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MAJOR RESEARCH PROJECT

ALEX JOHN COURT BSc (Hons) MBPsS PGDip

THEY'RE NICE AND NEAT, BUT ARE THEY USEFUL? A GROUNDED THEORY OF CLINICAL PSYCHOLOGISTS' BELIEFS ABOUT, AND USE OF NICE GUIDELINES

Section A: NICE Guidelines in UK Mental Health Services: A Review of How
They Have Been Received
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Section B: They're NICE and Neat, but Are They Useful? A Grounded Theory
of Clinical Psychologists' Beliefs About, and Use of NICE Guidelines
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Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2014


SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

DECLARATION FOR MAJOR RESEARCH PROJECT

Candidate name ALEX JOHN COURT (PRINTED)

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed  (candidate)

Date 4/4/2014

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed  (candidate)


Date 4/4/2014

Signed Anne Cooke (supervisor)

Date 4/4/2014

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be made available to external internet users through the CCCU institutional repository and the British Library EThOS service, and for the title and abstract to be made available to outside organisations.

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Date 4/4/2014

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Summary of MRP Portfolio

Section A is a scoping review, exploring the generic clinical guideline implementation literature, as well as literature specific to the use of NICE guidelines in UK mental health services. This review examines the proposed benefits of guidelines, highlights the inconsistent implementation of NICE guidelines and explores potential reasons for this. The theoretical assumptions underlying guideline usage are examined. The use of psychological theory in attempting to understand the behaviour of clinicians is also reviewed. It is proposed that further qualitative research is required to investigate clinicians' beliefs about, and use of NICE guidelines.

Section B presents the findings of a grounded theory analysis of clinical psychologists' use of NICE guidelines. A theoretical framework is presented, conceptualising the participants' (n=11) beliefs, decision making processes and clinical practices. The overall emerging theme is "considering NICE guidelines to have benefits but to be fraught with dangers". Attention is drawn to the proposed benefits and limitations of guidelines and how these are managed. Concerns are raised about the harm that guidelines could do to service users and to the profession of clinical psychology. The findings are integrated with existing theory and research, and clinical and research implications are presented.

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MAJOR RESEARCH PROJECT

SECTION A: LITERATURE REVIEW

NICE Guidelines in UK Mental Health Services: A Review of How They Have
Been Received.

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CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Clinical practice guidelines have become increasingly common in both physical and mental healthcare over the last two decades. This review examines the proposed benefits of guidelines, highlights the inconsistent implementation of NICE guidelines in UK mental health services and explores potential reasons for this. The generic research literature on guideline implementation is reviewed, before focussing in more detail on literature specific to the use of NICE guidelines in UK mental health services. The body of empirical research investigating this area is fairly limited. The available research suggests that external factors, such as resources, are key barriers to implementation of NICE recommendations. Many authors have published strongly worded criticisms of the use of NICE guidelines in mental health services. It is proposed that further qualitative research is required to investigate clinicians' beliefs about NICE guidelines. Developing a better understanding of clinicians' beliefs about, and use of NICE guidelines could help inform implementation strategies. Alternatively, it could highlight limitations of the guidelines and question the extent to, and the conditions under which they are more or less useful.

Keywords: NICE, clinical guidelines, decision making, implementation, mental health.

1. Introduction

1.1. The Age of Clinical Practice Guidelines and the Rise of NICE

Numerous authors have highlighted the increasing role of clinical practice guidelines¹ 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). Woolf et al. (1999) described a developing interest in guidelines across Europe, North America, Australia, New Zealand and Africa.

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). Using the example of guidelines available internationally for depression, Pilling (2008) demonstrated that the interest in guidelines had continued to increase at an extraordinary rate; he noted that Parry et al. reported that there were 170 guidelines for depression on the National Guidelines Clearinghouse (an international database) and that on the 31st December 2007, the number had risen to 446.

Guidelines are typically defined as “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances” (Field & Lohr, 1990, p.38). Woolf et al. (1999) suggest that the interest in guidelines stems from rising healthcare costs for providers, in the context of an increased demand for care and an aging population. There is a recognition of variation in service provision and an assumption that this can be partially explained by inappropriate care. Woolf

¹ Hereafter referred to as “guidelines”.

et al. suggest that the motivation underlying guideline production is an attempt to offer the best care possible in a cost effective manner.

The National Institute for Health and Care Excellence² (NICE) was established in 1999 to produce guidelines 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). The first NICE guideline for mental health was the schizophrenia guideline, published in 2002. Baillie, Bent, Leng, Kendall and Shackleton (2008) noted that in the years following this first guideline, 20 mental health guidelines were published, covering “all the main psychoses, substance misuse problems, common mental health disorders, personality disorders, childhood mental health and the dementias” (p. 257).

In a review of NICE’s first decade in existence, focusing on mental health, Kendall, Glover, Taylor and Pilling (2011a) proposed that NICE had become “probably the most comprehensive and methodologically advanced mental health guideline programme in the world, covering most adults and children with mental health problems” (p. 342). Baillie et al. (2008) described an increasing international interest in NICE guidelines, and in 2008 “NICE International” was established (NICE, 2009). The NICE International Review (2012) detailed that since its inception, NICE International had helped develop guidelines (across physical and mental health) in 75 countries.

²Originally named “National Institute for Clinical Excellence”. In 2005, the name changed to “National Institute for Health and Clinical Excellence”. In 2013 the name changed to “National Institute for Health and Care Excellence”.

Despite the apparent success of NICE, there is evidence that the level of implementation of NICE guidelines in UK mental health services is low (e.g. Mears, Kendall Strathdee, Sinfield, & Aldridge, 2008; Prytys, Garety, Onwumere, & Craig, 2011). Similar concerns have been raised within UK physical health services (e.g. Sheldon et al., 2004; Spyridonidis & Calnan, 2011).

1.2. Aims of Review

The aim of this paper is to review the empirical, theoretical and ‘grey’ literature related to the use of NICE guidelines in UK mental health services. It will cover the general literature on guideline implementation, as well as specifically focussing on literature regarding the use of NICE guidelines in UK mental health services. The review attempts to address the following questions:

- i) What are the proposed benefits of guidelines?
- ii) To what extent are NICE guidelines followed in UK mental health services?
- iii) What barriers have been identified in implementing NICE guidelines in UK mental health services?
- iv) Are there arguments against the use of NICE guidelines in UK mental health services?
- v) What further research is required?

2. Method

The following electronic databases were searched: PsychINFO, Medline, Web of Knowledge, ASSIA, Cochrane Library, Google Scholar and Google, using the keywords: “NICE guidelines” OR “NICE guidance” OR “Clinical Guidelines” AND “Attitudes” OR “Clinical Decision Making” OR “Implementation” AND “Mental Health”. Searches were limited to articles produced after 1998. It was hoped that this would capture literature written in

anticipation of NICE guidelines and literature written about, or in the context of NICE guidelines. When relevant studies were found, their reference lists were inspected to identify other appropriate studies. The “find similar” and “find citing articles” functions on electronic databases were also utilised.

The review utilised a mixed methodology (Grant & Booth, 2009), incorporating a scoping review and a systematic review. Overall, a scoping review (Grant & Booth, 2009; Jesson, Matheson, & Lacey, 2011) was conducted, reviewing the available literature, identifying gaps in knowledge and highlighting areas for future research. The generic literature regarding guideline usage and published views about NICE guidelines were reviewed in this way. This review aimed to be thorough, without claiming to be comprehensive. Due to the wide variety of literature covered, no formal quality assessment frameworks were utilised, as is typical in such reviews (Grant & Booth, 2009).

Due to the limited volume of empirical research focusing on NICE guideline usage in UK mental health services, it was possible to conduct a systematic review (Grant & Booth, 2009) of this material. Studies were included in this systematic review if they specifically investigated why guidelines were not implemented, or if they explored clinicians’ beliefs about guidelines as a result of investigating clinical decision making. Studies were included if they were written in English, published in peer reviewed journals and focused on the use of NICE guidelines in UK mental health services. Due to the scarcity of research available, no further stringent exclusion criteria were set. The critique of qualitative studies was informed by Reid and Gough (2000). The critique of studies utilising surveys was informed by Gauthier’s (2003) framework (further methodology details are included in Appendix A).

3. The Proposed Benefits of Guidelines

Guidelines are said to provide busy clinicians with easily accessible summaries, critically appraising the available evidence for various interventions (Parry et al., 2003; Woolf et al., 1999; Ruggeri, 2008). Parry et al. suggest that this is especially important for generalists such as general practitioners (GPs) who have to keep track of the evidence base over widely differing domains. Woolf et al. (1999) argue that identifying interventions that are not supported by science can draw attention to “ineffective, dangerous and wasteful practices” (p.528). Pilling (2008) suggests that guidelines could help focus future training of clinicians on the most effective interventions.

It is proposed that guidelines can help highlight under-recognised problems and interventions, together with neglected patient populations (Rawlins, 2011; Woolf et al., 1999). Woolf et al. (1999) note that guidelines can lead to new services being established to meet such needs. Entwistle et al. (1998) suggest another benefit to patients, highlighting that guidelines are often accompanied by summary versions for the general public. This can increase their knowledge of available interventions and empower them to take informed roles in shared decision making about their care. The involvement of service users in the production of NICE guidelines has been said to be a key development in reducing power imbalances between clinicians and service users in mental health services (Harding, Pettinari, Brown, Hayward, & Taylor, 2011; Kendall, Glover, Taylor, & Pilling, 2011b).

One of the key proposed benefits of guidelines is that they aim to improve cost effectiveness in a time of limited funding (Shapiro, Lasker, Bindman, & Lee, 1993; Woolf et al., 1999). Buxton (2006) notes that “economic evaluation plays a central role” (p.1133) in NICE.

It has been suggested that guidelines can be a helpful platform for validating a particular profession or intervention. For example, Ruggeri (2008) acknowledges that psychiatry is seen by many as a “soft science” (p.272) and suggests that “the publication of evidence based practice guidelines helps combat such misperceptions and helps people realise that there are specific ways to treat mental illness and that these treatments are actually effective” (p.272). Shaner (2002) suggests that guidelines can be a way to defend and preserve the place of psychological therapies in health services. Pilling (2008) suggested that NICE guidelines had been helpful in demonstrating the importance of psychological interventions, noting that out of the 13 mental health guidelines available at the time, psychological interventions were identified as key recommendations in 10. Pilling (2008) and Rawlins (2011) highlighted that NICE recommendations had a major role in the development of the Increasing Access to Psychological Therapies (IAPT) programme (DH, 2007); which led to a significant increase in funding for the provision of psychological therapies in the UK.

Kendall et al. (2011b) and Parry et al. (2003) argue that a strength of NICE is that it draws on input from numerous different professional groups and service users. This attempts to ensure that the power NICE guidelines can provide is not misused. NICE deliberately adopted this approach following concerns that other guidelines, created by one professional group, had been misused to serve the interests of the profession (e.g. Grilli, Magrini, Penna, Mura, & Liberati, 2000; Hollon & Shelton, 2001).

4. The Use of NICE Guidelines in UK Mental Health Services

NICE carries out regular searches of a wide range of electronic databases and collates audits³ of guideline implementation into the Evaluation and Review of NICE Implementation

³ Single and multi-site audits.

Evidence (ERNIE) database, available to search on its website. NICE awards ratings ranging from: “Practice appears to be in line with guidance” (results reported in audits are over 70%), “Doubts about or mixed impact in practice” (results between 41% - 69%), to “Practice appears not to be in line with guidance” (results are 40% or less)⁴. Table 1 details the results for the guidelines with the most audits currently available (as of 7th November 2013).

Table 1.

Summarising the ERNIE categorisation of audits on NICE guideline implementation

Guideline	<u>Number of audits showing:</u>		
	Practice appears to be in line with guidance	Doubts about or mixed impact in practice	Practice appears not to be in line with guidance
CG90 Depression in adults	0	10	9
CG22 Depression in children and young people	0	5	6
CG113 Anxiety	0	4	7
CG123 Common mental health disorders	0	6	7
CG42 Dementia	4	9	0
CG82 Schizophrenia	1	6	2

⁴ Range details were provided through personal communication with a NICE data analyst who noted that the percentages were chosen arbitrarily.

The figures in table 1 paint a clear picture of inconsistent implementation of NICE guidelines in UK mental health services. Only 5 out of the 76 audits (7%) demonstrated that “practice appears to be in line with guidance”. Audits identified by this review, that were not reported by ERNIE, display a similar picture. For example, Lewis, Buffham and Evenson, (2012) and Mankiewicz and Turner (2012) highlighted that despite NICE recommendation, psychological interventions were not routinely offered to individuals with a diagnosis of schizophrenia. Dunne and Rogers (2011) reported a series of considerable deviation from NICE guidelines in the treatment of individuals with a diagnosis of borderline personality disorder. For example, 61 per cent of patients were receiving long term medication, despite NICE advising against this. In summary, despite the many proposed benefits of guidelines, the available evidence suggests that uptake of NICE guidelines in UK mental health services has been inconsistent.

5. Investigating Implementation Barriers

The following sections of this review attempt to explore potential reasons for the inconsistent uptake of NICE guidelines in UK mental health services. The general research literature on guideline implementation is reviewed before focusing on literature specific to the use of NICE guidelines in UK mental health services.

5.1. General Research Literature on Guideline Implementation

The last 10 to 15 years have seen a developing research interest internationally in attempting to understand barriers to guideline implementation (Girlanda et al., 2013). This section begins by defining terminology and moves onto reviewing relevant literature.

5.1.1. Terminology. Within the literature, there appears to be a link between guideline implementation and evidence based medicine (EBM)⁵. Many of the prominent researchers have published in both fields and the terms have been used interchangeably (e.g. Grimshaw, Eccles, & Tetroe, 2004), presumably because they are seen as synonymous. The terms have even been combined as “evidence based medicine guidelines” (Saarni & Gylling, 2004).

EBM has been defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). Guidelines have been described as a way of increasing the practice of EBM, by providing clinicians with accessible summaries of the evidence with clear recommendations (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012). Kendall et al. (2011b) describe guidelines as “the most elaborate and well-developed expression of evidence based medicine in clinical care” (p. 314).

While there is clearly a link between the two terms, there are also important differences. For instance guidelines can quickly become out of date; if new evidence emerges after a guideline is produced, practice that follows the original guideline would no longer fit within the definition of EBM. Furthermore, the approach taken by developers of guidelines, such as NICE, to create recommendations has been challenged (e.g. Mollon, 2009a; Barkham, 2007; UKCP, 2011). For example, UKCP (2011) argue that NICE unfairly neglect evidence from practice based research, case studies and qualitative studies. A clinician whose practice is informed by evidence not included in the guidelines could therefore argue that they are practicing within the realms of EBM but not within guidelines. This review draws

⁵ Also referred to as “evidence based clinical practice”, in recognition of non-medical interventions, but EBM tends to be more frequently used.

upon literature from both fields but makes a point of highlighting whether the research is referring to EBM or guidelines.

5.1.2. From research to clinical practice. In a systematic review of the use of EBM across both physical and mental health, Grimshaw et al. (2012) note that “one of the most consistent findings is the failure to translate research into practice” (p. 50). This has been reported by numerous authors (e.g. Bero et al., 1998; Eccles, Grimshaw, Walker, Johnston, & Pitts, 2005; Grol & Grimshaw, 1999; Haines & Donald, 1998). Guidelines are intended to help facilitate the practice of EBM, but the literature consistently concedes that guideline implementation is also low, across both mental and physical health care (e.g. Berry & Haddock, 2008; Cabana et al., 1999; Girlanda et al., 2013; Goldney, 2004; Michie et al., 2005). In the context of the practice of EBM and use of guidelines being consistently low, the inconsistent implementation of NICE guidelines in UK mental health services is perhaps not unexpected.

5.1.3. Implementation barriers. Cabana et al. (1999) completed a systematic review of barriers to physicians’ use of guidelines⁶ and produced a conceptual model which attempted to account for variations in practice. This model suggests that guideline implementation depends upon three categories; clinicians’ knowledge (i.e. familiarity with guidelines), clinicians’ beliefs (e.g. level of agreement with guidelines) and external factors (such as resources). However, the validity of the model is potentially open to question. It was constructed by manually reviewing and collating the findings of 76 studies, no formal quantitative or qualitative methodology was utilised to construct or test the model. The model highlights an interrelation between the categories of external factors and clinicians’ beliefs.

⁶ Including physical and mental health guidelines.

For example a clinician may believe that it is not possible to implement guidelines due to a lack of resources. However, there is no consideration of whether clinicians' knowledge and beliefs are interrelated, despite this seeming likely. For example if clinicians are critical of, or apathetic towards guidelines, then it is hypothesised that they will invest less effort in increasing their knowledge of them. Despite its limitations, Cabana et al.'s model has proved influential, being cited over 3,700 times⁷, influencing future research and guideline implementation strategies.

Robertson and Jochelson (2006)⁸, Weinmann, Koesters and Becker (2007)⁹ and Giralanda et al. (2013)¹⁰ systematically reviewed strategies for increasing guideline implementation. Strategies included the provision of educational material, large scale didactic training, small scale interactive training, the use of local champions, audit and feedback, computerised reminders and providing educational material to patients. The consistent finding was that the success of these strategies was modest at best. An assumption underlying many of these strategies appears to be that increasing clinicians' knowledge will result in an increase in implementation. The fact that these strategies tend to be ineffective could suggest that knowledge is not a key predictor variable in understanding guideline usage.

5.1.4. Use of psychological theory. Eccles et al. (2005) stressed the importance of research into guideline usage being based upon psychological theory. Eccles et al. noted that clinical practice was a form of human behaviour and could therefore be studied using general psychological theories relating to human behaviour. They highlighted that in a previous

⁷ 3,772 as of 06.02.2014, source GOOGLE Scholar.

⁸ Focusing on the use of NICE guidelines, both physical and mental health.

⁹ Focusing on mental health guidelines.

¹⁰ Focusing on mental health guidelines.

review by Grimshaw et al. (2004) fewer than 10% of the studies drew upon psychological theory.

The theory of planned behaviour (Ajzen, 1985) is one of the most commonly used theories in this field (Perkins et al., 2007). This theory proposes that intention to perform a particular behaviour is influenced by an individual's beliefs (i.e. about the consequences / acceptability of the behaviour), subjective norms (i.e. influence of others) and perceived behaviour control (i.e. how much control the individual feels they have to perform the behaviour). It has become one of the most influential and popular conceptual frameworks for the study of human action (Ajzen, 2001; Armitage & Connor, 2001)

This theory has been utilised in a number of studies regarding guideline implementation (Perkins et al., 2007). For example Rashidian and Russell (2011) investigated the extent to which physicians followed statin guidelines and found that beliefs and perceived behaviour control were significant in predicting intentions to follow guidelines. However, the usefulness of the theory has been questioned, particularly in the light of the consistent finding that there is a significant gap between intention and actual behaviour (Browne & Chan, 2012; Conner & Norman, 2005; Sutton, 1998). Also, the use of regression models shows that the variables in the theory of planned behaviour tend to account for only between 20 to 40% of behaviour variance (Armitage & Connor, 2001; Godin & Kok, 1996). Browne and Chan (2012) suggest that the model is helpful but insufficient and in need of additional variables.

Robertson, Baker and Hearnshaw (1996) produced a comprehensive framework of the ways in which psychological theory could be relevant in attempting to change the behaviour of doctors, including encouraging them to follow guidelines. Robertson et al. (1996) suggest

that the following theories are relevant: self-efficacy (Bandura, 1986), preparedness to change (Prochaska & DiClemente, 1986), social influence (Hovland & Weiss, 1951), bereavement reaction (Parkes, 1978), inverse social facilitation (Latane, 1981), social comparison (Festinger, 1954), groupthink (Janis, 1982), power theory (Mintzberg, 1983) and cultural change (Katz & Kahn, 1966). The scope of this review does not allow for a full description and evaluation of each theory, however the idea of utilising these particular theories appears to be based upon an underlying assumption that guidelines should be followed. For example clinicians need to improve their sense of self efficacy (Bandura, 1986), or move from a stage of contemplation to action (Prochaska & DiClemente, 1986). This stance does not seem to consider the possibility that clinicians may have valid arguments for not utilising guidelines.

Michie et al. (2005) conducted a novel project, inviting 61 professionals, to brainstorm which psychological theories might help understand the behaviour of clinicians. These theories were then deconstructed and common constructs grouped together to form 12 domains¹¹. The usefulness of psychological theory in this field has been questioned, noting that complex theories can complicate matters rather than provide understanding (Oxman, Fretheim, & Flottorp, 2005). A strength of Michie et al.'s approach is that it collated and simplified a number of theories, into one practical framework. Also, unlike the theories proposed by Robertson et al. (1996), Michie et al.'s framework allows for exploration of clinicians' beliefs about guideline utility. Michie et al.'s framework is discussed further in section 5.3.2 of this review.

¹¹ (1)knowledge, (2)skills, (3)social/professional identity, (4)beliefs about capabilities, (5)beliefs about consequences, (6)motivation and goals, (7)memory, attention and decision processes, (8)environmental context, (9)social influences, (10)emotion regulation, (11)behavioural regulation, (12)nature of behaviour.

5.1.5. ‘Setting specific’ barriers. It has been suggested that implementation barriers are likely to vary between settings (Cabana et al., 1999; Girlanda et al., 2013, Perkins et al., 2007). The issue of whether guideline usage in physical and mental health services is comparable is a source of debate. Authors such as Bentall (2003) and Boyle (2000) highlight the differences between physical and mental health. Authors such as Parsons and Armstrong (2000) dispute the separation. This review will now turn to focus on guideline usage in mental health services in an attempt to investigate any potential setting specific barriers.

The review will focus specifically on the use of NICE guidelines. While some studies highlight the similarity between guidelines for mental health conditions produced by different organisations (e.g. Gaebel, Riesbeck, & Wobrock, 2011) others suggest the opposite. For example Croghan, Schoenbaum, Sherbourne and Koegel (2006) and Tyrer and Silk (2011) demonstrate important differences between mental health guidelines from USA and NICE; with USA guidelines emphasising the use of medication more than those produced by NICE. It is therefore hypothesised that implementation barriers are likely to differ for clinicians using NICE guidelines compared to clinicians using guidelines produced by different organisations. The review will focus specifically on practice in the UK. While NICE guidelines are utilised in other countries, factors such as funding, training and service organisation are likely to vary significantly across different countries, which could impact upon ‘setting specific’ barriers. Furthermore, while the findings of this review may have wider relevance, the aim of this review is primarily to inform debate in UK mental health services. Sections 5.2 and 5.3 of this review therefore focus specifically on literature regarding the use of NICE guidelines in UK mental health services.

5.2. Published Criticisms of the Use of NICE Guidelines in UK Mental Health Services

Numerous mental health clinicians have published comprehensive critiques both of the approach NICE takes to creating guidelines for UK mental health services, and regarding the way in which they are interpreted and utilised (e.g. Adams, 2008; Barker & Buchanan-Barker, 2003; Barkham, 2007; Fairfax, 2008; Hammersley, 2009; McQueen, 2009; McDonnell, 2012; Midlands Psychology Group, 2010; Mollon, 2009a, 2009b; Nel, 2011; Rogers, 2011; Smail, 2006; UKCP, 2011; Waft, 2011).

The arguments have been strongly worded at times. For example Mollon (2009b) describes NICE as “a most extraordinarily toxic and malign influence upon psychological therapy” (p.131). Hammersley (2009) expresses the hope that psychologists would be confident enough in their abilities to ignore NICE guidelines “devised for medical practitioners and the untrained NHS drones” (p.8). The Midlands Psychology Group (2010) use a controversial, yet powerful metaphor in comparing NICE to the Iraq war; noting a “mission creep” (p.5) where the initial objectives (removing weapons of mass direction; providing guidelines) gradually, yet intentionally changed over time to something more undesirable (invasion, even though no weapons of mass direction were found; controlling the practice of healthcare professionals).

The key themes in these criticisms are as follows:

5.2.1. Challenging the validity and reliability of diagnosis. The validity and reliability of psychiatric diagnosis has been fiercely criticised by many authors, notably Bentall (2003) and Boyle (2002). Recently the Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) (2013) produced a response to the DSM-5, comprehensively critiquing the classification system, noting that it is not backed up by

empirical evidence and ignores evidence that challenges its validity. Such challenges to the diagnostic system on which NICE relies, brings into question the validity and reliability of using NICE guidelines in mental health.

5.2.2. Challenging the notion that psychological therapies are akin to medication.

Many of the critics (notably UKCP, 2011) highlight that NICE guidelines treat psychological therapies as if they are similar to medication. It is argued that NICE guidelines describe psychological therapy as if it is something that is delivered to patients, in a uniform way by different clinicians, in a set number of sessions. These authors criticise this approach as simplifying the process of psychological therapy, putting too much emphasis on therapy techniques. Critics highlight that representing psychological therapy in this way ignores the wealth of research highlighting the importance of the therapeutic relationship (e.g. Assay & Lambert, 1999) and varying performance of clinicians (e.g. Miller, Hubble, & Duncan, 2008). It also presumes that therapy carried out by clinicians in routine practice is comparable to manualised therapy practiced in randomised controlled trials (RCTs). This notion has been disputed, with Barkham (2007) arguing that most psychological therapists practice integratively and that this approach is unlikely to ever be included in an RCT. This critique therefore suggests that the NICE guidelines do not capture the true essence of psychological therapies.

5.2.3. Comparing RCTs and routine practice.

Pilling (2008) concedes that RCTs do have limitations but proposes that they are the gold standard of research and few would dispute this. The current review reveals numerous authors who argue that NICE overly rely on RCTs, including most of the authors noted in this section. A key criticism is that the tightly controlled conditions in RCTs do not match the complexity of routine practice. This is

especially the case with individuals with comorbid difficulties, as they are usually excluded from RCTs, yet are common in routine practice. The argument follows that if the guidelines are based upon research that is not readily generalisable to routine clinical practice, then the guidelines will not be readily implementable. A common request of critics is that a greater variety of research methodologies be considered, including the use of practice based evidence and qualitative methods.

Authors such as Pilling (personal communication, February 19, 2012) dispute this criticism, quoting research suggesting that RCT findings are replicable in routine practice (e.g. Shadish, Matt, Navarro, & Phillips, 2000; Persons, Roberts, Zalecki, & Brechwald, 2006). However, it is questionable how generalisable the findings from these studies are. For example, Shadish et al. (2000) attempted to demonstrate that psychological therapies were effective under clinically representative conditions but still utilised numerous exclusion criteria¹². With the Persons et al. (2006) study, there are questions over how comparable the sample¹³ of this study is to UK NHS services. Furthermore, the interventions described in the study appear to be more individualised¹⁴ than would be the case in an RCT, questioning the argument that this study demonstrates that pure, manualised interventions delivered in RCTs are replicable in routine practice.

5.2.4. Arguing that service user choice is restricted. Critics of NICE guidelines tend to highlight the dominance of CBT in the guidelines. They worry that service users are increasingly only being offered CBT rather than considering which therapy may be of most assistance, or most acceptable to them. This links back to a key criticism of RCTs; due to the

¹² E.g. service users taking psychotropic medication, who probably form the majority in services, were excluded.

¹³ USA Private practice, service users described as particularly well-motivated, with above average levels of education.

¹⁴ Service users were said to receive individualised formulation driven interventions. Many service users also received other therapies, including couples therapy and 12 step groups alongside CBT.

randomisation, individual circumstances or preferences cannot be taken into consideration (Brewin & Bradley, 1989). Placing too much emphasis on the findings of RCTs continues this trend of ignoring individual preferences and needs.

Critics highlight that the favouritism of CBT is not in keeping with the research evidence. It is argued that when therapeutic modalities are compared using practice based evidence (e.g. Stiles et al., 2006) there are no differences between their effectiveness. This finding does not imply that there are no differences between modalities, because then there would not be a problem with just having CBT. It implies that there is value in different modalities. There is an assumption that different approaches will suit different individuals (Roth & Fonagy, 2005). While this assumption appears to have good face validity, Roth and Fonagy (2005) acknowledge that there has been very little research into the idea. They note that most psychotherapy trials would not have the statistical power to investigate this.

5.2.5. Questioning whether NICE are guidelines or mandatory. NICE present recommendations as non-mandatory guidelines, emphasising that they should not override clinical autonomy. Parry et al. (2003) stress that slavish adherence to NICE guidelines is likely to produce poor clinical outcomes. NICE and authors such as Parry et al. presumably take this stance due to an acknowledgement of the limitations of guidelines, such as those discussed in this section. However, authors such as Littlejohns (2000) enthusiastically note that due to the quality of NICE guidelines, few clinicians would ever need to practice in ways that were not NICE concordant. Furthermore, NICE guidelines are often seen as performance standards, centrally prescribed and monitored (Spyridonidis & Calnan, 2011). It therefore seems that while it may not be NICE's intention, some services are not recognising the limitations and appear to be using them as mandatory rather than guidelines.

5.2.6. Competing interests and professional identities. As well as the above key criticisms, there are also concerns between professional groups. Despite the efforts of NICE to include a range of professionals in guideline development, there have been concerns that this range of professionals is still not representative enough (e.g. UKCP, 2011; Barker & Buchanan-Barker, 2003). This criticism comes with an assumption that different professions may have different opinions towards guideline usage. The reports of the House of Commons Health Committee (2007, 2013) provide a unique opportunity to explore this assumption, as professional organisations were invited to present their views on NICE guidelines.

The Royal College of Nursing (2007), the BABCP (British Association of Behavioural and Cognitive Psychotherapies) (2013) and the BPS (2007, 2013) presented positive views regarding NICE guidelines. The Royal College of Psychiatrists' (2007) statement focused solely on critiquing NICE guidelines for dementia. This draws attention to the fact that not all mental health professionals are in support of the guidelines. However, the absence of a more generic statement from the College (i.e. not just focusing on dementia) and the absence of statements from the Colleges in 2013 might suggest a general satisfaction, or an absence of strong critical views about NICE guidelines.

The BACP (British Association of Counsellors and Psychotherapists) (2007, 2013) and UKCP (UK Council for Psychotherapy) (2013) statements were critical of NICE guidelines, incorporating the key criticisms detailed above. This could suggest that there is a split with the medical professions, CBT therapists and psychologists in favour of NICE guidelines and counsellors and psychotherapists against them. It could be argued that this is in line with the amount NICE guidelines recommend the interventions offered by these professions. This

could suggest that as well as the differing theory bases of the professions leading to different conclusions, views for or against NICE guidelines may be influenced by competing interests.

While the adoption of NICE guidelines certainly appears to be in line with the interests and theoretical bases of CBT therapists and medical professions, it is less clear whether this is also the case with psychologists. The BPS (2007, 2013) note that the guidelines have been broadly welcomed by psychologists in the NHS. However, this statement does not represent the viewpoints of the numerous psychologists who have published criticisms of NICE guidelines (e.g. Adams, 2008; Barkham, 2007; Fairfax, 2008; Hammersley, 2009; McGowan, 2009; Midlands Psychology Group, 2010; Mollon, 2009a, 2009b; Nel, 2010; Smail, 2006). This discrepancy is especially apparent when considering that Barkham (2007) submitted comprehensive criticisms to the Commons Review also, contradicting the positive outlook of the BPS (2007, 2013). This discrepancy between the views of the BPS and some of its members suggests that the relationship between professional identity and views towards NICE is not straight forward. It highlights that views seem to vary within, as well as between professions.

In summary, numerous criticisms have been voiced regarding the use of NICE guidelines in UK mental health services. It seems likely that these critical views held by clinicians will impact upon guideline usage. The next section of this review moves onto examine empirical research.

5.3. Empirical Research Focusing on Implementation of NICE Guidelines in UK Mental Health Services

The systematic review of empirical research revealed nine relevant studies (Appendix B). The studies are reviewed thematically, grouping the information according to Cabana et al.'s (1999) categories of knowledge, beliefs and external factors, due to the prominence of this framework in the guideline implementation literature.

5.3.1. Clinicians' knowledge. Rhodes, Genders, Owen, O'Hanlon and Brown (2010) tested the hypothesis that knowledge of guidelines is a key barrier to implementation. The staff of four secondary care assessment and brief treatment teams were tested on their knowledge of NICE guidelines for depression. Thirty two staff members (mental health nurses, social workers, managers, psychiatrists, clinical psychologists and vocational specialists) were given questionnaires. They were also asked to read vignettes and specify what the recommended intervention would be. Rhodes et al. (2010) concluded that most staff had appropriate levels of knowledge. The staff were said to respond to the vignettes in a way that was in keeping with NICE recommendations. This suggests that knowledge did not seem to be a key variable impacting upon guideline usage within these teams.

Turning to primary care, Gyani, Shafran and Rose (2011) and Gyani, Pumphrey, Parker, Shafran and Rose (2012) conducted large scale questionnaire surveys with GPs, enquiring about their knowledge and use of NICE guidelines. Gyani et al. (2011) reported that only 30% of the GPs who replied said that they had read the NICE guideline in question (obsessive compulsive disorder). This finding could help explain low rates of guideline implementation; if the majority of GPs are not reading the guidelines, then their recommendations are unlikely to be implemented. Gyani et al. (2012) reported a different

finding, with 75% of GPs stating that they had read the depression guideline. However, in keeping with the theory that knowledge is a key variable, they noted that concordance with guidelines was significantly higher amongst those who had read them.

5.3.2. Clinicians' beliefs. The Gyani et al. (2011) and Gyani et al. (2012) studies point to knowledge of guidelines as being a key factor affecting implementation. However, information from both studies highlights the relevance of clinicians' beliefs. Gyani et al. (2011) reported that 80% of the GPs said that they had read at least one NICE guideline for a mental health condition. The corresponding percentage for physical health guidelines was 97%. Gyani et al. (2011) did not reflect on what this discrepancy might mean, presumably due to a lack of data because of the limitations of a questionnaire survey. This finding could highlight important beliefs that impact upon guideline usage. For example it could suggest that the GPs see mental health as less important or relevant to them than physical health. Alternatively, it might be that the GPs deem NICE guidelines to be less relevant or helpful for mental health.

As well as the main focus of the questionnaire survey, Gyani et al. (2012) also interviewed six GPs, obtaining qualitative information. The qualitative analysis is not described in great detail but the data that are available highlight some important themes. For example, some of the GPs questioned the validity of the research included by NICE. This could perhaps explain why some GPs neglected to read them.

The Rhodes et al. (2010) study also appears to highlight the importance of clinicians' beliefs. It was reported that clinicians felt that social problems of service users were a significant barrier to referring for CBT. They noted that NICE guidelines do not account for

such social problems. It might therefore be that clinicians believe that service users do not neatly fit into the guidelines and therefore do not feel that they can always follow the recommendations. A similar finding was noted by Kovshoff et al. (2012). Fifty child psychiatrists and paediatricians were interviewed about their decision making processes in assessing and treating ADHD. The participants questioned the practicality of guidelines. The following quote was provided to demonstrate this point: “[...] it boils down to it that every person is an individual person, and you can’t use a guideline in our profession. I’m absolutely against that. That doesn’t work” (p.93). Kovshoff et al.’s concluding paragraph to their article recommended further research into guideline usage in routine practice. They argued that guidelines needed to “more accurately capture the real-world complexity of clinical decision making” (p.98).

It was highlighted by Kovshoff et al. that only 6 of the 50 participants reported drawing on NICE guidelines. Based upon the criticisms voiced, it seems likely that this occurrence is linked to the participants’ beliefs about the limited utility of guidelines. A similar finding was reported by Toner, Snape, Acton and Blenkiron (2010). In another questionnaire survey of GPs, Toner et al. (2010) reported that only 38% of the GPs to respond rated NICE as having a moderate or substantial impact upon their decision making. This may be due to their level of familiarity with the guidelines; if they have not read the guidelines then they cannot impact upon their decisions. It could however imply an appraisal of the usefulness of the guidelines, highlighting the beliefs of these clinicians.

Prytys et al. (2011) and Michie et al. (2007) explored clinicians’ beliefs about the NICE guidelines for schizophrenia. Prytys et al. (2011) interviewed 20 care co-ordinators across 4 CMHTs (Community Mental Health Teams) and analysed the results using thematic analysis.

Michie et al. (2007) built upon the study of Michie et al. (2005) described in section 5.1.4. They used the 12 domains drawn from psychological theory to guide semi structured interviews and a content analysis. Twenty CMHT workers (social workers, nurses, team managers, psychologists, and psychiatrists) from 3 NHS trusts were interviewed.

Prytys et al. (2011) reported that positive views were expressed about the guidelines. Guidelines were said to provide direction, help prioritise interventions and improve quality of care. However, a consistent finding was of care co-ordinators doubting the effectiveness of CBT and Family Interventions. There were pessimistic expectations for the recovery of individuals with a diagnosis of schizophrenia. Significantly, many staff felt that psychological interventions were less important than medication.

Prytys et al. concluded that staff knowledge was a key barrier to the implementation of the guidelines. While this may be the correct interpretation, there was no consideration of alternative explanations. The possibility that the staff could be expressing important views that need to be explored further was not considered. The fact that the staff doubted the effectiveness of psychological interventions could highlight a lack of knowledge. However, it could suggest that interventions that are successful in RCTs may not be as effective in routine clinical practice. Similarly, it might be that the outcomes viewed as important by researchers may not be deemed as important to care co-ordinators or service users. This could fit with the fact that in research, the success of interventions tend to be measured in statistical significance rather than clinical significance. Westen, Novotny and Thompson-Brenner (2004) argued that while research participants may show statistical significant change between pre and post interventions, they are unlikely to have “recovered” and may still have difficulties comparable to a clinical population.

Prytys et al. were transparent that the aim of their study was to find ways of increasing the use of NICE guidelines. Unfortunately, while this was clearly a very well conducted study, it may be the case that having such a focused goal prevented them from fully exploring any information that disputed their goal. This point is a key one, as if Prytys et al.'s conclusions are followed, it leads to recommendations based on increasing care coordinators' knowledge. If these beliefs of the clinicians are investigated further, it might lead to the same conclusion, but it might also reveal different information. For example, it might be that there are valid reasons why NICE guidelines are not always followed.

Michie et al. (2007) were also transparent in their aim of attempting to increase guideline usage. They reported that clinicians' beliefs and professional identity did not appear to prevent guideline implementation. Based upon the abundance of critical views from participants in other studies and those reported in section 5.2, it seems strange that these were completely absent from this study. As with Prytys et al., it seems likely that this finding may be due to unintentional researcher bias. This may have been to do with their coding or analysis. It may also have been to do with recruitment. For example the wording of the information sheets and recruitment material may have attracted participants who shared similar views to the researchers. Linked with this, the authors of the paper are prominent figures within the field, both in the field of psychosis and research aimed at increasing guideline usage. The presence of such authors may have made the research aims transparent to potential participants. Individuals whose views differed to the authors may have been reluctant to participate. Also, Michie et al. admirably provide a copy of the interview questions used in the study and it could be argued that the style of the questions seemed unlikely to reveal negative responses.

Michie et al. argued that professional identity did not seem an important factor. However, it may be that views vary both between and within professional groups (as demonstrated with psychologists in section 5.2.6). As this study interviewed a range of professionals, within a small sample (n=20), the number of individuals from each profession was very small (n=2-6). It may therefore be that studies focussing on one particular professional group may produce richer data.

A study that did focus on one professional group is Hemsley (2013). Nine counselling psychologists were interviewed regarding their beliefs about NICE guidelines and a thematic analysis is presented. The results indicate a complex mixture of positive and negative beliefs about NICE guidelines. The psychologists were reported to experience NICE as powerful, containing and they saw a need to negotiate with the guidelines. However, the methodology of the study can be critiqued, particularly regarding reflexivity, a vital component of qualitative methods (Watt, 2007). For example it is difficult to determine what came from the participants and what came from the researcher. Hemsley notes that open questions were used but gives no indication of the content or style of the interview questions. The validity of the themes and sub themes reported appears questionable. Hemsley helpfully provides numerous quotes to back up the labelling of these themes, yet a number of these do not appear to provide justification.¹⁵

Overall, the findings from these studies highlight the importance of investigating clinicians' beliefs when reviewing the implementation of NICE guidelines in UK mental health services. They highlight positive views about the guidelines and also criticisms.

¹⁵ In an attempt to clarify the questions regarding reflexivity, personal communication was made with the author. While Hemsley was obliging in providing a response, unfortunately it did not provide significant clarification. She was unable to provide a copy of the interview framework or any form of reflexivity exploration.

5.3.3. External factors. Another common finding across the studies mentioned already is the role of external factors as barriers to guideline implementation. Staff shortages and large caseloads were seen as crucial barriers to clinicians providing NICE recommended psychosocial interventions (Michie et al., 2007; Prytys et al., 2011; Sin & Scully, 2008). There were also doubts about the possibility of making referrals to other clinicians for NICE recommended interventions, with doubts about availability (Gyani et al., 2012; Rhodes et al., 2010).

6. Discussion

Guidelines have become increasingly relevant in both physical and mental healthcare over the last two decades. NICE has produced a large number of guidelines for use in UK mental health services. There are many proposed benefits to guidelines, yet the uptake of NICE guidelines in UK mental health services has been inconsistent. The general research literature on EBM shows that transference of research knowledge to clinical practice is generally low. Guidelines were intended to assist with this, but uptake of guidelines is also low.

Efforts to increase implementation tend to provide modest at best results. Barriers to implementation are thought to fall within three broad categories: clinicians' knowledge, clinicians' beliefs and external factors. Various psychological theories have been utilised in research attempting to change the behaviour of clinicians. The use of these theories tends to be based upon the assumption that guidelines should be followed, rather than starting from the position that clinicians may have valid reflections on their disadvantages as well as their advantages.

Numerous mental health clinicians have published strongly worded criticisms regarding the use of NICE guidelines in UK mental health services. These arguments challenge the assumptions underlying guidelines, namely that it is possible to produce standardised recommendations based upon diagnostic categories that will be clinically useful in routine practice in mental healthcare. The amount of empirical research investigating NICE guideline usage in UK mental health services is limited. External factors such as staffing levels are commonly cited as an implementation barrier. A number of studies draw attention to the importance of increasing clinicians' knowledge in order to increase guideline usage. However, the variables of clinicians' knowledge and beliefs appear to be interrelated. The empirical studies revealed positive and negative views of clinicians towards guidelines, with particularly rich data coming from the qualitative studies. The quality of the qualitative studies has been variable, with transparency and reflexivity not always clear. When reflexivity has been clear, there are questions of bias impacting upon the interpretations; specifically regarding researchers aiming to increase implementation of guidelines.

6.1. Future Directions for Research

The existing research base regarding the use of NICE guidelines in UK mental health services is small and would benefit from further studies. Clinicians' beliefs about the use of NICE guidelines in UK mental health services appears to be a key area for further investigation. Linked with this, an exploration of how guidelines are being utilised could reveal how the advantages and disadvantages of guidelines are managed in routine practice. Understanding more about clinicians' beliefs could help identify ways of intervening to increase implementation of guidelines. Alternatively, it could highlight limitations of the guidelines and question the extent to, and the conditions under which they are more or less useful.

The existing research literature shows the value of qualitative methods in generating rich data regarding clinicians' beliefs. Due to suggestions of bias in previous research, it is proposed that future qualitative research would benefit from paying further attention to issues of transparency and reflexivity. While it is not possible to be truly neutral, taking a position of curiosity would help future researchers remain open to an increased range of findings. Drawing on systemic theory to help clarify this position, Anderson and Goolishian (1988) suggest that it is unhelpful to try to draw conclusions too quickly as this lessens the opportunity for further investigation and increases the opportunity for misunderstanding.

It might be helpful if further research could be based upon or test the validity of Cabana et al.'s (1999) conceptual model that guideline adherence depends upon clinicians' knowledge, clinicians' beliefs and external factors. It would be particularly interesting to investigate whether Cabana et al.'s categories of clinicians' knowledge and beliefs are indeed interrelated, as proposed in this review. Future research may benefit from utilising the theoretical domains that Michie et al. (2005) suggested would be helpful in informing research into guideline usage. This could inform a study utilising content analysis, like the Michie et al. (2007) study. Alternatively, as the existing evidence base is small, it might be helpful for future research to attempt to generate new theory. Such a study could utilise grounded theory (Glaser & Straus, 1967; Charmaz, 2006) methodology, as this is a qualitative approach specifically designed to generate theory rather than test existing theory (Willig, 2001).

7. References

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MAJOR RESEARCH PROJECT

SECTION B: EMPIRICAL PAPER

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

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Abstract

There is a growing research interest into investigating why NICE (National Institute for Health and Care Excellence) guidelines are not consistently followed in UK mental health services. The current study utilised grounded theory methodology to investigate clinical psychologists' use of NICE guidelines. Eleven clinical psychologists working in routine practice in the NHS were interviewed. A theoretical framework was produced conceptualising the participants' beliefs, decision making processes and clinical practices. The overall emerging theme was "considering NICE guidelines 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, as a result of pressure, and also the rewards that follow from being seen to comply with NICE guidelines, 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. This is the first theoretical framework that attempts to explain why NICE guidelines are not consistently utilised in UK mental health services. Attention is drawn to the proposed benefits and limitations of guidelines and how these are managed. This study highlights the importance of clinical psychologists articulating and advertising their specialist skills. The findings are integrated with existing theory and research, and clinical and research implications are presented.

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

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 that it would 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. Mears, Kendall, Strathdee, Sinfield, & Aldridge, 2008; Prytys, Garety, Onwumere, & Craig, 2011).

It has been theorised that the barriers to the uptake of clinical practice guidelines fit into three broad categories: external factors (e.g. resources), clinicians' knowledge (i.e. familiarity with guidelines) and clinicians' beliefs (e.g. level of agreement with guidelines) (Cabana et al., 1999). Numerous mental health clinicians have published comprehensive critiques both of the approach NICE takes to creating guidelines for UK mental health services, and of the way in which guidelines are interpreted and utilised (e.g. Adams, 2008; Barker & Buchanan-Barker, 2003; Barkham, 2007; Fairfax, 2008; Hammersley, 2009; McQueen, 2009; McDonnell, 2012; Midlands Psychology Group, 2010; Mollon, 2009a, 2009b; Nel, 2011; Rogers, 2011; Smail, 2006; UKCP, 2011; Waft, 2011). The criticisms tend to challenge the assumptions that underlie the guidelines. For example: challenging the validity and reliability of the medical model basis of NICE; arguing that NICE treats psychological therapy as if it is akin to medication and disputing this notion; arguing that NICE overly relies on randomised control trials (RCT) and questioning the transferability of such studies to routine practice. Another common criticism is that NICE guidelines restrict the choice of interventions for service users. If such views are common amongst clinicians in routine practice, this could explain why implementation of NICE recommendations is low.

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 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 team staff (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 the use of NICE guidelines have been reported across the studies, with particularly rich data coming 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 questions of bias impacting upon the interpretations. In particular, some researchers, (notably Michie et al., 2007 & Prytys et al., 2011) appear motivated by a desire to increase implementation of guidelines, rather than fully 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. If knowledge and beliefs of clinicians are indeed important, then it seems likely that different professions will vary on these factors 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 seem to be in favour of NICE guidelines (British Psychological Society: BPS, 2007), with numerous CPs assisting with their production and with the BPS co-publishing some guidelines (e.g. NICE (2010) schizophrenia guideline). Yet other CPs have questioned the usefulness of NICE guidelines (e.g. Adams 2008; Barkham, 2007; Fairfax, 2008; Hammersley, 2009; McGowan, 2009; Midlands Psychology Group, 2010; Mollon, 2009a, 2009b; Nel, 2010; Smail, 2006). Smail (2006) suggests 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).

1.1.Rationale and Aims

It has been stressed that research into the use of clinical practice guidelines would benefit from drawing upon psychological theory, to help understand the beliefs and behaviour of clinicians (Eccles, Grimshaw, Walker, Johnston, & Pitts, 2005). 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 to help explain how NICE guidelines are utilised and the factors that impact upon this. The study also draws upon existing psychological theory to integrate the emergent theory into existing literature.

Due to suggestions of possible bias in previous research, it was felt that the evidence base would benefit from a study that did not begin with the aim of promoting or disputing the use of guidelines. It was hoped that taking this stance in this present study would allow full exploration of the benefits and limitations of guidelines and how these are managed.

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 regarding NICE guidelines within the profession. The position of some CPs towards NICE guidelines can already be assumed, as a result of either their involvement in guideline production, or the publication of their views. This research project aimed to investigate the views and behaviour of CPs in routine practice.

1.2. Research Questions

This study attempted to address the following questions:

- i) What beliefs do CPs hold about NICE guidelines?
- ii) What factors impact upon how CPs perceive NICE guidelines?
- iii) How do CPs describe their decision making processes regarding how they use NICE guidelines?

2. Method

2.1.Design Overview

Semi structured interviews were conducted with CPs and the information that emerged was analysed using grounded theory methodology (Charmaz, 2006). Grounded theory aims to move beyond a descriptive level of analysis and generate theory of social or psychological processes (Charmaz, 2006). Grounded theory enables a researcher to develop a theory from the data, rather than find evidence to support an existing theory (Willig, 2001). This makes the method particularly helpful in areas lacking existing theory, such as this one, where there are no existing theories accounting for the use of NICE guidelines in UK mental health services. This study utilised Charmaz's (2006) social constructivist approach which acknowledges the role of both researcher and participants in co-constructing data. The social constructivist position helps break down assumptions of what is seen as "real". It can lead to the development of an interpretive frame from which to view how reality is constructed and acted upon (Charmaz, 2006). There are detailed procedures for how to complete grounded theory analyses, first outlined by Glaser and Strauss (1967) and expanded upon by Strauss and Corbin (1990). However, Glaser (1992) highlighted that too strict an adherence to grounded theory protocol "forces" the data and encourages researchers to view the procedures as tools to be used flexibly. This flexible approach is emphasised by Charmaz (2006) and is utilised in this study.

2.2.Ethical Considerations

This study complied with the BPS (2010) code of human research ethics and was approved by the Salomons Independent Research Review Panel (Appendix C) and the Salomons Ethics Panel (Appendix D). The Research and Development departments of three English NHS trusts provided permission for their staff to take part in this research (Appendix E).

Participants were fully informed of the purpose of the study (Appendix F) prior to consenting to participate (Appendix G). The researcher endeavoured to maintain a stance of independence and curiosity in the interviews. It was hoped that this would allow participants to speak freely.

2.3.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 could already be assumed. CPs supervised or managed by this study's supervisors were excluded due to concern that they might not feel able to speak honestly if their views differed to those of the supervisors.

Recruitment included interviewing CPs who had responded to recruitment emails (Appendix H) (n=7) and CPs known to the principal researcher (n=4). No current colleagues were recruited in order to ensure that working relationships did not impact upon the research. Participants were recruited from three NHS trusts. Participant characteristics are presented in aggregated form (table 1) to help protect anonymity.

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’.

2.4.Procedure

Interviews ranged from 45 to 72 minutes. One interview took place over the telephone, all other interviews were held at the place of work of the CP. Initial participants were selected by opportunity and interviews were open, with limited direct questions. As per 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 if they would share their thoughts on NICE guidelines. After this question, the interviewer 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 researcher on the data (Holton, 2007). A list of potential open questions (Appendix I) were held in mind by the interviewer and used as prompts if necessary (Charmaz, 2006). The transcription of the first interview (Appendix J) demonstrates the researcher’s attempt to keep the participant talking, without asking questions.

Interviews were audio taped and then transcribed. The first three interviews were analysed using initial line by line coding (Appendix J) followed by focused coding, a process of deciding which initial codes best describe the data (Charmaz, 2006). The subsequent transcripts were analysed using focused coding (Appendix K). 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 the research diary (Appendix L), reflecting on the process (Charmaz, 2006).

Similarities and differences between the views of participants were explored through constant comparison (Glaser & Strauss, 1967), through sampling, interview questions and coding. Theoretical sampling (Glaser & Strauss, 1967), with the assistance of a pre interview questionnaire (Appendix M), 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) (Appendix N). Emerging codes and categories were constantly compared, testing their validity (Holton, 2007).

At the theoretical coding stage, a diagrammatic representation of the categories was created, with bespoke linkages between them, rather than drawing on existing frameworks (such as Glaser’s (1978, 1998) coding families or Spradley’s (1979) semantic relationships). Such diagrams are considered an intrinsic component of grounded theory methodology by authors such as Strauss (1987) and Clarke (2005), due to their ability to give a clear picture of the categories and the relationships between them. To assist in this process, theoretical memo sorting (Charmaz, 2006) was carried out.

The cyclical process of data collection, analysis, theoretical sampling and theoretical categorisation continued until “theoretical sufficiency” (Dey, 1999) was judged to be achieved; the point at which the emergent theory is held to have good explanatory power. This term makes no claim that the process has been exhaustive, as is often implied by the term “theoretical saturation” (Glaser & Straus, 1967), as it is usually unrealistic to claim this (Dey, 1999). This stage was reached after 11 interviews.

The sample size of 11 is typical for a qualitative study of this kind, due to the depth of analysis (Adler & Adler, 2012). Similar studies utilising grounded theory, interviewing health professionals (from one profession) had sample sizes of 6 (Tweed, Salter, & Denis, 2000), 8 (Crossley & Salter, 2005), 9 (Chaffey, Unsworth, & Fossey, 2010), 13 (Long-Sutehall et al., 2011) and 16 (Townend, 2008).

2.5. Quality Assurance

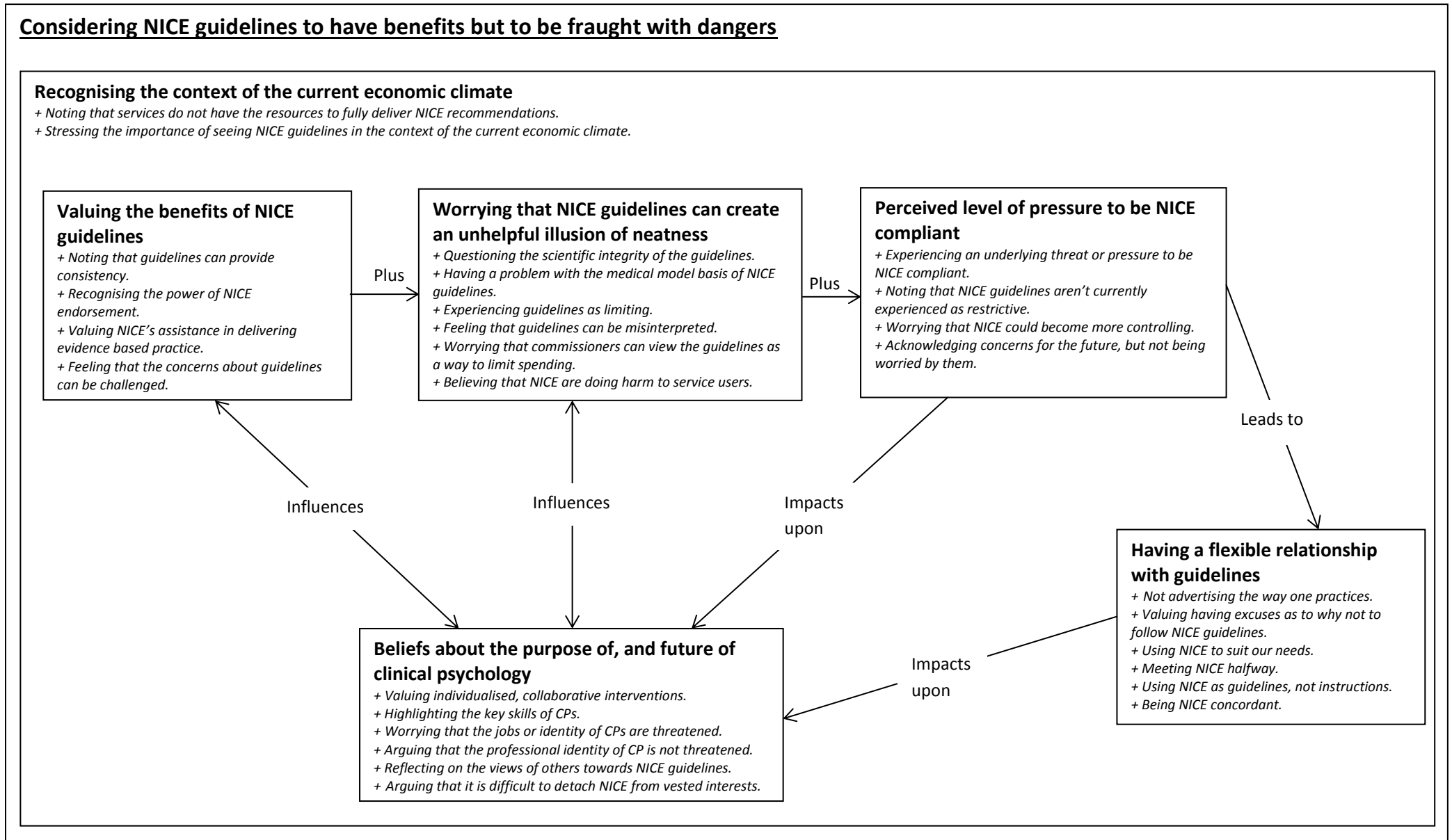
It is acknowledged that qualitative analysis depends on the researcher’s view (Charmaz, 2006). As such, numerous steps were taken to ensure reflexivity and transparency. A research diary (Appendix L) was completed, providing readers with a window into the thought processes of the researcher (Watt, 2007). A bracketing interview (Rolls & Relf, 2006) was conducted between the principal researcher and lead supervisor (Appendix O). This helped explore the impact of the researcher’s assumptions and experiences on the collection and interpretation of data. Examples of coding and category development were regularly checked and discussed both with the project supervisors and within a grounded theory discussion group. Participant quotations are presented in the results section and in further detail in Appendix P to ensure that the coding and categories are grounded in the data (Dey, 2007), enhancing the credibility of the findings (Hill et al., 2005).

Due to authors such as Glaser (1992) and Charmaz (2006) emphasising a flexible approach, there are ongoing debates about what constitutes ‘true’ grounded theory (e.g. Hood, 2007; Urquhart, 2013). This present study meets the criteria that Hood (2007) describes as representing the key components of ‘true’ grounded theory (Appendix Q).

3. Results

The analysis led to the construction of 68 focused codes, 15 subcategories, 6 categories and 1 overall theme. The goal of any research utilising full grounded theory methodology is to generate theory (Charmaz, 2006). Charmaz (2006) proposes that theories provide interpretive frames from which to view *how* and *why* individuals construct and act on their view of reality. This study presents a theory of *how* these participants construct their views about NICE guidelines, *how* they utilise the guidelines, *why* they do so and *how* their use of the guidelines impacts upon their beliefs. Urquhart (2013) and Straus and Corbin (1998) emphasise that demonstrating the relationships between categories moves an analysis from descriptive to theoretical. Figure 1 displays in diagrammatic form the proposed relationships between the categories. Categories are labelled in bold, with their properties (subcategories or focused codes) in italic.

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



3.1. 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 was valued. However, the CPs worried that the guidelines can create an unhelpful illusion of neatness, highlighting that routine clinical practice is more complex. All of the CPs valued individualised, collaborative, formulation-driven interventions and highlighted a difficult fit between this approach and the use of guidelines.

The combination of valuing the benefits, worrying that guidelines can create an unhelpful illusion of neatness and the perceived level of pressure to be NICE compliant led to the CPs having a flexible relationship with guidelines. Some CPs ignored the guidelines and others emphasised that they were guidelines rather than instructions. Some CPs reported picking up and dropping the guidelines to suit their needs. The use of the guidelines impacted upon the CPs’ beliefs. For example, participants who found ways of utilising the guidelines that were in keeping with their beliefs about the nature of distress and the role of CPs were more able to see the benefits of guidelines. However, the majority of the participants reported acting in ways that prevent others from seeing their specialist skills. For example purposefully not telling managers what they are doing, calling an intervention CBT when it is not, or integrating ideas from other modalities into CBT in a valid way, but then still labelling the intervention as CBT. This led to the majority of the participants fearing that if their skills were not recognised, then their professional identity and jobs would be threatened. In turn, this fear led to the majority of the CPs attending more to the concerns about guidelines rather than the benefits.

Full details of the coding and categories are presented in Appendix R and with quotation examples in Appendix P. The following information presents a detailed exploration of key elements of the analysis. Participant names have been changed to protect confidentiality.

3.2. Valuing the Benefits¹⁶ of NICE Guidelines.

The CPs saw many benefits of NICE guidelines, particularly seeing NICE 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)

The power of NICE endorsement was valued.

I mean I think when, I think access to psychological therapies for people with a diagnosis of schizophrenia has really increased as a result of NICE guidelines. (Sam)

3.3. Worrying That NICE Guidelines can Create an Unhelpful Illusion of Neatness

The CPs highlighted problems with the diagnostic system that NICE guidelines are based upon.

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

¹⁶ While the CPs expressed numerous benefits, due to a limited word count, it was decided to focus more attention of this write up on other areas of the model. It was felt that the benefits were aptly reported through the coding and category labelling in figure 1 (and appendix P) and require less further explanation.

Participants questioned NICE's reliance on RCTs, arguing that they 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 is 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, arguing that it is simplistic and misguided to assume that CBT is the only therapeutic modality required.

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).

CBT was seen as fitting well with the medical model and with NICE, whereas other therapies do not.

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 highlighted the difficulty in measuring other types of therapy.

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 therapies 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 or misunderstood and that people may believe that clinical practice is as "neat" as the guidelines can falsely imply.

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).

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

Well, I think you're onto something. And I hope that it doesn't stop with you. 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).

3.4. Perceived Level of Pressure to be NICE Compliant

Some CPs noted an underlying threat to be 'NICE compliant'.

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).

Other CPs did not currently experience a pressure to follow NICE guidelines.

I've never been asked in my job to quote NICE guidance or to specifically use it.
(Catherine).

There were concerns that NICE guidelines could 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. I think the area you're focusing on is very relevant because this is going to come to, closer and closer focus. (Morgan).

3.5. Beliefs about the Purpose of, and Future of Clinical Psychology

Linked with the concern that NICE guidelines can create an unhelpful illusion of neatness, participants worried that CBT therapists could be seen as a cheaper alternative to CPs as the skills of CPs are not being recognised.

There's a danger of, 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, particularly as NICE guidelines say CBT, erm, other, rather than other, 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).

NICE guidelines were seen as a threat to practicing integratively.

There is this need to categorise how we work and have an identifiable pure model. 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).

CPs were keen to highlight that they have bigger roles than just therapy.

But we're only talking about therapy here. There's a whole other things that psychologists do, and they're, they're not being valued. They're not being valued in an explicit way. Erm, because they don't fit with anything. (Naomi).

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 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. I think that's like a massive thing, isn't it? Boris Johnson doesn't know how much a loaf of bread and a pint of milk costs. Why would he? (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 and individualised.

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).

3.6. Having a Flexible Relationship with Guidelines

The CPs described a number of ways in which they managed to practice in line with their beliefs about the necessary elements of psychological intervention. Some CPs simply ignore NICE guidelines.

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]¹⁷ 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, like [REDACTED]. 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).

¹⁷ Therapy label omitted in the interests of confidentiality.

Some CPs were secretive about their practice due to a conflict between how they wanted to practice and the pressures and dominant discourses within their services.

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

The very fact that I've had to check with you about why what I said earlier was going to be anonymous is an indication of how tight and controlled the culture is really.

(Morgan).

CPs admitted that they often say they are offering CBT when in reality it is something different.

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).

CPs valued having excuses not to follow NICE guidelines.

So on the one hand it's very frustrating that we're supposed to work to NICE guidance that don't really come from our client group, but on the other hand the advantage is that we can say 'well, they don't really fit our client group', so, you know, we can retain a bit of protection from that, I think. (Jenny).

It was admitted that CPs can use NICE to suit their needs.

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).

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).

A common theme was CPs reporting that they used NICE as guidelines rather than prescription.

I guess, you know, I tend to see them as guidelines. I take the words kind of literally. So, for me, it feels like it's useful in providing a sense of direction, or of what might be useful in thinking of a particular disorder/diagnosis, whatever you want to call it, client group. But, 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 ideas from other modalities 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. I mean you're talking about thoughts and feelings and you're talking about it in an interpersonal context. (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 and the key elements, so you make your adaptation, as it were, knowingly, and don't just drift into something that was no longer recognisably CBT. (Sam).

Some CPs attempt to meet NICE halfway, they try to work within the language of NICE guidelines in order to get their perspectives across.

We have to find a way of arguing our point, you know, about integration, about – but we have to use, to do that I think we have to join the language, we have to kind of work within NICE, with NICE guidelines, with evidence base practice and try to find a way. Because otherwise, again, we're just going to be seen as very polarised. (Kim).

There was a desire for NICE to review its approach and realise that routine clinical practice is not as "neat" as the guidelines can imply.

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).

4. Discussion

4.1 Theoretical Integration

4.1.1 Guideline implementation theory. This study is the first to produce a theoretical framework conceptualising the beliefs about, and use of NICE guidelines in UK mental health services¹⁸. Previous studies to investigate the use of NICE guidelines in UK mental health services have tended to draw upon Cabana et al.'s (1999) theoretical framework¹⁹ by focusing on clinicians' knowledge, clinicians' beliefs and external factors. By reflecting on the context of limited resources, the participants in this present study highlighted the relevance of Cabana et al.'s category of external factors. This is a consistent finding in the existing literature, that services do not have the resources to fully deliver what NICE recommend (e.g. Gyani et al., 2012; Michie et al., 2007; Prytys et al., 2011; Rhodes et al, 2010)

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). The results of this present study demonstrate that clinicians' beliefs and knowledge appear to be interrelated, with some of the participants choosing to ignore NICE due to their beliefs. For example, beliefs about the questionable validity of diagnostic categories or the importance of interventions being based on individualised

¹⁸ While Michie et al. (2007) drew upon theory to inform their data collection and analysis, the results of the study did not produce a theoretical framework to help understand the use of guidelines.

¹⁹ Developed pre NICE, investigating the use of physical and mental health guidelines.

formulations. This suggests that it might be unhelpful for theoretical models to treat knowledge and beliefs as separate entities. Furthermore, CPs in the current study suggested that in some cases adherence to guidelines could result from a lack of knowledge, in this case about limitations of guidelines. This difference is significant and disputes Cabana et al.'s suggestion that there is a broadly linear relationship between knowledge and guideline adherence.

This study suggests that guidelines are utilised in many different ways, as opposed to a dichotomy of adherence versus non adherence. The theoretical model also suggests that there is a circular, reciprocal interaction between beliefs and guideline usage. These are important findings and challenge the appropriateness of viewing guideline adherence as a dichotomous, dependent variable in theoretical models such as Cabana et al. Furthermore, it challenges the usefulness of utilising models such as the theory of planned behaviour (Ajzen, 1985) to investigate the use of NICE guidelines in UK mental health services²⁰. Due to the format of the theory of planned behaviour, studies utilising this framework (e.g. Liabsuetrakul, Chongsuvivatwong, Lumbiganon, & Lindmark, 2003; Limbert & Lamb, 2002; Rashidian & Russell, 2011²¹) invariably view guideline adherence as a dichotomous, dependent variable.

As noted in the introduction to this study, there have been numerous published criticisms of the use of NICE guidelines in UK mental health services. All of the key criticisms appearing in this literature were expressed by participants of the current study. This suggests that these are not just the views of the disgruntled few who choose to publish their opinions, but appear widespread amongst clinicians. A strength of this study is that it groups these concerns into categories and subcategories. It places these into a theoretical framework

²⁰ As proposed by Prytys, et al. (2011) as an idea for future research.

²¹ Each of these studies investigated guideline usage in physical health settings.

alongside the benefits and reflects upon the dynamic interplay between the formation of beliefs and guideline usage.

4.1.2. Beliefs about the purpose of, and future of clinical psychology. While the participants criticised classification and other key assumptions of NICE guidelines, the participants valued the powerful endorsement that NICE can provide to psychological therapies. This is in keeping with the views of Pilgrim (2010) who argues that CPs tend to carry out their work in line with the dominant medical model in an attempt to gain status. Moncrieff (2009) argues that despite the lack of evidence supporting it, adopting the rhetoric of ‘specific cures’ for ‘specific psychiatric illnesses’ generates credibility and power for mental health professions. From a neo-Weberian framework (Freidson, 1970), this rhetoric can be seen as pivotal in mental health professionals managing to persuade others of the need for their service and exclude competitors. NICE guidelines could be seen as a powerful tool to enhance this notion of ‘specific cures’ for ‘specific illnesses’. The conceptual model from this study demonstrates that while adhering to this approach can give power, it can also lead to fear that specialist skills are not being fully appreciated. This results in a fear that power may be taken away from the profession.

The chair of the Division of Clinical Psychology, Pemberton (2014) recently acknowledged the challenge for CPs to justify their cost and demonstrate their worth, noting that in many areas posts were 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 are

compared through blind rating (Brosan, Reynolds, & Moore, 2007; McManus, Westbrook, Vazquez-Montes, Fennell, & Kennerley, 2010).

The Mowbray (1989) 'MAS report' proposes that CPs' skills are at 'level 3', highlighting the ability of CPs to integrate from various psychological models. Protocol driven therapies, delivered by single modality therapists are labelled as 'level 2'. As noted by the participants in this study, level 3 skills such as psychological formulation and integrative practice do not fit neatly within the framework of NICE. The results of this study suggest that CPs in routine practice are utilising level 3 skills but these are not always advertised and in turn, not recognised.

4.1.3. Safe uncertainty. The desire to have protocol driven therapy, reducing the need for clinical judgement has been criticised as naïve modernist thinking (Bohart & House, 2008; van Ooijen, 2011). This viewpoint argues that uncertainty can never be fully eliminated. It notes that an unrelenting desire to reduce uncertainty is more likely to create problems rather than reduce risks and costs. In line with this thinking, a useful lens through which to view what this study's participants are reporting might be Mason's (1993) theoretical framework of 'safe uncertainty'. NICE guidelines could be seen as a drive for certainty. Insisting that guidelines are rigidly followed leads to a position of 'unsafe certainty' where clinical judgement is reduced to an unsafe level. Not following the guidelines at all could lead to 'unsafe uncertainty'. The desired position of 'safe uncertainty' could be achieved if clinicians are given the freedom to be informed by guidelines but have room for clinical judgement and collaborative, individualised interventions.

4.2. Clinical Implications

4.2.1. Challenging dominant discourses. NICE appears to be experienced as a powerful force and there were fears that guidelines could be used in a more controlling way in the future. Foucault (1967) proposed that power is constructed through the use of discourses. Participants appeared to suggest that NICE's power is generated through the discourses of: being evidence based (drawing on the powerful discourse of science), reducing risk, reducing uncertainty and treating psychological therapy as if it is a linear, replicable process, akin to medication. The CPs in this study highlighted flaws in each of these discourses. Challenging these dominant discourses may help counter-discourses emerge and allow discussion about the limitations of guidelines and how best to manage them.

4.2.2. Seeing NICE as guidelines, not instructions. The participants were keen for guidelines to be utilised flexibly, with an awareness of their limitations. This would mean allowing clinicians to have room for clinical judgement and to deviate from guidelines when relevant. This would acknowledge that individuals seen in routine practice do not fit neatly into guidelines. This approach has important service organisation implications. 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 DH (2013) note that care packages will not be nationally mandated, to allow flexibility in meeting people's needs. This suggests that there is room for deviation from guidelines where appropriate. However, the DH also note that many organisations are looking at core interventions, based upon NICE guidance, that are to be provided to everybody in a cluster. This latter statement appears at odds with the views of the participants in this study and their conceptualisation of how guidelines are best utilised.

4.2.3. Demonstrating specialist skills. The majority of the CPs in this study described working in ways that prevent others from seeing their specialist skills. The emergent theory acknowledges that pressure to follow NICE guidelines can lead to this approach. The benefits of adhering to the rhetoric of ‘specific cures’ for ‘specific illnesses’ and thus gaining power through NICE endorsement is also highlighted. However, the emergent theory demonstrates the dangers of this approach, with the majority of participants fearing that their professional identity and jobs could be threatened. Numerous participants acknowledged that CPs are not good at explaining what they do and that this needs to change. This study draws attention to the importance of CPs improving the ways that they advertise their specialist skills.

4.2.4. A NICE review. A common conclusion from the CPs in this study was seeing NICE as a work in progress and wanting it to be continuously reviewed. This would include reviewing how NICE guidelines are created, such as the use of a questionable diagnostic system and the way that psychological therapies are measured. It would also include reviewing how guidelines are presented and utilised. For example more acknowledgement of their limitations and the fact that routine clinical practice is not as neat as guidelines can imply.

4.3. Research Implications

It would be interesting to repeat this study, speaking with members from different mental health professions, to see if the results would be similar, or whether important differences are revealed. Principles of Foucauldian discourse analysis (Foucault, 1967) were utilised in the discussion of these results. Completing a more in-depth discourse analysis could further investigate how the discourses used by the creators and supporters of NICE generate the

power that NICE appears to hold. This could then be compared with the results of this study, to see if these discourses are the ones that have been challenged.

This study highlighted a fear that level 3 skills such as idiosyncratic formulation and integration are not being recognised. It is acknowledged that integrative therapy is under researched due to the difficult fit with a research paradigm that favours manualisation and replicability of therapy (Barkham, 2007; DCP, 2011; Parry, Cape, & Pilling, 2003). It may be that more research is required utilising methodologies that do compliment this approach, such as case studies (e.g. Stenhouse & Van Kessel, 2002). Alternatively, a compromise could be sought where integrative practice could be included in RCTs, acknowledging that it cannot be manualised or replicated. The key variable to be measured would be the provision of individualised, collaborative therapy, drawing on a range of psychological theory and associated techniques, based upon psychological formulation.

4.4. Limitations

Due to its constructivist position, this study makes no attempt to claim that the findings are objective. The role of the principal researcher in co-constructing these data together with the participants is acknowledged. As such, it is possible that a different researcher may have co-constructed the analyses differently. As detailed in the methodology, numerous steps were taken to make the role of the researcher as transparent as possible.

There were limitations to both recruitment approaches; with CPs known to the researcher, it could be argued that pre-existing knowledge of the CP and their viewpoints may have biased the sampling. With CPs who responded to recruitment emails, the motivation to respond may have been influenced 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 is documented in detail in the research diary (Appendix L).

5. Conclusions

This study is the first to produce a theoretical framework to help explain why NICE guidelines are not consistently utilised in UK mental health services. The emergent theory details the participants' beliefs, decision making processes and use of guidelines. The guidelines were seen as a useful guide to the evidence base and the power of NICE endorsement was valued. However, the CPs worried that guidelines could easily be misunderstood and used in a rigid and limiting manner. There were concerns about the harm that misuse of guidelines could do to service users and also to the profession of clinical psychology. The participants' use of guidelines impacted upon their beliefs. CPs who were more able to practice in line with their beliefs about the nature of distress and the role of CPs were more able to see the benefits to guidelines.

The emergent theory challenges the assumption that there is a simple, linear relationship between knowledge and guideline usage. This study highlights the importance of CPs finding ways to ensure that their skills are recognised. A common conclusion from the participants was wanting NICE to be viewed as guidelines and not instructions. The CPs wanted NICE to be seen as a work in progress with numerous limitations. Overall, the participants considered NICE guidelines to have benefits, but to be fraught with dangers.

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Alex John Court BSc (Hons) MBPsS PGDip

MAJOR RESEARCH PROJECT

SECTION C: APPENDICES

APRIL 2014

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A: Further Details of Literature Review Methodology

Initial exploratory literature searches were conducted using a range of search terms in various electronic databases. When initial relevant papers were found, the keywords of these papers and relevant referenced and citing articles were studied. These keywords were then used in a more structured search strategy in November 2013. Searches were limited to articles produced after 1998, the year before NICE was formed. It was hoped that this would capture literature written in anticipation of NICE guidelines and literature written about, or in the context of NICE guidelines.

Search Terms

“NICE guidelines” OR “NICE guidance” OR “Clinical Guidelines”

AND

“Attitudes” OR “Clinical Decision Making” OR “Implementation”

AND

“Mental Health”

Electronic Databases Used

PsychINFO (to capture psychological literature), Medline (for biomedical literature), Web of Knowledge (for scientific (often theoretical) literature), ASSIA (for health & social science literature), Cochrane Library (for reviews), Google (for ‘grey’ literature) and Google Scholar (for a broad search to compliment the other searches).

Further Manual Searching

A number of authors who have conducted literature reviews on guideline usage (Bero et al., 1998; Grol & Grimshaw, 1999; Robertson & Jochelson, 2006) highlighted the difficulty in

locating all the relevant literature. It has been suggested that this is due to the literature being in both generalist and specialist publications, having a wide range of key words and often being “poorly indexed in bibliographical databases” (Robertson & Jochelson, 2006, p.6). With this in mind, when relevant articles were found, their reference lists were inspected to identify other appropriate studies. The ‘find similar’ and ‘find citing articles’ functions on electronic databases were also utilised.

Inclusion Criteria

All literature needed to be written in English.

For the systematic review of empirical literature on the use of NICE guidelines in UK mental health services, articles published in peer reviewed journals were sought. Due to the scarcity of research, any articles that utilised quantitative or qualitative research methodology to investigate the use of NICE guidelines in UK mental health services were included, no stringent exclusion criteria were set.

For the review of generic clinical practice guideline literature and published views of NICE, there were no exclusion criteria other than articles needing to be written in English. Any relevant literature that was identified was reviewed.

Results

Titles and abstracts were reviewed and where necessary scans of the full articles were undertaken to review relevance of literature.

9 peer reviewed articles were found in the systematic review of research studies investigating the use of NICE guidelines in UK mental health services.

159 documents including: government documents, peer reviewed journal articles, letters, websites and books were drawn upon in the review of the general guideline literature and the published views about NICE guidelines.

Full details of the results generated from each separate electronic database (before checking results for relevance) are as follows:

Database	Number of results
PsychINFO	202
Medline	180
Web of Knowledge	60
ASSIA* ¹	85
Cochrane Library* ²	8
GOOGLE scholar* ³	83
GOOGLE* ⁴	100

The following amendments were made to the searches:

*¹ For the database ASSIA, due to a limited return of results using all search terms, the search was conducted using only the terms “NICE guidelines”. This generated 85 results.

*² With Cochrane Library, the search terms “NICE guidelines” produced 0 results. Using the terms “Guidelines” AND “Mental Health” produced 8 results.

*³ The GOOGLE scholar search produced 3,190 results. Due to the unmanageably large return, the terms “psychological theory” were added to the search to attempt to narrow down the findings and produce results with a theoretical basis. This produced 83 results.

*³ The GOOGLE search produced 120,000 results. Utilising GOOGLE’s presentation of results in order of “PageRank” (a measure of counts and quality of links to a page) as a crude

measure of quality and relevance, the first five pages of results (50 results) were scanned for relevant results. As with the GOOGLE Scholar search, the terms "psychological theory" were then added to the search, bringing the results down to 1,960. Weighing up the possible benefits of screening all the results against the time constraints of the study led to the decision to just review the first ten pages (100 results) for relevant results.

Appendix B – Summary of Studies Focusing on Implementation of NICE Guidelines in UK Mental Health Services

<u>Study</u>	<u>Design</u>	<u>Notes</u>
Gyani et al. (2011)	Questionnaire survey + descriptive statistics.	795 questionnaires sent to UK GPs re their knowledge and use of OCD NICE guideline. 80 returned. 30% of GPs had read the guideline. Low response rate. GPs who replied may be more interested in NICE / OCD / research. 80% of GPs read at least one NICE guideline for mental health vs 97% had read at least one NICE guideline for physical health. No reflection on discrepancy, this discrepancy could be indicative of important beliefs. Study implies importance of knowledge, but analysis is limited.
Gyani et al. (2012)	Questionnaire survey + 6 interviews. Descriptive statistics + Interpretive Phenomenological Analysis (IPA).	830 questionnaires sent to UK GPs, re depression NICE guideline. 222 returned. 75% of GPs had read the guideline. Concordance with guidelines significantly higher amongst GPs who had read the guidelines. However, this is self-reported concordance. This is likely to be higher amongst those who have read the guidelines, as they know what they “should” say, it doesn’t mean that they actually do follow the guidelines. + known gap between intention and action. Limited info given on methodology and write up of IPA. Positive & negative views towards NICE. Guidelines clear and helpful but unnecessarily lengthy and repetitive. Doubts about validity of research included by NICE and whether resources available.
Hemsley (2013)	Interviews + thematic analysis	Interviewed 9 counselling psychologists to investigate how they positioned themselves in relation to NICE guidelines. Reveals complex mix of positive and negative views towards NICE. However, concerns re reflexivity. Not sure what has come from researcher and what from participants. Quotes provided don’t seem to back up the theme labelling. + Lots of use of term “pluralism” by researcher. No mention of whether this came from participants or from researcher, were participants directly asked about pluralism? Taken as a given that the participants don’t agree with the medical model, but no data from participants given to support this.
Kovshoff et al. (2012)	Interviews + “thematic analysis, drawing on principles of grounded theory”	Interviewed 50 child psychiatrists and paediatricians re decision making in assessment, diagnosis and treatment of ADHD. Excellent detail provided in explanation of methodology and results. Numerous quotes provided from participants to support findings. Only 6 participants mentioned drawing on NICE guidelines. When they were discussed, emphasis was around questioning practicality of guidelines.
Michie et al. (2007)	Interviews + content analysis	Built upon Michie et al. (2005), using the 12 domains drawn from psychological theory to guide interviews and analysis. 20 CMHT workers from 3 NHS trusts interviewed. Key factors identified were resources, such as staffing levels and also training and support needs. Absence of critical views towards guidelines. Questions of potential unintentional researcher bias, researchers wanting to

increase use of guidelines. Structure of interview schedule and content analysis affect results. + presence of researchers (key in field of guideline implementation and CBT/FI for schizophrenia) may have made the intentions of project clear, may have put potential participants off if they had views that were critical. + lots of different types of prof, within small sample, yet they concluded prof id not significant. Likely to need more people from each profession to fully investigate this.

Prytys et al. (2011)	Interviews + thematic analysis	Semi structured interviews with 20 care co-ordinators across 4 CMHTs. The thematic analysis is described comprehensively and results laid out in detail, linking themes to specific quotes from participants. Positive views expressed regarding guidelines, noting they provide direction, help prioritise interventions and improve quality of care. Workload and time pressures = crucial barrier. Themes also emerged regarding care co-ordinators doubting the effectiveness of CBT and FI and having pessimistic expectations for the recovery of individuals with a diagnosis of schizophrenia. Researchers seemed to dismiss these views. Questions of potential unintentional researcher bias, researchers wanting to increase use of guidelines, not open to info that disputes this?
Rhodes et al. (2010)	Questionnaire survey + vignette task.	32 ABT staff were given questionnaires. Also asked to read vignettes and specify recommended intervention. Most staff had appropriate levels of knowledge. Responded to vignettes in a way that was in keeping with NICE. Lack of resources impacted upon referrals for CBT. Social problems of service users considered a barrier to referring for CBT. Complexity of service users, not fitting with NICE?
Sin & Scully (2008)	Questionnaire survey + descriptive statistics	Questionnaire survey of 15 clinicians who had undertaken a training course in psychosocial interventions (PSI) and their managers (n=11). Aim was that training the clinicians in PSI would help meet the need of the recommendations from the schizophrenia and bipolar NICE guidelines. The questionnaire was said to collect quantitative and qualitative data but only quantitative data was reported. The findings of this study don't appear to provide a huge amount to the evidence base regarding the implementation of NICE guidelines. Main finding appears to be that staff shortages and time were key implementation barriers.
Toner et al. (2010)	Questionnaire survey + descriptive statistics.	Survey sent to 215 GPs. Response rate of 67%. Poor access to CBT considered greatest barrier. 38% rated NICE as having a moderate or substantial impact on their practice. Not much reflection on why this is low, what this could mean. The study referred to GPs "personally using CBT". This appears to be techniques of CBT, such as recommending pleasurable activities, brief thought challenging (within the GP consultation). This doesn't seem to be "classic CBT" as recommended by NICE. Amount of analysis is limited. The authors admit that the study does not "explore the merits versus drawbacks" of guidelines. + They acknowledge the gap between intention and action.

Appendix C - Salomons Independent Research Review Panel Approval Letter



Salomons Campus at Tunbridge Wells

Mr Alex Court
84 Parkside Avenue
BEXLEYHEATH
Kent
DA7 6NL

Date: 20th June 2012

Direct line 01892 507773
Direct fax 01892 507660
E-mail paul.camic@canterbury.ac.uk
Our Ref PC/dc/083/dissertations

Dear Alex

I am writing to inform you that the Independent Research Review Panel has approved your research project proposal. Please include a copy of this letter in your ethics application.

Information for Ethics Panels: I am writing to confirm that funding has been secured for the doctoral-level research project of Alex Court who is a clinical psychology trainee at our institution. This research project is in partial fulfilment of the Doctor of Clinical Psychology degree awarded by Canterbury Christ Church University. ~~Each trainee is assigned a Lead and Second Supervisor who will closely monitor the scientific and ethical components of this research project.~~

All research in the clinical psychology doctoral programme at Canterbury Christ Church University is carried out in accordance with the Research Governance Framework for Health and Social Care 2005. The University provides insurance coverage, against negligent harm, for our postgraduate students while undertaking research. A copy of our insurance letter is attached and this is automatically renewed each year.

All doctoral dissertation proposals are independently vetted by two members of the clinical psychology programme faculty before being given approval. Only those research projects that are deemed to be of significant clinical and scientific merit are approved.

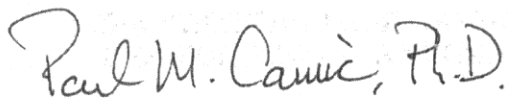
The above mentioned clinical psychology trainee is employed full-time by Surrey and Borders Partnership NHS Trust and is bound by the requirements of the Research Governance Framework (RGF). They are also required to adhere to the *Code of Ethics and Conduct* of the British Psychological Society.

Department of Applied Psychology
Faculty of Social and Applied Sciences

David Salomons Estate
Broomhill Road Southborough Tunbridge Wells Kent TN3 0TG (UK)
Tel +44 (0)1892 515152 Fax +44 (0)1892 539102

The Department of Applied Psychology at Canterbury Christ Church University stores research data for 10 years in a locked filing cabinet in the department's office. The office is in a building with 24 hour security. The custodian is Debbie Chadwick, a member of the administration staff. We store only anonymised data on a CD and may consist of transcribed interviews or numerical data from questionnaires. We do not store paper copies, audio or video files. Audio and video recordings should be destroyed after transcription and final analysis unless otherwise stipulated in the ethics application.

Yours sincerely,

A handwritten signature in black ink that reads "Paul M. Camic, Ph.D." The signature is written in a cursive style with a large initial 'P'.

Prof Paul M. Camic, Ph.D.
Research Director

Appendix D - Ethics Approval Letter



Salomons Campus at Tunbridge Wells

Alex Court
17 Priory Grove
Ditton
Aylesford
ME20 6BA

25 October 2012

Direct line 01892 507575
Direct fax 01892 507660
Our Ref V75

Dear Alex,

A Grounded theory of clinical psychologists' beliefs about, and use of NICE guidelines

Outcome: Full Approval

The panel would like to thank you for your submission and we are pleased to offer you approval for your proposed study. The panel had observations to offer on the proposed research for consideration in supervision; these do not have to be addressed to the panel.

- Consider with supervisor the rating scale presentation on p.28 of submission – Strongly Disagree to Strongly Agree – this did not seem reader or user-friendly in its current presentation.

We look forward to receiving a short report on progress and outcome on completion of the research, in order to complete our file. The report should be the same one that is provided to your participants. Please note that any changes of substance to the research will need to be notified to us so that we can ensure continued appropriate ethical process.

Yours sincerely,

M. Callanan

Professor Margie Callanan
Chair of the Salomons Ethics Panel

Cc A Cooke

Department of Applied Psychology
Faculty of Social and Applied Sciences

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Broomhill Road Southborough Tunbridge Wells Kent TN3 0TG (UK)
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Appendix E: Anonymised Research and Development Approval Letters

From: [REDACTED]
Sent: 14 December 2012 17:58
To: Court Alex (SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST)
Subject: RE: authorisation for nice guidelines clinical psychologists project

Hello Alex,

I have reviewed your registration form for "A Grounded Theory of Clinical Psychologists' beliefs about, and use of NICE Guidelines." I can formally advise you that you have authorisation to proceed.

Regards

[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
Mobile number- [REDACTED]

This message may contain confidential information. If you are not the intended recipient please inform the sender that you have received the message in error before deleting it. Please do not disclose, copy or distribute information in this e-mail or take any action in reliance on its contents: to do so is strictly prohibited and may be unlawful.

Thank you for your co-operation.

NHSmail is the secure email and directory service available for all NHS staff in England and Scotland NHSmail is approved for exchanging patient data and other sensitive information with NHSmail and GSi recipients NHSmail provides an email address for your career in the NHS and can be accessed anywhere

From: [REDACTED]
Sent: 10 January 2013 12:27
To: Alex Court
Subject: RE: R&D re NICE guidelines & Clinical Psychologists research

Hi Alex

Please do start the work associated with your MRP - I will issue the formal permission in due course but please accept this email as an interim permission given the low-risk nature of your study. I've been advised that the new secretary will be in post from next week so hopefully I'll be able to send you a definitive list of Trust psychologists to complement any details you may receive from the co-ordinator.

Best wishes for 2013

[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Alex Court
17 Priory Grove
Ditton
Aylesford
ME20 6BA

15 February 2013

Direct line
Direct fax
Our Ref

Dear Alex,

A grounded theory of Clinical Psychologists' beliefs about, and use of NICE guidelines

This proposal has been reviewed and approved for research governance purposes.

Good luck with the research work.

Yours sincerely,

The signature and other identifiable details have been removed to protect the anonymity of the participants

Appendix F: Information Sheet for Participants

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Salomons Campus

INFORMATION SHEET FOR PARTICIPANTS

Study: **Clinical Psychologists' beliefs about, and use of NICE Guidelines.**

Researcher: Mr Alex Court, clinical psychologist in training, Canterbury Christ Church University.

You are invited to take part in a research study. Before deciding whether or not to take part in the study, it is important to understand why the research is being carried out and what it will involve. Please read the following information carefully.

What is the purpose of the study?

NICE guidelines were introduced in 1999 to attempt to improve clinical effectiveness and reduce variation in practice across NHS Trusts. Research suggests that implementation of NICE guidelines is inconsistent.

There have been studies investigating other health professionals' usage of NICE guidelines but none to date focussing on clinical psychologists (CPs).

Many CPs appear to be in favour of NICE guidelines, with some assisting with their production and with the British Psychological Society co-publishing some guidelines. Other CPs have criticised the guidelines, arguing that they discourage psychological thinking.

This study aims to investigate what CPs in routine practice think about NICE guidelines and how this impacts upon their use of the guidelines. The aim of the study is neither to promote the use of NICE guidelines nor to dispute them: rather, to find out about how they are being used and to generate debate about their benefits and limitations, and how they are best used in services.

How is the study being carried out?

The researcher will travel to CPs to conduct semi structured interviews, lasting up to 60minutes, at their place of work, on a one to one basis, to discuss their views on the use of NICE guidelines. These interviews will be audio taped and then transcribed. The data from the interviews will be analysed using the qualitative method of grounded theory. The researcher may contact participants after the initial analyses to seek clarification or validation of emerging theories. If this does occur, this will take the form of a brief telephone conversation, which is not expected to take up much of participants' time.

Why have I been invited to participate?

The study is interested in the views of CPs working in routine clinical practice in the NHS.

Do I have to take part?

It is your decision whether or not to take part. If you do decide to take part you will be asked to sign a consent form and complete a brief questionnaire. You will still be free to withdraw at any time without giving a reason. You also have the right to withdraw retrospectively any consent given and to request that your own data, including recordings, be destroyed.

Is anyone excluded from participating?

The study is specifically interested in CPs, so non CPs will not be able to participate. CPs who are supervised or managed by either of the research project's supervisors (Ms Anne Cooke and Dr Amanda Scrivener) will not be able to participate.

CPs who have been involved in production of NICE guidelines or who have already published opinions on NICE guidelines will not be invited to participate as their positions are already known. This study attempts to establish the views of CPs in routine clinical practice.

The initial questionnaire completed with the consent form will be used to assist in theoretical sampling, to attempt to ensure that the participants included in the study come from varying backgrounds, with a variety of opinions about NICE guidelines. It

is therefore possible that a participant may consent to take part and complete the questionnaire but not be asked to be interviewed.

What are the possible disadvantages and risks of taking part?

A disadvantage is that this study requires you to give up 60 minutes of your time. It is however hoped that this topic will be of interest to participants and is clinically relevant, so will not be seen as too much of a disadvantage.

A potential risk is that the discussions in the interviews could lead to some participants feeling that they are being criticised, or that it is being implied that they should be using NICE guidelines more or less than they currently are. The researcher does not intend this to be the case. The researcher aims to approach the interviews from a respectful, neutral perspective, neither promoting nor disputing the use of NICE guidelines. If you feel that the researcher is being critical then you are encouraged to advise the researcher of this immediately and have the right to leave the interview at any time should you so choose.

What are the possible benefits of taking part?

This study could provide participants with the opportunity to reflect upon their own views about NICE guidelines and how they utilise them.

Overall, the study is a chance to further our understanding of how NICE guidelines are used by CPs. This could be considered especially important in the current climate of payment by results, managed care and the tight control of resources in the NHS, with less costly professions competing for roles previously held by CPs. This study could provide valuable information on how CPs practice and the skills that the profession can offer to services.

The study may also provide information that could be taken into consideration in the production of future NICE guidelines, or in the distribution strategies of guidelines.

Will what I say in this study be kept confidential?

All information collected about you will be kept strictly private and confidential. Information such as professional banding, years since qualification and specialist area will be recorded but names and other potentially identifying information will be

removed or altered. The audio-recordings will be kept on a password protected memory stick in a locked drawer. Following the conclusion of the study, the data will be kept according to Canterbury Christ Church University's policy. Data will be coded and kept electronically on a password protected CD in the Clinical Psychology programme office of the Department of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN3 0TG and on the memory stick in a locked drawer in the researcher's residence for 10 years. After 10 years all data will be destroyed.

What should I do if I want to take part?

If you wish to take part please e-mail Alex Court at ajc100@canterbury.ac.uk giving your name and contact details.

What will happen to the results of the research study?

The results of the research will be used for a thesis as part of a doctoral course in clinical psychology and will be submitted for publication. If you wish to receive a copy of the results of the study you may request this by contacting the researcher at ajc100@canterbury.ac.uk.

Who is organising and funding this research?

Alex Court is conducting the research as a clinical psychologist in training on the Clinical Psychology Programme, Dept. Of Applied Psychology, Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN3 0TG. This organisation is funding the research.

Who has approved this study?

The research has been approved by the Salomons Independent Research Review Panel and has been approved by the Salomons Ethics Panel as part of the Clinical Psychology Programme, Department of Applied Psychology, Canterbury Christ Church University.

Concerns

If you have any concerns or wish to make a formal complaint about the way in which this research has been carried out, you can do so by contacting the research project's lead supervisor at: anne.cooke@canterbury.ac.uk or by contacting Professor Paul Camic, the Research Director of the Clinical Psychology Programme at Canterbury Christ Church University, at paul.camic@canterbury.ac.uk.

Contact for further information

If you have any questions you can contact Alex Court, clinical psychologist in training for further information at ajc100@canterbury.ac.uk

Thank you

Thank you for taking the time to read the information sheet.

Faculty of Social and Applied Sciences
 Clinical Psychology Doctoral Programme
Appendix G: Participant Consent Form Canterbury Christ Church University
 Salomons Campus

CONSENT FORM

Study: **Clinical Psychologists' beliefs about, and use of NICE Guidelines.**

Researcher: Mr Alex Court, clinical psychologist in training, Canterbury Christ Church University.

Please tick box to confirm

- | | | |
|---|--|--------------------------|
| 1 | I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> |
| 2 | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. | <input type="checkbox"/> |
| 3 | I understand that I may complete the pre interview questionnaire but then not be asked to participate in an interview. | <input type="checkbox"/> |
| 4 | If I do take part in an interview, I agree to this interview being audio taped, transcribed and the information analysed using grounded theory. | <input type="checkbox"/> |
| 5 | I understand that the data from the interviews may be seen by responsible transcribers, other than the lead researcher. It will be ensured that transcribers are aware that the data is confidential and that they formally agree to respect this. | <input type="checkbox"/> |
| 6 | I agree that anonymised quotes from the interviews may be used in the write up and in any subsequent publication. I understand that all personal identifiable information will be removed from these. | <input type="checkbox"/> |
| 7 | I agree to take part in the above study. | <input type="checkbox"/> |

Name of Participant

Date

Signature

1 copy for participant; 1 copy for researcher.

Appendix H: Recruitment Email

From: [REDACTED]
Sent: 31 January 2013 14:53
Cc: ajc100@canterbury.ac.uk
Subject: For the attention of all Clinical Psychologists

Sent on behalf of Mr Alex Court:

Dear [REDACTED] Clinical Psychologists

For my major research project, as part of my training at Salomons, I am investigating Clinical Psychologists' beliefs about, and use of NICE guidelines.

I have ethics approval from the Salomons Ethics Panel and approval from [REDACTED] to interview their staff.

The study involves completing a very brief questionnaire (please see attached) and then an interview of up to 60 minutes. I have attached an information sheet to provide further details.

I would be very grateful if some of you would be willing to take part in my study. My hope is that participants will find this an interesting topic to discuss and that the project will produce interesting results.

If you are interested in taking part, please could you complete the attached consent form and pre interview questionnaire and return these to me at ajc100@canterbury.ac.uk . If you have any questions, or if there is anything that you would like to discuss further, please contact me.

Thank you very much for your time.

Kind regards

Alex

Mr Alex Court
Trainee Clinical Psychologist
2nd year
Canterbury Christ Church University
Salomons Campus

Appendix I: Interview Questions

Opening statement, leading to an open question:

“Thank you again for agreeing to speak with me today. I wonder if we could begin by you telling me about your thoughts on NICE guidelines?”

Follow up prompt questions to be used if needed:

“What do you think of NICE guidelines?”

“How do you use NICE guidelines?”

“How are NICE guidelines used in the service that you work in? Do you agree or disagree with this usage? Do you / have you had any influence over this?”

“When are they helpful and when are they not helpful?”

“Why do you think that some clinical psychologists might use them more/less than you? Is this a good or bad thing?”

“Do you think other clinical psychologists might hold different opinions to you about the guidelines / when to use them and when not to? If so, why do you think this is?”

“What are alternative solutions to NICE guidelines? What would be the advantages and disadvantages to these?”

“How do you think your beliefs about NICE guidelines impact upon your use of the guidelines?”

“Do you feel that there are pressures to use / to not use NICE guidelines? If so, what are these pressures / where do they come from and how do you manage them?”

Appendix J: Full transcript of First Interview with Line by Line Coding

This has been removed from the electronic copy.

Appendix J: Extracts of transcripts with examples of focused coding

Example 1

Alex: Yeah. Ok, so we're recording now then, so I wonder if we could start very very generally, very openly and if you could let me know what your thoughts are on NICE guidelines?

Kim: I guess, you know, I tend to see them as guidelines. I take the words kind of literally. So, for me, it feels like it's useful in providing a sense of direction, or of what might be useful in thinking of a particular disorder/diagnosis, whatever you want to call it, client group. But, for me, they're guidelines/

Using NICE as guidelines, not instructions.

Alex: Yeah.

Kim: Rather than somebody telling me what to do. So, in that way, when I look at, you know, because they're guidelines, I find it really useful/

Alex: Yeah.

Kim: To look at it and think 'ok, these are what a group of people that got together to look at this diagnosis thinks that people, you

know, that might be the most effective thing to do in this circumstance’.

Seeing NICE as a useful guide to the evidence base.

Alex: Oh, ok. Yeah.

Kim: And so I’d better take notice. I think that’s important to kind of er read them and know about them and have a sense of what the recommendations are from that. However, you know, as I said for me they’re guidelines, so when then you apply that to the clinical groups we’re working with, they may not fit, you know, nicely in the box that is described in the guidelines. They may have all other sorts of things going on with them that have an impact, and so we may have to adapt what we actually erm do that might not follow every single thing that the guidelines state.

Arguing that routine practice is more complex than NICE guidelines.

Alex: Yeah.

Kim: And so that’s how I always looked at them. However, you know, I know that, there is a pressure, you know, in that questionnaire, you know, you asked me to do, ‘are people under pressure to use them?’ Yes, I think they are. I think there is a lot of pressure for clinicians to use what the NICE guidelines say. And, of course, you know, there’s all the work, you know, in this trust now

Experiencing an underlying threat or pressure to be NICE compliant.

they're developing pathways and it's going to be about pathways that comply with NICE guideline, you know. But there's all sorts of criticisms that you could give to - you know, first of all we're psychologists and NICE guidelines are based on the diagnostic system, you know, where for us might make less sense at times. So that could be a criticism on that front.

Alex: Yeah.

Kim: Erm, and also, you know, does the research, you know, for children a lot of the time that research is very scarce, so it's kind of like thinking 'ok, they've given this recommendation, but actually the evidence for it' - it almost makes it feel as if NICE are saying that so that means that that's the best, you know, that's the evidence based information. And it might be the best evidence based information, but actually a lot of the times for research in children that evidence is more patchy. I think it's getting better, probably. And I'm not, you know, I'm not an expert in knowing whether the evidence is good quality or not. And I haven't gone through every single article that the people obviously reviewed, but I'm sure that there's a sense that actually there might not be a lot. And in some guidelines there is, you know, that's stated clearly actually there isn't a lot of evidence for this, but/

Highlighting that people may follow NICE guidelines without being familiar with the evidence they are based on.

Alex: Ok. So perhaps that message might be lost sometimes, that people think because it's NICE recommended it must have really good evidence and it must be a really good intervention/

Kim: Yes.

Alex: But actually it might be a bit more patchy.

Kim: Yes. I think that.

Example 2

Alex: Yeah. And I suppose one last question I've got, which is linked with those things we've been talking about – and I apologise if I'm repeating myself, because I've probably asked it before. But with one of the limitations you mentioned was the medical model and the fact that it's set up in the medical model, and you mentioned how it was a starting point and that it kind of made sense that it was done on the medical model because that is the dominant model. So it seems as though you're fairly kind of ok with it being done in that way. Is that right, do you think? Do you think that it's kind of the best option available at the moment or/

Sam: I'm not sure it's the best option. I think realistically it's understandable that that's how it started. I mean I think we can argue as psychologists that, you know, we don't want to categorise people by a diagnostic system that isn't itself evidence based. And all those arguments are very legitimate, but at the same time it all had to start somewhere/

Understanding why the medical model was chosen by NICE.

Alex: Yeah.

Sam: And I think it's completely understandable that it's started with the diagnostic system. I think the main criticism at this stage is that that 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?

Wanting NICE to review its approach.

Alex: Yeah.

Sam: And it should be that process of reflection, should be occurring. I'm not sure it is, but it should be, because if they're all about evidence based practice, you know, where is the evidence for the diagnostic system? Particularly a diagnosis like schizophrenia, it's so contested, and I think if you look at the evidence it makes no

sense whatsoever and you shouldn't be using it in an evidence based system.

Alex: No.

Suggesting that there are alternatives to the medical model.

Sam: It makes more sense to look at – if you're going to look at psychosis, which is such a broad experience, it makes more sense to look at phenomenologically at, you know, paranoia or voice hearing or whatever. That might make more sense. It would mean that you might have more guidelines, but there would be more focus so presumably they would be more concise.

Alex: It seems to me like that could be possible, it could be something that could happen.

Sam: Yes. Yes, I think it could happen, but only if NICE engage in that process of reflection on the, you know, the evidence base for the structure that they have.

Alex: Yeah.

Sam: And there's been a lot of controversy recently about the new DSM system, hasn't there, and the fact that, you know, that it's not really based on evidence/

Questioning the validity of diagnostic categories.

Alex: Yeah.

Sam: It's been talked about, and of course that's good, that's healthy that it's coming up in debate. I think NICE need to take that on board really/

Alex: Yeah.

Sam: And evolve and gradually move away from the diagnostic system.

Alex: Yeah, that makes sense. So it was a good starting point to have a guideline for schizophrenia/

Sam: Well I'm not saying a good. It was an obvious starting point. So I'd say it was an obvious starting point because, you know, the diagnostic system is dominant and I can understand why they started there. I mean it's an obvious starting point, but/

Understanding why the medical model was chosen by NICE.

Alex: And then the hope is that they/

Sam: That it shouldn't constrain them/

Alex: Move on to, say, a paranoia guideline, and hearing voices guideline, perhaps.

Sam: Yes. Indeed. It would be very sad if NICE weren't able to develop in that way.

Alex: Yeah.

Sam: You know, they refresh their guidelines every 5 years, why can't they look at, you know, the overall framework they've got for the guidelines, because it isn't evidence based and it needs examination. So I wouldn't say it was a good start or even the best start, but it was an obvious place to start and an understandable place to start/

Wanting NICE to review its approach.

Alex: But it's had some benefits and it's kind of/

Sam: It's got the whole thing started. Yeah, but it does need to develop.

Alex: Yeah.

Sam: And I don't think anyone should feel entirely happy with it.

Example 3

Morgan: Mmm, some of my colleagues would say, I can think of one person in particular who would say, that that's maverick and dangerous and that you're doing something, you know you're messing with a model. You're doing something for which there's no evidence of its effectiveness, you know, I daren't. That view, for me, comes under the naïve heading of erm, assuming that because something has attracted RCT funding it's the only thing that's effective. Erm, so you know I would be much more interested in, rather than just referring to the evidence, whether it's in NICE or not, I'd be more interested in having a collaborative conversation with my client about what the issue was, what they needed, what they thought might be helpful. I would want to get regular feedback in the session from them about whether they felt what I was doing, what we were doing was helping them or not helping them. I would want to tailor my approach according to that individual more than what may or may not have got published.

Arguing that an absence of evidence is not evidence of ineffectiveness.

Valuing collaborative decision making with service users.

Example 4

Jan: Because, there are weaknesses, so for example, NICE themselves say this, that actually if something is not in the NICE guidelines it's not evidence, that it is not effective, its just that there is a lack of evidence that it is effective/

Arguing that an absence of evidence is not evidence of ineffectiveness.

Alex: That's right, yeah.

Jan: And that different groups are better at actually creating evidence base than others, so that may be their strength, it doesn't mean that everything they do is superior.

Alex: Yeah.

Jan: For example, there's the few done at the moment with CBT being held up as the ultimate therapy and the only therapy. And I think its very divisive and actually very damaging. I think its damaging to clinicians and I think its damaging to patients, because clinicians are finding they're fighting for 'what's the best way? And my way is better than your way is better', because – and making the NICE guidelines rather than what's actually best for the client.

Worrying about the dominance of CBT in NICE.

Alex: Ok. And so do you think that the introduction of NICE guidelines has assisted with that in some way?

Jan: I think it has absolutely erm laid the way for it. Sorry, that's not the word I'm looking for, I lose words, not dementia. Yes, I think the NICE guidelines have done that, and I think it's actually been very harmful.

Alex: Oh, ok.

Jan: Erm, so now all they want, especially – well, I’m at CAMHS service so that’s all I can talk about, but all they want in a CAMHS service is CBT, and actually if we look carefully there isn’t an evidence base of CBT for children or for specific difficulties, but it’s still being waved as this generic ‘look, look, look CBT does everything’ and clients are then coming in and saying ‘well I want CBT, whatever that may be’ and that’s what they want. And it’s become another name for therapy, but it’s very directive and very controlling/

Worrying about the dominance of CBT in NICE.

Example 5

Ronda: So I think that a, I think there’s a danger – I mean if the NICE guidelines are viewed as something as a guideline, rather than a prescription, and it generates discussion and it’s sort of clear that we haven’t reached a state of saturation where the evidence is concerned, you know, but we are still learning and we’re updating all the time, so what’s in the guidelines should not be seen as set in stone/

Wanting NICE to be guidelines and not instruction.

Alex: Yeah.

Ronda: If it's like more a loose sort of guideline, then I think it's fine to some extent. But I think there is 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.

Feeling that managers / policy makers can follow NICE guidelines without questioning their relevance.

Alex: Yeah. Ok. So there's some real benefits from NICE guidelines, but there's also quite a lot of concerns as well.

Ronda: Yeah.

Alex: And I think there's lots of things you've said there that I'm really interested in and I'd like to kind of ask lots of questions, so I'm perhaps trying to hold that in mind and ask kind of a few at a time. And I'm just thinking, as you said there's lots of real benefits and concerns, and I think everybody I've spoken to has said something similar. And I'd be really interested to know how you manage that as a kind of individual clinician, how you kind of manage those pro's and con's in your own head and in your own practice?

Ronda: Erm, in my own practice, in terms of working with patients, I think it is important to be aware of the NICE guidelines, and it is

important to be aware of the evidence. But often when you actually sit in front of the actual patient, the problem is always that the model is fundamentally flawed/

Arguing that routine practice is more complex than NICE guidelines.

Alex: Ok.

Ronda: In my opinion, because it's never as clear cut as that. So it's never just OCD or just depression or just anxiety, and in practice I would say I go much more with the transdiagnostic approach and I sort of pick and take from the different guidelines. So I think it's much more important to be aware, to some extent, erm, of, erm, sort of the different treatment models and what they're sort of good for, what kind of problems seem to respond to the treatment models, and then very much adhere, I would say, I adhere more to the core philosophy of psychology, which is to er, be sort of a scientist practitioner and to also have several therapies at your disposal and then really tailor the treatment to the individual patient. So, and also to be aware of papers that sort of discuss, for example, if you have somebody with a more severe depression and a recurrent depression, then you need to adapt CBT and you need to sort of make it longer or see somebody for more sessions, or see somebody for shorter sessions but maybe twice a week. And I think it's very important to be sort of aware/

Using NICE as guidelines, not instructions.

Suggesting that CPs research skills put them in a position to interpret the evidence base.

Alex: Yeah.

Ronda: Of much more than just the NICE guidelines. So I would say I'm aware of them, but in my clinical practice I would go over and above the NICE guidelines. I think sometimes you can use the NICE guidance to make an argument for certain lengths of treatment, you know, if there's some sort of conflict around how long should this person be seen or/

Alex: Oh, I see. Yeah.

Ronda: This person has already had two courses of therapy, we shouldn't give them any more. Sometimes you can actually use the guidelines to make a case.

Using NICE to suit our needs.

Appendix L: Abridged Research Diary

December, 2011 – Research ideas were presented at the research fair (01.12.2011). I was interested in a few areas. Spent a lot of time over the Christmas break looking through different project ideas. I seem to be most interested in projects using qualitative methods. I have always been interested in a social constructionist approach rather than positivism but the majority of my experience with qualitative methods to date was with discursive psychology which I didn't warm to. I have read more about a variety of qualitative methods and am keen to learn more about them.

13.01.2012 – Met with Dr Amanda Scrivener to discuss a potential qualitative project in the area of psychosis, potentially thinking about why NICE guidelines for schizophrenia don't tend to be followed. I found this meeting very helpful. Amanda was easy to speak to and very good at asking questions that encouraged me to come up with ideas. Agreed that Amanda would be my external supervisor.

January & February, 2012 – Attempting to find an internal supervisor. Had helpful discussions with Anne Cooke, am very keen to have her as a supervisor, but it is a competition against other trainees. Can't help but think that this is not the best way for this process to be done, but to be honest I can see why it is done this way and can't think of a better alternative! I sent an anxious email to Paul Camic in this period late one night and got a very reassuring and helpful response minutes later, which I was very grateful for.

During discussions with Anne, the idea came up of moving away from psychosis and thinking about NICE guidelines in general, interviewing clinical psychologists and using the method grounded theory. I really like this idea. I'm starting to move away from my original position of assuming that NICE guidelines should be followed to more of a position of uncertainty and wanting to find out more (for my own benefit!) about the benefits and limitations of NICE guidelines.

29.02.2012 – Anne has agreed to be my internal supervisor.

May, 2012 – Completing MRP proposal form. I am noticing the pull between course requirements and grounded theory methodology. Amanda is keen on using purist grounded theory methodology and is encouraging me to question how I will complete a literature review for the project proposal and hypothesise which theories my project may draw on, as this should not be done in purist grounded theory at this stage. I have been reading around lots of grounded theory authors, including Charmaz (2008), Straus & Corbin (1998), Glaser & Strauss (1967), Birks (2011) and Willig (2008). Through my reading, talking with Amanda and Anne, I have come to the conclusion that I need to do a brief literature review for the proposal to satisfy course requirements. I need to acknowledge that this is a tentative review and once I begin the project, the emerging grounded theory may take me in a different direction. I have also decided that I will aim to collect the majority of my data and complete the analysis for section B before starting the literature review for section A of the MRP. I am not under any illusion that I am a blank slate as Glaser and Strauss (1967) appeared to suggest, but I do see the point that delving into the literature too deeply can harm a researcher's ability to generate their own theory, as they become distracted by the theories and findings of others.

14.06.2012 – Met with the Salomons Independent Research Review Panel today. I was nervous about this, wondering what they might think of the project. I was pleasantly surprised that both panel members seemed very interested in the project, noting that it seemed particularly relevant in the current clinical climate. The panel gave me some helpful advice on a few areas, particularly pointing me in the direction of Dey (1999) and his ideas of theoretical sufficiency rather than saturation. Plus, the panel highlighted that if necessary it was possible to interview clinicians without R&D approval if they are interviewed outside of trust working hours, off work premises and not recruited through their

position in the trust. The panel didn't criticise anything about the project and I gained full approval without needing to make any major amendments to the proposal.

25.10.2012 – I received full ethics approval from the Salomons Ethics Panel. I feel very pleased with this but also a bit overwhelmed, as it means I have to begin the project now!

29.11.2012 – I've been liaising with R&D departments over the last few weeks and getting very frustrated with it. Each NHS trust seems to tell me different things. One trust in particular seems confused that I am not conducting an RCT in a particular service and doesn't seem to understand qualitative research. I have spoken to numerous different people from this trust and they tend to ignore what I say and keep repeating the same questions that are not relevant to my project.

30.11.2012 – After discussing it with Anne and Amanda, I have decided to contact an ex colleague of mine to see if they will participate in my project. I contacted them through Facebook and we agreed to have an interview on the telephone, on a non-work day. I plan to use this interview as a pilot and will seek feedback at the end of the interview. If it goes well, I will use the data. If considerable changes are required to the interview style or approach of the project in general, then I will not use this data.

14.12.2012 – R&D approval received from first NHS trust(1). It took a bit of to-ing and fro-ing to work out which person would be the relevant person from the department for me to speak with, but once I was put in contact with the appropriate person they were very helpful.

27.12.2012 – Completed first interview, over the telephone, with ex-colleague (Amy). Transcribed the interview. The data seem rich. Issues of NICE being safe, nice and neat, came out. This seemed to link with my initial ideas about a drive for safe certainty. I wondered if I pushed this. After reviewing my comments in the interview transcript I don't feel I did. As this was the first interview I purposefully tried to talk as little as possible. I barely asked any questions or made any statements, I just encouraged the participant to keep speaking.

My thoughts on who to sample next (theoretical sampling): managers, people who haven't just qualified. People who are more passionately for or against the guidelines. People who are more pro CBT. People with some of these characteristics might generate different views to the first participant, opening an opportunity for exploring similarities, differences and reasons for this.

I am wondering about my recruitment of future participants, as it is likely to be people who self-select, why do they self-select? Someone who is passionate about nice and wants to be involved in research may be different to just knocking on someone's door and asking to speak with them. The risk of the "knocking on the door approach" is that this is likely to be with colleagues, who I already have a relationship with. The relationship could get in the way of the research (or help it?) and it could be argued that I only approached people who I knew would agree with my ideas. In defence of this, I don't consider myself to have any particular ideas or bias at this stage. This is one of the reasons that I am doing this study, to try to learn more about my own thoughts about NICE guidelines. I'm hoping to have a combination of "knocking on the door approach" to recruitment and people who self-select.

10.01.2013 – R&D approval received from another NHS trust(2). The contact person has been helpful and interested in the project but unfortunately needed a lot of chasing as they kept stating they would get back to me and then didn't.

11.01.2013 – I'm reading Moncrieff (2009) "The Myth of the Chemical Cure" and am interested by her thoughts that the profession of Psychiatry gained power from having a disease centred model, with specific treatments for specific diseases (even though the evidence behind this model is highly

questionable). I'm wondering if this might be a relevant idea in my project, power appeared to be a common theme in the first interview.

23.01.2013 – One of the NHS trusts(3) gave me a named contact person to liaise with from R&D. They were helpful but needed a lot of chasing. After two months of liaising with this individual (and numerous lengthy paperwork completed) they emailed me to say they were not the correct person and I needed to complete further paperwork and send it to somebody different. Very frustrated by this! Am starting to see why more research doesn't get done.

25.01.2013 – I was hoping to wait for R&D approval from trust 3 before recruiting, so that I could make an informed decision of which order to contact each trust. After the news on the 23.01.2013 I have decided to just begin recruiting in the other 2 trusts. I sent out a recruitment email to the trust training co-ordinators in these trusts, who have now kindly agreed to circulate the email to all trust psychologists.

01.02.2013 – I am pleasantly surprised that I have had 7 responses already of clinical psychologists stating that they would like to take part in the project. Some of them appear particularly interested in the project and keen to participate.

I've looked through the pre interview questionnaires. After the first interview, I was keen to interview somebody who was more in favour of CBT and someone who is not newly qualified. One of the clinical psychologists fits this, so I arranged to meet them. Luckily, one of this psychologists' colleagues also wanted to participate, so I arranged to meet with both of them on 14.02.2013. This feels like a "best of both worlds" approach, I am beginning to think about theoretical sampling with the selection of the 2nd participant but am also keeping the approach open and have selected the 3rd participant through convenience. I plan to keep both of these interviews open, following the lead of the participants. If any similarities or differences of opinions from the first interview emerge, I may raise this with the new participants to gain their views on this. I then hope to do line by line coding and focused coding on this data to help inform the theoretical sampling and questioning of future participants. If time doesn't allow for full analysis, I will base future sampling and questioning on memos made in this research diary.

5.2.2013 – A potential participant raised the important point of whether they would be identifiable if they were the only person from a particular speciality. I need to consider this further. I may need to tweak identifiable data slightly, without damaging data.

15.02.2013 – Thankfully the new R&D contact from trust 3 was very efficient and full R&D approval has been received. Now that I have R&D approval from 3 different trusts, I have decided to give up on attempting to gain approval from the trust that seemed particularly difficult and inflexible. Discussing this with Anne and Amanda, I feel confident that I will gain enough participants.

15.2.2013 - Going through emails from potential participants. Pleased and surprised at big response, people seeming keen to participate. Looking through pre-interview questionnaire, seeing some "sitting on fence" answers, hoping for more extreme views, to gain a varied sample. Noticing that they were largely adult mental health. Wanting other specialities. Thinking that only AMH are interested in NICE? Other specialities don't feel it applies to them? I'm aware as I am writing this that grounded theorists might criticise what I am saying as just trying to gain a representative sample rather than following the data. I feel that I am trying to theoretically sample, following the ideas that emerge and attempting to find participants with similar and different views. By wanting to sample CPs from different specialities I suppose this does fit with ideas of "representative" but I think it can still be argued as theoretical sampling as I am wanting to test whether CPs from different specialities have similar or different views to the ones I have interviewed already.

21.02.2013 – Reviewing notes from interview with Naomi. There appeared to be tension, an uncomfortable fit where she wanted to like NICE, saw it as really helpful in places, but also saw it as reductionist and simplistic and not really workable. Noticing that in the first 3 interviews the CPs emphasised the skills of a CP, despite me not specifically asking them to do so. There seems to be something about NICE that encourages CPs to potentially get defensive (or precious as Naomi called it) about their skills. It might be that NICE gives emphasis to 1:1 therapy from one modality, after somebody has been assessed and given a diagnosis. This doesn't appear to fit comfortably with the skills the CPs were highlighting. Naomi appeared to think it was bad to be aligned with NICE.

21.02.2013 – Interview with 4th participant (Jenny), not from AMH. Felt that the conversation didn't flow quite as well today. It might be due to the fact that Jenny highlighted that she tries to avoid using NICE, so it didn't seem quite so relevant to her. Although this in itself is an important finding, that she values excuses not to use NICE. It would be good to interview other CPs not from AMH to see if this is the same or different for them. Plus she raised a very interesting point that before NICE it was expected that CPs would be integrative, since NICE everyone has to have a pure modality; integrative is now seen as a bad thing.

24.02.2013 – Thinking of questions that I would like to explore with future participants (through sampling / questioning): Is there conflict between being model adherent and integrative; pros and cons of each? More thoughts on pre and post introduction of NICE, more integrative in past? Now more classifying therapies, for x do y, can't say integrative any more. Integrative doesn't fit with the evidence base. Areas where not many NICE guidelines are available is it still possible to be flexible? Is this OK? Or worrying? Can pick and chose when to use guidelines. Can use them when want power but say no, not based on our client group when don't want to use. Is this ok?

25.03.2013 – The importance of line by line coding. I was doing focussed coding on the 1st interview (that I already had line by line codes for). I wasn't really looking at the line by line coding that I had already done. I was starting to wonder why I needed to do the line by line coding. Then I was stuck on how best to describe a focussed code for a paragraph; I looked at line by line coding, it helped point out something that I would never have noticed had I not done it line by line (focusing on the words "red herring" – NICE can be misunderstood). This made me appreciate the importance of using the line by line coding.

26.03.2013 - Thinking of questions that I would like to explore with future participants (through sampling / questioning): worry about training in a nice endorsed therapy? Maybe newly qualified CPs do. Is this something older CPs value / feel they need to do?

Finished initial focused coding on 1st interview. I was aware of quite a bit of overlap between some of my codes. 50 or so of them, felt quite unmanageable so sorted them into sub folders of similar codes. I wonder if this may be the beginnings of categories? It felt like a natural process that I didn't even plan, but it does seem to be the start of emerging categories. I am sure that the number of codes will have to come down, I am coding too much and not "focused" enough. I remember this from one of the GT books that I read, that students new to the method tend to come up with too many codes to begin with.

I sent Anne and Amanda a detailed update email on 24.02.2014 with transcriptions of the first few interviews and details of my plans. Haven't heard anything back. I presume this means that they are happy with how things are progressing.

27.03.2013 - Sat at home preparing for next interview, looking through research diary and notes from previous interviews, really helpful to remember key points that I was thinking through before and what to ask in new interview. I'm really starting to see the value in this research diary and all my notes. (See Appendix S for an example of detailed notes made before interviews)

27.03.2013 – Thoughts after interview (with Jan): NICE has introduced unhealthy competition between therapeutic modalities. NICE = CBT. Jan is angry about this. Saw lots of limitations in CBT. Can use guidelines to own end. Use them when want to get recognition and support for own therapy but can dispute them when it is a therapy you don't value. Values eclectic and integrative work. Differentiated between them though. Shooting ourselves in the foot by abandoning this. Why have CPs if just do single model. Likes nice guidelines in theory but worries that they are misinterpreted. Don't know how to get around, because NICE do stress that absence of evidence isn't an evidence of ineffectiveness.

Didn't feel a need to use language of NICE and categorised therapies when talking to families and gps etc. used simple formulations. – different to other participant who felt that the introduction of NICE encouraged the use of single modalities and categorising them – ie x diagnosis needs y therapy. No room for integrative / eclectic. Is it that Jan is “a mini bulldog” as she described and sticking with how things were, using integrative / formulation driven work, whereas other participant is changing, going with flow of nice? Something to do with being in non adult services? Is this possible in an adult service? – ask others for their thoughts on this.

28.03.2013 - Question for future interviews – How do you use nice guidelines? This has been neglected I think. Lots of discussions have been theoretical, not on the actual mechanics of when do you read them, how do you fit this with your formulation etc? If don't like them, how get around? How use / try to avoid using?

04.04.2013 – Preparing for interview with Sam. Reflecting on why I picked Sam for interview. Views on questionnaire seem different to others. Favoured model is CBT, strongly disagree that NICE limits psychological thinking of CPs. Sam may help with constant comparison, giving different views to other participants. Look for similarities and differences and reasons for these.

11.04.2013 - Doing line by line coding of Paul's interview. Paul mentioned that NHS was about symptom reduction. People wanting closure / personal resolution need to go for private. This doesn't fit comfortably for me emotionally. Bring up more in other interviews? Key question for future interviews - Paul wanting to break down the barrier between MH and PH, MH is PH poorer cousin, breaking barrier would reduce stigma. Jan stressed MH is different to PH. What do other CPs think? Mh different to PH? Kept separate? Treat more similar? Advantages and disadvantages to both. NICE's role in this?

Paul valued being trained in a broad range of therapies. He used this to formulate. Treatment would then still be single model but formulation would have been informed by other models to pick best treatment. (i.e. he could refer on to a psychodynamic therapist, able to recognise when this is needed). Later talked about integrating other ideas into CBT framework. Sam talked about this as well.

Paul mentioned a desire to be both integrative and model adherent. Discuss in other interviews? (Amy wanted to be integrative but then give illusion of model adherent. Naomi wanted to be model adherent and integrative, fitting other ideas into CBT. Other CPs have valued integrative and not tried to make model adherent.

Thoughts coming into my head about fighting vs accepting limited scope of NHS. Can NHS be expected to be more than symptom reduction, short term, evidence based therapies?

28.04.2013 - Transcribing Sam's interview. Making me think of the interview with Jan, different modalities fighting against each other. Are CBT trained CPs more accepting of NICE, because it favours their approach. I'm wondering how to reflect this in coding etc?

Sam was pro NICE because in their service, NICE has helped established the need for psychological therapies for schizophrenia. Sam talked of how other modalities needed to do the research. But then reflected that bipolar work in routine practice is helpful but hasn't been seen in research. Sam suggested that there were problems with methodology etc. Sam feared that NICE might not ever promote psychological therapies for bi polar, despite it being helpful (clinical opinions). I'm thinking again that NICE is very powerful. "I haven't felt them (the limitations) to be limiting in my practice" is this the key? Everyone sees the positives and the limitations but if the limitations don't affect you, then you focus on the positives. I really like the following quote: **Sam:** "And I think it's completely understandable that it's started with the diagnostic system. I think the main criticism at this stage is that that 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?" Very interesting quote. Is this what I am doing? Starting to scrutinise NICE. See how NICE is thought of?

3.05.2013 - Coding workshop with Paul Camic. The main things that I took from this workshop were: Paul stressed that it is fine (and helpful) to go into coding with the questions "what am I looking for?" "what am I hoping to find?" he added that it is helpful to consider peoples intentions, motivations, discourses, beliefs, rules, values and stories when coding. Paul does not think that everything is codable and that it is ok to be looking for particular things and to code these and to leave other things. He suggested doing line by line coding for 2 interviews.

23.05.2013 – Reading through all notes and coding etc. Some of the key thoughts in my mind at the moment are:

Overall – NICE is very powerful,

- i) It gives endorsement to therapies. Other professions take note.
- ii) It can create services – e.g. IAPT, CBT for psychosis etc, Dementia guidelines. If NICE recommends it, can support argument for setting up service.
- iii) It has created (or enhanced) rivalry between therapeutic modalities. (& threatening existence of integrative work?)
- iv) Majority of funding going to CBT because it fits better with NICE, philosophy behind it etc, more able to test it. – limits development of other therapies, newly qualified CPs doing training in CBT / NICE backed therapies.
- v) Encourages medical model thinking.
- vi) Gives illusion of simplicity? X diagnosis requires y therapy.

30.5.13 - following the coding workshop, further reading and further practice at coding, I am revisiting my focused coding of 1st interview. I am finding this helpful to tweak a few of the coding labels, have added a couple and have removed overlapping of coding in many places. I had found that once I had created codes I was keen to code things many times over using lots of codes for one paragraph.

I am worrying that when I create a code I may have missed previous examples that fit well in that code. This might not be too much of a problem? If it had been the perfect fit earlier then I would have come up with it earlier, something probably fitted better. Plus the earlier instance has played a part as

it has probably consciously or subconsciously influenced me into thinking about that area, which I have then thought of later and created a code for.

6.6.13 - Transcribing Morgan's interview. I am struck by Morgan noting that it feels like a turning point. Morgan can feel the pressure coming. They can resist at the moment, but can feel it coming where it will be x diagnosis needs y treatment. I am really struck by this quote: "You know, its, if you took out people's personal investment and bias, and the benefits to them in their particular profession, I'm not sure you'd have much of an argument left on any side." How do we get around this? Is it possible? Is this a key thing? Everyone sees the same limitations etc but depending upon your bias (we all have our biases) you make different conclusions?

7.6.2013 – I'm thinking back to a recent meeting with Amanda re initial coding. "Selective attention" was mentioned. All CPs see limitations of NICE but chose to attend to different things depending upon their own agenda? E.g. if they support CBT then happy with power nice has given to CBT, so don't attend to the negatives.

Doing focused coding for Naomi's interview. She seems really confused about NICE, she will say one thing, I will agree, then she will argue with me. This maybe to do with the quality of my summarising and reflecting but I haven't had this problem in other interviews. I wonder if this suggests it is more her issue? I think she likes the flexibility of the guidelines but worries about the integrity of the practice of others if they are given flexibility.

Naomi suggested setting up guidelines by psychological processes. Showing that each process covers lots of people / cross diagnosis etc. e.g. rumination, fear of rejection, projective identification (social anxiety) etc. would this be a good alternative? Something to ask in future interviews? Is this what my project is about? Not really interested in ins and outs of alternatives? Just interested in if people think there are alternatives?

Reflecting on others views of NICE – maybe ask this more in future interviews? Naomi said she thought nurses would see NICE as being brilliant as that was the model they were trained in (medical model).

7.6.2013 - I'm feeling like this project is helping me with my own understanding of clinical psychologists' role and ability in providing therapy. I had previously considered a CBT therapist to do better CBT than a CP and a psychodynamic therapist to do better psychodynamic work than a CP. But this project seems to be showing that CPs value being integrative and this could either be explicitly or in thinking in other models to help your formulation and then bringing this into your single model approach.

Thinking about what Paul said about single model advocates and coding Jenny is making me reflect back to when I was a low intensity IAPT worker. One particular case I am thinking of, I was keen to help a wealthy older lady using BA when really I should have recommended private work for personal reflection / if I had been in a different service / different position, offered her something more reflective. As I was a single model advocate I was keen for it to be BA and for this to work.

Starting to have thoughts in my head about what the key take home messages of my research might be – initial thoughts are – NICE should be seen as guidelines, not as strict enforcers, not all interventions can / have been evaluated & NICE not up to date all time, need to do some of own scientist practitioner work. NICE won't fit for all clients, can draw principles but be aware this is fudging things. Single model therapists not the same as CPs. CPs do CBT differently to CBT therapists.

Maybe this research gives some understanding to the finding of the paper a colleague gave me re CPs being better at CBT than non CBT therapists.

Another thought is that people should be aware of the power of NICE and ensure that the power is used appropriately. Draw attention to the fact that NICE is based on invalid diagnostic categories (& plenty of other questionable science) so while it can still be a helpful guide, it shouldn't be seen as the bible.

25.06.2013 – I'm thinking that over prescriptive and misinterpreted are connected. Would it be a problem if they are prescriptive if not misinterpreted?

Thoughts after interview with Kim. Every CP sees the limitations of NICE. Different CPs have different conclusions. Kim likes to have the guidelines, to help us be scientist practitioners, helps to summarise the research. But Kim doesn't want them to become too prescribed. But does see the rationale for prescription and categorisation etc, tries to make more efficient. Need to be wary, sometimes NICE is held up as definitely the right answer when sometimes the evidence isn't clear. Plus sometimes it seems like a conveyor belt of y treatment for x condition can miss things.

Reflecting on why different CPs have different conclusions – it seems to do with how much the limitations affect them. Kim is able to work psychodynamically and integratively (not using this term but drawing on different models) and also values CBT for anxiety disorders. Appreciates that other CPs who can't work in this way may emphasise the limitations more. Kim is disliking being pigeon holed as someone who just does CBT and people referring for CBT when should be refer for CP. Worries about the future of more prescriptive NICE.

Key message for this project – highlight the value and limitations of NICE. See them used wisely. With great power comes great responsibility! We've seen the power, have we seen the responsibility? Need to make more of an effort to show the limitations, show that they are guidelines and not prescriptive?

28.06.2013 - Reading a GT study (Camic, 2010) that used 65 questionnaires. Camic quoted Straus and Corbin as saying 10-20 was norm for GT participants. Helpful that my study aims to be in the norm. Reading this paper made me realise the importance of talking in my mrip methodology / VIVA about the approach of interviewing. How this attempts to get into the participants world and go with what comes up. This can help challenge preconceptions etc (Charmaz). None of this is possible in a questionnaire. So although the number of participants is less, the data is so much richer.

Reading this paper has also increased my confidence as I recognised almost every reference to GT in the methodology and understood everything, to the point of being in a position to reflect upon the pros and cons of different approaches. It has also made me wonder about the word count, 8000 is suddenly feeling small.

1.07.2013 - Reading the July edition of BPS psychologist and clinical forum. Lots of articles and letters relevant to my project. Particularly the discussions around the dsm5 and DCP position statement. This reignited my interest for the project, showing how it is coming at a relevant time. It also made me realise how it is not possible to be in a vacuum and not be familiar with the literature before doing a GT study, as it is all around us in our chosen professions, we can't avoid it.

1.7.2013 - Use of motivational interviewing approach – I noticed when coding for Jenny that when I sided with her, she then gave the opposite view. E.g. she was worried about this research threatening

the freedom they have in her field. If I had said “yes, well, perhaps it should be threatened, what do you think the negatives of your practice are?”, she is likely to have argued her position. By valuing her position (“perhaps the research will help draw attention to the good sides of your practice?”), this allowed her to then bring up the negatives of the practice. This seemed to free her to express her opinions.

5.07.2013 - Coding Jan’s interview, noticing the following information: NICE can raise people’s expectations unrealistically, linked with evidence base doesn’t reflect what is done in routine practice. Reduced funding, put money into evidence base, yes, understandable, but doesn’t take into consideration evidence base is single presentation. I’m thinking that people could counter this with evidence showing practice based evidence, but that isn’t my point, I’m merely presenting the viewpoints of how practicing clinicians interpret the evidence and make their decisions.

Do I need a category re competition? Need to draw together the stuff about valuing CPs flexibility, range of training etc as at the moment it is all in different codes and categories. I am realising that my coding is not focused enough yet.

It might be possible for other therapies to emerge and be used / become nice backed, but need big bulldog/flag waver now due to competition, can’t just peruse the evidence yourself and start using. Another goal for this project – highlighting how CPs don’t consider integrative to be a weakness whereas it doesn’t fit within NICE language. Question for future interviews- is NICE doing harm? Can this be a category? Competition, damage to integrative approach etc

Re-read “raises expectations and then disappoints as there are limits”, this rings true with me. Setting CBT up as a magic cure sets us up to fail. It is not. Starting to get confused with initial categories as one code can appear to fit in many categories. Helpful for linking categories but will need to work out how to manage this.

Wondering if dangers of NICE will be a broad category with lots underneath it?

5.07.2013 - Reverting to line by line coding for start of Sam’s interview. Too much data to code by paragraph.

19.07.2013 – Thoughts: 3 positions? Or 2? Those who experience nice as restrictive and those who don’t but worry that it will be?

People thinking in different models and integrating into CBT. Like the broadening church of CBT, mindfulness, mentalisation, ACT etc. using language of power of CBT but then doing something quite different? CBT being watered down? What is CBT?

19.07.2013 - Had a grounded theory meeting with fellow trainees doing GT at university last week. Found it very useful to hear others having similar ideas, difficulties and successes and also boosted my confidence and enthusiasm again as I understood all of what others were saying about GT. I was also in a position to recommend books and consider the different approaches between authors such as Charmaz, Straus and Corbin and Glaser.

Had a discussion with a CP from placement yesterday about my project. She was very interested in it and said she would be happy to participate.

Coding Sam. Reflecting on power again. NICE is very powerful. Important for us to acknowledge this, consider the use of this power, is it good, bad, being done appropriately?

Thoughts – Sam is saying if RCT showed CBT to be helpful, even if it doesn't fit her client group, she can take the underlying principles of CBT, make adaptations and this would be the best approach to take with her clients. This could be challenged by somebody else who would say that your client group is completely different to the RCT, the evidence no longer applies, you'd be better off doing a different modality.

Next study day, need to spend considerable time playing with categories etc rather than starting fresh coding.

25.07.2013 - After coding the 6th session I feel in a position to start putting the codes into a tentative framework of initial categories. Up until now I have been grouping codes into categories that are absent of value judgements, just grouping like with like. Now I am attempting to begin the process of making a story from the data, moving codes into categories with values such as criticisms and benefits etc.

25.07.2013 – Thoughts: Ways to manage the system – acceptance of financial climate. Put medical model within the lacks scientific credibility category? Whether it is experienced as limiting or not is key. End with 2 groups? Those who are comfortable / pleased with NICE, accept the limitations. + those who feel restricted by NICE and not happy with the limitations?

Maybe the end of the model needs to be something about what conclusions are drawn. Are NICE guidelines ok to CPs? We all see the limitations and the benefits, what factors are important in the variation on conclusions? What are the worries for the future?

Thinking of this quote by Kim: "I wonder if that's where psychologists, you know, coming back to your earlier question about, you know, psychologists that are totally against NICE is that because they fear there is a real loss of what a clinical psychologist can offer?" I need to ask more participants about this in future interviews.

Feeling that it is important to work within the dominant model – not wanting to be seen as polarised! Makes me think back to Naomi feeling like an outsider. Plus Sam – saying that it is understandable working within the dominant model. ACT therapy? Bringing in that acceptance? Of it might not be ideal, but it is ok, need to work with it. Can be more successful than fighting against it?

Need something in the final model re: because of NICE guidelines we feel a need to use language of x therapy for y diagnosis. Go along with that on surface but do more integrative work secretly. But then if not advertising this, how do commissioners and managers know to use CPs rather than CBT therapists?

"But maybe we should be better at explaining what clinical psychologists do, coming back to the sense of how do we evidence what we do?" (Kim) -is this the final question from this research? NICE highlights how CPs aren't good at evidencing what we do?

Most interesting questions so far – how do CPs explain what they do? Does this fit with NICE? Is integrative practice ok? do CPs do CBT in same way as CBT therapists?

4.08.2013 - It might be tricky highlighting what is a benefit and what is a concern. E.g. NICE endorsing psychological therapies seems like a benefit but if the therapy is only CBT, then this endorsement is not viewed as a benefit by all.

Common themes – wanting to see NICE as guideline and not prescriptive as got concerns over NICE. Worried that it may become more prescriptive in the future. Some are happy with current situation, some are not. Why are those happy? Work secretly, able to hide. Or NICE supports their model. Or consider NICE appropriate in current climate. Or haven't felt NICE as personally restrictive. Why are some not happy? Models they value are not included. Have felt pressure.

CPs want them to be seen as guideline rather than prescriptive (they see benefits and concerns)–. (is this my overarching core category?)

Ok with the current situation

Not found NICE to be restrictive. NICE supports their model. Lack of evidence in own field. Current situation justifies the situation (lack of finances etc)

Not happy with the current situation

Worried re threat to prof id. Model they value not included in NICE. Experience restriction from managers / patients / colleagues.

10.09.2013 - Had a lecture from LGBT specialist psychologist. He noted that CBT did not work. Said it might do if it paid attention to attachment. This made me think back to the competition between modalities. Would he have said this if NICE guidelines weren't promoting CBT and clinicians feeling pressure to follow this? Or was his comment linked with jealousy / rebellion etc. Trying to criticise the more successful sibling?

Also thinking back to Forensic LD placement where an interesting GT study theorised that there were 4 types of sex offender. Could my project theorise about different ways of dealing with NICE? Eg – i) ignore completely (& be proud of this? Or hide?), ii) follow 100%, iii) follow creatively considering it to be in the spirit of CBT, iv) follow creatively and hide this and pretend one is doing CBT?

17.09.2013 - Thinking back to bracketing interview with Anne Cooke. I think I do have a desire / need to follow rules. There have been changes to the campus at Salomons, with a new company taking over. I feel uncomfortable sitting in the new café if I have not bought anything, as it seems “against the rules”. I don't like parking in the local residential streets as it seems unfair on the residents and “against the rules”. I'm wondering if this is what led me to this interest in NICE guidelines, a desire to have rules to follow and wanting to understand why others don't follow the rules.

28.09.2013 –Drawing out some tentative diagrams attempting to link tentative categories. Reflecting on what is missed out? Fears re profession id of CP? Cover this in chapter re limitations? Fear re integrative practice? Cover in chapter re limitations? Fear re competition between modalities? Cover in chapter re limitations? Ignoring nice +/- or saying your doing CBT when not.

Emerging stories that I want to tell –

- i) NICE has benefits and limitations. Need to be a guide, not prescriptive, so limitations can be managed.
- ii) NICE has a lot of power, needs to be used responsibly.
- iii) Integrative practice of CPs is challenged. This is still being done by many but kept a secret. If this is kept a secret then people wont know it is effective, then integrative practice will become more challenged.

These are stories that I have got from the data, but I am struggling to work out how to categorise and show this. Maybe book apt to meet a supervisor? (I have emailed to ask for meeting). Two separate

diagrams? One for “beliefs about” and the other for “use of”? First one detailing how they come to the conclusion that nice should be guidelines and not prescriptive. Use of diagram showing secretive use, being flexible, etc etc? Ask Amanda – is it that I am thinking too broadly? Need to narrow down my question?

10.10.2013 - Starting to think that the key story (/ core categories) is that NICE is experienced as very powerful and there is a conflict between this and wanting to have a flexible relationship with the guidelines. This can be expanded to highlight that NICE being powerful can be in CPs interests, e.g. when it endorses psychological therapy, but it can also be damaging, e.g. when it only tends to endorse manualistic CBT. Discussions could be held about whether NICE deserves to be so powerful and how this power is handled. Are the guidelines in danger of becoming prescriptions? How CPs currently use the guidelines can be demonstrated, showing that it is not just a case of CPs liking or disliking NICE or not knowing about the guidelines, the interplay is much more complex. Within all of this, sub stories emerge, such as how valid are the guidelines? Particularly bringing in challenges to diagnostic categories and the research that is then built on these categories. Then how transferable are the findings to routine practice. Also, CBT fits better with NICE than other approaches. Another sub story is CPs feeling that their professional identity and jobs are threatened. A story within this is about how integrative practice doesn't seem to fit with NICE. Suggest an RCT where clients are randomised to manualised CBT or integrative, formulation driven approach?

Beginning to think that these sub stories need drawing together better. How do they all connect?

Interesting quote from the participant perhaps most in favour of NICE – “in the absence of a better way of doing it, it's probably, it's probably the least worst, is to follow the NICE guidelines.” Hardly a huge endorsement!

This project has helped me to start developing my own views on NICE. I'm thinking that I would like to do extra training in CBT (picking this stream for 3rd year options) and have CBT as my base, I will then use underlying principles of CBT, rather than manualistic, I will also think in a variety of models and translate into CBT. This feels like it is having a flexible relationship with NICE, whilst being on the “right” side of the power of NICE (i.e. siding with the power rather than trying to fight it). While I am starting to take this position, I will also keep all the criticisms of NICE in mind and attempt to maintain that flexible relationship with the guidelines, not taking them as prescriptions, and fighting this case with others, that they need to be viewed flexibly.

Questions for future interviews – more info re the benefits of NICE? + how the CPs utilise NICE.

Note to self - Feeling that NICE attempts to make something complicated neat is a huge category within having concerns about NICE. Bring in safe uncertainty theory? Drive for certainty when we can't ever achieve certainty? The drive for safe certainty could be leading us into unsafe certainty? No NICE guidelines is unsafe uncertainty. A flexible relationship with NICE = safe uncertainty?

Coding Kim's interview – strong sense of concern re conveyor belt / mechanistic approach, losing touch with clinical judgement. This has come up for others too. Is this represented well enough in my emerging model? Thoughts for future interviews – themes from previous interviews – NICE have pros and cons. Big pressure to follow NICE, increasing in the future. CPs want NICE to be seen as guideline and not prescription. Want individual approach, not conveyor belt. How does this fit for you? Agree? Disagree? Are there ever times when you want to do something different to what NICE seems to be suggesting? How do you manage when you want to do something different to what NICE suggests? Or do you always follow it?

12.10.2013 - Theoretical coding. Re-read Cathy Urquhart chapter on theoretical coding. Reminded me of the value of diagrams to link categories together.

Coding kim's transcript. Thinking more about the discourse of evidence based practice. Should this be a more dominant category than I have it currently? The concern and dispute re the threat to integrative practice appears to fit within the topic of challenging the discourse of evidence based practice. Which in itself fits within nice trying to make something complicated neat.

Kim talked about the importance of working within NICE so that we can be heard, not fighting against it. This fits with my thoughts on NICE being powerful, work from CBT framework and integrate other models in. how to code this and ask further questions of further participants?

Is it about having two categories within how NICE is used. Working with NICE and working against it? Have a third category to represent valuing excuses not to use NICE? / not feeling NICE to be personally restricting yet?

13.10.2013 – Reading Lucy Johnstone's book on formulation, noticed a quote by Kinderman (2001) noting that CP is based on formulation. This is making me think of the importance of a category about professional identity of CPs. Formulation doesn't seem to fit with NICE. Plus there has been lots of recent info re dsm5 and calls for formulation led practice rather than diagnosis. It feels like a very timely project.

I've been spending a lot of time drawing diagrams trying to link codes and categories. I keep coming up with very complex diagrams. I feel they need to be simpler to be more effective. Out of all the GT papers I have read so far, the most effective ones have the most simple models. I seem to remember Paul Camic mentioning this in the coding workshop too.

17.10.2013 – emergence of “contemplating professional id of CP” as central category? I merged “valuing the skills of CP”, “feeling that the professional id of CP is threatened” and “arguing that the professional id of CP is not threatened” into one category “contemplating the professional id of CP”. I then attempted to see where this category would fit on the initial diagrams that I had been drafting. I was quite surprised to see that this category seemed to link with all of the other categories and therefore needed to go in the centre of the diagrams. I felt uncomfortable putting it in the centre. I'm not sure why I felt uncomfortable with this, I think my reservation came from wondering whether this should be the key point that people see when they look at the diagram. I then went back to NVIVO and refreshed myself with the content of the categories and it reminded me that the topic of “contemplating the professional id of CP” was indeed a central theme in most of the interviews and generated a large proportion of the total codes of the project.

I set up a GT discussion thread on Facebook to run ideas past each other. Got some really helpful feedback on a query I had regarding naming of some categories. I was considering merging the benefits and concerns into one category and was thinking of names for the category. Discussing this with my colleagues made me realise the categories seemed more powerful (and more simplistic in a model) if they were kept separate and had simple labels rather than trying to find a complicated way of describing them.

18.10.2013 - I was going through the data in NVIVO today and realised that my category of feeling an underlying pressure to follow NICE should not have been a category, rather it is a sub category of a new category “viewing NICE as guidelines vs feeling pressure to be compliant” (unsure if this category name will remain the same). I realised that not all CPs had found NICE to be restrictive and felt the pressure. Many had felt the pressure and most CPs worried about the pressure in the future or the possibility of the pressure. It therefore felt important to have all of these views represented. This also fitted with a previous worry about having “feeling an underlying pressure to follow NICE” and

“wanting NICE to be guidelines and not prescription” as stand alone categories without any sub categories. Now they are both sub categories of the same category. The overall explanatory diagram doesn't feel quite as powerful but it is more representative.

18.10.2013 - Thoughts prior to interview with Catherine: Start with the generic question about views on NICE. See where it takes us. I have a knowledge in my head of the things the other participants have said and my thoughts on these, so even if I don't mean to, I am likely to steer prompts / questions with this knowledge in mind. Then at some point, highlight the themes from previous interviews – NICE have pros and cons. Big pressure (for some) to follow NICE, increasing in the future. CPs want NICE to be seen as guideline and not prescription. Want individual approach, not conveyor belt. How does this fit for you? Agree? Disagree? Anything important missing?

Then - Are there ever times when you want to do something different to what NICE seems to be suggesting? How do you manage when you want to do something different to what NICE suggests? Or do you always follow it?

Questions around the power of NICE? Is the power justified? Are there any worries about the power? Good elements, bad elements. What could / should be done about it? (previous participants mentioned about more reflection / responsibility from NICE.)

Definitely need focus to be more on how CPs manage seeing NICE as good and bad. Follow NICE? Follow creatively? If follow creatively, do they advertise this? Do they ignore NICE?

26.10.2013 – It was helpful talking to Anne yesterday. I feel that I have become so immersed in the data, it was getting hard to “see the wood for the trees”. Talking through my thoughts on the emerging grounded theory was really helpful as Anne was able to see things from a fresh perspective and was able to highlight the key ideas. She also highlighted the importance of making sure that the project fulfilled the requirements of the course. She acknowledged that the emerging grounded theory was of interest to the profession of clinical psychology but for the requirements of the course, I needed to ensure that there was a psychological underpinning to the theory.

I had previously acknowledged that the bulk of my data comes within the question “what are CPs beliefs about NICE?” Talking to Anne highlighted that it would be helpful for me to unpack this area, explaining what the underlying beliefs of CPs are. This would be the major emphasis of the project (in keeping with the fact that the majority of the data is on this), then leading into “how guidelines are utilised” (with the beliefs in mind), almost as a conclusion. The psychological theory is then likely to come in when discussing the CPs beliefs. For example, the NICE guidelines appear to be based on the premise of diagnosis, then a manualised treatment plan. The CPs all seemed to challenge this, suggesting that CPs have a different way of conceptualising psychological distress and approaches to intervention. This could bring in theory such as Bentall and Boyle. It also links in with the MAS report (1989) where Derek Mowbray highlighted 3 levels of psychological thinking, noting that single model therapists were at level 2, CPs at level 3. It may be that NICE focuses on level 2 and ignores level 3. This GT highlights that some CPs still feel able to work at level 3, but many are feeling pressured into moving to level 2 and others are worried that the future is moving towards a level 2 way of thinking.

Plus, Anne has made me realise that I don't need to keep on conducting more and more interviews. I think I was aiming for 12 interviews, as I had read a quote that 12 was good for a qualitative study. Talking to Anne reminded me that I don't need to aim for an arbitrary number, I need to collect what

works for my data (within reason). I have conducted 9 interviews and have 2 more booked in. The way things are going, it might be the case that I can stop interviewing after these 11 interviews.

1.11.2013 - Section A - I have deliberately focused more on section B up to this point. I have considered a plan for section A but haven't looked into the literature in any great depth. I have done this due to GT methodology of attempting not to let a literature review affect the construction of the grounded theory. I acknowledge that I cannot be an empty slate, as I have existing knowledge but I felt that completing section A would likely influence my construction of GT. Now that I have interviewed 8 participants and completed an initial analysis, I feel ready to work on section A and feel that it should not detrimentally affect my thinking and analysis of section b now.

1.11.2013 - Looking through the MRP guidelines, I'm having thoughts around the difficult fit between GT and course requirements. In GT methodology it is not a case of doing a thorough literature review and finding some theories/ideas to test, but this seems to be how the MRP guidelines are set up. I was quite comfortable with my approach of having an idea – why aren't NICE guidelines for psychosis implemented, then thinking this through with supervisors, doing some brief reading around, coming up with the idea of having a broad focus of questioning whether NICE should or should not be followed and investigating what CPs in routine practice think and what they are doing. I then focused on section b, not wanting to do a thorough literature review first, as it may impact upon my thinking and GT theory development. I then have come back to do section A. I feel that this can be done, but it just feels a bit clumsy and not linear in the way that a quantitative project would be and the way that the MRP guidelines seem to be set up.

1.11.2013 - Discovery of Hemsley's paper. I was shocked when I discovered Hemsley's (2013) article re thematic analysis of counselling psychologists relationship with NICE. I was worried that this would make my project surplus to requirements. Reading the paper changed this view. I wonder if I am being especially critical as I feel threatened by the paper, but I found it easy to criticise. The introduction seemed confusing to me, it didn't neatly introduce why the project was being done. The reflexivity that is vital to qualitative projects is missing. We have no indication of the questions that she asked participants. It seems to come from an assumption that NICE is bad. Did she start with the idea of pluralism in her head already? Were clients asked about this? Or did this emerge? Was the focus purely on counselling psychologists view of NICE and the threat to professional identity? Or did this emerge? Looking at the examples Hemsley provided of quotes and how she interpreted these was revealing, for example:

“You have the kind of intellectual tools and knowledge to reassure yourself and hopefully convince others that this is really rather poor, low grade understanding of what constitutes good evidence, valid evidence. It's not doctoral level understanding as I said. Any psychology student of an undergraduate course would have that kind of understanding of what constitutes evidence.” (Peter)

This was deemed to be “counselling psychology is not seen to resist NICE guidelines but wanting to meet it at the ‘table’”. This seems like resistance to me. If Peter is meeting NICE anywhere it is on the battle field (or the playground, with belittling statements) rather than at the negotiation table.

She also uses participants from NHS and private practice. I would assume they would be different populations with different interests and pressures etc. The paper is focused purely on the professional identity of counselling psychologists in relation to NICE. I hope that mine will have a broader focus. The professional id of CPs will feature heavily in mine, but mine is also highlighting strengths and weaknesses of NICE and highlighting the need for them to be seen as guidelines and not instructions.

Hopefully this will be helpful for other professionals and not just CPs. Highlighting the challenge to the medical model way of thinking (rather than assuming it as Hemsley did) may also be helpful.

Helpful elements to arise from Hemsley's paper is that experiencing nice as powerful was a key theme. Benefits and concerns of NICE were highlighted. NICE was also deemed as being containing. This appears to fit within my idea of NICE being a drive for safe certainty. It was also highlighted how CBT can be done in different ways as well as people being secretive and saying they do CBT when they don't.

4.11.2013 - After spending a couple of days on section A, I am pleased that I made the decision to hold off on section A until I had done the bulk of my analyses on section B. Lots of the information that I am finding for section A, is supporting my analyses of section B. This is great for triangulation (if this is the right word? Which I'm not sure it is according to a social constructivist approach) but if I had known this in advance then I would have been wary that I was simply putting my ideas on the data rather than trying to draw the information from the data.

Thoughts re separating theory between section A and section B. Section b, reflecting on why NICE would want to make something complicated appear simple: safe uncertainty, defence mechanism of breaking work down into categories and tasks to defend against having to think about individuals and human suffering. Plus Moncrief, psychiatrists got power from categorisation, do CPs want as well? Link in with CPs contemplating professional id / the benefit of nice endorsing psychological interventions.

20.11.2013 – Completed 11th interview today. As recommended by grounded theory authors such as Morse (2007) the questions that I have put to participants in latter interviews have been based on analyses to date. This helps with constant comparison, looking for similarities and differences between participants. Doing this helps test the validity of codes, categories and emerging theory. Working through this process with the 11th participant seemed to support the validity of my analyses to date. We had some really interesting discussions but it felt like I had reached a stage where the participant wasn't saying anything that surprised me or questioned the validity of my analyses that I had completed so far. Once I noticed this, as information came up that fitted with my categories and emerging theory, I ran my categories and emerging theory past the participant. I was pleased to hear that the participant seemed in agreement with all of my categories and linkages. Furthermore, the participant seemed really interested in my analyses. Due to the analyses completed to date, I had anticipated that this might be my last interview. After how things went today, I feel even more sure that I probably won't need to do any more interviews, as I feel that I may have achieved "theoretical sufficiency" (Dey, 1999). I will only be in a position to make a formal decision on this once I have fully completed the analyses (and run it past supervisors and the GT group etc.)

13.12.2013 - Looking through Sophie's interview again, thinking about what she said about NICE being comforting. Is this an overarching category of many of the benefits of NICE? One of the simplified main findings of project is that if clinicians are not pressurised into using NICE, they treat NICE as guidelines, drawing on them as one justification for an intervention (not the only justification). If they are pressurised, they act secretly? An interesting observation is that one participant (Ronda) provides quotes for worrying about prof id and saying prof id is not at risk. This suggests that the codes and categories represent a range of views within participants as well as between.

15.12.2013 - Next steps. I have completed the interviews and coding. I am re-reading Charmaz, Straus and Corbin and Urqhalt, focusing specifically on construction of theory and write up. My next step will be to revisit my coding and categories and to revisit the emerging categories and hypothesised links between these. I envisage that now I have more data (and a refresher of GT theory) I will need (/want) to make some changes to the categories and how these all link together.

15.12.2013 – Have come up with a diagram that I like. It looks very simple to me. I wonder if this is just because I am so familiar with the data? I want the model to come across as simple and straight forward to follow, but not so much that it doesn't reflect the amount of work that has led to its creation. I read a fantastic (and humorous!) paper recently by Oxman, Fretheim and Flottorp (2005) called the "OFF theory". They make some "tongue in cheek" critiques of the use of psychological theory in guideline implementation research. They note that it usually just makes things more complicated.

15.12.2013 – I have been reading the MRPs of previous trainees recently to gain knowledge of structure and style etc. Reading the acknowledgements of other trainees has made me start to think about who I will acknowledge. There are some obvious ones, who will definitely go in. A thought popped into my head about acknowledging Glaser and Straus for "discovering" GT and then to Charmaz for putting a social constructivist spin on it. I'm not sure I will put them in, but the fact that the thought came into my head made me realise that I do really like the GT method. Glaser & Straus described it as a drugless trip. I'm not sure I would go that far, but I certainly am finding it enjoyable.

19.12.2013 - I have been reading a lot of theory today, particularly focusing on power and sociological theory, i.e. Weberian and Marxism views on professions. I am concerned that 8,000 words will not be enough to fully do justice to the project.

20.12.2013 - Wondering about my "reflecting on the current financial climate" category. I like this for the model, it gives context. However it is a shallow category, if anything it is just a focused code. This feels ok, in terms of Charmaz's flexible approach but I'm not sure how to represent this in my tables of codes etc in the appendix.

20.12.2013 - Reviewing my notes and research diary, reflecting on the timing of the literature search for section A and my current reading around theory to help with theoretical integration of section B. I think this has come at a good time. I am reading Charmaz and Urqhalt who stress the importance of "upscaling" grounded theory so that it has theoretical integration within the literature. If I had done my literature searches in more detail earlier, I think it might have influenced my analysis. Doing it at this stage means that I have the bulk of the analysis carried out but can draw on the literature to help put the finishing touches to the analyses and ensure the best theoretical integration possible.

Reading a paper by economists, about decision making theory ("The Evolutionary Economics of Decision Making") and thinking that decision making appears to be an area that crosses discipline boundaries (especially after having read sociological theory yesterday). I am concerned as to how examiners may interpret this and whether the project is psychological theory or sociological or economic etc. To me, decision making is a psychological process that is influenced by other areas such as sociological and economic issues. Reading the Kenrick et al. (2009) paper adds weight to this as while they are discussing "economic theories" they use the word "psychological" numerous times. This is also making me wonder whether I need (or could benefit from) more theory regarding decision making in my section A. Although the more I read about economic decision making theories, the more I doubt that these are actually of any relevance to this project, e.g. theories such as Diminishing

Marginal Utility or Risk Aversion versus Risk Seeking do not appear relevant to CPs use of NICE guidelines. Or do they? Could it be that the creators of NICE guidelines see non NICE evidenced therapies as diminishing marginal utility, i.e. that the potential extra benefits from an experimental non evidenced based therapy are not deemed as significant as the initial gain a patient would get from a NICE backed therapy such as CBT. Linked with this, risk aversion versus risk seeking fits with this, that it is safer to be risk averse and go for the evidence base than it is to go for a therapy that it is difficult to research, even if that therapy could be more effective.

I'm thinking again about upscaling theory, when I first read Urquhart's thoughts on this I wasn't overly impressed, I considered it more important to keep the theory grounded in the data rather than trying to make it more abstract and generalisable. I then thought about my emerging theory, it could be that when making decisions, professionals consider the pros, the cons, the impact on their professional identity (and job security) and the pressure that they are under when deciding upon their decision. Furthermore, in turn their decision and how they act impacts upon their professional identity (and job security) which impacts upon future decision making. This feels simplistic, but does seem to offer more explanatory power than other theories of decision making that simply state "beliefs" are important (alongside subjective norms and perceived behaviour control, theory of planned behaviour), or people attempt to maximise their expected satisfaction (expected utility theory).

This is making me think that my study's outcomes are two fold, firstly it presents a general theory on professionals decision making and secondly, it populates this theory with data regarding CPs beliefs about and use of NICE guidelines, with particular focus on how CPs experiencing NICE as a powerful force and the pros and cons of this, with particular concerns around believing that NICE makes something complicated neat.

30.12.2013 – Reading more theory, particularly like Aronson's ideas re cognitive dissonance in decision making. However, I know that I'm not going to have room to explore all of these ideas that I am reading about.

27.01.2014 - I'm very aware as I am writing up this project that I could easily write a book on this rather than just 16,000 words. It is frustrating that I am having to leave out lots of interesting information. I do however see the value of attempting to convey the findings in a succinct way, to make them more accessible to a wider range of people (and probably more interesting, I might be the only person interested in reading a book about the use of NICE guidelines!). In keeping with this, I'm aware that I can only tell part of the whole picture of the results if I am to stay within word count. This is highlighting the need for transparency and reflexivity in documenting what led to the final write up.

27.01.2014 – I have written 2,000 words for my methodology. Checking other MRPs using GT and course guidelines I realise that I am going to have to chop the method in half to about 1,000 words. I feel quite upset about this as I enjoyed writing the section and have utilised a lot of GT theory and references. It made me realise how much I have learned about GT. I have saved the 2,000 word version and will use this for prep for my VIVA and will probably revisit it in the future if I need to refresh myself of GT methodology.

27.01.2014 – I wrote a paragraph suggesting that NICE may be a defence mechanism. I really like this idea, however it doesn't really fit with the rest of the write up. Plus it doesn't really follow the data, it is more my thoughts. I am therefore regrettably deleting this. I thought I would include the paragraph here as it adds insight into my (emerging and changing) views on NICE.

“NICE as a defence mechanism. Another hypothesis regarding why the creators and supporters of NICE advocate making something complex appear neat, is that this is a defence mechanism (Freud, 1894). Jaques (1953) proposed that organisations employ defence mechanisms to help defend against the anxiety generated by their work. This idea has been utilised in healthcare, perhaps most notably by Menzies (1960) who analysed the ways in which nurses contained the difficult feelings generated by caring for seriously ill patients. Amongst other observations, Menzies proposed that the nurses attempted to deny the individuality of the patients by treating them by category of illness and avoid emotional contact through structured, task focused contact. This could suggest that making something complex appear simple, through the use of NICE guidelines, helps professionals defend against the pain of fully appreciating the individual nature of psychological distress. This may help staff to see a barrier between “sane” staff and “insane” patients (Hyde & Thomas, 2002), rather than interpreting psychological distress as human reactions to life situations.”

10.02.2014 – I am checking through my initial drafts of section A and B and am thinking back to the difficult fit between course requirements and grounded theory methodology. In section A I suggest it might be helpful for future research to test Cabana’s conceptual model. In my section B discussion I link the results of my project to Cabana’s model. This looks as if I was using grounded theory to test a model. This approach is not within grounded theory protocol (and would be heavily criticised by grounded theorists). What actually happened is that I completed the research, then visited the literature (in line with grounded theory methodology) and wrote about Cabana in the section B discussion. I then wrote section A and Cabana’s research was a significant part of the section. As it influenced a lot of the structure of the section, I needed to fully explore the future research implications. This then leads to the uncomfortable situation, caused by course requirements, where readers will see section A before seeing section B. I hope that readers of my project will read the research diary and appreciate that I did follow grounded theory methodology (by doing the research before exploring the literature) and have not attempted to test theory using grounded theory.

03.03.2014 – Anne has given me feedback on my first draft of section B. She has given positive feedback but has also given a lot of constructive criticism. My first response was to get defensive of my work. I felt that I could challenge lots of her criticisms. However, the more I think about her feedback, the more I am able to take from it. One key piece of feedback is that my label of “NICE attempting to make something complicated appear neat” does not accurately represent the views of the participants. While this was the language used by one of the participants, it does not convey the context. For example there is nothing wrong with making something complex appear neat, it seems helpful. Whereas the CPs were saying that it was an unhelpful, false illusion. I have thought through what to change the label to and have discussed this on the online forum with the grounded theory discussion group. I have come up with “Worrying that NICE can create an unhelpful illusion of neatness”.

04.03.2014 – Received feedback from Amanda on my section b. She said that she didn’t feel that she should give feedback on the results and discussion section as she did not want to impose her views on my work. I see her point of view but am a little disappointed with this. I suppose that she must think the project is along the right lines or she would have highlighted that she thought it needed changing (even if she didn’t give specific feedback). I have emailed her back to see if I can get some overall feedback even if she does not wish to give specific feedback.

07.03.2014 – Met with Anne to discuss her feedback and suggestions for changes to section B. This felt like a helpful meeting. I have come to the conclusion that I need to change my overall theme and headings of most of the categories. I feel sad to lose the overall theme of “experiencing NICE as a

powerful force” but I think that the changes improve the model. Having a new overall theme of “mixed views as to whether NICE guidelines are compatible with the way that CPs conceptualise distress” is much neater and tells a more coherent story. I was struggling to tell the take home messages with the old model. With the new model and new overall theme it seems much clearer. To be honest I probably should have always had this new theme as my overall theme. I reflected in this research diary earlier about how central CPs reflecting about their professional identity seemed to be in the model. The changes to the category labelling helps make the take home messages clearer also. Changing “having concerns about nice” to “worrying that NICE can create an unhelpful illusion of neatness” is much more powerful. I was keen for my model to be simple but I think I went too far with the original model. The new labelling of categories still feels simple but seems more interesting! This label in particular is also actually more in keeping with the data. With the original labelling, I was struggling to work out how the sub categories all fitted. Putting “worrying that NICE can create an unhelpful illusion of neatness” as the overall category label makes it much clearer what the sub categories are and how they link to each other.

I get the impression that Anne would prefer my model to look something like a previous trainee’s GT model who looked at CPs beliefs about the power of compulsion (Parsloe, 2012). I can see her point, as there are similarities. However, I think the framework of my model needs to be different. One of the key ideas that kept coming up for me is that all CPs see the benefits and the concerns of NICE but they make different conclusions. My model helps explain how they get to these conclusions and what they do with these beliefs. I really like the model by Parsloe (2012) but I think my model is necessarily different. Furthermore I feel that my model is more of a “theory” in that it explains processes rather than just describing two positions that CPs take towards something (beliefs about compulsion in Parsloe’s case).

21.03.2014 – I had been having second thoughts about the change of overall theme, so spoke with Anne again. We discussed how while the new theme fitted well, it is very specific to clinical psychologists. While this may be a good thing, it may also mean that important take home messages from the project are missed by other professions (if they ignore the project, thinking it is only relevant to clinical psychologists). Anne highlighted that the project seemed to be distinguishing between validity and utility, as all of the participants criticised the validity of NICE guidelines but there were mixed views regarding utility. I really liked this idea when speaking with Anne but when I got back to looking at the data and trying to redraft the model and the write up, it just didn’t seem to fit. It felt like I was trying to “force” the data as Glaser would say. I had a tough day struggling with this but then later in the day I revisited the transcripts and focused codes (rather than staring blankly at the overall model as I had been doing for many hours) and I re-discovered the fact that most participants had expressed mixed views towards NICE. I thought about having this as an overall theme. This fits the data and is more of a general take home message. However, it felt too general, what does “mixed views” mean? I then thought it would be more interesting (and closer to the data) to use an actual quote from one of the participants. I decided to go with “Considering NICE guidelines to have benefits but to be fraught with dangers”. I think each of my participants will look at this theme and agree that it sums up the conversations that we had. It gives a clear message about what the model (and rest of the write up) is going to be about. It also feels quite powerful.

21.03.2014 – New insight? I have been re-reading Charmaz’s (2006) guidelines on judging a GT study. She emphasised that an effective study will have clear take home messages that offer new insight. I was wondering if my project does this. I think the study does have many important new insights, particularly the fact that CPs are utilising level 3 skills in routine practice, but tend to

practice in ways that means that these are not recognised. It also has important theoretical messages for researchers interested in guideline implementation research. I discussed this with Anne, I argued that the results of my study (particularly categorising the benefits and concerns about NICE) may not come as a huge surprise to her, or to me now, but they will surprise others. I argued that there are many clinicians, managers and researchers banging their heads against the wall in frustration, confused as to why people do not follow NICE guidelines. I also made the point that it is important to try to remember what I did not used to know. The results of my study feel obvious to me now, whereas 3 years ago they would have come as a revelation. I started this project to find out more about the pros and cons of NICE guidelines and how they are utilised as I was unclear on this. For example I used to get confused as to why people would ignore the guidelines. This project has given answers to these questions that I had.

Appendix M: Pre Interview Questionnaire Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Salomons Campus

PRE INTERVIEW QUESTIONNAIRE

Study: Clinical Psychologists’ beliefs about, and use of NICE Guidelines.

Researcher: Mr Alex Court, clinical psychologist in training, Canterbury Christ Church University.

The information from this questionnaire is intended to assist in theoretical sampling, to attempt to ensure that the participants included in the study come from varying backgrounds, with a variety of opinions about NICE guidelines.

Please could you read through and complete the following background information questions:

Name.....

Address of place of work

.....

Specialism that you are currently working in (e.g. CAMHS, Adult mental health, Addictions etc)

Other areas that you have specialised in during your years of qualified practice

.....

.....

Which year did you qualify as a clinical psychologist?

Current NHS banding

Country that you completed your clinical psychology training in

.....

What would you describe as being your preferred theoretical modality / modalities? (e.g. CBT, Psychodynamic, Systemic, Integrative, etc)

.....

.....

Have you ever been involved in NICE guideline production? (If so please state how)

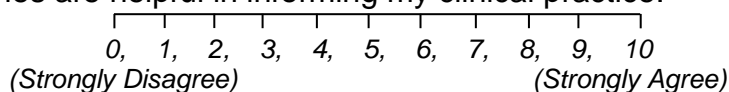
.....

Have you ever published a view on NICE guidelines? (If so please state where this was published and when)

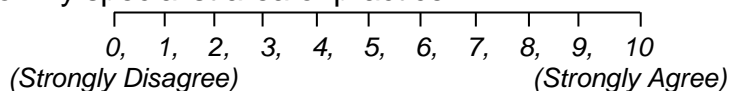
.....

Please could you read the following statements and rate your level of agreement with each, by circling a number on the scale between 0 (strongly disagree) and 10 (strongly agree):

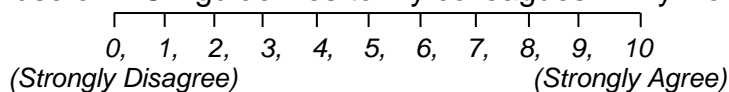
NICE guidelines are helpful in informing my clinical practice.



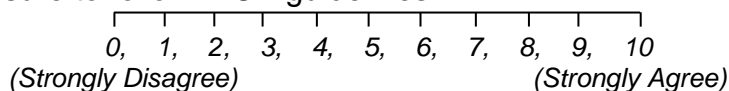
I have a thorough and up to date knowledge of all available NICE guidelines that are appropriate for my specialist area of practice.



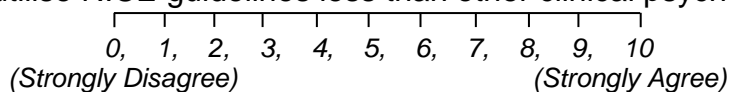
I promote the use of NICE guidelines to my colleagues in my workplace.



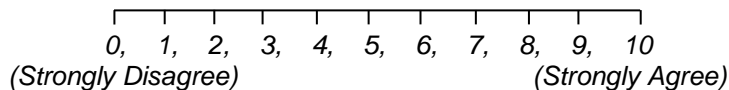
There is pressure to follow NICE guidelines.



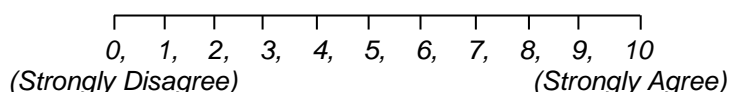
I think that I utilise NICE guidelines less than other clinical psychologists.



The medical model basis of NICE guidelines makes them difficult for clinical psychologists to utilise.



Having NICE guidelines which should be followed limits the psychological thinking of clinical psychologists, which has a detrimental effect on both formulation and intervention.



Thank you for taking the time to complete this questionnaire.

Appendix N: Interview Question Examples from Latter Interviews

The following examples demonstrate the interviewer drawing on ideas from previous interviews and analyses and using these to formulate questions. This helped with constant comparison of the participants and their views, helping to check the validity of emerging categories and their properties.

Example 1

Alex: It's reminded me of a conversation I had with another psychologist who – *he/she*²² said that *his/her* opinion of the NICE guidelines was that when they came in, or in fact rather before they came in, *he/she* said that most psychologists would say that they worked eclectically or integratively and worked in collaboration with the client, and then after NICE guidelines came in, the therapies as well as the diagnosis started being categorised and started being prescriptive and it started being a bit less ok to say that you're working integratively.

Sam: I think that's true...

Example 2

Alex: I suppose, there's one person who I have met who probably came the closest to those views, and *she/he* was saying that *she/he* could 100% see all the limitations with NICE guidelines, but *she/he* also valued the benefits of them, that it is good to stick with evidence-based practice if you've got a limited amount of money or if you've got long waiting lists, it's good to stick with what we know works rather than trying out something else which may well be really good, but if there's not the evidence for it, then it's the taxpayers paying for it. We should go for what the evidence is for.

²² Gender anonymised on transcript to help protect confidentiality

Sophie: I see that point, but I think it fundamentally misses the point about how that evidence base is gathered and I think the limitations of the gathering of that evidence base, not just for medical interventions but also psychological interventions, you just can't miss the point that actually...

Example 3

Ronda: Which you see a lot in current job adverts where they're looking for psychologists to work in long term needs services and deliver short term interventions for complex problems, which for me is a sort of very concerning contradiction.

Alex: Yeah. And I think that seems to be – it's making me think of lots of the different things people have been saying, seem to come under a category, for me, of that NICE guidelines is trying to make something really complicated, nice and neat.

Ronda: Yep.

Alex: And lots of people are saying things around that. And I was wondering, why do you think the people who create NICE guidelines are trying to make something complicated and neat? Is there a valid reason for trying to do that, or is it just a misunderstanding or/

Ronda: (interrupting) Well (deep inhalation), I mean, I think it's because, it's lots of different reasons. Erm, I think sometimes, I mean I think, you know...

Example 4

Alex: ... I think it is something that some of the psychologists I've spoken to have been worried about it, it being limiting, and so particularly as you've kind of guessed really, some of the people are perhaps a bit more integrative and eclectic were quite worried by the CBT dominance really of the guidelines.

Sam: Yes. But I think also there's widespread acknowledgement that the reasons that CBT dominates in psychological approaches throughout the NICE guidelines is because there's been a number of prominent people who've done a lot of research in the last 20 years/

Alex: Yeah.

Sam: And it's not that CBT's necessarily more effective, it's just that people have gone out and done the research and that to some extent CBT lends itself to the kind of research that NICE guidelines likes. And I think you could say, well if you were a NICE guidelines proponent you could easily come back and say 'well, you know, do your research' and give that message back to other models. And I don't think that's a bad thing.

Example 5

Jan: ... the NHS is stressed out of it's mind at this point, who's got time for an evidence base?

Alex: Yeah. And I think that's something that one of the psychologists who I've spoken to before, and *he/she* was quite in favour of CBT, and *she/he* said that *he/she* could see the benefit from lots of different approaches, but *she/he* said with the NHS being in the situation

it's in at the moment we've got the evidence base for CBT, we can see that that works, so *she's/he's* quite happy to go along with that.

Jan: That's what's happening, but I think it's extremely dangerous. Because the evidence base is exactly that, it's for single presentations. It is not for complex presentations we're getting in CAMHS. And the truth is that the threshold for CAMHS is so high now that actually the clients we're getting are not CBT eligible clients. So it's a bit of a – that is a complete contradiction. IAPT services, yes that's great, but that's – and they're going to be IAPT services for CAMHS. Great, that middle band. But for a CAMHS service it is foolish to think we can do CBT only.

Example 6

Alex: I'm just thinking about another thing that has been mentioned and links in with something that has come up in other interviews, as well. It's about the absence of guidelines for your particular clientele. I'm thinking of one particular person I've spoken with, and a couple of other people were a little bit similar. They were saying that there aren't guidelines for their clientele, but their managers still expect them to do a certain type of CBT for depression because that's what the NICE guidelines say. When they say, 'Well, that's not our client group,' the managers are still saying, 'Well, it might not be your client group, but that's what the evidence says.' This one particular person I spoke to was very angry about that.

Sophie: I would be angry, too...

Example 7

Paul: Erm, but, much of it might just be about funding. CAT, I've always found it to be an effective form of therapy, I've used it many times, but Tony Ryle is just less of an effective flag-waver than Tim Beck, you know, the reach of Tim Beck in cognitive therapy has just been that much more dramatic; so it could just be about funding as well?

Alex: Yeah. That's something that some people have mentioned to me before actually in these interviews, that, sometimes the NICE erm backed therapies like CBT or family interventions for psychosis, because they've got the NICE backing, they can then attract lots more funding.

Paul: Yeah, it can become a bit of a vicious circle, you do enough research to get yourself in the NICE guidelines and then you attract more research money...

Example 8

Alex: One thing that hasn't come up in today's conversation or not directly anyway, but has come up in some other conversations I've had, is about erm, comparing clinical psychologists to other professionals, erm so, for example comparing a CBT therapist and a clinical psychologist, and thinking about the intervention, say, it's something that we touched upon a little bit today, but I wondered: is that something that you have any thoughts about? Any positives, any negatives?

Paul: It's something that's come up a lot in this team; it's an ongoing source of debate and sometimes source of great tension in it....

Example 9

Alex: Yeah, what came up in the other interviews. Yeah, I suppose that's one thing we haven't talked about today too much, I don't think, is that in some of the other interviews I've done its come up about the types of evidence that NICE look at. We touched upon that a little bit earlier, I think, but some people I've spoken to have been quite worried that NICE guidelines they don't really take account of all the evidence that's out there, they just focus on like the gold standard RCT's and things, whereas other people I've spoken to have said that they're quite happy with the way NICE does things really, that they look at all the different types of evidence and then they rank which they think is most important. And they said that they were quite happy with that approach really because they wanted to see what were the most effective types of therapy. I didn't know if you had any thoughts on that?

Example 10

Catherine: I would expect a clinical psychologist to have a degree of knowledge and understanding of research and of the basis of the guidelines to understand, back to again, the limitations of them so that they weren't thinking "oh, my manager's throwing that set of Guidelines at me, I've got to do everything it says"...

Alex: Yeah. And I'm just thinking kind of linked with that conversation, one of the things that seems to have come up in quite a few of the other interviews, I'm just wondering, it might not be quite the same for you because it seems to be that here the pressure isn't really there to follow NICE. Because something that's come up a few places where there is that pressure, is that people are a little bit worried that if their managers are wanting CBT for depression, CBT for anxiety, CBT for psychosis, then they're thinking why don't they just hire a CBT therapist rather than a psychologist/

Catherine: Yeah.

Alex: And they can get them at a lower band.

Catherine: Yeah.

Alex: And that seems to be something that quite a lot of the psychologists were quite worried about.

Catherine: Yeah. I think that's an accurate concern. It isn't something that I suppose has worried me in my role, but I know colleagues, I know friends, I know teams that have been completely kind of either downgraded in terms of their banding or, you know, whole teams of psychologists being laid off and these IAPT therapists or CBT therapists coming in.

Example 11

Alex: That's really interesting to hear though about clinical decisions perhaps not always being that great though, and perhaps it is good to have those guidelines to draw on as well. Because I think one thing I have noticed from the previous interviews I've had, near enough every psychologist I've spoken to have all seen kind of real limitations with NICE and have all been on varying levels, sometimes quite angry with NICE for the way things are going. But then I don't think there's been a single one of them that's said 'let's get rid of NICE'. I think absolutely every one of them, even the ones who are the complete kind of anti-NICE, as anti as they get, they've all still said they'd feel uncomfortable if NICE were to go. And what is that about, do you think? Is it about the fact that that clinical judgement on its own sometimes does have its limitations?

Kim: Yes. I think that's right. I think we're scientist practitioners (laughs), aren't we, so we should be interested in research, shouldn't we? So I'm kind of smiling about that because in the end, you know, there's probably, within psychology there's going to be, you know, psychologists that actually very much want to be involved in research and are very good scientists, and others that are more of practitioners. You know, and I'm sure there are some that are equally, you know, 50/50, but probably some people sit more on one side or the other...

Example 12

Alex: But is that something to do with - it's triggering a memory of some conversations I've had with other people - where there've been some debates about perhaps the purpose of the NHS, and some people have said it's just about symptom reduction and that anything more than that, particularly I think we were talking about adults with one person I was talking to, and *she/he* was saying that anything further than symptom reduction has to really go for private therapy. And I wonder would that be different for kids, do you think, or does that fit within the trying to do the most efficient perhaps short term therapy to move people on?

Kim: Erm, it's a hard one, you know, because I think children are slightly different actually. Erm, you know, it's the whole debate about prevention versus intervention or, you know, what kind of treatment or whatever, isn't it? And I think, you know, the CAMHS could and should be seen as also a preventative service...

Example 13

Alex: ...when you said about erm, you wanted them to be guidelines rather than something that you had to follow. I think that's something that's come up in a few of the discussions I've had, but one person in particular I spoke to, *he/she* was very keen on saying that *he/she* wanted them to be guidelines, *he/she* wanted to have flexibility, but then *he/she* was very worried about other people having flexibility and other people not sticking to the guidelines. And it seemed as though it's a bit of a tricky thing to try and hold. And I wonder if that's one of those things that there can't really be an easy answer to, we either want flexibility or we want people to stick to the guidelines, and there's not really a very good way of measuring that, in my mind. I wondered if you had any clearer thoughts on that.

Kim: No. You know, there aren't any answers. I always think that, you know, in your practice what I think you need to do is to be able to justify why you did what you did. Erm, and NICE guidelines are part of that, could be part of that justification, at times, 'I did this because NICE guidelines say so', but you could also use other things that are the basis of your decision-making.

Appendix O: Reflections after the Bracketing Interview with Anne Cooke 25.04.2013

Anne and I discussed how I am not sure of my own views towards NICE and that these have changed in the past and continue to change. We discussed how I have worked at places in the past where the culture is that NICE guidelines are a very good thing and it is obvious that they should be followed. Whilst working in these places I accepted this view and promoted this view to others. I have also worked with people who are very critical of NICE guidelines and I could see their point of view.

We discussed how when I started this research project my intention was to investigate why NICE guidelines for schizophrenia don't tend to be followed; with a goal of improving adherence. After discussions with Anne and Amanda and some brief reading around the subject, my position changed to one of curiosity, wanting to investigate the benefits and limitations of NICE, mainly to help clarify my own understanding and beliefs about them. We discussed how I can find myself agreeing with the view point and arguments of participants who are pro NICE and then when I meet a participant who is very anti NICE, I find myself agreeing with them. Anne highlighted how this is an important observation, signifying how we can be influenced by those around us and that workplaces could be very much influenced by one person's strong views or a strong culture. This is something I need to be aware of when interviewing participants and analysing the data, noticing when I am agreeing with one point of view, and attempting to notice other perspectives.

Anne had sent me through the questions before hand. Most of the questions were expected, but the question about how my family background may have influenced my decision to do this research seemed harder to think about and perhaps didn't feel relevant. The more I thought about this and discussing this with Anne in the interview, made me realise that I have

had strict parents and have been brought up to follow rules. I have generally liked the stability of having rules and like these to be stuck to. This may have influenced my decision to do my MRP on NICE guidelines. However, I don't feel that I am particularly trying to promote or to dispute NICE guidelines and am genuinely interested in how best to use them. So I don't feel that my tendency to like rules will affect my judgement in this analysis but I feel that it is something that I should be aware of. For example I may find myself siding with pro NICE statements due to the security of having rules to follow. Alternatively, I might find myself siding with anti NICE statements due to wanting to challenge the strict upbringing that I had.

I noticed in this interview, and have noticed in previous discussions with Anne, that Anne appears to be viewing this project as attempting to highlight the limitations of NICE in order to challenge the powerful discourse of evidence based practice and NICE. I agree that it would be good to challenge this viewpoint, as I feel NICE and the discourse of evidence based practice can be limiting. I am perhaps a little more open to alternatives though. If the data to emerge from the analysis highlights more positives about NICE then I will be more than happy to highlight these codes and categories, I don't feel particularly wed to either trying to promote or to dispute NICE. I hope to follow the lead of the data and see what emerges. It might be that the data highlights positives and negatives of NICE. If this is the case, I hope that this research will help those who dislike NICE to see some of their positives and for those who promote their use, to recognise their limitations.

Appendix P: Table of Codes and Categories with Quotation Examples

Theme	Category	Sub-category	Focused Codes	Text examples
<p>Considering NICE guidelines to have benefits but to be fraught with dangers</p>	<p>Valuing the benefits of NICE</p>	<p><u>Noting that NICE guidelines can provide consistency</u></p>	<p>Noting that guidelines can help organise services</p>	<p>“erm, and I think it is, it is really helpful that the guidelines are there, because it does provide a bit of a framework to organise your services and the interventions and kindof the packages of care that you’re trying to offer clients.” (Amy)</p> <p>“Erm, I think the way I do draw on NICE guidance is I do – when we’re getting referrals direct from GP’s to secondary care, erm, because [REDACTED] don’t tend to get referred to IAPT services, and so we do, I now have an understanding with our team manager that new referrals present for anxiety and depression that are requesting counselling should go to IAPT first, erm, rather than come direct to us, and that’s now happening, that we don’t – so we follow the stepped care model.” (Jenny)</p> <p>“I think what they’ve been helpful for, is in a team like mine, where the majority of people would have a diagnosis of schizophrenia, and that would be the NICE guideline that is most applicable, it makes it very clear what kind of kind of care pathways we should be routinely offering.” (Sam).</p>
			<p>Highlighting that NICE guidelines can help the public know what to expect.</p>	<p>“I think it helps the public to know what they can expect. And I think that’s really helpful.” (Jenny)</p> <p>“They also do patient friendly guidance and things like that as well, which of course in this day and age with service user involvement is hugely important.” (Catherine)</p>
			<p>Valuing the shared language that categorisation and NICE guidelines provide.</p>	<p>“The fact is you still need a kind of a category list, don’t you? You need some language to kind of describe or categorise behaviours in one way or another. And actually, you know, NICE guidelines start with a definition of what it is they are dealing with, you know, and they say what is included and what isn’t included in that category. So, you know, I think that’s fair enough.” (Kim)</p> <p>“I suppose it’s all tied up in the evidence base and finding a language, a shared language and a common understanding about what we do. Erm, and I suppose I view them as being a way to have those conversations. And I like the NICE guidance in that they bring about a sense of consistency and they invite a kind of shared understanding.” (Jenny).</p>
		<p><u>Recognising the power of NICE endorsement</u></p>	<p>“I mean I think when, I think access to psychological therapies for people with a diagnosis of schizophrenia has really increased as a result of NICE guidelines.” (Sam)</p> <p>“If psychological interventions are mentioned in the NICE guidelines, it almost justifies you being there.” (Amy)</p> <p>“NICE guidelines do put psychological interventions on the map.” (Amy).</p> <p>“Erm, but, if we didn’t have them (NICE), we wouldn’t have services like this, and whilst services like this aren’t perfect by any manner or means, they’re a bit better than what was there before.” (Naomi)</p>	
		<p><u>Valuing NICE’s assistance in delivering evidence based practice</u></p>	<p>Seeing NICE as a useful guide to the evidence base.</p>	<p>“I think that they’re actually doing a good job. I think it’s actually quite wonderful thing to say ‘look, we’re pulling together what works, this surgery works, this medication works’. I think it’s actually quite wonderful. I think it’s really, really a very helpful guidance. And I think it’s helpful for therapy to have that guidance.” (Jan)</p> <p>“People might not have time to do it all themselves (reviewing the evidence base). I can see a busy GP, for instance, is quite happy just to look something up (in NICE guidelines).” (Morgan)</p> <p>“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)</p> <p>“I think they generally brought a benefit in the sense that they’ve made – they bought clarity, really, about the evidence base and how systems of care should work and what interventions are effective, and that clarity is helpful.” (Sam)</p>

		Feeling that NICE provides a safeguard against bad practice.	<p>“You know they provide a safeguard as well, and I think you know you can't erm, just, I guess qualify and go off and do whatever you want, because it could be unethical, or it could be harmful, you'd hope that if you are trained as a clinical psychologist that you aren't going to be like that, and you're very thoughtful and caring, but we don't know do we, there might be some people out there, who erm, so it, it is a safeguard” (Amy)</p> <p>“It requires practitioners to think about what they're doing and what they're offering, and it's quite good that there are some overarching general national guidelines, so that patients, when they come to a service, can be sure that what they're, offered is actually based on something.” (Ronda)</p>
		Considering it understandable to go with the evidence base in the climate of reduced resources.	<p>“If you're making funding decisions in an environment of reduced finances, less money, erm, you, it's a bit of a no-brainer, that there's this thing that looks good, looks as though it is helpful, but there's no evidence for it, and there's this other thing, that looks just as good, just as helpful, and there is evidence for it. I know which I'd put my money into.” (Paul)</p> <p>“You know, it comes back to I think NICE is, you know, there are only so many resources, you know, and there's all the need out there, and how do you decide how you allocate those resources? And so I can't be agai..., so NICE is an attempt to kind of help with that, and I think that's fair enough.” (Kim)</p>
	<u>Feeling that the concerns about guidelines can be challenged.</u>	Acknowledging the problems with NICE guidelines but arguing that we would be worse off without them.	<p>“You know, it needs to evolve and it needs to improve, but actually I think it's also important not to – or just to acknowledge that it's – I think NICE has done really well. I think it is an admired institution.” (Sam).</p> <p>“Well I think if we didn't have the NICE guidance I think we would be worse off, actually. And although I think there are lots of problems with them and I don't like the way that they can be used, I think, fundamentally, I think they've been helpful in trying to bring together some consistency and just a bit of, you know, there's a national understanding, isn't it, about what people should be offered, and I really like that idea, you know.” (Jenny).</p> <p>“Erm, the argument is certainly a fair one, it's whether, whether I would conclude the same, I think the argument is slightly more complex than that.” (Paul).</p>
		Arguing that it is possible for other therapies to emerge and gain NICE backing.	<p>“If you get enough momentum behind research the NICE guidelines will quickly reflect it. I would imagine that mentalization-based therapy will become well-evidenced in the next few years, just because of the amount of work you see in that.” (Paul).</p> <p>“And there is – the greatest thing that CBT has given us, and it is a great thing, is to actually, it's a wake-up call, listen we need an evidence base. I think that's been very valuable.” (Jan).</p> <p>“Erm, I think also, well I hope, that one of the things that will come out of the development of the whole NICE guidelines system is an emphasis on research and evaluation by other models who will gradually build up their own evidence base and will be able to erm challenge the dominance of CBT. I see absolutely no reason why that won't happen. I've every reason to think that it will.” (Sam).</p>
		Challenging criticisms of CBT.	<p>“I think the perception of CBT as a therapy is often very different to the reality of it, and that's basically there for the people that advocate it, it's something you can almost prescribe like a medication, but it also, counts for a lot of people who stand against it. Er, I think there's a notion in some of the courses ... some of the clinical psychology courses, that CBT is a collection of techniques, or that should be taught as a collection of techniques, which it most certainly isn't; in fact one of the things you do with trainees is you try and get them beyond being technique-led, in order to understand the principle; in order to best select what they're going to do.” (Paul).</p> <p>“So I think it's true that the NICE guidelines have started to categorise therapists and, you know, if you work as I do with people with the diagnosis of schizophrenia you need to be able to say that you do CBT. At the same time actually it doesn't need to be limiting, because CBT is such a broad approach these days, and there are certain key things you have to do. But I think you'd find them across a wide range of psychological interventions. So I personally don't find it particularly limiting.” (Sam).</p>
		Seeing value in CBT.	<p>“yes, definitely and as you say it depends on the individual and not everybody erm, you know, to play devil's advocate, not everybody wants to explore their past experiences or where things have come from, and they want, they're distressed in the here and now, they want to manage that now and so it might be that you do a piece of CBT work and that helps to get a formulation of why the issues developed, from a CBT perspective and what's maintaining them in the present, erm and have some strategies to manage that distress in the present and that might be all that person wants to do and that's absolutely fine.” (Amy).</p> <p>“And for all the faults that I've sort of seen to talk about about CBT, the fact is patients sometimes will come and ask for CBT because they've heard of it, they know what it is, or they think they do. So if it gives somebody a language to talk about their distress or their difficulties or their issues, that's got</p>

			<p>to be useful. So, again, it's about the therapist being flexible enough to adapt and tune in to what it is they think they're saying they want, and being able to talk to them in a way that they understand. And CBT, once you get it, I think can be quite simple and it is quite patient friendly." (Catherine).</p> <p>"There are surely approaches, even CBT, it may be very beneficial to people. Actually, I have seen that be a beneficial approach to somebody. I'm not saying that the things that NICE guidelines recommend may not be helpful." (Sophie).</p> <p>"I feel quite comfortable with the sense that CBT is a really useful thing for anxiety disorders, a useful model, you know, and I think it's useful to have it, you know, to use the evidence and the research on that to kind of work in that way with ██████████ that may present with, you know, all of the anxiety disorders. So – and I feel quite comfortable with that. So maybe I'm sitting on the fence even more, even though I think, you know, my personal view on, you know, feeling more affiliated with the psychodynamic way of thinking." (Kim).</p>
		Understanding why the medical model was chosen by NICE.	<p>"I'm not sure it's the best option. I think realistically it's understandable that that's how it started. I mean I think we can argue as psychologists that, you know, we don't want to categorise people by a diagnostic system that isn't itself evidence based. And all those arguments are very legitimate, but at the same time it all had to start somewhere, and I think it's completely understandable that it's started with the diagnostic system." (Sam).</p> <p>"I'm not dead keen on doing it by diagnostic category really, erm, but I think I'm accepting of it that it's just one way to do it and it's good enough." (Jenny).</p> <p>"Erm, so I guess then you're left with: is it good enough? Does it do enough to justify its own existence? To that extent, I guess the answer for me, is probably." (Paul)</p> <p>"So, you know, it's unhelpful that the medical paradigm and the diagnostic paradigm has kind of shaped them. But, you know, I think that has been much debated and I can understand why they have done that, because you have to use a paradigm and I guess one has to acknowledge that the medical paradigm has been dominant." (Sam).</p>
Worrying that NICE can create an unhelpful illusion of neatness	<u>Feeling that guidelines can be misunderstood or misinterpreted.</u>	Admitting to not having a clear understanding of NICE guidelines.	<p>"Okay. My thoughts on NICE guidelines are mixed. Erm, partly, I think I don't know the contents of them inside out." (Sophie).</p> <p>"That's an element which, see I'm not sure now if my knowledge of NICE guidelines, but I'm not sure where that's mentioned, I think it probably is mentioned about cognitive assessments in NICE guidelines for schizophrenia anyway." (Amy).</p> <p>"Only, well, I don't think I know enough about how NICE works to really be able to have a clear opinion about that. But my feeling is that I'm probably not supportive of the approach that they use. There was something on the news, wasn't there, about the economic formula that they use or something, and that it's flawed or – I don't know. But, no, I don't think I understand their process, or I don't think I know their process well enough to have a confident opinion about it. But, no, I really don't like the way certain information is privileged by NICE." (Jenny).</p>
		Worrying about others misuse of NICE guidelines.	<p>"I still keep coming back to I don't think NICE are doing anything wrong really. I think it's just a shame that it's so open to misuse, and I think it is being misused." (Jan).</p> <p>"I think where it perhaps gets misinterpreted is when people think it is the voice that tells you what you should do, which I think then means that therapeutic and er professional guidance from the individual therapist, or the individual teams looking after in-patients, that it would be wrong for them to be entirely guided by the guidelines, because there's certainly limitations to the guidance, and I think that most professionals who were aware of, you know, how the NICE guidelines came in to being, and the point of them, would be aware of that." (Catherine)</p>
		Highlighting that people may follow NICE without being familiar with the evidence it is based on.	<p>"It's difficult because I don't, I honestly don't think many people read erm the evidence base that erm, that's included in the NICE guidelines, when they say about all the RCTs, I think they have it as an appendix at the back don't they, I don't think many people go through and read all of that research and that evidence so I think there is just this idea well we know it's effective, we know it works, but I think it's a little bit blurry as to know how it works and in what particular outcomes and what area it's effective" (Amy).</p> <p>"You know, for ██████████ a lot of the time that research is very scarce, so it's kind of like thinking 'ok, they've given this recommendation, but actually the evidence for it' – it almost makes it feel as if 'NICE are saying that, so that means that that's the best, you know, that's the evidence based information'. And it might be the best evidence based information, but actually a lot of the times for research in ██████████ that evidence is more patchy. I think it's getting better, probably. And I'm not, you know, I'm not an expert in knowing whether the evidence is good quality or not. And I</p>

			<p>haven't gone through every single article that the people obviously reviewed, but I'm sure that there's a sense that actually there might not be a lot. And in some guidelines there is, you know, that's stated clearly actually there isn't a lot of evidence for this." (Kim)</p> <p>"The NICE guidelines is saying CBT, what they actually have an evidence base for is actually the behavioural aspect of CBT. There isn't a huge evidence base for the cognitive aspect of CBT, and certainly not for the cognitive aspect of CBT for ██████████, it comes back to behavioural. And people don't know that, they think 'oh CBT will fix everything'. So it's exposure therapy. Wow. We're back to that." (Jan).</p>
		Feeling that managers can follow NICE guidelines without questioning their relevance.	<p>"Yeah, I'm aware that there are some NICE guideline meetings that happen in the trust and we get feedback, but they're off, and there are lots of things like gap analysis and are we doing what it says in the guidelines without necessarily questioning how relevant or applicable that is, in my opinion." (Sophie).</p> <p>"We are still learning and we're updating all the time, so what's in the guidelines should not be seen as set in stone. If it's like more a loose sort of guideline, then I think it's fine to some extent. But I think there is 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).</p> <p>"If you were to get a manager who was, you know, particularly now we're getting more care pathways and payment by results, this is more likely to happen. This is more likely to be referenced what the NICE guidelines say. You could get somebody saying that's the only time you should be doing MBCT is with people who have had three or more episodes of depression who are in remission. In which case, we wouldn't be doing nearly all of the MBCT that we have been doing, you know, successfully over the last five years with people with a whole range of other issues." (Morgan).</p>
		Worrying that service users may misinterpret NICE.	<p>"I think families, you know, these days may read NICE guidelines and say, you know – it's almost like it can be empowering for families if they think they need, you know, a certain intervention to kind of be able to say 'actually, I think this is what we need'. However, families are not doctors or specialists in whatever field, and they might not get the diagnosis right. And that can be difficult. So, you know, NICE can be a problem in that way too, you know, of people expecting something because they think their child has bi-polar, you know, is one of the one's that – you know, and you assess the child, you assess the situation and you don't think the child has bi-polar, and that can create a bit of a conflict." (Kim)</p> <p>"I wonder if that's the way it's been sold as 'this is the best thing ever, this is what will help you, definitely, no matter what'. But that isn't the case. That doesn't help everybody. So if somebody feels – I think, again, that's the thing with IAPT. If you go through the IAPT steps and somebody, for whatever reason, perhaps has been assessed as mild to moderate, but actually they haven't disclosed everything that's gone on and they haven't got any better, and they've had CBT, then they think "well, I'm unfixable. I'm broken, I can't be fixed". And I think that can lose people and they don't want to be seen by another psychologist because they think they're just going to fill in another form or ask questions from a questionnaire or something. So it's important that you're not limiting the patients understanding of what's happening, and they're not just in one box when actually there's a whole load of other things we could use." (Catherine)</p>
		Arguing that an absence of evidence is not evidence of ineffectiveness.	<p>"It's a wonderful idea, but it needs to be a guideline and not be a final word, because, there are weaknesses, so for example, NICE themselves say this, that actually if something is not in the NICE guidelines it's not evidence, that it is not effective, it's just that there is a lack of evidence that it is effective." (Jan).</p> <p>"Some of my colleagues would say, I can think of one person in particular who would say, that that's maverick and dangerous and that you're doing something, you know you're messing with a model. You're doing something for which there's no evidence of its effectiveness, you know, I daren't. That view, for me, comes under the naïve heading of erm, assuming that because something has attracted RCT funding it's the only thing that's effective." (Morgan).</p> <p>"And I think it's also a little bit naïve to think that because, for example, there is some evidence for ACT, but the number of RCTs that has been done on ACT is quite limited. Erm, now just because there's far less evidence, RCT-type evidence for ACT, than for CBT in certain areas doesn't mean that it's less effective. You know it could mean that it's more difficult to evaluate what ACT does, using, the kind of questionnaires that are used don't pick up so easily what ACT does. It could be that there are all kind of political reasons why ACT therapists haven't been in positions of power where they've been able to draw out the funding money to do the RCTs. You know, you know, just because something hasn't got an RCT showing its effectiveness doesn't mean it's not effective." (Morgan).</p>

			<p>“you know, evidence is always changing, they’re based on our current understanding of the evidence but that doesn’t mean that something else that hasn’t been examined isn’t working.” (Ronda).</p>
		<p><u>Worrying that commissioners can view NICE as a way to limit spending</u></p>	<p>“So I think in an era of shrinking resources there is always that potential for commissioners to see, to view the NICE guidelines as a kind of way to limit spending. And that would always be a concern.” (Sam).</p> <p>“I think if we weren’t in a recession, I know NICE predates the recession, but erm, you know NICE is now being used, can be used in the service of restricting the amount of resources given to certain kinds of approaches because they’re not in NICE. So, I think that the recession is extremely significant in all this.” (Morgan).</p>
		<p><u>Believing that NICE is doing harm to service users.</u></p>	<p>“Well, I think you’re on to something. And I hope that it doesn’t stop with you. 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).</p> <p>“I think it can harm patients if you, for example, take the example of IAPT, where, you know, some of the principles that IAPT is based on is based on research where they’ve taken only a certain subsample of patients. You know, they have quite strict selection criteria for the studies, and this kind of client group might respond very well to a fixed number of sessions, for example, and of working within this model sort of very – in my view restrictive CBT model – but then if you take that in to the outside worlds, most patients are a lot more messy and you can’t actually fit them in to the same kind of boxes. And, you know, I hear time and time again from colleagues who work in IAPT “well, you do what you can in those 6 sessions” or even 20 sessions, but it’s often not enough and then people come back. And I think, in my opinion, that is quite harmful, because I see patients time and time again who have more complex problems, who talk about being seen in a sort of shorter term way and often say well it opens everything up but then you’re just left with all of that stuff.” (Ronda).</p> <p>“I worry about that (pause) for the patients. I worry about that for, the denigration of our profession. And I worry that the NICE guidelines don’t, you know, the evidence doesn’t demonstrate all of the evidence. There’s more evidence out there that isn’t published.” (Naomi)</p> <p>“it is dehumanising of clinicians, it’s deskilling of clinicians, which can’t be good for the clinician or the client. And it’s definitely dehumanising of the client too.” (Jan).</p>
		<p><u>Experiencing guidelines as limiting</u></p>	<p>Worrying that NICE guidelines may lead to neglecting other therapies.</p> <p>“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).</p> <p>“I think there is a worry because if all the money, erm if all the evidence is behind CBT and family work, I think a lot more funding goes into developing those therapies at the risk of other therapies, being neglected or, maybe they won’t get the funding or the time, erm to develop them and nurture them and see if they could be just as effective, or, or maybe they are not effective at all, in which case why would I, why should I be doing narrative work if it’s not, if it’s not helpful.” (Amy).</p> <p>“Yeah, it can become a bit of a vicious circle, you do enough research to get yourself in the NICE guidelines and then you attract more research money.” (Paul).</p>
		<p>Worrying about the dominance of CBT in NICE guidelines.</p>	<p>“I worry that someone’s going to come along and make me do CBT all day, and that would kill me! I don’t think I could do it. So, yeah, no I do. I don’t know if I particularly – yeah, I suppose I am a bit worried. I’m more worried that somebody will come along and make me do CBT all the time. I think that would be really awful. I do mean for me personally, but I also mean, because I think, you know, CBT works well for some people, but I think it doesn’t work well for a lot of people, and so it would be really unhelpful if we’re all doing CBT. And I think it just isn’t helpful to have a ‘one size fits all’ approach. You know, so I really object to that.” (Jenny).</p> <p>“but I think it’s almost like a, erm, 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).</p> <p>“That’s my view about CBT coming out rather than NICE guidelines, but it kind of really all comes together.” (Naomi).</p> <p>“We all want what works, so if they’ve got something that works that’s great, but there’s something competitive about it and dismissive about it to other clinicians. It’s obvious that I’m not CBT besotted. It’s obvious. And I’m not CBT besotted because actually I can see it’s limitations. I would charge for</p>

			<p>it if I thought it was fantastic. So, here's the worry of an experienced clinician who's actually being pushed into a corner and told 'this is what you should do', and it offends every judgement. Now, I'm – the NICE guidelines have also raised up EMDR, for example, and that's something I do promote, and I do encourage, so in my own way I'm saying 'well, look, there it is', but why are we having this fight at all? EMDR is right at times, CBT is absolutely right at times, and at times it's a combination, and at times it's family therapy. What are we doing? So I think it's a real lack of foresight in the NICE guidelines." (Jan)</p>
		Questioning the effectiveness of just providing short term interventions	<p>"erm, when I worked in primary care I used to see individuals with common mental health problems, so anxiety, depression, 6 to 12 sessions and I felt it was kind of quite helpful to contain and manage the distress, but I never really felt it got to, erm, or offered the opportunity to get to what the root of the issue was in the first place, so I often saw CBT as kind of putting a bit of a plaster on the problem rather than looking at the cause, and my worry is that, erm, we continue to look at therapy in that way and that NICE encourages us to look at therapy in that way particularly with advocating sort of family work and CBT work as being, erm, managing the distress now, in the here and now rather than really exploring the past experiences, or what might have led to developing the psychoses for example." (Amy)</p> <p>"It may or may not be cost effective. It may be cost effective. That's probably quite a difficult question to answer. Is it cost effective to give somebody with complex difficulties six to ten sessions of CBT? Erm, you'd have to trace that person, what happens to them five years later when a similar problem occurs. Maybe they haven't fully resolved it the first time. They have to come back again, and again, and again. How do you compare that with giving somebody 50 sessions of relational therapy, er, where they may or may not need to come back. They may have internalised something more long lasting, I suppose. I think it's quite difficult to make those decisions about what's really cost effective actually." (Morgan).</p>
		Seeing value in approaches not recommended by NICE.	<p>"It's not in the NICE guidelines. It's too soon. So there are a lot of people who are not getting really good therapy. Cos it's not in the NICE guidelines yet." (Jan).</p> <p>"So I like the idea that, you know, that it allows some discussion around different types of approaches, but I think it can also, the NICE guidance, I think, also can close down discussions about working in different ways. And so I think, you know, I think it opens up discussions within psychology, I think there's more of a shared understanding where it opens up people to thinking 'oh yes, I must refer for psychological therapy', a bit of a shame that they often think 'I must refer for CBT'" (Jenny).</p> <p>"The CBT research does fit nicely, all the criteria that NICE Guidance will set out, so obviously a lot of the NICE Guidance CBT is the recommended line of treatment, and things like that, from a psychological point of view. 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)</p>
	<u>Questioning the scientific integrity of the guidelines</u>	Questioning NICE reliance on RCTs.	<p>"Erm, I guess what's problematic is, erm, the type of evidence that's allowable and included in NICE and the type of evidence that's not included, so for example, all the research around the importance of the therapeutic relationship rather than the model in terms of effectiveness of therapy isn't represented in NICE to my knowledge, in a significant way anyway." (Morgan).</p> <p>"You know, a lot of the times they use, you know, very pure kind of client groups with a very pure diagnosis, and single diagnosis, a lot of the time. And I know that there's been developments, you know, kind of to try to do more than that, but a lot of the time the evidence that then is presented is on those groups." (Kim).</p> <p>"I think partly they're not always implementable, you know, NICE Guidelines. You know, like going back to the research they're based on, 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 is that doesn't paint an accurate picture of the kind of client groups you're actually dealing with. And, certainly in my area of work, very complex, all sorts of things going on, it's not one thing or another, you've got to take a person as a whole and you've got to work with the difficulty that they're bringing to you." (Catherine).</p> <p>"Well, except that. I think if you look at some of the actual CBT manuals that are used in research trials, they're interesting things to read, but that's not how I do CBT. I mean CBT that's done in RCT's is a certain kind of CBT, but it's not reflective of CBT generally, I think, and I think there is a difference between what goes on in trials and what goes on in the real world, even within CBT. And of course that would be true of other kinds of therapies too." (Sam).</p> <p>"You could ask a hundred experienced psychotherapists who work with dissociation to tell you exactly what they used that works, and a hundred of them</p>

			<p>will tell you independently what they do, how they do it, and how that has an impact, and yet that's not good enough. So I think that's where it misses out on the experience and the expertise of really hardworking, well meaning, well informed and intelligent therapists who have got good things to say. And I think they're perhaps ignored or not taken seriously enough, somehow, when, you know, then you've got other struggling therapists who have got their presentation in the room, but there's no guidelines, but actually if the guidelines were a little bit more flexible, there would be. Do you know what I mean? Like if they put more research in it could be more helpful to the greater good." (Catherine).</p>
		<p>Highlighting that the majority of evidence is based on working age adults.</p>	<p>"Jan: Erm, so now all they want, especially – well, I'm at CAMHS service so that's all I can talk about, but all they want in a CAMHS service is CBT, and actually if we look carefully there isn't an evidence base of CBT for children or for specific difficulties, but it's still being waved as this generic 'look, look, look CBT does everything' and clients are then coming in and saying 'well I want CBT, whatever that may be' and that's what they want." (Jan).</p> <p>"I feel like I have quite a flexible relationship with the NICE guidance because mostly they're based on evidence and studies with working-age adults, and that doesn't necessarily means it translates in to [REDACTED]. And the evidence with [REDACTED] is really scant. So I think that's where I feel like, you know, yes there were probably some things that translate fairly well in to [REDACTED], you know, PTSD is very similar however old you are, in terms of symptomology, but depression and anxiety more generally can present quite differently." (Jenny)</p> <p>"I think it's also being really aware of the discourses that are used. 'Well, these are the generic guidelines. You shouldn't discriminate against that group because they're not mentioned in them.' It's interesting, but also, you have to be very aware of the kind of, actually, those guidelines aren't necessarily designed for those people and they might not be suitable, so actually, by forcing something on them, that's, in its own way, another form of discrimination, so you have to be very careful about how people play those sorts of lines." (Sophie).</p>
		<p>Highlighting the difficulty in researching psychological therapies.</p>	<p>"yeah, and I guess, and I think it depends on erm, what outcomes people are looking for what they're deciding as being what's helpful and what isn't helpful and how that's all defined, erm, because I know a lot of the other research that is out there about the common factors, so actually it's not really so much the intervention, the er techniques, so much as the relationship which is the biggest predictor of outcome, erm and I think that idea is hard to conceptualise and put into NICE guidelines, I mean it's hard to say what psychologists do half the time anyway." (Amy).</p> <p>"I think it's much harder to capture some of the things I think we're working with, so I think, you know, if you think about Erikson's stage 8, you know, Integrity vs Despair, how on earth do you measure integrity? You know, so I think there's a problem with outcome measurements." (Jenny).</p> <p>"I think they are biased towards the quantitative research, and not qualitative research. And that needs to change. 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).</p> <p>"I just don't believe that therapies are simple as you come and you do it and you feel better. I just think that's a very linear model of time and change, and I just don't believe that that's how things work." (Jenny).</p>
		<p>Arguing that CBT fits well with NICE whereas other therapies do not.</p>	<p>"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, of CBT and numbers of sessions." (Amy).</p> <p>"Research is usually based around symptoms, and the NICE guidelines reflect these things, erm and CBT's success is the success built around symptom reduction." (Paul).</p> <p>"CBT lends itself to the kind of research that NICE guidelines likes." (Sam).</p> <p>"The problem is that NICE guidelines they're so rigorous, which is fine, you know, there's a lot of rigorous – the research needs to be rigorous, but the problem is that, you know, if you're from a different model, if you're working with a different model that doesn't pathologise in the same way then you're not going to get the evidence from that model because it doesn't fit with their, with their way of looking at research." (Naomi)</p> <p>"If you're asking the Department of Health to fund a, a particular intervention they're going to say: show me that it works. It makes sense from their point of view, it's obviously an incredibly complicated answer that you have to give about you know, how you define recovery, how you define a therapy working. 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).</p>

		<p><u>Having a problem with the medical model basis of NICE guidelines.</u></p>	<p>Questioning the validity of diagnostic categories.</p>	<p>“You could pick apart the whole thing (NICE) potentially on the basis of questioning the validity of diagnosis.” (Morgan).</p> <p>“I feel absolutely certain, myself, that the DSM-IV categories in mental illness are flawed.” (Paul).</p> <p>“The problem I have it’s probably with the diagnostic categories and the way NICE guidance is based around them. So I think, you know, PTSD and OCD are quite – I think they’re clearer in diagnostic categories than say something like GAD and depression, which I think within it has such breadth of symptomology.” (Jenny).</p> <p>“My issues with the DSM was more about the different powerful lobbies to get to influence it in the States. Erm, if it was an entirely academic exercise just driven by, I don’t know, the leading minds in the field, a sort of academic utopian ideal, it would probably look very different.” (Paul).</p> <p>“I think that my reservations about them is the fact that they’re based around the diagnostic system that I don’t use, and so, for instance, the one most relevant to my job is the NICE guidelines for schizophrenia. But I don’t really believe in schizophrenia, I don’t think it’s a thing (laugh). So, you know, it’s unhelpful that the medical paradigm and the diagnostic paradigm has kind of shaped them.” (Sam).</p> <p>“I just don’t like the fact that it’s all done by this diagnostic category which, you know, lumps together a whole lot of people that don’t necessarily have a huge amount in common.” (Sam)</p>
			<p>Arguing that the medical model is dehumanising.</p>	<p>“It’s too simplistic and it’s dehumanising for the clinician and particularly the client. I am this.” (Jan).</p> <p>“You can present it simplistically for surgery, you can present it simplistically for medication, but you cannot apply the same reporting to something like mental health. Because mental health can’t be compartmentalised. Because you have to take in to account that person and that person’s experience and that person’s context. You can’t just say CBT, that’s a good idea.” (Jan).</p> <p>“It’s understanding a set of problems by what they look like, and at it’s extremist form, applying erm, a protocol-driven erm, intervention that doesn’t really require a great deal of psychological-thinking and it is all about housing the problem in the individual rather than in the system, their experiences, their interactions with other aspects of their life.” (Naomi).</p> <p>“I think there was a sense of ok with eating difficulties this is what we do, you know, and I think it’s very much a medical mechanistic model, I guess, you know, if this is present then we do this. You know, this is the illness, we do this treatment. It’s medical model, isn’t it, whereas actually I think us as psychologists do more than that. We don’t do this is the diagnosis, this is treatment.” (Kim).</p>
			<p>Suggesting that there are alternatives to the medical model.</p>	<p>“Well, there’s alternatives to dealing with people with psychological distress that aren’t medicalised. It’s psychological distress, it’s not medical distress.” (Naomi).</p> <p>“I think it’s really important to maybe move away from this very dominant medical model and really make it clear that actually there are some other models and not everybody agrees with this way of practising, and I think it’s quite important then to sort of, when people are too rigid about something like the NICE guidelines, to sort of point out the limitations.” (Ronda).</p> <p>“I think it’s completely understandable that it’s started with the diagnostic system. I think the main criticism at this stage is that that 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? And it should be that process of reflection, should be occurring. I’m not sure it is, but it should be, because if they’re all about evidence based practice, you know, where is the evidence for the diagnostic system? Particularly a diagnosis like schizophrenia, it’s so contested, and I think if you look at the evidence it makes no sense whatsoever and you shouldn’t be using it in an evidence based system. It makes more sense to look at – if you’re going to look at psychosis, which is such a broad experience, it makes more sense to look at phenomenologically at, you know, paranoia or voice hearing or whatever. That might make more sense. It would mean that you might have more guidelines, but there would be more focus so presumably they would be more concise.” (Sam).</p>

		Arguing that routine practice is more complex than NICE guidelines.	<p>“When you actually sit in front of the actual patient, the problem is always that the model is fundamentally flawed, in my opinion, because it’s never as clear cut as that. So it’s never just OCD or just depression or just anxiety.” (Ronda).</p> <p>“You know, you have to use them carefully because they don’t – when you actually start applying them to individuals, they very quickly stop making sense.” (Sam).</p> <p>“Well their primary diagnosis might be schizophrenia, but if you wanted to use the diagnostic system as its designed, they pick up 3, 4, 5, 6 diagnoses including ones around personality disorder, maybe ones around mood disorders like depression. Now, of course, each NICE guideline – there’s a different NICE guideline for all those things, so then it becomes quite confusing. If somebody has a diagnosis of schizophrenia but also meets the diagnostic criteria for say emotional unstable personality disorder, which one am I supposed to follow? Because the NICE guidelines on schizophrenia would suggest 16 sessions of CBT, but, you know, that may not be enough and it may not be the most helpful thing for somebody who also has a disturbance of personality. So then they become difficult to make so much sense of when people have multiple complex problems. The diagnostic system itself is rather stretched because it tends to think of these things as separate when in fact of course they’re all part of the person’s experience. And the service you offer as a psychologist is a single service to a person, not of this group sort of set of separate diagnoses but to a single person who has a single stream of experience.” (Sam).</p> <p>“Actually, the people that I work with in this particular service, who aren't unique in terms of being complex, I think lots of people have multiple complexities in their different areas and different services, but they don't fit neatly into any one particular box at which you could potentially throw one particular guideline, or even a multitude of guidelines at.” (Sophie).</p>
Perceived level of pressure to be NICE compliant		<u>Experiencing an underlying threat or pressure to be NICE compliant.</u>	<p>“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. yeah, I think erm, I think for me, I'd, I feel that I need to make sure I'm offering a CBT intervention.” (Amy).</p> <p>“It feels increasingly like it's the Bible. You know, its sort of, erm, anything that's not the word of God is kindof not really allowable. So, not amongst psychologists, but among, you know, more at a kind of, higher service level.” (Morgan).</p> <p>“I think these days you have to be trained in a NICE recommended therapy to get a job in the NHS. I don't think you would get a job in the NHS otherwise.” (Morgan).</p> <p>“In the Trust, as a whole, there is a rhetoric of us needing to adhere to NICE guidelines. The Trust does quite a few audits on NICE guidelines and how well we are using them.” (Ronda).</p>
		<u>Noting that NICE guidelines aren't currently experienced as restrictive.</u>	<p>“I can see that could become so if they were implemented in the wrong way, it could become restrictive or prescriptive, but I've never experiences them like that. There's a sort of distant worry that they could be, but I haven't actually experienced that. And I don't think, certainly when NICE was created, that was never the idea. So I have some hope that it won't happen.” (Sam).</p> <p>“I've never been asked in my job to quote NICE Guidance or to specifically use it.” (Catherine).</p> <p>“I personally don't feel the pressure to follow any particular guideline in this particular service. That might be because I haven't been told that's what I'm meant to be doing and I'm not doing it, or I have been told and I've conveniently forgotten, I don't know.” (Sophie).</p> <p>“So we don't have that much – in the psychology team here – people have quite a sensible approach to the NICE guidelines, and we're not under a lot of pressure to apply them rigorously.” (Ronda).</p>
		<u>Worrying that NICE could become more controlling.</u>	<p>Worrying about the future.</p> <p>“It's not something that's overly restricted, how I work now. But I am concerned that it may do in the future.” (Morgan).</p> <p>“And given that commissioners have got less resources to play with, they might be more interested in commissioning services that more tightly follow NICE guidelines and therefore limit the possibility of providing something different or more than the guideline suggests. So at the moment it's a distant fear, but I think it's a realistic fear.” (Sam).</p>
		Worrying about	“Certainly under payment by results the care packages that are starting to come through connecting with the different clusters, you start to think well it's

		PBR.	<p>all getting rather prescriptive, where's our freedom of movement in this, where's our clinical judgement?" (Sam).</p> <p>"Yeah, 'here's the booklet with the guidelines. Go away and do it'. Yeah. Terrible. That would be my view, yeah." (Catherine).</p> <p>"I think, as I've said before, 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. I think the area you are focusing on is very relevant because this is going to come to, closer and closer focus." (Morgan).</p>
		<u>Acknowledging concerns for the future, but not being worried by them.</u>	<p>"So I'm not too worried about that. I can see why that's a worry for some people, but, no, I think in practice these things look more restrictive than they are, well in theory." (Jenny).</p> <p>"Erm, (pause), erm, I guess I can envisage situations or scenarios, if they were to occur in my service, for example where some kind of treatment wasn't given and questions were asked 'why was this not done? This is what NICE Guidelines says, why did you not do that?', that that would bring around perhaps more of a pressure to be able to justify why you haven't done certain things. But I don't think they would be able – because I think partly they're not always implementable, you know, NICE Guidelines." (Catherine).</p>
Beliefs about the purpose of, and future of clinical psychology	<u>Worrying that the jobs or ID of CPs are threatened.</u>	Worrying about CBT therapists being seen as a cheaper alternative.	<p>"Erm, because of NICE, I think different universities are actually promoting CBT almost as a – so it's filtered through to the universities. And I think that's very dangerous that they're promoting CBT as the most important therapeutic method. And I think that as psychologists we're shooting ourselves in the foot, because you don't need to be a clinical psychologist, a Doctor of clinical psychology to do CBT. With IAPT you can have lots of different grades of people actually doing it. So, it's just a worry. I suppose for me somehow the nice guidelines and CBT have become fused." (Jan).</p> <p>"I think that's why, there's a danger of, NICE guidelines do put psychological interventions on the map and its helpful cos they're mentioned and its erm evidence-based so we know that it works to an extent, 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, particularly as NICE guidelines say CBT, erm, other, rather than other, 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).</p> <p>"Yeah. I think that's an accurate concern. It isn't something that I suppose has worried me in my role, but I know colleagues, I know friends, I know teams that have been completely kind of either downgraded in terms of their banding or, you know, whole teams of psychologists being laid off and these IAPT therapists or CBT therapists coming in." (Catherine).</p> <p>"The Department of Health don't give a fuck. They just want to know that these people have got better. They don't care who does it. Us, precious, our preciousness, I mean it is precious. It is precious, and we should be precious about it, but we're just seen as being precious." (Naomi).</p>
		Being keen to differentiate from single modality therapists.	<p>"That's the worry that I have that managers will see clinical psychologists as equalling CBT therapists, you know psychology equals CBT, erm and I think you can do a lot more than that and, so I think it could limit how psychologists are seen in the team." (Amy).</p> <p>"It was a while ago, they said 'so what is your CBT training?', and I found that deeply offensive. I've got much, much more to offer than that, and CBT methods as it's appropriate, I wouldn't call myself a CBT therapist though. And I don't think I need to be at the doctoral level to be a CBT therapist. I'm more than that." (Jan).</p> <p>"I think that's what I'm paid for. I'm not paid to be a CBT therapist, I'm paid more, and the reason I'm paid more is because I can be more creative. So, yeah, if I was paid to be a CBT therapist then I should be doing only CBT." (Jenny).</p> <p>"Then when erm, we put jobs out to advert, they get upset if we are only advertising for clinical psychologists, which in the past our service lead has caved in on and has just advertised for a psychological therapist, and in giving preference to a clinical psychologist in the interview, but the advert has still been in this compromised position." (Paul).</p> <p>"My short answer to that is, yes. Erm, the controversial answer is, I'd do it better. And my basis for saying this is that there was some research done a</p>

			<p>few years ago, where they looked at rating CBT done by different professionals, and they based it blind, and very clearly, clinical psychologists stood out as just doing better CBT than single-model trained CBT therapists, nurse therapists and others. Erm, I, my sense is that that's probably because the psychologist is more likely to understand the foundation principles of the therapy they're using. They are less likely to get tripped up by the, all the kind of unexpected extras that clients come with. That aren't always evident in the assessment. They might, also, be more realistic about what the CBT as a therapy can achieve. Erm, whereas if you're trained in CBT as a single-model you're probably quite an advocate of it, you'll probably be in slightly more danger of overstretch in the therapy, so if you're giving 16 sessions you might try and resolve every issue in the formulation, and end up then resolving less because you're more widely spread, than if you're more focused." (Paul).</p> <p>"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).</p> <p>"Erm, but they are restricted in what they can do. Now, unfortunately, with these types of professions, people aren't always aware of what they can't do. So in physical health, it's reasonable that, say, a very highly qualified, very experienced modern Matron on a ward, erm, would be a very, very highly-valued member of his or her team, but they would also be aware that if a patient needed a heart bypass it wasn't time for them to suddenly scrub up and reach for a scalpel. Whereas in mental health, erm, someone who has been trained as, say, a nurse therapist using just CBT isn't as aware of the things that they can't do." (Paul).</p>
		Seeing NICE guidelines as a threat to integrative practice.	<p>"I think it is about locating – because I think there is this need to categorise how we work and have an identifiable pure model. 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).</p> <p>"It's (integrative practice) 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).</p> <p>"I think, you know, and again it comes down to the kind of clinical psychology identity and where we fit. But I think the criticism of what is integrative is a fair one, you know (laughs). But, again, there is the sense of why should we kind of put everybody in to boxes, isn't it, so psychotherapists do psychodynamic therapy, family therapists do systemic therapy and clinical psychologists do CBT or whatever it is that we do. So, yes, I think that's right, and it's frustrating at times. I think that's true. But it's a much harder point to argue in this day, and, you know, that's a fair criticism of NICE, you know, in this sense that it needs to be evidence based, and how do you evidence base what psychologists do, what the strengths of psychology may be, which I think is to integrate and to formulate and to kind of be able to bring different points of view and different factors in to play, you know, and understand them. And how do you bring that asset, you know, that sense of what we can offer and make it relevant enough in this day and age of evidence based practice." (Kim).</p> <p>"So I think it's true that the NICE guidelines have started to categorise therapists and, you know, if you work as I do with people with the diagnosis of schizophrenia you need to be able to say that you do CBT." (Sam).</p>
		Highlighting the difficulty explaining what CPs do.	<p>"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).</p> <p>"There's something unquantifiable about what a clinical psychologist brings, and it's very hard to demonstrate that without actually just doing it." (Naomi).</p> <p>"I think it's mainly, I think what it is, oh, I mean when you, if you're a clinical psychologist it's more about your approach and how you view things and your thought processes and your view of the world if you like, that's different, erm, and to try to communicate that is really hard." (Amy).</p> <p>"I wish I could have a PAT answer. I've heard PAT answers for it but, you know, I just think they're a bit tripe really. It's just a different way of being. It's a different way of operating in the team. You place yourself in a different part of the system erm, and you notice thinks and you take it further." (Naomi).</p>
		Arguing that CPs have bigger roles	<p>"But we're only talking about therapy here. There's a whole other things that psychologists do, and they are, they're not being valued. They're not being valued in an explicit way. Erm, because they don't fit with anything. It doesn't (pause) – because when I'm consulting, talking to a counsellor erm,</p>

		than just therapy.	<p>who's saying 'I hate these outcome measures, they're awful. They get in the way of the therapeutic relationship', and I'm talking with them about different ways of managing that and how they might be able to use them clinically and all these things, nobody – in a way that they can accommodate, because I can, tap in to their way of thinking as well as the CBT therapist way of thinking. No one notices that. No one says 'oh, I've noticed that so-and-so counsellor is now using the outcome measures. How did that happen?' Nobody – so it's things that the way of communicating, the way of understanding different members of a team, the way the system works. We do that, and it's an additional thing that we do on top of the clinical work." (Naomi).</p> <p>"you can demonstrate that in other ways, erm, rather than just on the individual one to one work, erm, so I run formulation sessions for the team and so I'll sit and we'll talk about a client for an hour, a case discussion and we'll formulate from different models, so then it can, I don't know if that's a personal thing that I'm trying to do to demonstrate that there is more to psychology than just the CBT or family therapy approach, so I think that's quite helpful." (Amy).</p> <p>"There are also the more softer skills around erm, being able to formulate how well a team is functioning, which comes into a bit more into the clinical psychologists training. If they haven't done it in their training directly then they will at least have been expected to get an understanding about systemic models and systemic theory they would be able to draw on that in order to get their team to perform, to function better, more cohesively, reduce stress in the team. Erm, whereas, other professions just may not view it in that way. They may see team stress as being purely about financial or resource constraints, and be less able to work within that if they don't control those elements." (Paul).</p>
		<u>Arguing that the professional identity of CP is not threatened.</u>	<p>"It's very difficult. I think there might be a slight danger more at the primary care level. At the secondary care level, I'm not so sure." (Ronda).</p> <p>"I mean our training is very much broader and, I think generally speaking, as a profession we've managed to maintain a really high standard so that I think, in general, a clinical psychologist who specialises in CBT is equipped to think in terms of first principles and to make these kind of adaptations and to reach groups of people who probably struggle, or couldn't, fit in to a more standardised CBT approach. So it may be that people from other backgrounds can be trained as CBT therapists, but I think unless you have that breadth you will only be able to work in a particular way in which you've been trained. So I think clinical psychologists will always be needed, even if services become dominated by CBT, just because our training equips us to think and to work and to adapt. And to integrate because, you know, there are lots of things coming in to CBT these days, from other models, and we know those other models because our training's broad enough, but if someone's just trained as a CBT therapist it's going to take them a lot longer to understand and to make use of that." (Sam).</p> <p>"So we just don't have the funding to be able to have a family therapist in each service and an art therapist and a CBT therapist. Do you know what I mean? So that's why you do have psychologists because between us, you know, there are people who are, who prefer family therapy, and CBT, and mindfulness, and CAT and MBT, so between us we do have a lot of skills, and some of us have more than one, and so I think that's why you've got psychologists because there's less money so you do need people to work flexibly." (Jenny).</p>
		<u>Reflecting on the views of others towards NICE guidelines.</u>	<p>Seeing other CPs as having similar views.</p> <p>"I mean, I don't think my views are radically different from many of the people I work with, many of the psychologists I work with." (Morgan).</p> <p>"I'd, I'd hope that other people erm, saw it how I see it, (laughs), cos otherwise, otherwise I'd feel like I was erm kind of just, almost just doing what I wanted and dismissing what the evidence base said, but I think erm, I think other psychologists would agree to an extent because otherwise why bother having clinical psychologists if you could just employ CBT therapists and family therapists, erm and you wouldn't need clinical psychology at all as a profession." (Amy).</p> <p>"We did have a half day recently amongst our ██████████ psychology service across the Trust, and we talked about how we decide what we offer people therapeutically, and pretty much everyone is working similarly, you know, in terms of being formulation driven, no-one was really working, you know, 'if this person's presenting with this diagnostic category, therefore I must offer them this'. No-one was working with that." (Jenny).</p>
		<u>Highlighting a difference of views amongst CPs.</u>	<p>"I think CBT therapists would view that differently. I think everybody else views it the way I do. Us and them. I actually mean a clinical psychologist who favours CBT and who, heaven forbid, may have been almost totally trained up in CBT, that they're actually coming out of their training with very little else. Very concerning. So they would like what's going on with NICE guidelines, but I cannot see anybody else who does." (Jan).</p> <p>"I think this approach of dividing mental health problems into different categories and then saying 'we have a treatment for all of these disorders' is a very psychiatric one. And I think in psychology the discipline is a bit divided anyway. In my opinion there are some people in the discipline of</p>

			<p>psychology who are failed psychiatrists, because they very much adhere to this kind of model, especially if you think about CBT models, yes we have social anxiety, this is the prescriptive treatment, if the person administering the treatment does it in the right way then the patient should get better. And it's just too simplistic." (Ronda).</p>
		Valuing the difference of views amongst CPS.	<p>"Well I think it's nice that there's some people who are in favour and some who are against. That's good, that opens discussion, it opens thinking, it opens opportunity to share, to – we want to be effective." (Jan).</p> <p>"I think it's fine to have different views on these things. I think what's not fine is to not hear that there's different views." (Jenny).</p>
		Highlighting a split between researchers and clinicians.	<p>"So I'm kind of smiling about that because in the end, you know, there's probably, within psychology there's going to be, you know, psychologists that actually very much want to be involved in research and are very good scientists, and others that are more of practitioners. You know, and I'm sure there are some that are equally, you know, 50/50, but probably some people sit more on one side or the other. And I would say I sit more on the practitioners side, and less research side." (Kim).</p> <p>"Maybe he's not, maybe he's not very comfortable with the chaos, I don't know. You know, I don't know. I don't know the man. I don't know, maybe they're kind of in their... they're prominent research figures. They're very big in their areas of panic and OCD or what have you, and maybe they've got, maybe they're more in their ivory towers, as people call it, doing their research, you know, rather than being on the front line seeing how things actually are. I think that's like a massive thing, isn't it? Boris Johnson doesn't know how much a loaf of bread and a pint of milk costs. Why would he? It's that kind of detachment from those kinds of things, and I think that's why you can't detach the context of NICE guidelines from the power structures that we're in." (Sophie).</p> <p>"I mean in the NICE guidelines there are people who know what clients look like, but David Clarke he (laugh) – he just doesn't see people that we see. In my mind, you know, when he talks about clients – I've seen him speak – he talks, his frame of reference is middle class, white middle class, you know, he talks about people with panic disorder throwing up or wanting to throw up in Marks & Spencers – our clients don't want to fucking throw up in Marks & Spencers, they're down in like a deprived area of Woolwich, like in the pound shop, haven't got enough money to buy their kids – it's not – the social circumstances are not, the same and he doesn't – my concern is that people at the top of the profession, haven't really seen the grit of the profession, and so when they're making decision about what's going ahead based on the research that they've done, erm, they're going to be biased." (Naomi).</p> <p>"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. And those people respond – maybe their disorder, you could package their problem up much more neatly because it's just not as complex, and then they might respond to a very narrow model, so, it might be that their clinical world is nice and neat like their research work, because it's a very specialised service. Yeah, it has certain entry criteria, even in to the service." (Ronda).</p>
		Reflecting on the views of other professionals.	<p>"I've met a lot of clinical psychologists now and I have more in common with all the clinical psychologists even when they're really different from me than I do from a CBT therapist. Especially a nurse CBT therapist." (Naomi).</p> <p>"Erm, well I would say they thought they were absolutely brilliant, you know, and there's no problems with them whatsoever and that's what we should do. All the time. (laugh) Because their training and their profession has always been within that medicalised model." (Naomi)</p> <p>"Yeah, I think definitely something as a guidance but I think that my view differs to maybe how erm managers and commissioners and other colleagues might view them." (Amy).</p> <p>"I'm always really impressed that a lot of the doctors, doctors as in psychiatrists, come in to contact with, they know 'oh, I've read a paper the other day and they said this', and you're kind of like 'yeah, great', you know, because probably, you know, that's good they keep up with the research. But a side of me also does wonder whether they, yeah, kind of hold researchers as kind of 'this is the Holy Grail, and this is, you know, this is the answer to – this is what we should do because this paper says so'. Erm, I think that goes with the training they had, and again coming back to the medical model, you know, where there's a diagnosis, you know, and this is the treatment, you know, and this is what you do. And I think that has to do with the training and how it goes. So, yes, possibly (pause) less sceptical on, you know, possible doctors, medical doctors, may be less sceptical about the research than us psychologists are." (Kim)</p>

	<p><u>Highlighting the key skills of CPs</u></p>	<p>Suggesting that CPs research skills put them in a position to interpret the evidence base.</p>	<p>“I think also because we’re trained in research methods and the training is at doctorate level, most, perhaps not all, but I think (laughs) most clinical psychologists do like to keep in touch with the literature and the research and to remain abreast of developments in their area of interest. And I think that’s an enormous asset, and if you do research yourself even better, but that simply to remain in touch with it is important. And I don’t think that’s particularly emphasised in, in a standard CBT training, but actually it adds huge value. So, you know, my knowledge and practice now is hugely different from when I trained 20 years ago. I got a one hour lecture in CBT for psychosis 20 years ago, and there was no suggestion I should actually do any (laughs). So, you know, most of what I do now I’ve learnt since. So I think that emphasis on continuing professional development on a familiarity with, and regular use, of the research base, maybe doing research ourselves it’s something we bring that other, CBT practitioners who aren’t clinical psychologists rarely have, they might but it’s rare, I think, whereas it’s routine for us.” (Sam).</p> <p>“As a clinical psychologist you are much better placed to understand the research and the evidence. I think someone who has been a low intensity therapist and then a high intensity therapist, just hasn’t had that training in research and evidence and won’t be able to unpick it.” (Paul).</p> <p>“I would expect a clinical psychologist to have a degree of knowledge and understanding of research and of the basis of the guidelines to understand, back to again, the limitations of them so that they weren’t thinking “oh, my manager’s throwing that set of Guidelines at me, I’ve got to do everything it says”. I think, you know, most people with the qualifications we have could argue with their manager appropriately, if necessary, or could look, you know, with kind of an open mind at the Guidelines and assess their opinion on their patient.” (Catherine).</p>
		<p>Valuing CPs training in a variety of therapeutic models.</p>	<p>“I really think that’s a, you know, a treat because there aren’t, to my knowledge, many other types of qualified practitioners out there who are exposed to that level of formal training and wide and diverse models and treatment interventions on offer. And I think that is a great strength of a clinical psychologist working in Britain today.” (Catherine).</p> <p>“You need to be able to call on those different psychological theories and models in order to see which one best explained who you’re in the room with.” (Paul).</p> <p>“You know, there are lots of things coming in to CBT these days, from other models, and we know those other models because our training’s broad enough, but if someone’s just trained as a CBT therapist it’s going to take them a lot longer to understand and to make use of that. So I think we always have an advantage.” (Sam).</p>
	<p><u>Valuing individualised collaborative interventions.</u></p>	<p>Considering it important for interventions to be based on individualised formulations.</p>	<p>“Actually, the people that I work with in this particular service, who aren’t unique in terms of being complex, I think lots of people have multiple complexities in their different areas and different services, but they don’t fit neatly into any one particular box at which you could potentially throw one particular guideline, or even a multitude of guidelines at. You know, you need to have that, you know, overarching perspective with some basic principles of how to understand what might be helpful, what’s going on, the kind of assessment and formulation skills, that, obviously, the cornerstone of clinical psychology.” (Sophie).</p> <p>“you know, when I make a decision it has a thinking behind it, you know, and we do go back to the formulation, you know, so this child is presenting eating difficulties, but actually this is much more of an anxiety, associated with anxiety, rather than anything else, or it could be associated with an attachment disorder rather than an eating disorder per se, or, you know, in a neglect context or whatever it is. You know, and so I can’t just then be making those parents feed that child, because actually I have to address the anxiety, which actually NICE guidelines say I should be doing this for (laughs). So even though on the surface this child is very thin and they’re not eating enough, actually there’s all this other stuff that we’d then need to address, and I’m justifying why I’m doing this in this way because of this.” (Kim).</p> <p>“As it would have come out of a psychological formulation to begin with, it would, hopefully, stand more of a chance of being the right problem to focus on. Thinking more about parsimony in terms of interventions. You know, if there’s one bit that’s just maintaining all the other bits that are happening, focusing your time on that.” (Paul).</p>
		<p>Highlighting the importance of evaluating individual interventions.</p>	<p>“And I think understanding the evidence base means that I have an understanding of what elements are likely to be most helpful, and that’s as far as it goes. I mean beyond that it’s a question of the evidence of the actual individual therapy that you’re doing, and evaluating that. And it might be somebody’s prepared to do measures, but even if they’re not you can have a conversation about it. You know, I always build in regular reviews so that we pause for thought about is this helpful, is this working, is there something we need to do differently? And at the end always having a final session in which we think about what’s been helpful, and I ask for feedback.” (Sam).</p>

			<p>“But if I were to say oh well yeah I'm doing a piece of psychodynamic work with this client dur dur dur, erm they might say well that's not mentioned in NICE guidelines why are you doing that and how do you know if it's working or not. Whereas you know, I know if something is working if somebody is continuing to see me and telling me it's helpful.” (Amy).</p> <p>“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 <u>doing something that clients were telling me was not helping but I don't feel I need NICE guidelines to do that.</u>” (Morgan).</p>
		Valuing collaborative decision making with service users.	<p>“Erm, so you know I would be much more interested in, rather than just referring to the evidence, whether it's in NICE or not, I'd be more interested in having a collaborative conversation with my client about what the issue was, what they needed, what they thought might be helpful. I would want to get regular feedback in the session from them about whether they felt what I was doing, what we were doing was helping them or not helping them. I would want to tailor my approach according to that individual more than what may or may not have got published.” (Morgan).</p> <p>“And, certainly in my area of work, very complex, all sorts of things going on, it's not one thing or another, you've got to take a person as a whole and you've got to work with the difficulty that they're bringing to you. Again, you know, you can't do psychology on someone, they have to be an active part of that sort of treatment, that kind of pathway, and that's very much where I sit as a therapist.” (Catherine).</p> <p>“I always want to meet with them and I always want to talk to them about psychological approaches and have a discussion with them about whether they feel it might be a useful thing for them. But I tend to do that leaving it wide open in terms of what that might mean. I don't think of myself as making a very prescriptive offer because I want them to participate in deciding what shape or form that will take.” (Sam).</p> <p>“I think it would be a very worrying position to be in if psychologists did think that there was a 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, and to be very mindful of your own assumptions and judgments about what is acceptable. What is distressing, what isn't distressing, and what is positive for that person. Actually, that kind of facilitation of, not even helping, because that also implies a power imbalance, but sometimes, <u>just going back to some real basics about listening to what that person is going through.</u>” (Sophie).</p>
		<u>Arguing that it is difficult to detach NICE from vested interests.</u>	<p>“Well, I mean, you know, you can think of a lot of these kind of discussions as discussions about people shoring up their own power base can't you. So, you know Psychiatrists will be in favour of diagnosis because that's what they do, and that will shore up their power base. Psychologists will talk about formulation because that's what they do and that will shore up their power base if that became the currency. NICE guidelines overwhelmingly support CBT, so it's no surprise that CBT therapists might you know be a bit more positive about them. You know, its, if you took out people's personal investment and bias, and the benefits to them in their particular profession, I'm not sure you'd have much of an argument left on any side.” (Morgan).</p> <p>“And I think you might even see more of the tension, because of the cuts to the health service, every sort of professional body needs to fight for their existence, it needs to fight for jobs and for jobs on higher bands and sort of the hierarchy and, you know, so people have certain investments in certain things being endorsed so it gets played out on a sort of political level, and it's not necessarily always about which treatment works.” (Ronda).</p> <p>“Actually, at the end of the day, you're probably going to be sitting with somebody who may have come to you in some form of distress or turmoil, and actually, what they need is to be heard, listened to, and given some empathic kind of human contact and you know, there's no NICE guidelines that can say that, and there's no medication, there's no money, there's no value in selling that. That's another thing, as well, isn't it, that people kind of sell their approach? If NICE guidelines recommend this particular thing, 'Ooh, join this new CBT for OCD course.' It costs you £300 for a day to know and do this NICE-approved da-da-da-da. Yet you can't detach those sorts of things from those.” (Sophie)</p> <p>“‘Oh, NICE guidelines recommend it.' Okay, great, yes, wonderful. We can pat ourselves on the back for doing something that people are going to be approving of. Okay, great. ‘Yes, you can have funding for this therapy that so-and-so is running who developed the NICE guidelines.' Wonderful. <u>Where is that money going? Has it got a little TM market?</u> (Sophie)</p>
	Having a flexible relationship with	<u>Meeting NICE halfway.</u>	<p>Considering it important to work within the language of NICE and</p> <p>“There's a point that we have to find a way of arguing our point, you know, about integration, about – but we have to use, to do that I think we have to join the language, we have to kind of work within NICE, with NICE guidelines, with evidence base practice and try to find a way. Because otherwise, again, we're just going to be seen as very polarised.” (Kim).</p> <p>“I mean, you know, we're competing against drug companies, really, so, erm, and erm, trying to demonstrate that drugs don't necessarily get to what the</p>

guidelines	<p>categorisation.</p> <p>problem is. So, if this drug is for this then we need to have a psychological therapy for this. I think it creates – I think it has erm, I think it has created power, but it’s also been very divisive.” (Naomi)</p> <p>“I think that might relate to just, a kind of scientist practitioner loop that a lot of the research is published in the States for, too, and they use DSM language in categories, and if we want to publish here in the U.K. erm, we probably want it to be U.S.-friendly. For example, we’ll format in APA guideline, and use DSM language.” (Paul).</p> <p>“I think this rhetoric of ‘we should work with it’ is probably – I mean you have to sort of work, because a problem is if you go work in a service, in a sort of everyday life, and if you go around and you make this your mission and you constantly argue against everything other people are saying, I think you will just create opposition and it wouldn’t get you anywhere. It’s a sort of political playing field, and I think very much that we need to work on this and we need to find ways of changing it, and I think some of that needs to come from within.” (Ronda).</p>
	<p>Considering it important to highlight the limitations but continue to use NICE.</p> <p>“What I think is important is just continue to be aware of the limitations of all this, of NICE guidelines and the research where these recommendations were based from, and all those sorts of things just continue to be sceptical, be aware of the limitations but continue to try to gather more evidence, to continue to try to get better research protocols.” (Kim).</p> <p>“But, like I say from the beginning, I think having that guidance and that framework can never be bad to have it, absolutely not, but an understanding of the limitations or how they can be used.” (Catherine).</p> <p>“I’m not saying that the things that NICE guidelines recommend may not be helpful. I guess it’s the lack of thought that might go into the collection of the evidence. Like I said, it’s not about throwing the baby out with the bathwater. It’s about being very clear and honest about what you’re doing, why, and when you’re going to use it.” (Sophie).</p> <p>“Erm, I think, I think it’s helpful to have guidelines, and I think it would be a shame if we didn’t have something like the NICE guidelines. So I think it’s a good enough system. I think it is just about educating the people who use it to use it intelligently.” (Jenny).</p>
	<p>Wanting NICE to review its approach.</p> <p>“If there’s no guidance – I’ve a little bit of a panic about letting go of NICE, and I’m not particularly invested in it. So if I’ve a little bit of a panic, so would other therapists. And it does seem to be something about in these uncertain times to have least have something. Erm, on the whole though, I think it would be a good idea to (pause) – I mean what you’re doing is interesting because you’re doing an audit on NICE itself, which is why I responded. I think it’s a nice idea. NICE obviously surveying everyone, and you’re stopping and saying ‘is NICE helpful for mental health?’ And 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, which is what you’re doing. And I like that a lot.” (Jan).</p> <p>“You know, they refresh their guidelines every 5 years, why can’t they look at, you know, the overall framework they’ve got for the guidelines, because it isn’t evidence based and it needs examination. So I wouldn’t say it was a good start or even the best start, but it was an obvious place to start and an understandable place to start. It’s got the whole thing started. Yeah, but it does need to develop. And I don’t think anyone should feel entirely happy with it.” (Sam).</p> <p>“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? And it should be that process of reflection, should be occurring. I’m not sure it is, but it should be, because if they’re all about evidence based practice, you know, where is the evidence for the diagnostic system? Particularly a diagnosis like schizophrenia, it’s so contested, and I think if you look at the evidence it makes no sense whatsoever and you shouldn’t be using it in an evidence based system.” (Sam).</p>
	<p><u>Using NICE to suit our needs.</u></p> <p>“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).</p> <p>“So, it’s almost as if, the, erm, the fact that something features in NICE is your kindof 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</p>

			<p>ending up doing it with groups of people that would not be NICE approved.” (Morgan).</p> <p>“So I would say I’m aware of them, but in my clinical practice I would go over and above the NICE guidelines. I think sometimes you can use the NICE guidance to make an argument for certain lengths of treatment, you know, if there’s some sort of conflict around how long should this person be seen or, this person has already had two courses of therapy, we shouldn’t give them any more. Sometimes you can actually use the guidelines to make a case.” (Ronda).</p>
		<p><u>Using NICE as guidelines, not instructions.</u></p>	<p>“So it’s, it is important to, erm, to work with what NICE guidelines are saying, but in the back of my mind I’m always thinking well it is guidelines and I know that there is emerging evidence for other, other interventions, or maybe a combination.” (Amy).</p> <p>“Erm, in my own practice, in terms of working with patients, I think it is important to be aware of the NICE guidelines, and it is important to be aware of the evidence. But often when you actually sit in front of the actual patient, the problem is always that the model is fundamentally flawed, in my opinion, because it’s never as clear cut as that. So it’s never just OCD or just depression or just anxiety, and in practice I would say I go much more with the transdiagnostic approach and I sort of pick and take from the different guidelines.” (Ronda).</p> <p>“So I follow the NICE guidelines in the sense that I think all of these people should have access to psychological therapies. I’m not specifically going to say ‘here I am, offering you 16 sessions of CBT’, because I don’t want to start like that. It doesn’t feel collaborative, it doesn’t feel a helpful beginning. So whilst I know in my mind that the NICE guidelines says I should do that, I go with an open agenda and say, ‘Well, let’s think about’ – and many people, when I meet with them, are tentative and we might make an initial contract to meet 3 or 4 times to talk about – for some people it might be to talk about the fact they’ve got problems sleeping. They don’t want to talk about psychosis at all. And it’s only once they’ve got to know me and I’ve got to know them a little bit that the agenda changes and we agree to talk about maybe more difficult things, like a psychotic experience. So by the end, or 10 sessions in, we might be doing something you could call CBT psychosis. But we may not have started like that.” (Sam).</p> <p>“erm, I see them as being quite broad, and they’re guidelines, so in my mind they’re not, erm, they are something which is open to interpretation.” (Amy).</p> <p>“Erm, I mean most of the time, as far as I can ever see, its, you know, just says CBT. So it’s actually quite an unhelpful guideline in some ways, because what sort of CBT are we going to talk about? Third wave methods? Mainly B or are we going to talk about mainly C? It leaves it wide open to interpretation. That suits me, as a practitioner.” (Naomi).</p> <p>“I guess, you know, I tend to see them as guidelines. I take the words kind of literally. So, for me, it feels like it’s useful in providing a sense of direction, or of what might be useful in thinking of a particular disorder/diagnosis, whatever you want to call it, client group. But, for me, they’re guidelines, rather than somebody telling me what to do. So, in that way, when I look at, you know, because they’re guidelines, I find it really useful.” (Kim).</p>
		<p><u>Valuing having excuses as to why not to follow NICE guidelines.</u></p>	<p>“So on the one hand it’s very frustrating that we’re supposed to work to NICE guidance that don’t really come from our client group, but on the other hand the advantage is that we can say ‘well, they don’t really fit our client group’, so, you know, we can retain a bit of protection from that, I think.” (Jenny).</p> <p>“I think the field in which I work, I feel quite lucky that NICE Guidance isn’t pressed upon me to use, as such.” (Catherine).</p> <p>“I kind of don’t want to say this because I don’t want you to publish this and it to be known, because actually it’s lovely. I think we’ve a lot of freedom in [redacted] services. Yeah, please – I kind of don’t want you to write that (laughs). Because I think it might get taken away, because I don’t think people realise.” (Jenny).</p> <p>“I personally don’t feel the pressure to follow any particular guideline in this particular service. That might be because I haven’t been told that’s what I’m meant to be doing and I’m not doing it, or I have been told and I’ve conveniently forgotten, I don’t know, but there aren’t the guidelines that are applicable to our service users.” (Sophie).</p>

		<p><u>Not advertising the way one practices.</u></p>	<p>Being secretive about ones' views.</p>	<p>"I don't think my views are radically different from many of the people I work with, many of the psychologists I work with. Erm, I wouldn't say them publicly in a meeting with managers. Erm, but er, I don't think they're particularly unusual views amongst psychologists, probably." (Morgan).</p> <p>"Well I, well I certainly wouldn't advertise what I do to the managers." (Amy).</p> <p>"It's certainly affected the services that I work in and the culture of the services. The very fact that I've had to check with you about why what I said earlier was going to be anonymous is an indication of how tight and controlled the culture is really." (Morgan).</p> <p>Note - before we started recording, Naomi made a point of checking that the door to the room was definitely closed and noted that she did not want anybody listening in on our conversation.</p>
			<p>Ignoring NICE.</p>	<p>"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] 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, like [redacted]. 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).</p> <p>"I think they're one of those things that I read and I might either think that it doesn't apply, or we're doing it anyway, or that kind of makes sense but I don't necessarily hold them internally, go, 'Oh, I'm doing what it says in the NICE guidelines.'" (Sophie).</p>
			<p>Labelling an intervention as CBT when its more fudgy around the edges.</p>	<p>"I think – do I think it's ok to do CBT and be...? I think I do tend to try and use one model when I formulate, but I do think I draw on different approaches when I work with somebody. So, I think I might – if I was formulating somebody using a CBT model, then 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).</p> <p>"yeah, I think erm, I think for me I'd, I feel that I need to make sure I'm offering a CBT intervention, erm, but like I said I guess in reality what you are doing in the clinical room might be quite creative erm drawing on different models" (Amy)</p> <p>"I do use CBT for psychosis quite a lot. I'm quite familiar with that model. I know that that's an approach that does work with a lot of people and, you know, I'm working with some of my assistant psychologists to give that model of treatment. So I will feed back to the team that that's what I'm doing, broadly, with that person, but that doesn't mean that I am only doing CBT for psychosis with that person, I would bring in DBT elements, for example, if that was thought to be necessary, or more kind of systemic or schema focused work if – because for me I guess it just depends on what language you're able to use with the patient that you're working with, and what languages they use. You know, people who like schema work will talk with their voices in the sense of "one part of me thinks this" or, you know, "one part of me thinks this", and you can very quickly bring in the schema focus, things like that. But a lot of the therapies are also very similar to each other. So, you know, it's not always the case that you're just doing CBT, you're often doing other things. But the broad model you might be working with, in terms of session by session might well be a CBT framework." (Catherine).</p> <p>"I think, you know, you could easily then fall into the trap of saying 'ok, let's just call it CBT to satisfy, you know, those who make those decisions, but what we do in reality is actually very different'. I think there's a danger in doing that because then you're sort of buying in to the model and you're saying 'yeah, I'm doing the CBT and it works' rather than saying 'actually, no, I wasn't doing CBT, and it still works'." (Ronda)</p> <p>"you fudge, not fudge, but you just kind of make what you do fit into a particular guideline." (Sophie).</p>
		<p><u>Being NICE concordant.</u></p>	<p>Drawing on different models and integrating into CBT.</p>	<p>"I consider myself to be pretty integrative, but kind of try and erm ground it in CBT so that I can think that I'm doing CBT." (Naomi).</p> <p>"You can integrate – I quite often make use of psychodynamic or systemic ideas which I might, you know, bring in to my CBT work. So my work might be broadly CBT but there might be a session in which we're, you know, talking about maybe family relationships, and I need to be thinking systemically and I start doing some circular questioning, or something like that, which I think is perfectly fine within a CBT model. I mean you're talking about thoughts and feelings and you're talking about it in an interpersonal context" (Sam).</p> <p>"It's quite hard except for pure behavioral therapy, pure classical psychoanalysis, to think of models that are pure in inverted commas. Erm, so I think if you're doing good CBT you're integrating erm, the core principles of Rogerian Therapy, you're integrating the cognitive theory, behavioral theory, erm,</p>

			<p>but you're also including ideas from systemic therapy, especially the work of people like Anna Vizzor up at UEA when she started to bring in systemic ideas into CBT, so I wouldn't be as close as dividing those two. But, erm, I don't know, maybe that's just me trying to find a get out, from the fact that I suspect I probably am an integrative therapist, erm, I think most clinical psychologists are more likely to call on ideas from other models and other therapies, in order to assess what they are, what the labels says that they're doing. I think even if you're doing maybe systemic therapy in a child and adolescent team, as a clinical psychologist, you're probably using within that systemic therapy ideas from a broad-range of other models anyway. Maybe I'm just providing myself with an excuse, to say that I'm both model adherent and integrative." (Paul).</p>
		<p>Focusing on the underlying principles to a therapy rather than following a manual.</p>	<p>"RCT's are generally done with a population of people who are, you know, prepared to fill out multiple measures, usually in every session, and who reliably attend, and who are, as it were, up for the treatment right from the off, because they have to be in order to sign the various consent forms, and several, so that's a highly selective group of people. So, in the real world, where you see a much broader – some of those kind of people around – but you see a much broader group, 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 principals of the treatment and the key elements, so you make your adaptation, as it were, knowingly, and don't just drift in to something that was no longer recognisably CBT." (Sam).</p> <p>"If there isn't a guideline for your client group, you need to have almost a better understanding of what it is that intervention is about in order to be able to... The mechanics of how that works, how that might apply to your group or not, and how to assess that rather than just kind of blindly applying something and going, 'Well, this is what the evidence base says.'" (Sophie).</p> <p>"Erm, well, I guess I wouldn't necessarily agree that the manuals are the therapy; erm, the manuals are a broad reflection of what the creators of the therapy would want it to look like. If you ever see any clips of Tim Beck doing CBT, though he calls it cognitive therapy, he doesn't set an agenda, he doesn't get out thought records, doesn't set behavioral experiments, but he just naturally uses the underlying philosophy of it, and it works. Erm, he would fail, for example, at cognitive therapy rating scale... erm, yeah, I guess I stick more with an understanding of the foundation principle of the therapy in the room, rather than a cookbook approach." (Paul).</p> <p>"And, you know, the NICE guidelines are just a starting point. I think there still is, and there should be, plenty of room for clinical judgement of adaptation and flexibility around the individual needs of the person. I have no qualms about making adaptations and moving away from manualised treatments, because I think to actually really increase access to psychological therapies and ensure that people have these options, you have to do that, if you don't do that then only a tiny minority of people will ever receive the kind of manualised intervention that the RCT's offer. And I, you know, I don't think it should be exclusive in that way. I don't think it should only be well educated, literate people who are happy to fill out reams of measures and good at keeping appointments." (Sam).</p>
		<p>Having strict boundaries.</p>	<p>"I guess if you're asking: would I end up giving CBT to someone because it's in the NICE guidelines but actually my psychological formulation has been pointed towards it. No, I don't think I would; no, but then, erm, what would I do? I think if it seemed, if it seemed reasonable I'd have the conversation with the client. Erm, I've always found that the best supervisor any therapist can have is always the patient in the room with you. Erm, so I would present it as: 'we've talked about erm, your background and how you've led to now have this sense of emptiness and low mood, and there seems to be a lot of unresolved issues to do with patterns of relationships you got into a young age, and how they're replicating themselves now. We, here, offer therapies that focus more on your thoughts and behaviors, erm, so the choice would be that I could either refer you on to someone else to recap the sort of relationships you get into and how they relate to your childhood, or, we can see if by affecting your thoughts and behaviors that might have a knock-on effect to influence how you relate to others, and do you want to give it a try?' and then be very clear about the scope of it. Then maybe build in a much earlier review session in the therapy that might not otherwise have done. They would get to session four and say, 'We gave this a shot and we are not really seeing much benefit at the moment what do you think?'" (Paul).</p> <p>"Erm, it's, it's a difficult balance to make. I think if the client was coming for erm, symptom reduction, you've probably got a lot less of an issue, because your DSM categories are usually based around symptoms. Research is usually based around symptoms, and the NICE guidelines reflect these things, erm and CBT's success is the success built around symptom reduction. So, if that's what the patient is coming for then it's much less of a problem. If they're coming for some sort of personal resolution, or what Americans often call closure, erm, then you're more likely to be unstuck. Then it might be a case of saying that the NHS just doesn't offer, the things that they're after, and then talking about how they would go about finding a good, private therapist, and different forms of accreditation in what they're in." (Paul).</p>

Recognising the context of the current economic climate.	<u>Noting that services do not have the resources to fully deliver NICE recommendations.</u>	<p>“I mean, you know, you can say ‘look, this person’s got depression’, you can go back to supervision and say can I have 18 sessions because that’s what it says in the NICE guidelines, but then you’ve still, you know – the evidence has helped build these services, but actually we’re not delivering the evidence. So they’re kindof, so even if, even if I can completely sign up to a medicalised model of a disorder, which I can’t, we’re not, delivering what, because of budget, budget pressure.” (Naomi).</p> <p>“I know in some schizophrenia research erm it was highlighted that, you know, for the NICE Guidance for example, one of the recommendations is that anybody with a diagnosis should be offered family therapy. It’s not CBT, but it’s family therapy, so, you know, and I think that will be brilliant. I think if I could offer full family therapy to everyone with schizophrenia, that would be great, but I can’t. We run a county wide service, so I couldn’t work with every family of the people.” (Catherine).</p>
	<u>Stressing the importance of seeing NICE guidelines in the context of the current economic climate.</u>	<p>“I think NICE guidelines have to be seen in the context of which you're trying to provide a service for people with limited resources. I don't think that what's written in those guidelines can be understood outside of that context. Because actually, there might be other things if there weren't constraints on resources. Other things might be more helpful, and I think that that's a massive point.” (Sophie).</p> <p>“But my sense is it's more around (pause) economics and kind of (pause) the need to reduce the funding or not increase the funding so much to the NHS. And to make sure, I suppose, that that money is well used so that less money is being stretched further. So I don't think it's badly motivated. I trust that they're trying to make the most of the limited money that's available.” (Morgan).</p> <p>“I think it’s also desperate times and people are actually reacting to things in desperate ways.” (Jan).</p> <p>“Sorry, let me just add something to that, because, but also clinical psychologists in this day and age need to understand that these decisions are being made in financial terms and by business models, and you have to adjust. You can’t be “oh, I’m just working with individuals. I’m going to do any therapy I want because that’s what I’m trained in”, you have to understand that there are financial consequences, and in order for you to be the most effective clinical psychologist in the NHS, you are going to need to make sure you’re keeping an eye on your waiting lists and that you’re not making people wait undue time. You have got to use your skills in the most cost effective way possible that doesn’t completely contradict everything I’ve just said about, you know, so it would also be naïve, yeah. It would also be naïve, I guess, for a clinical psychologist to think that the finance people and the business people don’t care, don’t matter, because of course they do, and politically and sociologically that’s very important, and ultimately pays our, you know, pays our wages.” (Catherine).</p> <p>“I suppose I thought there was nothing terribly wrong with the system as it was when I first qualified, before the NICE guidelines. (pause) but it requires you to sort of trust clinician judgment more, or to trust that an experienced clinician (pause) would make sensible reasonable decisions about what's effective and helpful for somebody rather than to centrally prescribe that. I don't think that's the kind of culture that we're in really at the moment. Yes, I think it's changed radically. I think it's become much tighter, and much more centralised, much more anxious, and much less well-resourced. All of those things create this sort of centralised control system.” (Morgan).</p>

Appendix Q: Hood's (2007) Key Components of a Grounded Theory Study (influenced by Glaser and Straus (1967)).

- 1) A spiral of cycles of data collection, coding, analysis, writing, design, theoretical categorisation and data collection.
- 2) The constant comparative analysis of cases with each other and to theoretical categories throughout each cycle.
- 3) A theoretical sampling process based upon categories developed from ongoing data analysis.
- 4) The size of sample is determined by the theoretical saturation of categories rather than by the need for demographic representativeness, or simply a lack of additional information from new cases.
- 5) The resulting theory is developed inductively from the data rather than tested by data, although the developing theory is continuously refined and checked by data.
- 6) Codes emerge from data and are not imposed priori upon it.
- 7) The substantive and / or formal theory outlined in the final report takes into account all the variations in the data and conditions associated with these variations. The report is an analytical product rather than a purely descriptive account. Theory development is the goal.

Appendix R: Table of Codes and Categories

Theme	Category	Sub-category	Focused Codes	
<u>Considering NICE guidelines to have benefits but to be fraught with dangers</u>	Valuing the benefits of NICE	<u>Noting that NICE guidelines can provide consistency</u>	Noting that guidelines can help organise services	
			Highlighting that NICE guidelines can help the public know what to expect	
			Valuing the shared language that categorisation and NICE guidelines provide	
			<u>Recognising the power of NICE endorsement</u>	
		<u>Valuing NICE's assistance in delivering evidence based practice</u>	Seeing NICE as a useful guide to the evidence base	
			Feeling that NICE provides a safeguard against bad practice	
		<u>Feeling that the concerns about guidelines can be challenged</u>	Considering it understandable to go with the evidence base in the climate of reduced resources	
			Acknowledging the problems with NICE guidelines but arguing that we would be worse off without them	
			Arguing that it is possible for other therapies to emerge and gain NICE backing	
			Challenging criticisms of CBT	
			Seeing value in CBT	
			Understanding why the medical model was chosen by NICE	
		Worrying that NICE guidelines can create an unhelpful illusion of neatness	<u>Feeling that guidelines can be misunderstood or misinterpreted</u>	Admitting to not having a clear understanding of NICE guidelines
				Worrying about others misuse of NICE guidelines
	Highlighting that people may follow NICE without being familiar with the evidence it is based on			
	Feeling that managers can follow NICE guidelines without questioning their relevance			
	Worrying that service users may misinterpret NICE			
	Arguing that an absence of evidence is not evidence of ineffectiveness			
			<u>Worrying that commissioners can view NICE as a way to limit spending</u>	
			<u>Believing that NICE is doing harm to service users</u>	
	<u>Experiencing guidelines as limiting</u>		Worrying that NICE guidelines may lead to neglecting other therapies	
			Worrying about the dominance of CBT in NICE guidelines	
			Questioning the effectiveness of just providing short term interventions	
			Seeing value in approaches not recommended by NICE	
	<u>Questioning the scientific integrity of the guidelines</u>		Questioning NICE reliance on RCTs	
			Highlighting that the majority of evidence is based on working age adults	
			Highlighting the difficulty in researching psychological therapies	
			Arguing that CBT fits well with NICE whereas other therapies do not	
	<u>Having a problem with</u>	Questioning the validity of diagnostic categories		

	<u>the medical model basis of NICE guidelines</u>	Arguing that the medical model is dehumanising
		Suggesting that there are alternatives to the medical model
		Arguing that routine practice is more complex than NICE guidelines
Perceived level of pressure to be NICE compliant		<u>Experiencing an underlying threat or pressure to be NICE compliant</u>
		<u>Noting that NICE guidelines aren't currently experienced as restrictive</u>
	<u>Worrying that NICE could become more controlling</u>	Worrying about the future
		Worrying about PBR
		<u>Acknowledging concerns for the future, but not being worried by them</u>
Beliefs about the purpose of, and future of clinical psychology	<u>Worrying that the jobs or ID of CPs are threatened</u>	Worrying about CBT therapists being seen as a cheaper alternative
		Being keen to differentiate from single modality therapists
		Seeing NICE as a threat to integrative practice
		Highlighting the difficulty explaining what CPs do
		Arguing that CPs have bigger roles than just therapy
		<u>Arguing that the professional identity of CP is not threatened</u>
	<u>Reflecting on the views of others towards NICE guidelines</u>	Seeing other CPs as having similar views.
		Highlighting a difference of views amongst CPs
		Valuing the difference of views amongst CPs
		Highlighting a split between researchers and clinicians
		Reflecting on the views of other professionals
	<u>Highlighting the key skills of CPs</u>	Suggesting that CPs research skills put them in a position to interpret the evidence base
		Valuing CPs training in a variety of therapeutic models
	<u>Valuing individualised, collaborative interventions</u>	Considering it important for interventions to be based on individualised formulations
		Highlighting the importance of evaluating individual interventions
Valuing collaborative decision making with service users		
<u>Arguing that it is difficult to detach NICE from vested interests</u>		
Having a flexible relationship with guidelines	<u>Not advertising the way one practices</u>	Being secretive about ones' views
		Ignoring NICE
		Labelling an intervention as CBT when its more fudgy around the edges
		<u>Valuing having excuses as to why not to follow NICE guidelines</u>
		<u>Using NICE to suit our needs</u>

		<u>Meeting NICE halfway</u>	Considering it important to work within the language of NICE and categorisation
			Considering it important to highlight the limitations but continue to use NICE
			Wanting NICE to review its approach
			<u>Using NICE as guidelines, not instructions</u>
		<u>Being NICE concordant</u>	Drawing on different models and integrating into CBT
			Focusing on the underlying principles to a therapy rather than following a manual
	Recognising the context of the current economic climate		Having strict boundaries
			<u>Noting that services do not have the resources to fully deliver NICE recommendations</u>
			<u>Stressing the importance of seeing NICE guidelines in the context of the current economic climate</u>

Appendix S: Example of Notes Made Prior to Interviews

Writing up notes like this provided a structured way of reviewing previous transcripts, coding, notes, information in the research diary and the participant specific information, such as information from their pre interview questionnaire. Doing this before interviews helped me to plan what kind of information I might like to explore further with participants if the opportunity presented itself (whilst trying to follow the lead of the CP as much as possible – see Appendix N for examples of questions used in interviews).

Thoughts prior to interview with [REDACTED]

Remember to ask if got any question before start.

Aim to start with general conversation, see where goes. Have some notes from previous interviews, may bring them in, might not, see how goes.

- Working in [REDACTED] do you feel that NICE guidelines fit the people you see? (*are there instances when the evidence behind the guideline were based on a different client group? (this is what the [REDACTED] psych said)*).
- On questionnaire, gave 9/10 strongly agree for nice guidelines can have a detrimental effect on both formulation and intervention. More info on thoughts on this please?
- On questionnaire gave 8/10 strongly agree pressure to follow nice guidelines. More info on this please?
- Areas where not many nice guidelines available ([REDACTED] / [REDACTED] etc) still able to be flexible. Ok? Worrying? Can pick and chose when to use guidelines. Can use them when want power but say no, not based on our client group when don't want to use.
- HOW is NICE used in [REDACTED]? Similar to adults?
- worry about training in a nice endorsed therapy? Maybe newly qualified cps do. Is this something more experienced cps value / feel they need to do?

Some people have mentioned that it is helpful to have a **nice recommended therapy qualification** on your CV, will help getting jobs. Others have said that this could be problematic, could pigeon hole you. What are your thoughts on this? What would be bad about being pigeon holed as following NICE?

- pre and post introduction of nice. More integrative in past. Now more classifying therapies, for x do y. cant say integrative any more. Integrative doesn't fit with the evidence base.
- Is there conflict between being model adherent and integrative. Pros and cons of each?

Some Cps said cbt isn't manualised, it is possible to integrate other modalities and it will still be cbt. Beck doesn't do agenda setting etc. its just about the philosophical approach. VS Other cps appear to feel more uncomfortable about this, will integrate different ideas into what they call cbt but aren't sure it actually is cbt anymore but hide this from managers. Others will think in different modalities and then translate to cbt.

- Not worried about payment by results? Can do a v general clustering then get better formulation later. Agree / disagree?
- Not perfect but best option available. Agree / disagree?
- Something about If too individualised giving too much time, prevents time for others? something about limitations of therapy on NHS? Symptom reduction or something more?

Cbt fit better with nice than other interventions? Is this ok? Or problem? Nhs can only be expected to treat symptoms. Or this is only scratching the surface?

Worrying cp could be seen as a luxury?

Difficulty in measuring change in some therapies. In financial climate, go for what has been shown to work. Best option. Other therapies may not work.

Something that has come up a lot – emphasising the role of CP, how different to CBT therapists etc, not just indiv. Why do u think this has come up from talking about NICE? Where is the link?

Importance of non 1:1 work of cp. How is this measured in the service? Nice a threat to this cos it tends to focus on 1:1 thx? Same in [REDACTED]?

CBT discussed a lot in interviews about nice. Why?

Some cps think that nice doesn't take account of all evidence, eg practice based evidence, other cps say it does take account of different types of evidence, it has a hierarchy of significance it puts on each, and this is appropriate. Uses best quality. What are your thoughts on this?

People can misinterpret nice guidelines. Some people see this as worrying, others see it as a role for CP, to be in a good position to help interpret them – research training, training in different modalities etc.

Is there flexibility on how to use guidelines? Or set in stone?

Are they restricting? Is this good or bad?

Difficulty explaining what cp do? Doesn't fit neatly with nice? Nice trying to make a complicated thing neat. Best option? Or problem? Putting the problems and blame in an indiv rather than society / relationships etc?

Nice based on flawed categories of mental illness, but best option available? Gives shared language. Or real problem?

Nice can be helpful in endorsing psych thx

Tension in team between cp and other therapists?

Some people have said that there is a discrepancy between the cbt in rcts and the cbt in routine practice, with rcts being pure and routine practice not being pure. Other people have disagreed, saying that cbt isn't manualised, it is a philosophical approach that is by its definition an integrative approach. What are your thoughts on that?

Something about evidence base being important?

A shared language that NICE and diagnoses provides (not just thinking about diag, thinking about nice – ie therapies are categorised and fitted to diagnoses categories). Is this a good thing or a bad thing? Eg x condition needs y treatment?

Think other cps agree / disagree with your views on nice? Y?

Appendix T – Letter to R&D and Ethics Committee

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Salomons Campus
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Broomhill Road
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TN3 0TF

09.04.2014

Dear Research and Development

Study Title: A Grounded Theory of Clinical Psychologists Beliefs About, and Use of NICE Guidelines.

I am writing to inform you that the above study has now been completed. Please find attached a brief summary of the findings of this research. Please do not hesitate to contact me if you require any further information.

Yours sincerely



Alex Court
Trainee clinical psychologist

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Faculty of Social and Applied Sciences
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Dear Research Ethics Committee

Study Title: A Grounded Theory of Clinical Psychologists Beliefs About, and Use of NICE Guidelines.

I am writing to inform you that the above study has now been completed. Please find attached a brief summary of the findings of this research. Please do not hesitate to contact me if you require any further information.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Alex Court', written in a cursive style.

Alex Court
Trainee clinical psychologist

Ajc100@canterbury.ac.uk

Appendix U - End of Study Summary Report for Participants, Ethics Committee and R&D.

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

Background

There is a growing research interest into investigating why NICE (National Institute for Health and Care Excellence) guidelines are not consistently followed in UK mental health services.

It was felt that Clinical Psychologists (CPs) were a particularly important profession to investigate. They are important members of UK mental health services and their use of NICE guidelines had not been formally researched. Furthermore, there appear to be conflicting views regarding NICE guidelines within the profession.

Aim

The aim of this study was neither to promote the use of NICE guidelines nor to dispute them. The study attempted to construct a theoretical framework to help explain how NICE guidelines are utilised and the factors that impact upon this.

Method

Eleven CPs, working in routine practice in the NHS were interviewed (recruited from three NHS trusts). Grounded theory methodology (Charmaz, 2006) was utilised to guide the data collection and analysis.

Findings

A theoretical framework was produced conceptualising the participants' beliefs, decision making processes and clinical practices (Appendix 1). The overall emerging theme was "considering NICE guidelines to have benefits but to be fraught with dangers". The 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 CPs worried that guidelines could easily be misunderstood and used in a rigid and limiting manner. There were concerns about the harm that misuse of guidelines could do to service users and also to the profession of clinical psychology.

The participants reported drawing on specialist skills such as idiosyncratic formulation and integrative practice, despite these skills not fitting comfortably within the NICE guidelines format. However, as a result of pressure, and also the rewards that follow from being seen to be “NICE compliant”, they tended to practice in ways that prevent these skills from being recognised. This led to many of the participants fearing that their professional identity was threatened. They worried that if people mistakenly believed that routine clinical practice was as neat as guidelines falsely imply and their specialist skills were not recognised, then single modality therapists would be seen as a viable, cheaper alternative to CPs.

Clinical Implications

The results of this study challenge dominant discourses around the validity and utility of NICE guidelines in UK mental health services. Challenging these dominant discourses may help counter-discourses emerge and allow discussion about the limitations of guidelines and how these are best managed.

The participants of this study were keen for guidelines to be utilised flexibly, with an awareness of their limitations. This would mean allowing clinicians to have room for clinical judgement and to deviate from guidelines when relevant. This would acknowledge that individuals seen in routine practice do not fit neatly into guidelines. This has important service organisation implications, as NICE guidelines are increasingly being viewed as performance standards, centrally prescribed and monitored.

This study highlights the importance of CPs finding ways to improve the way that they articulate and advertise their specialist skills.

Mr Alex Court

Trainee Clinical Psychologist

Canterbury Christ Church University

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Supervised by Ms Anne Cooke and Dr Amanda Scrivener

Reference

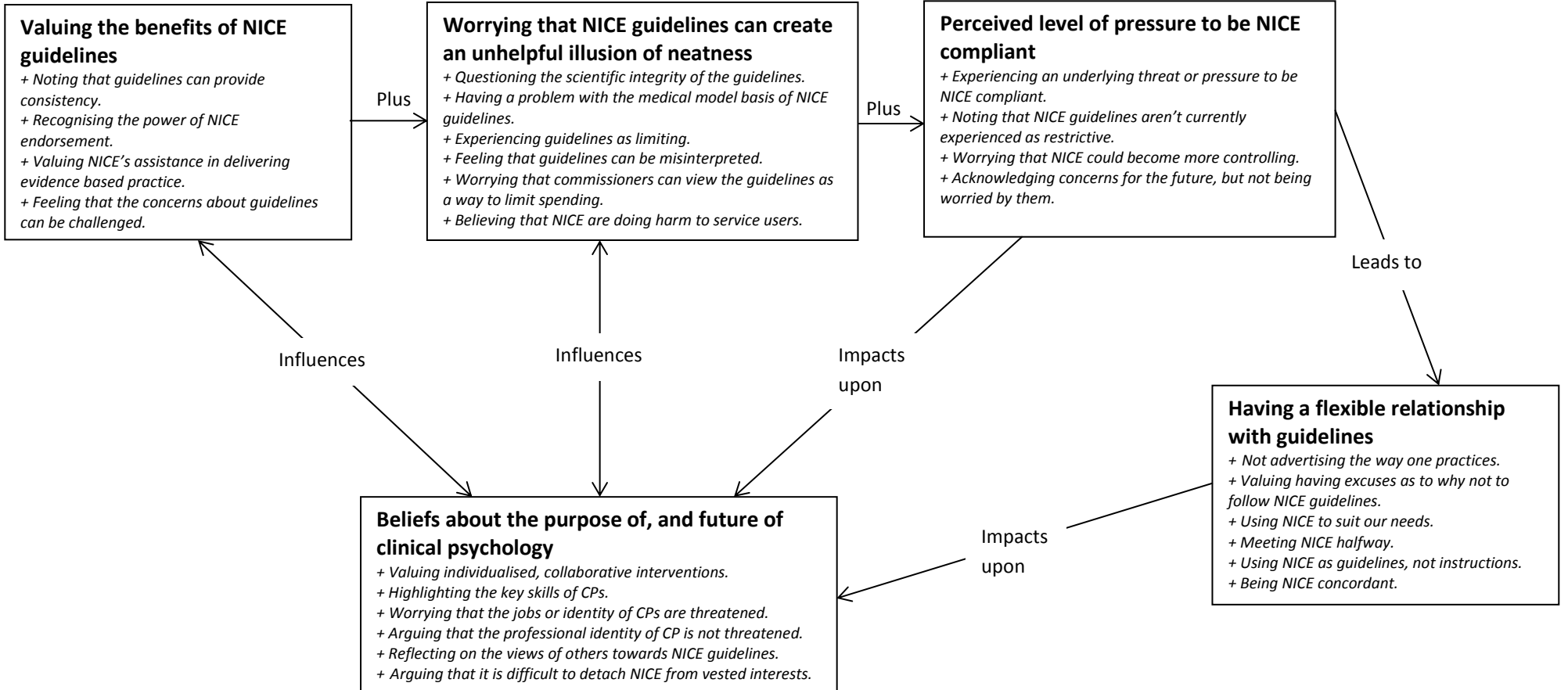
Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage.

Appendix 1. Model conceptualising the clinical psychologists’ beliefs about, and use of NICE guidelines.

Considering NICE guidelines to have benefits but to be fraught with dangers

Recognising the context of the current economic climate

- + Noting that services do not have the resources to fully deliver NICE recommendations.
- + Stressing the importance of seeing NICE guidelines in the context of the current economic climate.



Appendix V – Journal Author Guidelines

Psychology and Psychotherapy: Theory, Research and Practice

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Edited By: Andrew Gumley and Matthias Schwannauer

Impact Factor: 1.69

ISI Journal Citation Reports © Ranking: 2012: 44/75 (Psychology); 56/114 (Psychology Clinical); 58/121 (Psychiatry (Social Science)); 79/135 (Psychiatry)

Online ISSN: 2044-8341

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Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

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