Article

Investigating the use of NICE guidelines and IAPT services in the treatment of depression

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ABSTRACT

Background There is evidence that the National Institute for Health and Clinical Excellence (NICE) guidelines for mental health disorders are used to varying degrees in primary care. A lack of access to cognitive–behavioural therapy (CBT) has been found to be a barrier to their implementation. The Improving Access to Psychological Therapies (IAPT) initiative was created in 2007 to increase the availability of NICE-recommended psychological treatments for depression and anxiety disorders within the National Health Service in England.

Aim This study aims to investigate whether general practitioners (GPs) who have access to IAPT services and use NICE guidelines are more likely to use NICE concordant treatments for depression than those who do not. Depression was chosen as it is the most common mental health problem facing primary care physicians.

Method Questionnaires were sent to 830 GPs in southeast England and six GPs were interviewed. The response rate to the questionnaires was 27% (n = 222).

Results Ninety-five per cent of GPs were aware of the NICE guidelines for depression, and 76% had read them. Concordance with the guidelines was significantly higher when GPs had access to a local IAPT service or had read the NICE guidelines.

Conclusions The interviews revealed favourable views to IAPT services when used, although access to treatments was still a common barrier to the implementation of the NICE guidelines for depression.

Keywords: clinical guidelines, depression, evidence-based treatments
Introduction

Depression is currently ranked by the World Health Organisation as the fourth leading cause of global burden of disease and is expected to be the second most common disease by 2020. In the UK, it is the third most common reason for visits to a general practitioner (GP). The prevalence estimates for depression in the British population range from 2.3 to 10% and patients wait 8 years on average before seeking treatment. The most recent Adult Psychiatric Morbidity Survey (APMS) found that only half of patients with a depressive episode received treatment. However, this is higher than the proportion of patients diagnosed with other common mental health disorders (with the exception of patients with phobias). The APMS found that 15% of people with mixed anxiety and depressive disorder received treatment, with comparable figures of 44, 31 and 25% for those with generalised anxiety disorder, obsessive compulsive disorder and panic disorder, respectively.

A recent survey found that GPs can diagnose depression well in patients with long-term conditions on the basis of vignettes. The higher proportion of people with depression receiving treatment may be explained by the fact that depression is required to be screened for by GPs by the Quality Outcomes Framework (QOF). However, once depression is identified, it is important that patients receive treatment in line with research evidence. A recent study in England and Wales found that only 38% of those receiving treatment for depression were receiving care which could be considered evidence-based, although another recent study found that there is adherence to guidelines for the use of antidepressants for moderate and severe depression but few patients were referred to primary care mental health workers.

Of all those suffering with depression, fewer than half will be correctly diagnosed in primary care and of those that are diagnosed, fewer than 20% will be referred to secondary care. Furthermore, there is evidence that patients referred to secondary care may be better served in primary care. Psychological treatments are demonstrably effective for depression and patients have been shown to prefer them over psychotropic medication. However, a lack of access to them in the UK has been cited as a reason why the illness has been largely untreated.

The National Institute for Health and Clinical Excellence (NICE)

The National Institute for Health and Clinical Excellence (NICE) gives health professionals advice on providing patients with the highest clinical standard of care. NICE place an explicit emphasis on increasing the use of evidence-based treatments. In December 2004, NICE produced the first guideline for the treatment and management of depression in adults. This was updated in 2009, alongside a new piece of guidance for the treatment of depression in adults with chronic physical health problems.

The NICE guidelines for depression

NICE’s depression guideline is arranged in a ‘stepped-care’ model (Figure 1), which recommends that the intensity of treatments should be guided by the severity of depression. This is a cost-effective model that ensures that patients receive the least-burdensome treatment.

For the treatment of mild to moderate depression, NICE currently states that advice should be given on sleep hygiene and the patient should be actively monitored by means of regular check-up appointments. Psychological treatments such as computerised cognitive-behavioural therapy (CBT) and individual-guided self-help programmes are recommended, as is structured group exercise. In the event that a patient declines any of these treatments it is recommended that group CBT should be offered. The use of pharmacological treatment is not recommended for mild to moderate depression, neither is the use of St John’s wort.

For the treatment of moderate to severe depression, NICE recommends individual CBT, interpersonal therapy, behavioural activation or behavioural couples therapy, if the patient has a regular partner. The same is recommended if patients have mild to moderate depression and have not responded adequately to prior recommended treatment. If a patient declines these interventions, NICE states that counselling or psychodynamic therapy can be offered. Generic selective serotonin reuptake inhibitors (SSRIs) are also recommended. Other forms of antidepressant medication such as tricyclic antidepressants and Venlafaxin have increased risk of overdose, and are only advisable when there is an inadequate response to SSRI medication. The use of Dosulepin is not advised by NICE. Patients with severe depression and either suicidal ideation, self-harm or self-neglect should be considered for inpatient care or electroconvulsive therapy.
Use of the NICE guidelines for mental health disorders

Investigations into the use of clinical guidelines for mental health disorders have had varying results. Currin and colleagues found that fewer than 4% of GPs used clinical guidelines in the treatment of eating disorders.22 Ehlers and colleagues found that only 55% of GPs in London were aware of the guidelines for post-traumatic stress disorder (PTSD) and only 15% had used them.23 A similar study into the use of guidelines for obsessive compulsive disorder (OCD) found 49% of GPs were aware of the NICE guidelines and only 30% had read them.24 A survey of GPs conducted in Southwark, London, found that 20% of GPs working with patients suffering from anxiety or depression found the NICE guidelines useful.25

A questionnaire study into GPs’ use of NICE guidelines for depression conducted in May 2007 found that 62% of respondents had read the NICE guidelines for depression, although fewer than half felt the guidelines had affected the management of their patients.26 In this study, it was found that GPs felt that reading the NICE guidelines did not have an impact on the treatments they offered their patients with depression. This was also found in a study into the use of the NICE guidelines for depression in secondary care in south London. This study found that 90% of members of a community mental health team had read the NICE guidelines, but most felt that the guidelines had had little effect on their practice. This study aims to investigate whether reading the NICE guidelines has an effect on the self-reported treatments used by GPs.11

Improving access to psychological therapies

In October 2007, £173 million was pledged by the UK government to fund an initiative designed to address the need for a much larger psychological therapies service aimed at providing evidence-based psychological treatment for patients suffering from depression and anxiety disorders.27 This initiative was named Improving Access to Psychological Therapies (IAPT) and aimed to train 3600 new therapists in NICE-recommended treatments and open services across the country within 6 years. In February 2011, the government’s investment in the programme was increased to £400 million, extending the programme’s support up until March 2015.28 After successful pilots,29 IAPT services were rolled out nationally and patients who received NICE-recommended treatments for depression were more likely to recover than those that did not receive NICE-recommended treatments.30 Furthermore, IAPT services were beneficial to patients with depression that ranged from mild to severe.
The impact of IAPT on GPs’ use of NICE guidelines for depression

The main barriers to the use of mental health guidelines appear to be the large number of guidelines produced, a lack of time to read the guidelines and a lack of access to psychological therapies.\textsuperscript{16,31–33} The new IAPT services were specifically designed to remedy the lack of access to recommended psychological treatments for depression and anxiety, and it is important to establish whether they have had the consequent effect of increasing the use of NICE-recommended treatments by GPs. The aim of the study was to investigate the use of NICE guidelines for depression by GPs and the relationship between access to IAPT services and concordance with NICE-recommended treatments. The focus of this study was on depression rather than anxiety as depression is one of the most common mental health problems facing GPs, following mixed anxiety and depressive disorder.\textsuperscript{3}

Hypothesis

GPs who use the NICE guidelines and have access to IAPT services will be more concordant to the NICE recommendations than those who do not.

Procedure

The study took a cross-sectional design with both qualitative and quantitative elements in two parts. The first part used questionnaires to investigate which treatments GPs report they use to treat depression and whether the treatments offered are associated with whether or not GPs had access to IAPT, or had read the NICE guidelines. Interviews were used in the second part of the study to ascertain GPs’ views toward NICE and IAPT. Both qualitative and quantitative elements were used as it was believed that the methods would complement each other.\textsuperscript{34,35}

Questionnaires

The quantitative element of the study comprised sending questionnaires to GPs in Hampshire, Berkshire and Buckinghamshire, in the southeast of England. A questionnaire was chosen as it allowed the participation of many GPs quickly and at little cost. The format of the questionnaire was based on questionnaires used by previous investigations into the use of the NICE guidelines for PTSD and OCD.\textsuperscript{24,36}

This area was chosen as it was local to the investigators. Overall, the southeast of England is a comparatively wealthy area, with the second highest average gross disposable household income per head of the 12 regions in the UK, after London.\textsuperscript{37}

Participants

The study focuses on GPs based in the Hampshire region (n = 800). GPs were recruited via the Hampshire Practice and Patients Services Agency (HPPSA) to take part in the survey. A further sample of GPs (n = 30), who had previously taken part in a study regarding the awareness of NICE OCD guidelines in the neighbouring counties of Berkshire and Buckinghamshire and had indicated they were willing to take part in future studies, were also invited to take part in the survey.\textsuperscript{36}

Analysis

A score was calculated for each GP in order to determine how compliant they were with the NICE guidelines for depression following Toner et al.\textsuperscript{26} The overall concordance score coded how each GP managed each severity of depression (mild, moderate and severe) and how much standardised feedback they received on a patient’s treatment. One point was awarded per NICE-recommended treatment routinely prescribed by severity (e.g. ‘active monitoring’ for mild depression). If a treatment was offered that was specifically listed in the guidelines as being inappropriate, such as offering electroconvulsive therapy for mild depression, the use of counselling for severe depression or the use of Dosulepin for any patients, a point was deducted from the score. Because feedback on treatment outcomes is recommended by NICE\textsuperscript{10} and is important for patient outcomes,\textsuperscript{3} GPs that always obtained feedback were awarded 2 points, those that ‘sometimes’ obtained it were awarded 1 point, those that ‘rarely’ obtained it were awarded 0 points, and GPs who never obtained it were deducted a point. The maximum possible concordance score was 24 points and the minimum possible concordance score was –1. The same procedure was undertaken, but all variables relating to non-psychological therapies were removed. This index allows the investigation of whether having access to IAPT services and reading the NICE guidelines led to increased concordance for NICE’s recommendations for psychological therapies, rather than all types of treatments and receiving feedback. For this index, the maximum possible concordance score was 15 points and the minimum was –1.
All quantitative data were entered into SPSS Version 18 for analysis. A two-way analysis of variance (ANOVA) with bootstrap was used to measure the effects of reading NICE guidelines and access to IAPT services on concordance. Fisher’s exact tests were used to investigate associations between categorical variables in 2 \times 2 contingency tables. The size of the potential sample was chosen based on calculations of predicted response rates previous research undertaken\(^3\) and power calculations were conducted using G*Power 3.\(^3\) Cramer’s Phi was used to report effect sizes when an association between categorical variables was tested, partial eta squared for when an ANOVA was used and Cohen’s \(d\) for independent \(t\)-tests.

Interviews

Recruitment for the interviews was undertaken using convenience sampling methods. Participants had taken part in the questionnaire study and had indicated they were willing to be contacted for further research. All those who were willing to be contacted (\(n = 43\)) were sent a letter of invitation, and of these six GPs were available for interview (three male, three female). The interviews were conducted in the GPs’ surgeries. A semi-structured interview was used to assess GPs’ views on the NICE guidelines for depression and the treatments used for depression, with an emphasis on IAPT services.

The interview was semi-structured and designed to assess the GPs’ views towards the NICE guidelines, both in general and for depression specifically; whether they followed the NICE guidelines, their views towards IAPT and their treatment plans for patients with depression. The length of the interviews ranged from 7 to 34 minutes (mean 19 minutes).

Analysis

The interviews were digitally recorded and fully transcribed by NP and HP. Interpretative phenomenological analysis (IPA) was used by AG, NP and HP to analyse the transcribed interviews.\(^3\) AG analysed the entire dataset, and 33% of the interviews were analysed by NP and HP and discussed to ensure reliability. All transcripts were independently read by all three authors undertaking the analysis. All authors were involved in the decision as to what the final emergent themes were, and these were discussed until a consensus was reached. All transcripts were kept intact throughout the analysis to maintain a sense of context. The analysis was undertaken based on the description of IPA given by Smith and Osborn.\(^3\) The analysis was undertaken in accordance with Elliott, Fischer and Rennie’s review of good practice in qualitative research.\(^4\)

Ethical issues

NHS approval was gained through the National Research Ethics Service (ref: 10/H05050/6), and the University of Reading Research Ethics Committee (ref: 09/70A). Compliance with the Data Protection Act was ensured by removing all participants’ names from interview transcripts and using anonymised participant numbers. No deception was used in the study.

Results

Questionnaire study

Response rates

The response rate from the initial questionnaires sent was 23.5% (195/830) and 3.9% (27/700) after the questionnaires were sent out for the second time, giving a total overall response rate of 26.7% (222/830). The response rate was 25.5% in Hampshire and 60% in Buckinghamshire and Berkshire.

Use of NICE guidelines

When answering the questionnaire, 95.5% of GPs stated that they were aware of the NICE guidelines for depression and 77.8% stated that they had read them. GPs were asked if they followed any other guidelines for depression than the NICE guidelines. The proportion of GPs that followed other guidelines was 30.6%. Of the GPs that did specify which other guidelines they followed, 50% (34/68) stated ‘local guidelines’.

Typical treatments prescribed

GPs were asked which treatments they would typically prescribe when managing a first episode of depression. Figure 2 shows the possible treatments recommended by NICE and the percentages of GPs who reported that they would typically prescribe these treatments. The NICE concordance scores calculated were not normally distributed according to the Shapiro–Wilk test (\(W \approx 0.985\), \(P = 0.019\)). The mean score was 11.36 (SD = 3.72) with a minimum score of 3 and a maximum of 20. The most common treatment offered by GPs that was not recommended by NICE was medication for
the treatment of mild depression (14.5%, 31/222). Two GPs stated that they would offer their patients St John’s wort, which the NICE guidelines explicitly recommend against.

**Impact of IAPT and the NICE guidelines on concordance**

GPs were asked whether they had access to a local IAPT service and if they referred to it. The majority of GPs (69.4%) reported they had a local IAPT service. One hundred and forty-three GPs (64.4%) said they refer to IAPT. A number of GPs (18.5%, 41/222) wrote on the questionnaire, ‘IAPT just starting/stayed’.

A two-way ANOVA with a bootstrap was undertaken to investigate the effect of access to IAPT services and reading the NICE guidelines on concordance with their recommendations. The bootstrap was used due to the non-normality of concordance scores. The data showed homoscedasticity according to Levene’s test ($F(3,207) = 0.27, P = 0.847$). A main effect was found for both having read the NICE guidelines ($F(1,206) = 11.13, P = 0.001, \eta^2_p = 0.051$) and having access to IAPT services ($F(1,206) = 11.13, P = 0.001, \eta^2_p = 0.051$). A significant interaction was also found between these two factors ($F(1,206) = 7.60, P = 0.006, \eta^2_p = 0.036$). The direction of the effects was exactly the same as the previous ANOVA.

A two-way ANOVA was undertaken to investigate whether having access to IAPT and reading the NICE guidelines had an effect on the proportion of patients they would offer CBT to treat depression. However, as the data were heteroscedastic two-t-tests were used instead. These found an effect of reading the NICE guidelines ($t(210) = 3.398, P = 0.001, d = 0.469$), but not for having access to IAPT services ($t(92.63) = 3.40, P = 0.434, d = 0.163$). GPs who had read the NICE guidelines were likely to offer CBT to a larger proportion of patients.

**Psychological treatments**

The same analysis was undertaken, concentrating on GPs’ concordance with the NICE recommendations for psychological therapies, rather than feedback or other treatments, such as pharmacological therapies or electroconvulsive therapy. The data showed homoscedasticity according to Levene’s test ($F(3,206) = 0.80, P = 0.494$). A main effect was found for both having read the NICE guidelines ($F(1,206) = 11.76, P = 0.001, \eta^2_p = 0.054$) and having access to IAPT services ($F(1,206) = 11.13, P = 0.001, \eta^2_p = 0.051$). A significant interaction was also found between these two factors ($F(1,206) = 7.60, P = 0.006, \eta^2_p = 0.036$). The direction of the effects was exactly the same as the previous ANOVA.

![Figure 2](image.png)

**Figure 2** Treatments normally prescribed when managing first episode of depression by severity of depression. CBT, cognitive–behavioural therapy; ECT, electroconvulsive therapy; TMS, transcranial magnetic stimulation
The use of NICE guidance and IAPT in treating depression

Antidepressant use

The mean percentage of patients prescribed medication as part of their care for depression according to responses was 60% (SD = 20.1). The majority of GPs (97.3%) indicated that they would typically prescribe SSRIs and 2.7% would prescribe something else (e.g. serotonin–norepinephrine reuptake inhibitors). Table 1 summarises the responses. GPs who stated that they would offer medication to patients with mild depressive symptoms were not significantly more likely to have access to IAPT services (69.9% vs. 74.2%, respectively, $P = 0.033$, $\Phi = 0.631$).

GPs who had access to IAPT were significantly less likely to offer medication to patients who were severe than GPs who did not have access to IAPT services (88.7% vs. 98.4%, respectively, $P = 0.015$, $\Phi = 0.156$). This was not the case for patients with mild depression (15.2% vs. 13.1%, respectively, $P = 0.437$, $\Phi = 0.027$) or moderate depression (98.4% vs. 91.4%, respectively, $P = 0.052$, $\Phi = 0.127$), although there was a trend for GPs who had access to IAPT to offer fewer patients medication with moderate depression than those who did not have access.

Interview study

There was some variability in the responses to the questions asked. The two main areas of discussion were GPs’ views on the NICE guidelines and their views towards access to psychological treatments and/or IAPT. The themes that emerged from discussions on the NICE guidelines are shown in Table 2.

The themes that emerged when GPs were asked about their views towards IAPT and psychological therapies are shown in Table 3. In the wider discussion of psychological therapies access to treatments was found to be a theme that emerged in all interviews.

Figure 3 The effect of access to IAPT and reading the NICE guidelines on NICE concordance

Table 1 The most common medications offered by GPs

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of GPs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>115 (51.8)</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>76 (34.2)</td>
</tr>
<tr>
<td>Sertraline</td>
<td>32 (14.4)</td>
</tr>
<tr>
<td>SSRI (not specified)</td>
<td>17 (7.7)</td>
</tr>
<tr>
<td>Mirtazapene</td>
<td>5 (2.3)</td>
</tr>
<tr>
<td>Tricyclic</td>
<td>2 (0.9)</td>
</tr>
<tr>
<td>Trazodone</td>
<td>1 (0.5)</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>1 (0.5)</td>
</tr>
</tbody>
</table>
Discussion

Improving access to psychological therapies

The IAPT initiative seeks to redress the lack of access to psychological therapies, enabling an increase in the implementation of the NICE guidelines. This study aimed to investigate whether the NICE guidelines for depression were being followed in primary care and whether this was connected to the new government initiative. The questionnaire responses showed that the majority of GPs had access to IAPT services and referred to them. GPs who had access to IAPT services reported that they were more concordant with the NICE guidelines. This was also found to be the case when solely looking at psychological therapies recommended by NICE. These findings suggest that the IAPT initiative has been successful in increasing access to evidence-based psychological therapies and facilitating the implementation of the NICE guidelines for depression. This study did not compare the outcomes of patients who received NICE concordant therapies and those that did not. However, an evaluation of IAPT services in their first

Table 2  Themes arising from discussion on the NICE guidelines

<table>
<thead>
<tr>
<th>Superordinate theme</th>
<th>Subordinate theme</th>
<th>Supporting quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive views on the NICE guidelines</td>
<td>The NICE guidelines have had an effect on medication used in the treatment of depression</td>
<td>I certainly think, I say, I think we've certainly been influenced in terms of choice of drugs I think we've switched. We used to use paroxetine/fluoxetine as the main drug. I think we now don't. We now use citalopram and sertraline ... so I think that probably, that probably, my colleagues would say that that's the biggest impact it's had is changing the drug choice. (Participant 1)</td>
</tr>
<tr>
<td>Guidelines are very clear</td>
<td>Yeah I think the language is clear ... yeah ... yeah ... I think all the guideline is fairly easy to read. (Participant 6)</td>
<td></td>
</tr>
<tr>
<td>Allows GPs to take the cost-effectiveness into account</td>
<td>“(I use the guidelines) to look at the cost effectiveness of various drugs cause that’s what it’s all about really.” (Participant 2)</td>
<td></td>
</tr>
<tr>
<td>Negative views on the NICE guidelines</td>
<td>They are repetitive and contain unnecessary elements</td>
<td>They're fairly clear ... it's just the repetitiveness of them, you know, you feel you've got to read through quite a lot until you get to the bones of the guideline. It's a bit repetitive sometimes. I think it has to be because of the way they are. Like or dislike? I don't really have any sort of feelings of liking about them: they are as they are. (Participant 2)</td>
</tr>
<tr>
<td>Guidelines do not reflect local provision</td>
<td>They go on a lot about treatments that aren't available to us. So there sort of ... a lot of it is irrelevant, because we don't have access to talking therapies to any extent. (Participant 1)</td>
<td></td>
</tr>
<tr>
<td>Lack of trust in research</td>
<td>Can't they ... it's like any research, can't you almost get your results to say what you want to say? (Participant 5)</td>
<td></td>
</tr>
<tr>
<td>Local Guidelines</td>
<td>If I wasn't talking to you guys this afternoon [whispers: which I would much rather be doing] I'd be at a collaborative meeting, one of which the subject today is managing depression and using the local guidelines for depression and the services that are available. (Participant 5)</td>
<td></td>
</tr>
</tbody>
</table>
The use of NICE guidance and IAPT in treating depression

Use and effect of the NICE guidelines

The majority of GPs stated that they had read the NICE guidelines for depression. This finding supports...
Toner et al's finding that the majority of GPs have read the NICE guidelines for depression.26 However, it contrasts with previous investigations which found that few GPs had read the NICE guidelines for OCD and PTSD.24,36 GPs who read the NICE guidelines were also more likely to offer their patients psychological treatments recommended by NICE, and offer CBT to a greater portion of their patients.

Attitudes towards the NICE guidelines

The majority of GPs interviewed had positive attitudes to the NICE guidelines; however, this view was not shared across the sample. This contrasts with the results from previous studies.25,26 Two interviewees questioned the validity of the research used to create the guidelines, arguing that the findings of clinical studies are heavily motivated by researchers' aims. Questioning the validity of the evidence base and having concerns about the authorship of guidelines have consistently been found to be barriers to the use of clinical guidelines, particularly where conflicts of interest or cost-effectiveness are concerned.16,31–33,45,46 However, the fact that NICE also take cost-effectiveness, as well as burden of disease, into account was regarded to be a positive element to the NICE guidelines by one GP.47,48

Previous qualitative research has identified time pressure as being a barrier to the use of the guidelines.16,31–33 Rather than arguing that they have too little time to read the guidelines, interviewees emphasised the repetitive and lengthy nature of the guidelines as a barrier to their use. A number of GPs stated that they used local guidelines to aid their treatment of depression. Further investigation in the interviews found that these were based on the NICE guidelines, but took local access to treatments into consideration. These local guidelines were also often very short, addressing GPs' concerns that NICE guidelines were overly long. Furthermore, locally produced guidelines may alleviate concerns held by GPs over their authorship.

Limitations

This study has several limitations, including a response rate of 27%, which may introduce a response bias. However, the response rates are similar to those in previous research.3 It is possible that there could be a bias as respondents may have a particular interest in managing depression. Although the percentage of GPs who responded to the questionnaire was lower than the response rate obtained by Toner et al, the actual number of respondents was higher and provided good statistical power.24,26,36,38 The study was also undertaken in a comparatively wealthy area in England and these findings may not be representative of the rest of the country.

Another limitation of using questionnaires is that they do not allow participants to express themselves beyond the given format, potentially missing important insights relating to the topic. For this reason, qualitative interviews were also conducted. These interviews formed an idiographic study of GPs' attitudes and offered valuable insight into the barriers to the use of clinical guidelines. However, it is important to note that the views of the GPs in this sample were heterogeneous. A relatively small number of GPs were interviewed; however, this sample size was noted to be adequate by Smith and Osborns' protocol for IPA.39

Conclusions

This study has shown that both the NICE guidelines and access to IAPT services have an effect on the treatments GPs report to offer their patients with depression. Patients treated by GPs who had access to IAPT services or had read the NICE guidelines were more likely to receive NICE-recommended treatments. However, access to psychological therapies was still seen as a barrier to the implementation of the NICE guidelines and GPs interviewed stated that they required still more access to psychological therapies and need to be made aware of the locally available treatments.

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ETHICAL APPROVAL

Ethical approval was gained through the National Research Ethics Service (ref: 10/H05050/6), and the University of Reading Research Ethics Committee (ref: 09/70A).

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CONFLICTS OF INTEREST
None.

REFERENCES


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