practice guidelines' (p. 337).

The National Institute for Health and Care Excellence (NICE) was established in 1999 to produce guidance for health professionals working in the UK National Health Service (NHS). The aim was to improve clinical effectiveness and reduce variations in practice across NHS Trusts (Department of Health (DH), 1998). There is evidence that the level of implementation of NICE guidelines in UK mental health services is low (e.g. Court, 2014a; Haddock et al., 2014; Mears, Kendall, Strathdee, Sinfield, & Aldridge, 2008).

Berry and Haddock (2008) highlighted the paucity of research into factors affecting the use of NICE guidelines in UK mental health services and stressed the need for such research. A number of studies have since been published. In relation to NICE guidelines for mental health conditions, research has investigated adherence to guidelines in UK services by: GPs, (Gyani, Shafran, & Rose, 2011; Gyani, Pumphrey, Parker, Shafran, & Rose, 2012; Toner, Snape, Acton & Blenkiron, 2010), care co-ordinators (Prytys, Garety, Jolley, Onwumere, & Craig, 2011; Sin & Scully, 2008), community mental health teams (Michie, et al., 2007; Rhodes, Genders, Owen, O'Hanlon, & Brown, 2010), psychiatrists and paediatricians (Kovshoff et al., 2012) and counselling psychologists (Hemsley, 2013).

The significance of external factors, such as resource problems, has been a consistent finding across the existing studies. Both positive and negative views regarding NICE guidelines have been reported, with particularly rich data emerging from studies utilising qualitative methodology (e.g. Kovshoff et al., 2012; Prytys et al., 2011). However the quality

of the qualitative studies has been variable, with reflexivity not always clear (e.g. Hemsley, 2013) and researcher allegiances sometimes appearing to impact on interpretations. In particular, some studies (notably Michie et al., 2007 & Prytys et al., 2011) appear to assume from the outset that the aim should be to increase implementation of guidelines, rather than taking a position of exploring the advantages and disadvantages of guideline usage. Furthermore, many of the existing studies (e.g. Michie et al., 2007; Prytys et al., 2011; Rhodes et al., 2010) based findings on a small sample of participants from a variety of professional backgrounds. It seems likely that different professions will vary on their beliefs about, and knowledge of NICE guidelines as a result of their differing amounts and types of training and varying professional identities.

There have been no studies to date focusing on clinical psychologists' (CPs) beliefs about, and use of NICE guidelines. CPs play important roles in multidisciplinary teams in terms of: providing psychological therapies, consuming and disseminating new research, teaching, assisting others to work in psychologically informed ways and carrying out local audits. They are influential in contributing to the design of new services and the development of existing ones (e.g. Care Services Improvement Partnership, 2007). It could therefore be argued that CPs have a leading role to play in relation to NICE guideline adherence.

Many CPs appear to be in favour of NICE guidelines (British Psychological Society (BPS), 2007); numerous CPs have contributed to their production and the BPS has co-published some guidelines, for example the schizophrenia guideline (NICE, 2010). However, many have also questioned their usefulness (e.g. Adams 2008; Barkham, 2007; Fairfax, 2008; Hammersley, 2009; McGowan, 2009; Midlands Psychology Group, 2010; Mollon, 2009a, 2009b; Nel, 2011; Smail, 2006). Smail (2006) suggested that CPs are 'selling [their] soul' (p.17) by not challenging NICE guidelines. Mollon (2009b) argues that the fact that 'psychologists, and the BPS, have colluded in this betrayal of our profession through an

endorsement of the crude medical model of NICE is deeply puzzling – a phenomenon that itself deserves careful study' (p.130).

**Aims**

Eccles, Grimshaw, Walker, Johnston and Pitts (2005) suggest that research into the use of clinical practice guidelines would benefit from drawing upon psychological theory in order to help understand the beliefs and behaviour of clinicians. However, psychological theory has not been utilised to any great extent in the existing evidence base (Michie, et al., 2007, being a notable exception). The current study attempted to generate new psychological theory, producing a theoretical framework which might help explain how NICE guidelines are utilised and which factors might impact upon this.

As researcher allegiance has been an issue in previous research, it was felt important that this study aimed only to examine, rather than to promote or dispute the use of guidelines. It was hoped that this approach would allow full exploration of the benefits and limitations of guidelines and how CPs manage their use in practice.

It was felt that CPs were a particularly important profession to investigate. They are important members of UK mental health services and their use of NICE guidelines has not been investigated. Furthermore, there appear to be conflicting views within the profession with respect to the guidelines.

**Research Questions**

This study attempted to address the following questions:

i) What beliefs do CPs hold about NICE guidelines?

ii) How do CPs describe their use of NICE guidelines?

# Method

## Design Overview

Semi-structured interviews were conducted with eleven CPs and the information that emerged was analysed using grounded theory methodology (Charmaz, 2006). Grounded theory enables a researcher to develop a theory from ('grounded in') the data, rather than seeking evidence to support an existing theory (Willig, 2001). This makes the method particularly helpful in areas lacking existing theory, such as this one. This study utilised Charmaz's (2006) social constructivist approach which acknowledges the role of both researcher and participants in co-constructing the knowledge that emerges from study.

## Ethical Considerations

This study was approved by a review panel and ethics committee at Canterbury Christ Church University. The Research and Development departments of three English NHS trusts provided permission for their staff to take part in this research. Participants were fully informed of the purpose of the study. The principal researcher (first author) endeavoured to maintain a stance of independence and curiosity in the interviews. It was hoped that this would allow participants to speak freely.

## Participants

Participants were CPs in routine practice in the NHS. CPs who had published views about NICE or had been involved in guideline production were excluded, as their positions already appeared clear. Information about the study was circulated within Trusts: participants either responded to recruitment emails (n=7) or were known to the first author (n=4). No current colleagues were recruited in order to ensure that working relationships did not impact upon

the research. Participant characteristics are presented in aggregated form (table 1) to help protect anonymity.

**Procedure**

Interviews ranged from 45 to 72 minutes and adopted an open questioning style. In line with the recommendations of Glaser (1998) and Charmaz (2006) there was no preconceived interview schedule. All interviews began with an open question simply asking the participant to share their thoughts on NICE guidelines. The interviewer (first author) then attempted to follow the participants' lead, making a concerted effort to try to understand their point of view and actions (Charmaz, 2006). This helped 'enter the participants' world' (Charmaz, 2006, p.19) and limit the influence of the researchers' pre-existing beliefs, assumptions and allegiances on the data (Holton, 2007).

Interviews were audiotaped and then transcribed. The first three interviews were analysed using line by line coding followed by focused coding (Charmaz, 2006). The subsequent transcripts were analysed using focused coding. Tentative categories and subcategories were then formed, attempting to seek an 'underlying logic of apparently disparate events' (Dey, 2007, p.188). Throughout this process, theoretical memos were kept in a research diary, reflecting on the process and on possible emerging themes (Charmaz, 2006).

Similarities and differences between the views of participants were explored through constant comparison (Glaser & Straus, 1967). Theoretical sampling (Glaser & Straus, 1967), with the assistance of a pre-interview questionnaire (Appendix M of Court, 2014b), helped ensure that participants with a variety of opinions were recruited. In latter interviews, participants were asked questions influenced by the analysis to date (Morse, 2007). Emerging codes and categories were constantly compared, testing their validity (Holton, 2007).

The cyclical process of data collection, analysis, theoretical sampling, theoretical categorisation and then further data collection continued until 'theoretical sufficiency' (Dey, 1999) was judged to have been achieved. This is the point at which the emergent theory is considered by the researchers to have good explanatory power and no significantly novel information is deemed to be emerging from additional data collection. Unlike 'theoretical saturation' (Glaser & Strauss, 1967) there is no claim that the process has been exhaustive, an aim which Dey (1999) argues is often unrealistic. This stage was reached after 11 interviews. This sample size is typical for a qualitative study of this kind (Adler & Adler, 2012).

**Quality Assurance**

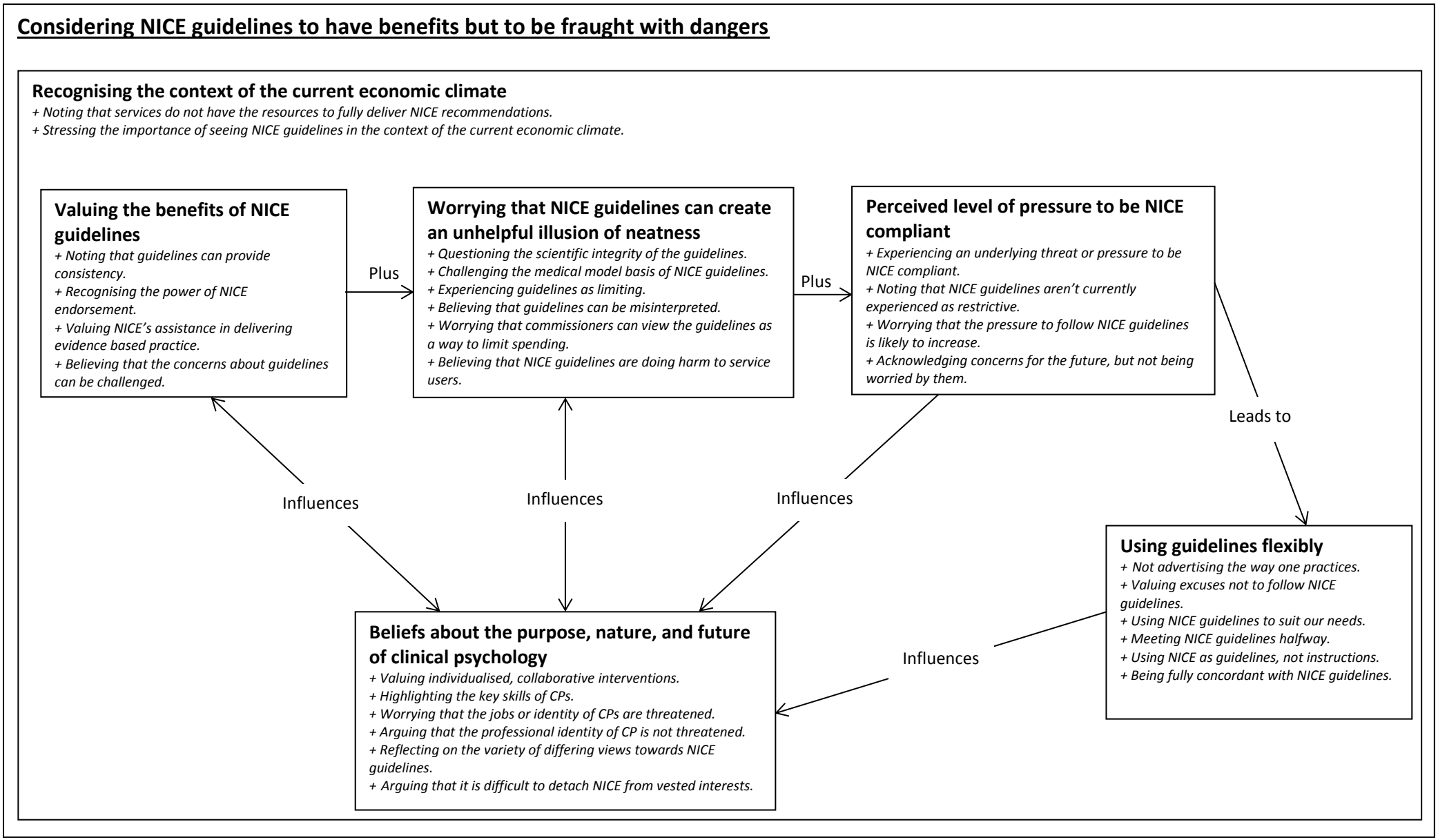
It is acknowledged that qualitative analysis is inevitably influenced by the researchers' views and standpoint (Charmaz, 2006). As such, numerous steps were taken to ensure reflexivity and transparency. As recommended in all qualitative research, a research diary (Appendix L of Court, 2014b) was completed throughout the study, to help think through emerging ideas and to give readers a window into this process (Watt, 2007).

To further aid the process of reflexivity, a bracketing interview (Rolls & Relf, 2006) was conducted between the principal researcher (first author) and lead supervisor (second author). This aimed to explore the impact of the researcher's assumptions and experiences on the research (reflections from this interview are available in Appendix O of Court, 2014b). Furthermore, coding and category development was regularly checked between the study authors and also within a grounded theory discussion group made up of other researchers (all trainee clinical psychologists) completing grounded theory studies. Detailed examples of quality assurance, reflexivity and transparency are available (Court, 2014b).

## Results

Figure 1 presents a model of the clinical psychologists' beliefs about NICE guidelines, how they report drawing on them in their practice, and the relationships between the two.

**Figure 1.** Model conceptualising the clinical psychologists' beliefs about, and use of NICE guidelines.



**Model Summary**

The CPs acknowledged that NICE guidelines have to be seen in the context of the current climate of limited resources. The overall emerging theme was 'considering NICE guidelines to have benefits but to be fraught with dangers'. The guidelines were seen as a useful guide to the evidence base, and the power of NICE endorsement for psychological interventions was valued. However, the CPs worried that the guidelines can create an illusion of neatness which is unhelpful in the context of the complexity of clinical practice in the NHS. All of the CPs valued individualised, collaborative, formulation-driven interventions and saw this approach as sitting uneasily with the use of guidelines. Nevertheless they experienced a pressure to use them.

This tension led CPs to use guidelines flexibly. Some CPs ignored them. Others drew on them selectively according to the needs of the individual client, emphasising that they are guidelines rather than instructions. However, the need to be seen to follow guidelines had the perverse effect of leading participants to act in ways that obscured their particular skills as CPs. Some reported concealing the details of their practice from managers. Often they would use a range of psychological theory to inform a tailored, formulation driven intervention but then label it as if it were a unimodal, diagnosis driven treatment, for example 'CBT for depression'. The majority of participants were very wary of guidelines for this reason, and saw them as a threat to their professional identity and indeed to the future of the profession. Full details of the coding and categories are presented elsewhere (Court, 2014b). The key findings are presented here, together with direct quotes to ensure that the analysis 'stays close to the data' (Charmaz, 2006, p49). Participant names have been changed to protect confidentiality.

**NICE Guidelines have Benefits.**

The CPs saw benefits in NICE guidelines and viewed them as a useful guide to the evidence base.

> They provide a framework and an overarching knowledge base which summarises research in that particular area. And I think that's a great strength, you know, if you don't have to go through millions of literature searches to get at the same thing, NICE have done it for you. (Catherine)

Endorsement by NICE was seen as helpful in improving access to psychological treatments:

> …access to psychological therapies for people with a diagnosis of schizophrenia has really increased as a result of NICE guidelines. (Sam)

**NICE Guidelines can Create an Unhelpful Illusion of Neatness**

The CPs highlighted problems with the diagnostic system on which NICE guidelines are based.

> You could pick apart the whole thing potentially on the basis of questioning the validity of diagnosis. (Morgan).

Participants questioned NICE's reliance on randomised controlled trials (RCTs), arguing that such trials do not represent the complexity of routine practice.

> A lot of them are based on like RCT's where somebody has to have pure depression in their sample in order to carry out the research. But, realistically, I mean that's always a limitation of RCT's in that it doesn't paint an accurate picture of the kind of client groups you're actually dealing with. (Catherine).

CPs worried about the dominance of CBT in the NICE guidelines, suggesting that it has been oversold and might fall out of favour.

> There could be a bit of a ticking timebomb a little bit that erm, over time I think managers and other kind of commissioners and people will begin to realise that CBT isn't this magic curing thing. (Amy).

The guidelines were seen as privileging CBT over other therapeutic approaches and this was linked to the use of diagnostic categories and medical concepts and language in CBT research.

> I think CBT also fits very nicely because it's the most medical of the erm therapies I think, and so I think it's attractive to psychiatrists and other professionals who can understand then, when it's in units, isn't it, it's almost like so many sessions is almost like a dose, of how much medication you need, erm, so it is, it's easy to communicate what psychology does if it's all languaged in this way. (Amy).

CPs noted that the issue of outcome measurement was complicated in therapies with different philosophical underpinnings and that this might have contributed to their relative absence from the guidelines.

> I can't imagine some, one of the more traditional existentialist therapies like Yalom-based therapy, getting NICE backing because how they would define whether the therapy is working isn't immediately measurable, and it's that question of how measurable it is. (Paul).

Participants were concerned that if particular approaches were not backed by NICE then their development would be neglected.

> Our Trust, for instance, has got lots of training programs that have been developed over the last few years in various things like IPT, EMDR, MBCT, CBT, all the therapies that are in the NICE guidelines and only the therapies that are in the NICE guidelines. (Morgan).

This concerned CPs as they saw value in other modalities.

> So obviously a lot of the NICE guidance, CBT is the recommended line of treatment… But I think that is to the detriment of the other types of work which can be incredibly effective for a lot of people. (Catherine)

The CPs wanted NICE to acknowledge the difficulty in measuring psychological therapy.

> I think NICE needs to realise that psychological therapies are not like medication and you can't evaluate them in the same way, you need a broad range of evidence. (Sam).

The CPs worried that NICE guidelines could be misinterpreted by those with power but with little understanding of the complexities of clinical practice.

> I think there's a danger that erm, policy makers, erm, might not have the sort of full background understanding or the critical thinking that is necessary to assess the guidelines, and they might prescribe pathways for services that are too restrictive. (Ronda).

Bearing in mind the concerns, there was a belief that NICE guidelines were doing harm to service users.

> This feels like research that needs to be picked up and be ongoing, because with best intention NICE are doing harm. That is the bottom line. (Jan).

**Pressure to be 'NICE Compliant'**

Most participants felt pressured to comply with NICE guidelines. Some experienced this as a threat.

> Yeah, yeah it can feel quite threatening actually, that there's almost an undercurrent of, of threat that if we're not doing what the NICE guidelines say, erm, erm, then we won't be commissioned, because I think NICE is quite a powerful force, and I think that erm, it does have an influence on everyday clinical practice definitely. (Amy).

There were concerns that NICE guidelines might be used in a more controlling manner in the future.

> … that will get tighter and tighter as we move to payment by results and being commissioned to do... much more specific kind of commissioning for specific things. Specific problems using specific approaches… this is going to come to, closer and closer focus. (Morgan).

**Using Guidelines Flexibly**

The CPs described a number of ways in which they managed the helpful and unhelpful aspects of the guidelines. Some CPs simply ignored them.

> Okay. Erm, well, I don't use them. I can feel the pressure from my service and my managers and erm, it's in the water, isn't it. It's in the general culture now. But you

know, I do [redacted] [1] with all kinds of people who fall outside of what NICE say I should be using. I do [redacted] with all kinds of people. I use other approaches that aren't in the NICE guidelines at all. Er, I do what I see to be effective. I'm not against evidence-based work. I think it's important to evaluate what you're doing in different ways and I do that. I wouldn't want to continue doing something that clients were telling me was not helping but I don't feel I need NICE guidelines to do that. (Morgan).

Some CPs avoided talking about aspects of their practice due to a conflict between what they believed was a helpful way to practice on the one hand, and the pressures and dominant discourses within their services on the other.

Well I, well I certainly wouldn't advertise what I do to the managers. (Amy).

For example, they sometimes described what they were offering as 'CBT' even where they felt this label did not adequately or accurately reflect it.

I would probably say I'm doing CBT, even if I'm not doing, you know, even if it's a bit fudgy around the edges. (Jenny).

Some participants described using guidelines selectively as a 'rhetoric of justification' for practices that they believed were helpful.

Well, it supports EMDR, but the CBT therapists will discount that, just as I discount the CBT promotion…Yes. That's the problem is that we actually use it to suit ourselves. Yeah, I do. (Pause, then laughs) If it was more grounded in reality, it would be a good thing. But it doesn't feel like it. It feels like I can just pick it up and drop it down as it suits me. So I use it to suit my own ends. (Jan).

[1] Therapy label omitted in the interests of confidentiality.

> So, it's almost as if, the, erm, the fact that something features in NICE is your kind of political doorway into, into the er heavenly realms. And you know, once you're in, you know, you can kind of play around a bit, kind of thing. But if you don't have the key to that door, you're not in the NICE guidelines, you can't really start. It's a bit of a fudge, I think, because people are trained on the basis that this therapy is NICE approved, but they're then ending up doing it with groups of people that would not be NICE approved. (Morgan).

CPs frequently referred to the fact that guidelines are just that, guidelines, rather than being prescriptive.

> For me, they're guidelines, rather than somebody telling me what to do. (Kim).

Other CPs ensured that they were seen as NICE concordant through integrating wider psychological ideas into CBT.

> You can integrate – I quite often make use of psychodynamic or systemic ideas which I might, you know, bring into my CBT work…which I think is perfectly fine within a CBT model. (Sam).

The participants stressed the ability of CPs to understand the underlying principles of therapies and make adjustments rather than following manuals.

> You have to adapt what you do. But I think when you make those adaptations you have to be familiar with the manualised treatments and the kind of things that have been evaluated in RCT's, and you have to know that stuff and you have to understand the underlying principles so that when you make those adaptations you don't, you remain true to the principles of the treatment. (Sam).

There was a desire for NICE to apply its principles to itself and evaluate both its underlying assumptions and the effectiveness of its methods.

> I think the main criticism at this stage is that it really ought to be under review, and maybe NICE should apply its own methodology to itself. And so what is the evidence base for the diagnostic system? And what is the evidence base for, you know, producing guidelines using a diagnostic system that itself isn't evidence based? (Sam)

> I think it deserves further research. So perhaps I would say that I'm not sure that it should be there, I'm not sure it shouldn't be there. I think it needs to be absolutely reviewed. (Jan).

**Beliefs about the Purpose, Nature and Future of Clinical Psychology**

Participants worried that because of the political forces at play, CP's skill base is being obscured and there is a risk of being replaced by single-model therapists with less training who are perceived as cheaper.

> NICE guidelines do put psychological interventions on the map… but there's a danger then, that it's erm, we're not fully understanding the scope of what psychological interventions offer, that it's not just CBT, because then there is the risk that the Trust will just, erm I guess get rid of erm clinical psychologists who are expensive to train and to employ, and just employ CBT therapists… when in reality when you're doing a piece of work, which might be CBT orientated, as a clinical psychologist I will be bringing in lots of different therapy kind of techniques and models and formulations from different erm models of psychological therapies, so I don't think it's as purist as maybe NICE guidelines might encourage people to think. (Amy).

CPs were keen to differentiate themselves from single modality therapists.

> I think there is a world of difference between somebody who is a trained CBT therapist and somebody who's a clinical psychologist who does CBT. (Sam).

It was acknowledged that it can be difficult to explain what CPs do.

> Maybe we should be better at explaining what clinical psychologists do, coming back to the sense of how do we evidence what we do? You know, and I think that's fair enough. I think that's a good question for us as a profession really, isn't it? (Kim).

A significant theme was CPs' knowledge of a range of psychological theory, and their ability to draw on those 'first principles' flexibly to design and adapt a tailored intervention for each service user rather than following a manual. They felt that this sat ill with the widespread approach adopted by NICE of dividing both problems and interventions into fixed categories.

> I think it's much harder to say, now, that we're working in a sort of eclectic or integrative way. When I first qualified that was really common, and I don't hear that so much anymore. (Jenny).

> It's (integration) seen as weak or a criticism, and actually I think that's our biggest strength, and that's what I mean by we're shooting ourselves in the foot. As psychologists it would be nice if we actually worked to maintain our identity and what we have that's special to offer. (Jan).

A split was highlighted between CPs who are researchers and those who are clinicians. It was suggested that CPs who contribute to the development of NICE guidelines may have different viewpoints to CPs in routine practice.

> Maybe they're more in their ivory towers, as people call it, doing their research, you know, rather than being on the frontline seeing how things actually are. (Sophie).

> Well I think some of the researchers who I'm thinking about, they do work in very sort of specialised centres, and they would then see that kind of patient group who might be also eligible for their studies… so, it might be that their clinical world is nice and neat like their research work, because it's a very specialised service. (Ronda).

All of the CPs were keen to stress the importance of interventions being collaborative, individualised, and based on a human relationship between client and therapist. They worried about this becoming lost in the current context.

> I think it would be a very worrying position to be in if psychologists did think that there was a ch-ch-ch-ch-ch, a do this, do this, do this, and that would be okay. I think that fundamentally misses the point about engaging with another person on a collaborative level, to genuinely understand what it is that they're experiencing. (Sophie).

## Discussion

This study is the first to produce a theoretical framework conceptualising beliefs about, and use of NICE guidelines in UK mental health services. CPs acknowledge that the guidelines have benefits, including better access to research evidence for clinicians and to psychological therapies for service users. However, participants in the current study also saw them as fraught with dangers. These included reification of psychiatric categories and psychological 'treatments', and promotion of a technocratic mind-set. Participants were also concerned that increasing reliance on guidelines, particularly by managers and commissioners without

specialist knowledge, could devalue both CPs' particular skills and the importance of listening to and collaborating with individual service users. They used a number of strategies to manage the tension between the helpful and unhelpful aspects of guidelines. In particular, participants described drawing on specialist skills that go beyond the guidelines – for example a collaborative, integrative approach to therapy based on an individualised idiosyncratic formulation and informed by a range of psychological theory - but not reporting this to managers.

**Knowledge**

Previous studies of guideline adherence among clinicians have focused on clinician knowledge, clinician beliefs, and external factors such as resource availability (Cabana et al., 1999). A number of research studies have been based upon the assumption that a greater knowledge of the content of guidelines would increase adherence (Gyani et al., 2011; Gyani et al., 2012; Rhodes et al, 2010). Participants in the current study, however, were all aware of the guidelines. Indeed, some participants even suggested that blind adherence to guidelines could sometimes follow from *lack* of knowledge, for example about their limitations or underlying assumptions, on the part of colleagues and managers. In the current study, adherence appeared to be more related to the other two factors, namely resources and beliefs.

**Resources**

Participants consistently pointed to the current economic and service context as a limiting factor in guideline implementation, suggesting that services do not have the resources to deliver all the recommended interventions. This echoes the findings of other recent UK studies (e.g. Gyani et al., 2012; Michie et al., 2007; Prytys et al., 2011; Rhodes et al, 2010).

## Beliefs

Clinician beliefs as outlined above, and particularly beliefs about the nature of distress and helping appeared to be key. Whilst participants saw benefits in guidelines, their reservations were similar to those expressed in published critiques (see reviews by Court, 2014a; UKCP, 2011). This suggests that the points made in the latter are not just the views of the disgruntled few who choose to publish their opinions, but may be widespread concerns. In particular, participants were concerned that in the current political context, adherence to guidelines will become increasingly mandatory rather than advisory. They also pointed to the danger of psychiatric categories and also specific approaches to helping becoming unhelpfully reified. The following section examines these concerns, concluding that they appear to be justified in the current context.

## Guidelines or Prescriptions?

Many of the participants to this study worried that the introduction of 'Payment by Results' (DH, 2002) would lead to NICE guidelines being utilised in a more prescriptive fashion. The Department of Health (2013) states that care packages will not be nationally mandated, to allow flexibility in meeting people's needs. However, it also notes that many organisations provide certain 'core interventions' based on NICE guidance to everyone allocated to a particular service 'cluster'. Increasingly, organisations mandate from the outset which approach should be used. The model of generic mental health services employing professionals with a broad training, able to draw on theoretical first principles to provide individualised treatment based on a collaborative formulation, is increasingly being replaced by one of model-specific services employing therapists with a shorter training in one, NICE-approved model only, offering predetermined, often short, packages of care to people with a particular diagnosis (Cooke & Watts, 2016). Commentators have linked this development to

the current dominance of 'naïve modernism' in the intellectual sphere (Bohart & House, 2008; van Ooijen, 2011), an anxiety-driven quest for 'safe certainty' on the part of clinicians and managers (Court, 2014b; Mason, 1993), and in the political sphere of market capitalism, 'austerity' measures and privatisation of public services (Cooke & Watts, 2016).

**Specific Issues for Clinical Psychology**

The tensions expressed by participants of this study reflect those for the profession as a whole. CPs have been active in contributing to the development of guidelines (and of 'evidence based practice' more generally) and in advocating for their implementation (Marks, 2015). However, many vocal critics have also been CPs (e.g. Mollon, 2009a, 2009b; Nel, 2011; Salkovskis, 2002. See Court, 2014a for a review).

On the one hand, participants valued the powerful endorsement that NICE can provide to psychological therapies. They sometimes even presented work as NICE-concordant (for example, as CBT) when the reality was more complex. This can be read in a number of ways. On the one hand, it can be seen as an idealistically motivated attempt at 'systemic eloquence' (Oliver, 1996) using the dominant discourse as a resource in the service of clients (Green, 2014). On the other, it can be read as an example of personal or political self-interest. Pilgrim (2010) argues that CPs 'collude' with the dominant medical model in an attempt to gain status.

One striking finding from the current study was the perverse incentive within the current system for CPs to claim to be doing protocol-driven, single-model therapy whilst actually conducting much more sophisticated interventions, drawing on a range of psychological theory and based on an individualised formulation co-constructed with the service user. Mowbray (1989, 2009) describes the ability to conduct such interventions as 'Level 3 skills', suggesting that they are what differentiate CPs from the therapists who

provide ‘Level 2’ protocol-driven interventions. In a context where CP posts are already being replaced with cheaper ‘CBT therapist’ or ‘Psychological Wellbeing Practitioner’ posts (Marks, 2015), this perverse incentive may therefore represent a significant threat. There is an urgent need for CPs to articulate and demonstrate the value of their particular skills. A recent chair of the Division of Clinical Psychology, Pemberton (2014) acknowledged the challenge for CPs to justify their cost and demonstrate their worth, noting that in many areas posts are being downgraded and CPs losing influence. The CPs in this study were keen to differentiate themselves from single modality therapists, even noting that CBT by a CP is different to CBT by a CBT therapist. There is empirical evidence to support this claim; with CPs scoring higher than CBT therapists when their CBT interventions were compared through blind rating (Brosan, Reynolds, & Moore, 2007; McManus, Westbrook, Vazquez-Montes, Fennell, & Kennerley, 2010).

**Clinical Implications**

The current findings point to the importance of allowing skilled clinicians flexibility in what they offer clients. This sounds common-sense but appears to be increasingly under threat, with some services prescribing not only the ‘brand’ of therapy offered but requiring clinicians to work to protocols for each ‘diagnosis’ and specifying the number of sessions (Cooke & Watts, 2016; Rhodes, 2016). Greater flexibility would arguably not only be more satisfactory for service users, some of whom have complained about poor care resulting from unthinking adherence to protocols (Hamilton et. al., 2011) but is likely to be more efficient overall (the most effective intervention is the one that is right for the individual) and could help ameliorate the current high levels of stress and sickness absence among therapists (Rhodes, 2016).

Participants to this present study suggested that NICE should be reviewed, including the process by which guidelines are created, the assumptions on which they are based (such as the validity of diagnostic categories), the way that psychological therapy is measured and recommendations about implementation.

**Research Implications**

Firstly, it would be interesting to repeat this study with members of professions other than clinical psychology.

Secondly, it seems important to develop therapy research methodologies that do not depend on manualisation of particular 'therapy packages' (Barkham, 2007; Barkham et.al., 2010; DCP, 2011; Parry, Cape, & Pilling, 2003). Examples might include case studies (e.g. Stenhouse & Van Kessel, 2002), therapy process research (DCP, 2011), or comparison of different services (Pilling, 2016).

Thirdly, historical, sociological and discourse analyses would be helpful to elucidate the historical, political and linguistic forces which are contributing to the current reliance on guidelines and the dominance of 'evidence based practice' more generally (see e.g. Freshwater & Rolfe, 2004; Hall et.al, 2015)

**Limitations**

Consistent with its constructivist position, this study makes no claim that the findings are objective. The role of the researchers in co-constructing these data together with the participants is acknowledged, and different researchers may have co-constructed the analyses differently. As detailed in the methodology, numerous steps were taken to ensure transparency regarding the researchers' assumptions, beliefs and allegiances.

There were limitations to both recruitment approaches; with CPs known to the lead researcher it could be argued that pre-existing knowledge of the CP may have biased sampling. CPs who responded to recruitment emails may have been motivated by particularly strong views for or against NICE guidelines. As the aim was to speak with typical CPs from routine practice, rather than those with particularly strong views, it was felt that a combination of both recruitment strategies would help offset the limitations of each approach. In an attempt to provide transparency, the decision making behind the selection of participants was documented in detail and is available in Court (2014b).

## Conclusions

This study is the first to produce a theoretical framework which attempts to help explain why NICE guidelines are not consistently utilised in UK mental health services. The benefits of guidelines were valued; however, there were concerns about the harm that misuse of guidelines could do to service users and also to the profession of clinical psychology. The emergent theory challenges the assumption that there is a simple, linear relationship between knowledge and guideline usage. This study also highlights the importance of CPs finding ways to ensure that their particular skills are recognised and utilised in the current service and political context.

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Table 1

*Participant characteristics*

| | |
|---|---|
| Gender | 9 Women, 2 Men |
| Speciality | 6 adult mental health, 2 child and adolescent mental health, 1 learning disabilities, 1 forensic, 1 older people mental health |
| Band | 2 band 7, 5 band 8a, 1 band 8b, 3 band 8c |
| Country of training | 10 were trained in the UK |
| Years since qualifying | Range 2 – 21. Mean 8.2. Standard deviation 5.8. |
| Preferred therapeutic modality | 3 Cognitive Behaviour Therapy (CBT), 5 Integrative, 2 Cognitive Analytic Therapy and 1 ‘Psychodynamic, Systemic and CBT’. |