DECISION-MAKING IN STEPPED CARE FOR COMMON MENTAL HEALTH PROBLEMS

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FIGURES AND TABLES

ABSTRACT

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Decision-Making in Stepped Care for Common Mental Health Problems

Stepped care is designed to provide mental health treatment in the most effective and efficient way. It aims to provide patients with low intensity interventions in the first instance and only move onto high intensity treatments if outcome is not 'successful'. However, there is a paucity of research about how health professionals make decisions about treatment and the experiences of patients within this decision-making process. Using a multi-method approach, this study aimed to explore health professional and patient decision-making in stepped care for anxiety and depression. 24 health professional interviews from three stepped care sites were conducted, which included the completion of an active information search (AIS) think-aloud task. In addition, 14 patients were interviewed about their experiences of decision-making whilst being managed within stepped care model. Qualitative interview data was analysed using the principles of Framework analysis, while some of the data collected in the AIS think-aloud task lent itself to quantitative analysis.

This study revealed that three core tensions exist when making decisions within the stepped care model. These are 1. The notion of standardisation of outcomes versus the individual needs of patients; 2. The public health orientation of stepped care versus the therapeutic orientation of health professionals and; 3. The rhetoric about patient choices versus the realities of shared decision-making in a resource-limited system.

The complexity of decision-making within the stepped care model was highlighted. The success of stepped care relies on ensuring that there is an adequate workforce to deliver the intended interventions, where this is not present health professionals are faced with difficult decisions and it is clear that those most affected are the less-experienced frontline workers. Scarcity of resources impacts heavily upon the decisions that are made. This can have a substantial impact upon variability in treatment decisions and on the ability to allow for patient choice to be incorporated. Decisions that are made for a patient are influenced by the need to provide them with the treatment that they want (which may not be regarded as what they need within the stepped care model nor necessarily by the health professional) and the capacity of the service. The problem that exists with primary care mental health is that the current demands exceed capacity. Optimal patient care is, in part, traded off by the need to meet the demands of the service. Improving the flexibility of the service may be one solution to the problem and adopting a stratified/stepped care approach might help to resolve some of the tensions and help to relieve some of the capacity issues.

DECLARATION

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LIST OF ABBREVIATIONS

AIS   Active Information Search

CBT   Cognitive Behavioural Therapy

CAMHS   Child and Adolescent Mental Health Services

CCBT   Computerised Cognitive Behavioural Therapy

EMB   Evidence-Based Medicine

GAD   Generalised Anxiety Disorder

GMHW   Graduate Mental Health Worker

GP   General Practitioner

HI   High Intensity

HP   Health Professional

IAPT   Improving Access to Psychological Therapies

LI   Low Intensity

NHS   National Health Service

NICE   National Institute for Health and Clinical Excellence

OCD   Obsessive Compulsive Disorder

ONS   Office for National Statistics

PCMHW   Primary Care Mental Health Worker

PCT   Primary Care Trust

PTSD   Post Traumatic Stress Disorder

QOF   Quality and Outcomes Framework

SEU   Subjective Expected Utility

TPB   Theory of Planned Behaviour

TRA   Theory of Reasoned Action

WHO   World Health Organisation

INTRODUCTION

Origins of Thesis

This thesis builds on, and is grounded in, my ongoing interest and experience in research within mental health. Using qualitative approaches, it focuses on exploring stakeholder experiences of decision-making within stepped care, a model implemented to address the significant discrepancy between supply and demand of psychological therapy. The study is situated in a time of great organisational change. However, while stepped care implementation is occurring at a vast pace, and is recommended within policy and guidelines, the way in which decisions are made within the model has received limited attention. The purpose of this thesis is to better understand these processes from the perspective of both health professionals and patients and to provide recommendations for future research and for policy and practice.

Organisation of the Thesis

The thesis is divided into ten chapters. The first three chapters provide a rationale for the research, a review of relevant empirical and theoretical literature, and a discussion of methods. The origins of the thesis, along with a discussion of current mental health policy and a review of stepped care literature, are outlined in Chapter 1. Chapter 2 provides a review of theoretical models and empirical studies of decision-making. Chapter 3 subsequently reviews methods for capturing the decision-making process.

The methodological issues associated with the study, which includes an exploration of the chosen methodology, are presented in Chapter 4. The overall aims of the research, role of the researcher and ethical considerations are also highlighted in this chapter.

The following five chapters are concerned with the methods adopted for the two studies included in this thesis and their findings. Chapter 5 provides information about the adoption of qualitative interviews, sampling and details data collection and analysis.

Chapter 6 then details the the second method adopted to explore decision-making, an active information search (AIS) think-aloud task, the development of patient scenarios, the findings from the pilot of this task, and the process of data collection and analysis. Chapters 7 and 8 provide a full account of the health professional and patient interview findings. The findings from the AIS think-aloud task are then presented in Chapter 9.

Chapter 10 concludes the thesis by providing a synthesis of the main findings and discussing these in context of the wider literature. Strengths and weaknesses of the study are identified and recommendations for future research and policy and practice proposed.

CHAPTER ONE: **MENTAL HEALTH & STEPPED CARE**

Introduction

This chapter begins with a brief overview of mental health problems, their prevalence and defining features. Mental health policy initiatives will be outlined along with a discussion of the treatments available in primary care and how mental health services have adapted and changed to meet the demands placed upon them. Finally, the adoption and implementation of stepped care into the UK health care system will be discussed.[1]

Mental health problems – Prevalence and Definition

The World Health Organization (WHO) has indicated that one in four people worldwide suffer from various forms of mental health problems and estimate that by 2020 depression will be the second leading contributor to the global burden of disease (Murray & Lopez, 1996). Globally, mental illness is said to account for approximately 10.5% of the total burden of disease (Sayce & Morris, 1999) and costs the UK over £110 billion a year (Friedli & Parsonage, 2007). Such problems are said to be characterised by a variety of symptoms (Singleton & Lewis, 2003) which present to such a degree that they impact not only on the individual's mental health but upon all aspects of their health and well-being including their physical health and ultimately their quality of life (Spitzer et al., 1995).

Mental health problems can be defined on the basis of the symptoms that a person is exhibiting. For example a diagnosis of depression may be given where symptoms such as feelings of worthlessness, diminished ability to think or concentrate, or persistent levels of low mood, tearfulness or sadness are present. Using this explicit conventional medical model classification approach helps to identify diagnostic patterns and prevalence rates. The term 'common mental health problems' is used within the mental health field and is

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[1] An overview of the literature search strategy used for the first three chapters of this thesis is presented in Appendix 1.

indicative of the high prevalence of specifically anxiety and depression. Surveys of psychiatric morbidity in both general and specific populations across the UK found that at least one in six (16.5%) of the population exhibit symptoms of a 'common mental health problem' (Centre for Economic Performance's Mental Health Policy Group, 2006).

Other models which are not readily considered, however, could be considered appropriate when defining common mental health problems. For example mental health problems, can also be regarded as being socially constructed where significance is placed upon their social meaning and the resultant consequences. Dowrick (2009; 2004) argues that defining mental health problems, specifically depression, using the conventional diagnostically-led approach is questionable. He challenges the validity and utility of this approach and considers it potentially ineffective within primary care. The World Health Organisation acknowledges the associated problems with taking a wholly diagnostic approach to the management of mental health problems and highlights the importance of taking into account the holistic nature of these problems (WHO 2008).

Whilst there is support for understanding mental health problems outwith the confines of the traditional medically-led theories and approaches, the current mental health system management of these problems drives professionals to adopt the former approach whereby mental health problems are given a diagnostic label. In light of this, and as an established definition of common mental health problems does not exist, for the purpose of the study, common mental health problems are defined as depression and all anxiety disorders (e.g. social anxiety, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), social phobia and all other phobias) (Bower & Gilbody, 2005a; Goldberg & Gourney, 1997). Mixed anxiety and depression is estimated to affect almost 9% of the population, whilst anxiety and depression alone affect 4.5% and 2.5% of the population respectively (Singleton *et al.*, 2000), with approximately 97% of people who experience mental illness suffering from these disorders (Richards & Suckling, 2008). Ninety per cent of people identified as having common mental health problems are managed entirely in a primary care setting (Goldberg & Huxley, 1992) and approximately one third of people who attend a GP surgery have mental health problems taking up at least a one third of the GP's time (Jenkins *et al.*, 2002).

Mental Health Policy Initiatives

Current and recent policy initiatives within health services such as Our Health, Our Care, Our Say (Department of Health, 2006); Best Research for Best Health (Department of Health (Research and Development Directorate, 2006); Creating a Patient-Led NHS (Department of Health, 2005a); Standards for Better Health (Department of Health, 2004b); Consent: Patients and doctors making decisions together (General Medical Council, 2008) and Organising and Delivering Psychological Therapies (Department of Health, 2004a); emphasise the need for a service that:

- Takes into account individual needs, preferences and choices
- Provides equal access to services and treatment for everyone
- Provides patients, their carers and relatives with suitable and accessible information about their care and treatment

The publication of the National Service Framework for Mental Health (Department of Health, 1999) was a significant driver for these initiatives. It identified that, despite the high prevalence of mental health problems within the UK, insufficient priority was placed on managing these problems. Of significant importance was the recognition of the huge demands that were currently placed on primary care services. Standards two and three of the framework (detailed in Figure 1) focussed on the role that primary care has in managing mental health problems, with specific emphasis on improving identification, assessment, access and providing effective interventions for managing these problems.

Figure 1: Standards two and three of the National Service Framework for Mental Health (Department of Health, 1999)

Standard Two

Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed.
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

Standard Three

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care.
- be able to use *NHS Direct*, as it develops, for first-level advice and referral on to specialist help-lines or to local services.

A current mental health initiative, New Horizons, recognises the importance of involving the wider workforce such as primary care, alcohol and substance misuse services, occupational health, and the voluntary sector that have an important part to play in achieving successful outcomes. It also outlines the benefits that improving well-being can have for the whole population in terms of physical health, educational attainment, employment and reduced crime. A summary of the New Horizons strategy overall aims and actions needed to meet these are summarised in Figure 2.

Figure 2: New Horizons overall aims and actions (Department of Health 2009)

> **Overall aims:**
>
> - improve the mental health and well-being of the population
> - improve the quality and accessibility of services for people with poor mental health.
>
> **In order to achieve these aims the Government seek to:**
>
> - Give greater priority to mental health and well-being, better public understanding and awareness, and improved access to mental health services and therapies.
> - Look at ways to extend choice and improve personalisation in mental health.
> - Efficiently use resources available ensuring value for money.
> - Achieve a greater range and level of research funding that better addresses identified gaps in knowledge and increases the level of research on prevention.
> - Develop a robust partnership across the public, private and third sector working with local people to deliver the necessary change to improve mental health and well-being for individuals, families, carers and communities of all ages and backgrounds.
> - Develop initiatives to help reduce stigma.

Treatments in Primary Care for Common Mental Health Problems

Within primary care various treatment options for common mental health problems are available and offered, including pharmacological treatments and psychological therapies. Such treatment options are outlined in the National Institute for Health and Clinical Excellence (NICE) clinical guidelines which have been developed for common mental health problems including for anxiety, depression, OCD and PTSD (NICE, 2011; 2009a; 2005a; 2005b). More recently due to the recognition of the high incidence of depression in people with chronic physical health problems a guideline for people experiencing this has been developed (NICE, 2009b). These guidelines are based on the best available evidence and aim to assist and improve health care professional decision-making in mental health care by providing recommendations to improve treatment and quality of care. NICE

guidelines outline the use of the following treatments for people experiencing anxiety or depression in primary care.

Pharmacological Treatments

Antidepressants, whilst not recommended as an initial treatment for mild depression are used for more severe forms of depression and in the longer-term management of GAD and panic disorder (NICE, 2010).

Psychological Therapies

There has been a rise in the demand for psychological therapies (Barry, 2006). Psychological therapies, although differing in psychological orientations, have a number of identifying features (Frank, 1967) such as:

- A therapeutic relationship or alliance between the health professional and patient
- An interpersonal context, environment or methods.
- A model or theory that informs how the health professional acts and interprets the interaction with the patient(s).
- A defined purpose for the patient to receive the treatment such as to improve general well-being by alleviating distress or improving mood.
- Providing advice or guidance to the patient or supporting the patient to seek strategies for themselves.
- Providing information to patients about their condition in an accessible, easily understood manner.

Psychological therapies are delivered by a range of health professionals and can involve individuals, groups or families. Psychological therapies considered by NICE as appropriate for common mental health problems include:

Low Intensity Psychological Therapies
- Pure Self-help – bibliotherapy (the use of written materials to assist people to manage and overcome their problem by changing their behaviour)

- Guided self-help – as bibliotherapy but with the guidance of a health care professional
- Computerised CBT (CCBT)
- Structured group physical activity programmes
- Sleep hygiene

High intensity Psychological Therapies

- Cognitive behavioural therapy (CBT)
- Group-based CBT
- Support groups
- Interpersonal therapy (IPT)
- Behavioural activation (although evidence less robust for this compared to CBT or IPT)
- Behavioural couples therapy
- counselling
- short-term psychodynamic psychotherapy

Evidence-base for Psychological Therapies and Pharmacological Treatments

Psychological therapies and pharmacological treatments can be effective for treating a variety of common mental health problems in primary care and evidence supports the use of specific therapies for different problems. Based on existing evidence, including systematic reviews and meta-analyses, Table 1 provides a summary of the recommendations have been made about the appropriateness of these therapies. This table summarises the evidence presented within NICE guidelines for anxiety, depression, OCD and PTSD (NICE, 2011; 2009; 2005a; 2005b).

Table 1: Recommendations about appropriate therapies for common mental health problems[2]

Common Mental Health Problem	Recommendations	
	Psychological Therapies	**Pharmacological Treatments**
Depressive Disorders		
Mild to Moderate Depression (with or without a chronic physical problem)	*Low Intensity Psychological Therapy:* GSH, CCBT, Structured physical activity programme, Group CBT	Antidepressants not recommended unless: 1. a past history of mild-severe depression; 2. initial presentation of subthreshold depression symptoms present for at least 2yrs; or 3. subthreshold depressive symptoms or mild depression that persist(s) after other interventions
Moderate to Severe Depression (without a chronic physical problem)	*High intensity Psychological Therapy:* CBT, IPT, BA, Behavioural couples therapy (where applicable), Counselling or short-term psychodynamic therapy (for those who decline other therapies offered)	Combination of anti-depressant PLUS high intensity intervention recommended
Moderate to Severe Depression (with a chronic physical problem)	*High Intensity Psychological Therapy:* Group-based CBT, CBT (if group-based CBT not available, appropriate or declined), Behaviour couples therapy (if applicable)	Antidepressants offered to those with persistent sub-threshold depressive symptoms, or mild to moderate depression who have not benefited from a low-intensity intervention in place of a high-intensity intervention OR alongside individual CBT if severe depression
Complex and Severe Depression (without a chronic physical health problem)	*High Intensity Psychological Therapy:* CBT, IPT, Behavioural activation, Behaviour couples therapy (if applicable)	Antidepressant e.g. selective serotonin reuptake inhibitor (SSRI), Antipsychotic medication (for people who have depression with psychotic symptoms)

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[2] Organisational and service level interventions such as collaborative care have been excluded as their interventions include more than psychological and pharmacological interventions

Complex and Severe Depression (with a chronic physical health problem)		Antidepressant e.g. selective serotonin reuptake inhibitor (SSRI), Antipsychotic medication (for people who have depression with psychotic symptoms)
Anxiety Disorders		
Generalised Anxiety Disorder (GAD)	*Low Intensity Psychological Therapy:* Individual non-facilitated self help, GSH, psychoeducation groups	
GAD with functional impairment	*High Intensity Psychological Therapy:* CBT, Applied relaxation	SSRIs
Panic Disorder	High Intensity Psychological Therapy: CBT Low Intensity Psychological Therapy: Self-help (bibliotherapy), support groups	SSRIs or tricyclic antidepressants (TCAs) ONLY in longer-term management
Obsessive Compulsive Disorder (OCD)	*Low Intensity Psychological Therapy* (according to impairment): Brief individual CBT including exposure and response prevention (ERP) with self-help materials, individual or group CBT (including ERP)	SSRI or combined treatments
OCD with co-morbidity	*High Intensity Psychological Therapy:* CBT	SSRI or clomipramine, or combined treatments
Post Traumatic Stress Disorder (PTSD)	*High Intensity Psychological Therapy:* Social and emotional support, individual brief single-session interventions (debriefing)	
PTSD with symptoms present within 3 months of trauma	*High Intensity Psychological Therapy:* Brief psychological interventions Trauma-focused CBT	Not recommended as a first line treatment. Hypnotic medications for management of sleep disturbance, Antidepressants at an early stage in order to reduce the later risk of dependence
PTSD with symptoms present more than 3 months after trauma	*High Intensity Psychological Therapy:* Trauma-focused CBT, Eye movement desensitisation and reprocessing	Augmented with trauma-focused CBT a course of paroxetine, mitazapine, amitriptyline or phenelzine

Whilst the recommendations presented in Table 1 are based on robust development procedures, and have a role in improving the quality of decision-making, there are limitations that need to be accepted. Much of the evidence is inadequate or varied and many of the recommendations are based upon this restricted evidence-base.

CBT is considered by many as the 'gold standard' treatment, and recommended as the psychological treatment of choice for both anxiety and depression (NICE, 2011; 2009). However, in terms of effectiveness, there exists a mixed evidence-base. Numerous studies have shown that CBT is as effective for treating depression as antidepressant treatment (DeRubeis *et al.*, 2005;Gloaguen *et al.*, 1998;Jarrett *et al.*, 1999;Jacobsen & Hollon, 1996) and that positive outcomes can persist in the long-term, particularly in the maintenance of recurring depression (Paykel, 2001). The positive impact it has in treating people with anxiety disorders is also widely supported (Stewart & Chambless, 2009;Hunot *et al.*, 2007) when in comparison to no treatment or placebo (Norton & Price, 2007) or to other forms of therapy (Borkovec & Costello, 1993). In addition, it has been highlighted that providing CBT in combination with antidepressants is more effective than medication alone (Keller *et al.*, 2000).

Taking into account the methodological considerations of many studies, however, is said to limit the conclusions that can be made. Concerns over therapist experience (DeRubeis *et al.*, 2005), non-representative clinical samples being studied (Stewart & Chambless, 2009; Persons & Silberschatz, 1998) and the severity of the individuals' depression at the outset (Elkin *et al.*, 1995) are regarded as impacting upon the way in which CBT implementation within trials reflects reality. Stewart & Chambless (2009) further stressed, whilst interpreting the findings from a meta analysis of effectiveness studies, that as many studies do not compare the effects of CBT to a control group, we cannot be entirely confident that individuals' improvement is not due to other factors such as the passing of time rather than the therapy itself.

Aside from CBT, where there is an extensive, albeit mixed, evidence base, for the majority of psychological treatments the evidence available is more limited. It is important is to acknowledge that for such therapies that lack of evidence is not evidence of ineffectiveness. Thus whilst specific therapies have been recommended in the treatment of

common mental health problems a number of other approaches may additionally be equally as effective.

With respect to the recommendations made for pharmacological treatments trials have provided evidence for the effectiveness of medications in the management of more severe forms of anxiety and depression (Anderson et al., 2008; Kirsch et al., 2008). However, the comparative efficacy of pharmacological treatments over the long-term is to be established as is whether combining pharmacological approaches with psychological approaches (Baldwin et al, 2005). Additionally, many patients express negative views about taking them including concerns about dependence (Haddad, 1999) and would prefer a 'talking' or psychological therapy (Summerfield & Veale, 2008; Prins *et al.*, 2008; Bedi *et al.*, 2000; Riedel-Heller *et al.*, 2005; van Schaik *et al.*, 2005; Dwight-Johnson *et al.*, 2000).

Limited Resources – Demand Versus Supply

Although psychological treatment is provided within primary and secondary care there exists a huge disparity between need and provision within current services and thus achieving equitable and accessible services is often restricted (Kessler *et al.*, 1999). Increasing prevalence of mental health problems is placing considerable pressure upon mental health services, where their capacity to provide adequate services is outweighed by the competing demands of patient need. In particular, resources are limited due to a lack of professionals able to provide such therapy. Service provision is often characterised by long waiting lists (Lovell *et al.*, 2003), with many patients waiting months or even years to receive psychological treatment (Anderson et al., 2005; Lovell & Richards, 2000). A large UK survey carried out by the Office for National Statistics on behalf of the Department of Health in 2000, revealed that among those patients experiencing a common mental health problem, only four percent were in receipt of a psychological therapy (Office for National Statistics, 2000). A recent survey by the Royal College of General Practitioners of more than 1150 GPs found that 65% of patients were 'rarely' able to access psychological treatment within two months, 20 percent 'sometimes' accessed treatment, and only 15 percent of their patients 'usually' did (Field *et al.*, 2010). It has thus been necessary for more effective and efficient models of treatment to be considered (Lovell & Richards, 2000).

Accessing Mental Health Services

The way in which mental health care is accessed within primary care has been described by Goldberg and Huxley (Goldberg & Huxley, 1980) in their 'Pathways to Care' model. Using the concepts of levels and filters they proposed that in order to access specialist mental health care an individual must move from one level to the next by passing through one of three filters. The process by which an individual moves through the pathway is said to be influenced by various factors such as severity, availability of services and relationship with or attitudes of physicians. This model is presented in Figure 3.

Figure 3: The Pathways to Care Model (Goldberg & Huxley, 1980)

Level 1: General population
Filter 1: Illness behaviour
Level 2: Psychiatric disorder in primary care
Filter 2: Recognition by the primary care professional
Level 3: Conspicuous psychiatric morbidity
Filter 3: Referral to specialist care
Levels 4 & 5: Specialist care
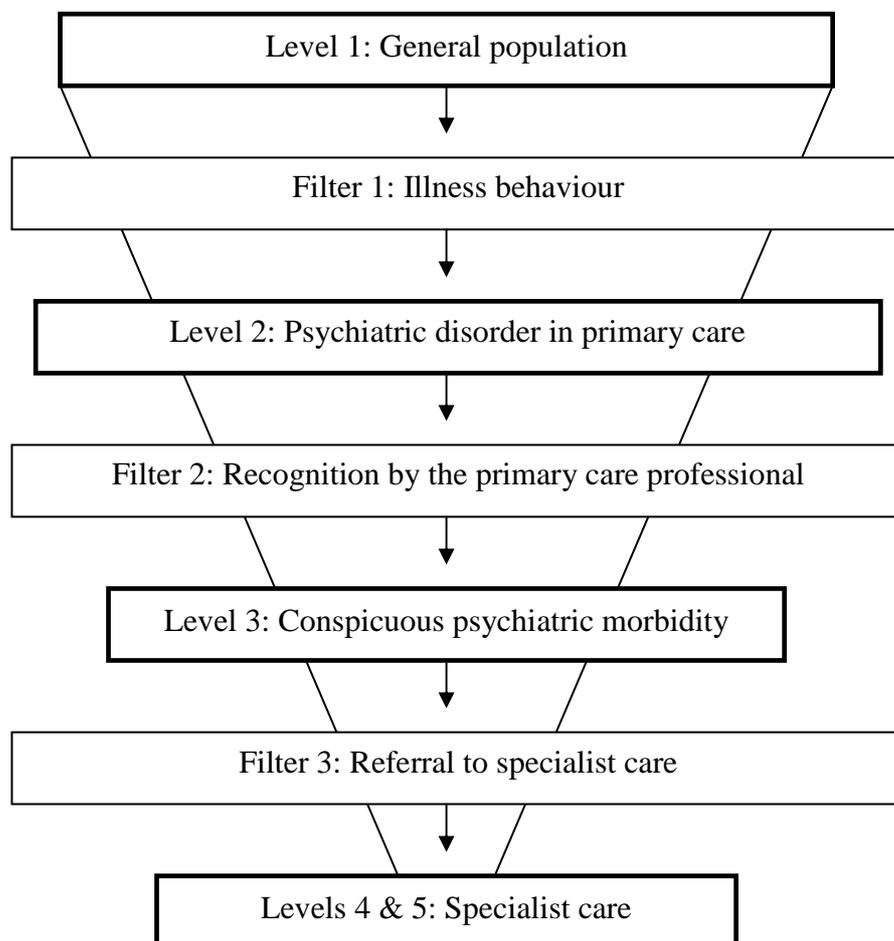
The pathways to care model highlights the importance of the primary care practitioner in determining whether a patient receives care, and the sort of care that they receive. In making these decisions the model suggests there are three filters. These relate to:

i.   Patient behaviour
ii. Diagnosis by the primary care professional
iii. Referral to specialist mental health services

The focus of this PhD is on the third filter. One of the key issues affecting referral is the availability of treatments (Royal College of General Practitioners, 2000). Referral to specialist care involves sending patients to a range of treatments of differing type, complexity and cost. Stepped and stratified approaches refer to how patients are allocated to these different treatments.

Improving Access to Psychological Therapies (IAPT) Programme

The Improving Access to Psychological Therapies (IAPT) programme launched in 2006 aimed to improve access to psychological therapies. Its implementation was initiated by health economist Lord Richard Layard in 2005 (Layard, 2005). Layard made a case on the grounds of economics and psychological well-being, for investment in the provision of psychological therapies to improve the health of the nation and ultimately to reduce the burden of incapacity benefit by increasing the number of people who are fit for employment. In his report he highlighted the need to invest in 10,000 new therapists to provide a workforce that had the capacity to implement NICE guidance. In response, the Labour government made a sizeable investment in psychological therapies, with a total of £173 million over a three year period. IAPT supports primary care trusts (PCTs) to implement NICE guidance. A large proportion of the money was allocated to invest in training psychological therapists to provide evidence-based treatments.

In line with political, social and economic drivers, the IAPT programme, in aiming to improve access to psychological therapies, saw the need, and a major role, for less intensive therapies in the initial stages of a patient's treatment. A clear distinction is made between low and high intensity interventions within its application.

Delivery of Psychological Therapies in IAPT– Low and High Intensity Workers

A variety of different professionals are involved in the delivery of different psychological therapies. Low Intensity Therapy Workers include Psychological Wellbeing Practitioners, Graduate Mental Health Workers, Primary Care Mental Health Workers and Gateway Workers who provide high volume, low-intensity CBT-based therapies including guided self-help. High Intensity Psychological Therapists provide more intensive face-to-face CBT. High-intensity workers come from a variety of health care backgrounds such as psychologists, occupational therapists and primary care counsellors while the majority of low intensity workers are graduates of a relevant discipline such as psychology.

Stepped Care Approach

Stepped care is a model of healthcare delivery that originated in the United States and has been applied to a range of health problems, particularly long-term conditions such as asthma (British Thoracic Society & Scottish Guidelines Intercollegiate Network, 2009). The stepped care approach for the management of asthma is based on the severity of the disease with mild episodic, mild persistent, moderate and severe categories , based on the presenting levels of symptoms, are advocated at each step to assist with decision making about treatment. Within the mental health field the model was first applied to the treatment of substance misuse problems (e.g. Sobell & Sobell, 1993; Breslin et al., 1997). In the US the model aims to provide patients with treatments that are 'least restrictive' in terms of the anticipated impact and intrusion that the treatment has upon their day-to-day life (Sobell & Sobell, 2000). Its incorporation into the UK mental health care system, where there exists a number of demands on the resources available, has a slightly different emphasis. It was viewed as a potential solution to ensuring that the efficiency of service provision and the overall benefit to patient populations is increased (Kaltenthaler et al., 2002; Scogin et al., 2003).

The model aims to rebalance resources across patient treatment pathways in order to treat a greater number of patients in need. Stepped care can be described as a sequence of treatment options where patients are, in the first instance, offered a treatment that is 'least restrictive' of those available in terms of treatment intensity and specialist therapist time

required, but which is still likely to provide significant health gain. In stepped care a significant proportion of patients start with an evidence-based 'least restrictive' treatment as a first step (regardless of the severity of their problem or their individual preferences). The model is 'self-correcting' where a systematic process of monitoring the results of treatments and decisions about treatment provision is conducted. Where the initial treatment is associated with no significant gain (determined through the administration of outcome measures), more 'restrictive' options are explored (where 'restrictive' might reflect their cost, complexity and burden on the patient). A process of 'stepping-up' to a potentially more effective treatment then takes place. Although less crucial than 'stepping up', there may be instances where a patient may be 'stepped down' to a less intensive treatment should their symptoms improve and where continued support at a lower intensity may be of benefit.

The vast majority of the self-help (e.g. bibliotherapy and computerised treatments) and other low-intensity psychological therapies (e.g. guided self-help) are based on CBT techniques. Moving through the steps involves increasing the amount of therapist involvement and consequently leads to increasing costs. Stepped care thus standardises systems and procedures in order to improve efficiency (Katon *et al.*, 1999; Scogin *et al.*, 2003). The stepped care model differs to the way in which mental health services were delivered traditionally, with more focus on management within primary care services rather than secondary care. It has an explicit aim to improve efficiency (Scogin et al., 2003) by managing care in a more systematic way and incorporating assessment of outcome (Bower & Gilbody, 2005b).

Stratified Approach

In stratified care (also described as matched or multiple-access model), patients can access more intensive steps without initially receiving less intensive interventions (Lovell & Richards, 2000). In this approach the type of treatment initially received as well as the intensity of the treatment, will be matched to the key features of the patient's initial presentation (normally severity, but might involve other factors). Allocation of a treatment using a stratified approach requires decisions to be made about what treatment would be most effective. Thus matching patients to appropriate treatments may improve outcomes.

This process has been referred to as '*aptitude treatment interactions*' (Cronbach & Snow, 1977).

There are a number of potential advantages and disadvantages to stratified care. A model based on stratified principles potentially allows the needs of the patient to be met more readily by ensuring that those with long-standing or complex conditions receive the appropriate level of intervention in a timely manner (Rush *et al.*, 2006), a factor that has been considered as important in the commissioning of psychological therapies (Royal College of Psychiatrists & Royal College of General Practitioners, 2008). Others have further highlighted the need to match individuals' needs to a treatment, particularly if the initial approach is not likely to benefit them and where 'better alternatives are available' (Sobell & Sobell, 2000, p575). However, within psychotherapy research matching treatments to individual patients can be difficult (Smith & Sechrest, 1991). Furthermore as guidance surrounding the threshold for referring a patient to secondary mental health services is sparse (Paxton *et al.*, 2000), a stratified approach may lead to increasing costs, particularly if patients who may have benefited from low intensity treatments are provided with higher intensity interventions.

NICE Guidelines

NICE recommends a mixed 'stratified' and 'stepped' model. Initial stratification is based on severity, risk, previous treatment failure or functional impairment. However, the guidelines also suggest that procedures exist for 'stepping up' to more intensive treatments if outcomes are less than optimal. A four-step approach is described in the NICE guidelines for the management of depression (NICE, 2009). Figure 4 presents the model.

Figure 4: Overview of a four-step model for depression (adapted from NICE Depression Guidelines 2009)[3]

	Focus of the intervention	Nature of the intervention
Step 4 MH specialists inc. crisis teams, inpatient	Severe and complex; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care
Step 3 Primary care team, PCMHW/high intensity worker	Persistent moderate or severe symptoms or mild to moderate symptoms with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
Step 2 Primary care team, PCMHW/ low intensity	Persistent sub-threshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, medication and referral for further assessment and interventions
Step 1 GP, practice nurse	All known and suspected presentations of depression	Assessment, support, psycho-education, active monitoring referral for further assessment and interventions

Intensity of treatment ↑ (left)   Number of patients ↓ (right)

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[3] Collaborative care only suggested for depression at Step 3 where the person also has a chronic physical health problem and associated functional impairment

Implementation of Stepped Care into the UK Health Care System

The implementation of the stepped care approach is designed to alleviate the demand on health care resources, potentially reducing waiting list times (Care Services Improvement Partnership North West Regional Development Centre, 2007), simplifying patient care pathways and assisting with the management of a large number of patients with common mental health problems at a lower cost. However, there have been, and continue to be, a number of difficulties surrounding the implementation of the model. Whilst a review of stepped care highlighted that it has the potential to improve the efficiency by which psychological therapies are delivered (Bower & Gilbody, 2005b), there currently exists very little evidence of stepped care and little consensus as to how patients should flow through the system (Sobell & Sobell, 2000). The difficulties associated with making these decisions have resulted in much variation in the way that the model has been managed over different sites (Wolstenholme *et al.*, 2006).

A major aspect of stepped care is that the treatment initially suggested must also be one that is considered to have positive health benefit. Stepped care can have any number of steps from two upward and is dependent on local resources and service preference. For the management of depression, NICE describes a stepped model involving four qualitatively different steps (see Figure 4). This starts with the assessment, support, psycho-education and active monitoring of the problem, moving to low intensity psychosocial interventions such as guided self-help/group therapy then to high intensity psychological interventions and finally to longer-term individual therapy or inpatient specialist services if benefits (health gains) of the previous steps are not apparent (Bower & Gilbody, 2005a; Lucock *et al.*, 2008). As discussed earlier, however, should a patient present with issues such as high severity or risk, then NICE advises they should be directed straight to specialist services without the need to systematically move through all of the steps.

Low Intensity and High Intensity in Stepped Care

As Figure 4 illustrates, a GP or practice nurse who is presented with a patient with a recent onset mild depression with no risk of self harm may opt for an 'active monitoring'

approach. This involves the GP or nurse monitoring symptoms and giving support and advice. If, following monitoring over period of 3-4 weeks there is no improvement, then the patient may be offered guided self-help. This low intensity psychological therapy provides the patient with limited health care professional contact, usually a low intensity worker. A process of systematic monitoring of the patient's symptoms, whilst in receipt of this treatment, occurs at regular intervals. Again, if there is no significant improvement to the patient's symptoms (as assessed using an agreed measure), they may be offered a more intensive treatment such as brief psychological therapy e.g. brief CBT, delivered by a range of workers with less experience than those who deliver more intensive treatments at higher steps e.g. high intensity workers, primary care mental health professionals or counselling delivered by counsellors. Following these steps should a person continue to have persistent symptoms they may be offered more intensive CBT. Interventions provided at each level of the model are divided not only by mental health professional time but also by their role. Thus moving up through the steps of the model involves not only an increasing intensity of intervention but also an increase in the level of experience that the health professional delivering that intervention has.

Low Intensity Psychological Therapies

The provision of low intensity psychological therapies is indicated at step two of NICE guidance on depression and some anxiety disorders (NICE, 2009; 2010)

Low intensity treatments include:

- Computerised cognitive behavioural therapy (CCBT)
- Guided self-help
- Support groups
- Group CBT
- Physical activity programmes

These interventions are brief and are conducted over a period of up to seven sessions (Department of Health, 2008b). In addition, patients may be provided with guided self-help based on CBT principles. Guided self-help refers to interventions that require minimal therapist contact and aim to provide the optimal balance between efficiency and

effectiveness (Gellatly et al., 2007). NICE, in their guidelines for the treatment of depression, define guided self-help as:

> *'A self-administered intervention designed to treat depression, which makes use of a range of books or a self-help manual that is based on an evidence-based intervention, mainly CBT, and is designed specifically for the purpose.'*
> (NICE, 2009a, p182).

This intervention normally takes place over three to six sessions (NICE, 2009) and patients receive guidance from a mental health worker of generally no more than three hours (Gellatly et al., 2007). In line with the recommendations of NICE guidance, guided self-help is aimed at patients with mild to moderate symptoms.

High Intensity Psychological Therapies

For more severe levels of depression and anxiety more intensive talking therapies may be provided. Within stepped care patients would be 'stepped up' to these types of treatments when low intensity therapies have proven ineffective or if the problem is moderately severe or severe. High intensity psychological therapies provided at steps three and four of NICE depression guidelines and step five of anxiety guidelines can include:

- CBT with integrated and structured self-help materials of six to eight sessions delivered over eight to twelve weeks
- Behavioural activation
- Structured problem solving
- Mindfulness-based cognitive therapy
- Interpersonal therapy
- Couples therapy
- Psychodynamic psychotherapy
- Rational emotive behavioural therapy

Evidence for Stepped Care

Early evidence for a stepped care approach for mental health problems was found in the Australian STAR*D study (Rush *et al.*, 2006). Patients with major depressive disorder were initially provided with a first level treatment (citalopram only) and 'stepped-up' to higher levels (which included the option of CBT at level two and further management using medication at levels three to five) should no improvement occur. Findings highlighted that remission rates were highest for those completing treatment in the first two levels as opposed to those who needed 'stepping-up' to levels three and four. Additionally, although not statistically significant, patients who chose to switch to CBT at step two (with or without augmented medication) had better outcomes than those only taking medication. A potential limitation to the generalisability of the findings is that all patients had to take medication as a step one treatment and this may have impacted on the subsequent decisions that they made at higher treatment steps. The potential influence of this is highlighted in that only three percent of patients chose to switch to CBT alone at step two.

More recent evidence is derived from the evaluation of the two IAPT demonstration sites – Doncaster and Newham (Clark et al., 2009). While both sites were focused upon improving provision of services for individuals with depression or anxiety the population and services provided differed. Doncaster focused on those presenting primarily with a depression and anxiety but those with PTSD or OCD were excluded. Newham took patients with depression and all anxiety disorders. The provision of low intensity interventions was the main aim of Doncaster whereas Newham initially focused on high intensity CBT. The evaluation used an observational prospective cohort study of patients receiving low intensity treatments that involved session-by-session outcome monitoring of depression and anxiety symptoms. Patients' initial and final scores who had attended at least two sessions were compared. Outcome measures included the Patient Health Questionnaire (PHQ-9) (Kroenke *et al.*, 2001), Generalised Anxiety Disorder Assessment (GAD-7) (Spitzer *et al.*, 2006), Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) (Barkham et al., 2001) and an employment self-report questionnaire (Department of Health, 2008a). Large numbers of referrals were evident at both sites with self-referrals being high in Newham. Evidence found that at both sites stepped care increased patient throughput considerably. Significant clinical improvements were found on all measures at both sites. Furthermore 55 to 56 percent of patients classified at

assessment as a clinical case were no longer clinical cases at the point of leaving the service. The vision of IAPT to assist with getting people back to work was found with unemployment rates dropping and, furthermore, outcomes were in line with previous trials of people with anxiety and/or depression. Improvements in Doncaster were related to duration of illness where individuals with a problem present for more than four years showed less improvement than those with problems of shorter duration. As Newham is an ethnically diverse site additional analyses were conducted. It was found that while clinical outcomes were not influenced by ethnicity, that self-referral improved access for under-represented groups.

A study by the Care Services Improvement Partnership in conjunction with a consulting services company (Symmetric SD), aimed to develop a model that takes into account NICE guidelines alongside economic and resource allocation factors to better understand the application of a stepped care patient pathway approach for depression (Wolstenholme et al., 2006). It was highlighted that the introduction of a stepped care approach at pilot PCT sites, where stepped care has been fully implemented, has shown to have a positive impact upon waiting times. Initially, without the existence of steps two and three patients faced waits of up to eight months; however data collected found that, on average, waiting times are three weeks. With guided self-help at step two increasingly becoming a central component of stepped care for depression care in both the USA and UK (Scogin *et al.*, 2003; NICE, 2009) there has been recent interest in evaluating its effectiveness. A number of studies demonstrate encouraging evidence for guided self-help in terms of efficacy and cost-effectiveness for anxiety and depression (van Boeijen *et al.*, 2005; Anderson *et al.*, 2005; Bower *et al.*, 2001; Gega *et al.*, 2004; Farrand *et al.*, 2008) .

Whilst these findings are promising there are a number of limitations to the conclusions that can be drawn. Of particular relevance is the research design, a weakness of a prospective cohort design is the difficulty in determining whether the associations between the outcomes and the treatment are of a causal nature or not. Such studies, unlike randomised controlled studies, cannot control for additional factors that may influence the outcomes as effectively and thus the validity of the study can be compromised. Additionally, while recovery rates were higher than would be expected for people with longer-term problems, the benefits were less clear for those with more recent onset and as follow-up collection data was low it is unclear if benefits are sustained over time. As the

provision of services, and thus the implementation of stepped care, at the sites varied is difficult to identify exactly what moderated positive outcomes. Similar to the STAR*D trial (Rush *et al.*, 2006), Clark et al's (2009) evaluation also failed to take into account the types of individuals presenting in routine treatment delivery. Doncaster excluded patients with mild depression, OCD or PTSD and those who had psychosis, drug or alcohol problems, and or significant risk.

In addition, the evidence of effectiveness of guided self-help is not uniformly positive (Mead & Bower, 2000; Richards et al., 2003; Lovell et al., 2008; Proudfoot et al., 2004). A recent meta-analysis and meta-regression (Gellatly et al., 2007) identified the importance of understanding the contribution of different moderators of treatment effects in self help. In exploring these, while evidence for guided self-help interventions was supported, the effect sizes identified were smaller than those reported by NICE. It additionally provided some insights into moderators such as mode of delivery, the theoretical model adopted and, specifically related to guided self-help, the content of the guidance. The inclusion of more recent studies may have been the reason for this but the review also highlighted a lack of a sufficiently powered trial of guided self-help. Such a trial needs to be conducted before a firm conclusion can be drawn.

Outside of the UK studies have been conducted in the Netherlands. In an evaluation study exploring the feasibility of adopting a stepped care to the management of depression Meeuwissen et al (2008) found referral levels to mental health services did not alter and following the adoption of stepped care the numbers of referrals from primary to secondary care reduced. Semi-structured interviews with health professionals revealed high levels of adherence to their protocol. Professionals also identified a number of benefits of the approach including increasing patient access to treatment, improved follow-up procedures and support with clinical decision-making. The findings highlight the potential for improving the efficiency of managing depression using such stepped care, however, as much of the data collected relied on health professional and self-report issues such as adherence may be overestimated.

A recent randomised trial found that in comparison to usual treatment (a stratified approach where the patient is matched to a therapy based on problem experienced and other patient characteristic contextual factors), patients with anxiety and/or depression

treated within a stepped care approach and randomised to brief therapy or CBT showed no better outcomes (van Straten *et al.*, 2006). However this study has limitations. The stepped approach adopted considered CBT as a first step, with those patients who were 'severely ill' having the opportunity to receive medication, which does not reflect the proposed starting point within the UK. Additionally only patients that met certain DSM-IV criteria were included, which limits the generalisability of the study to routine care.

A more recent randomised controlled trial conducted within an elderly adult population aimed to identify the impact of a stepped care upon preventing the onset of depression or anxiety in those displaying sub-clinical manifestations of the problems (van't Veer-Tazelaar et al., 2009) over a 12 month period. The findings highlighted that, in comparison to usual care, patients receiving treatment within stepped care showed a 50 percent reduction in the incidence of clinical depression or anxiety. Although the findings are promising, the generalisation of the findings to the UK may be limited due to the way stepped care was implemented. The model comprised of four steps – watchful waiting; CBT-based bibliotherapy; brief CBT based problem solving treatment and finally referral to primary care physician for discussion of medication. The mental health workforce delivering the treatments was also different with district community psychiatric nurses providing the interventions at steps two and three. An economic evaluation conducted alongside the trial found that stepped care was good value for money, dependent on the willingness to pay for a disorder-free year, but incremental costs identified were higher than had been reported in some previous trials. The costs associated with providing a two-intervention stepped programme were identified as possible causes of these inflated costs.

There is much national and international interest about the implementation of stepped care and findings from current trials will emerge in the next few years. However, currently the evidence base for the incorporation of a stepped care approach remains sparse and studies that have been conducted in this field appear to have numerous methodological issues, which preclude firm conclusions being made.

Decision-Making in Stepped Care

The ongoing pressure for health care systems to evolve have been driven primarily by the need to improve the provision and efficiency of mental health services and also by national policy agendas that aim to better meet the needs of the population and improve patient participation in health care decision-making (Department of Health, 2005a; 2006). The Department of Health aim to '*promote a culture of choice that entails responsible, supported decision-making*' (Department of Health, 2007a) showing commitment to ensuring that the National Health Service (NHS) delivers patient responsive and centred care. This is supported by the British Social Attitudes Survey (Bromley & Hewton, 2005) that 65% of people want to be able to choose their own treatment. The process of treatment decision-making should be viewed as a collaborative one between patient and health professional (Tillett, 1996).

Although stepped care is described in the NICE guidelines for depression and anxiety (NICE, 2009; 2010), in line with policy issues they also stress the importance of shared decision-making, information needs (informed choice), and patient preferences. Within stepped care there exists a tension between decision-making and patient choice and the model could be viewed as forcing patients to receive less intensive services, thus restricting choices about their mental health care. Decisions, as recommended by NICE are based primarily on the severity of the presenting problem, thus little choice essentially exists between steps (between different intensities of intervention) and is limited to choices within steps (between treatments of equal intensities). For example a patient at step two, in theory, may choose, depending on the availability within their mental health service, between guided self-help, CCBT, or any other interventions presented at that step (Care Services Improvement Partnership & National Primary Care Research and Development Centre, 2006) but they may not necessarily have the opportunity to choose CBT. It has been suggested that stepped care fails to involve patients in decision-making (Bower & Gilbody, 2005b). In relation to patient choice and preference, studies have indicated that patients favour psychological interventions and appreciate time spent with caring professionals (Priest *et al.*, 1996; Unutzer *et al.*, 2002; Raue *et al.*, 2009; Cooper *et al.*, 2003; Dwight-Johnson *et al.*, 2000), however the main focus of the NICE guidelines is the introduction of step two, in which different delivery modes are used and therefore offering interventions which patients are unlikely to expect. Minimal interventions such as guided

self-help and CCBT will reduce time spent with a health care professional and, although there is some evidence to suggest that patients are satisfied with treatment in this form (MacDonald *et al.*, 2007; Richards *et al.*, 2006; Rogers *et al.*, 2003), patients may view it as a less acceptable form of treatment.

Monitoring the effects of the treatment a patient is receiving must occur continuously within stepped care to ensure that appropriate treatment decisions are made in an efficient and effective manner (e.g. determining when to 'step' up to a more intensive treatment). Decisions should be made on a sound evidence base; they must be sensitive to the costs of the treatment; they must consider not only the impact that previous treatments have had on the patient's mental health symptoms but the experiences of the individual and the impact that the treatment has on other aspects of their life. Perhaps, most importantly, decisions must also be made with consideration of the role that the patient has in the decision-making process.

It is clear that all individuals with the same condition will not respond to treatment in the same way and thus ensuring the patient has the ability to express their preference for one treatment over another plays a key role in ensuring positive outcomes are achieved. Choice, however, does not necessarily fit with the fact that decisions to 'step' individuals up to a more intensive step are essentially driven by outcomes. A recent mixed-methods study explored differences in patients at two IAPT sites who were 'stepped-up' from low intensity to CBT in comparison to those who had received a low intensity or those 'stepped' directly to CBT intervention following initial assessment (Horn, 2010). The findings showed that the likelihood of a patient receiving a low intensity intervention or CBT could not be predicted by assessment characteristics such as age, gender, presenting mental health problem or outcome measures. The findings were reflective of current literature that highlights the ambiguities concerning characteristics that may predict outcome following the receipt of a low intensity intervention. In addition, the likelihood of a patient being 'stepped-up' could only be predicted by their level of anxiety at assessment, with those receiving CBT displaying significantly higher scores than those receiving a low intensity intervention. Qualitative interviews were subsequently conducted with eleven patients to explore their experiences of being 'stepped-up'. Data was analysed using interpretive phenomenological analysis, with five sub-ordinate themes relating to the therapeutic process and organisational influences being identified. Four themes - the 'fit'

of the intervention, the experience of change, the relationship with workers and power were all regarded as having an influence on the fifth - the 'emotional experience of 'stepping-up'. These findings provide a useful insight into the experiences of patients in the stepped care model and the factors involved in the decision to 'step-up'. Whilst the research design of this study is robust there are a number of limitations. In relation to the first study many of the patients who were 'stepped-up' to CBT received a larger number of sessions than would usually be recommended. In addition, all patients who were interviewed expressed positive views of the service and their experiences of being 'stepped-up'. Finally the study is limited in that it fails to take account of the views of those health professionals making the decisions about patients' treatment and thus can only speculate why, for example, severity seems to play little part in the 'stepping-up' process.

Whilst outcome may not predict whether a patient is 'stepped-up' or not, a survey exploring CBT therapist views and attitudes of CBT, including their opinions about particular patient characteristics, found that 61 % of CBT therapists identified mild levels of severity were likely to lead to a positive outcome (MacLeod *et al.*, 2009). However, motivation, expectancy, adherence and self-efficacy characteristics were considered to be better predictors of outcome.

Davison (2000, p580) emphasised that stepped care could be viewed as 'doing more with less' where meeting the requirements of the model by providing more patients with treatment but at the detriment of the time spent with each individual. Being led by a model driven by the health of the public rather than individuals, he argued that health professionals are less likely to have the opportunities to identify, evaluate and make decisions based on the potential impact that the problem is having on other aspects of the individual's life. He claimed this could potentially limit the benefit that patients are getting from the treatments that they are receiving. Similar views were asserted by Power (2009) who identified the increased pressure for mental health services to take a community approach to the well-being of individuals but stressed the importance of considering the individual patient in addition to the broader community. Tensions therefore exist when considering the wider public health and service priorities compared with those focused on patient-centred policy regarding involvement of patients in decision-making and their rights to have a choice.

The literature reflects the fundamental role of decision-making within stepped care. Conflicting demands of the public health focus of stepped care with healthcare policy focusing on the importance of patient choice exist. There is a great emphasis on improving the efficiency of the delivery of mental health services but this needs to be done whilst meeting patient need and without sacrificing the quality of the care they receive. Making treatment decisions is therefore difficult when it is apparent that the decision that is regarded as suitable by the patient does not necessarily comply with that of the resource-limited service (Wailoo *et al.*, 2004).

Secondly, professional decision-making (both in terms of assigning to steps and 'stepping-up') is at the foundation of stepped care. Whilst 'stepping-up' is said to be made on the premise of outcome measure scores it is apparent that the decision-making process is potentially more complex. In stepped care, professionals are faced with making decisions about what type of treatment is most appropriate, and whether patients require additional treatment after they have received help at a particular step. Making decisions in stepped care systems that improve the efficiency of service provision but also support patients' choice and preference is thus a key challenge. Little is known about how the actual process of decision-making within the model is conducted.

Chapter Summary

- The prevalence of common mental health problems is high and the majority of people are treated in primary care settings.

- A variety of psychological and pharmacological treatment options are available and vary depending on severity of the problem.

- Psychological therapy is favoured by patients as a treatment choice; however there exists a great disparity between need and provision within current services.

- The stepped care model of service delivery has been adopted to increase the efficiency of service provision by providing patients with low intensity interventions (lower costs), in the first instance, moving to higher intensity interventions (higher costs) when benefits are not apparent.

- There have been a number of difficulties surrounding the implementation of the stepped care model into the UK health care system and the model has been criticised for potentially ignoring policy and restricting patient choice.

- There has additionally been little consensus over how decision-making should occur in this model.

CHAPTER TWO: DECISION-MAKING THEORETICAL MODELS & EMPIRICAL STUDIES

Introduction

This chapter discusses theoretical models of decision-making processes within health care, before reviewing the published empirical evidence concerning how decisions are actually made in practice.

Decision-Making in Mental Health Care

Two core tensions exist in decision-making in health care. The first relates to where the relative 'power' is, and the *roles* of the health professional and the patient. The second concerns the *drivers* of professional decision-making: whether decisions are driven by external evidence as defined by standardised outcome assessments and guidelines or if they are driven by clinical 'intuition'. Clinical 'intuition' or judgement draws upon professionals' experiences or knowledge about particular patients, conditions or surroundings in order to make a decision (Aveyard & Sharp, 2009).

Models of Decision-Making Roles

A number of decision-making models have been suggested that outline the roles taken by the health care professional and patient. This includes evaluating the way information is exchanged and the considerations that occur before a treatment decision is actually made.

In essence there are three general models – paternalistic, informed and shared models (see Figure 5 for a summary). Whilst these models are applicable for all health care professionals, for simplicity they will be discussed in terms of the decision-making that occurs between a doctor and their patient.

Figure 5: Models of decision-making about treatment (adapted from Charles et al, 1999)

Analytical stages		Paternalistic model	Shared model	Informed model
Information exchange	**Flow**	One way (largely)	Two way	One way (largely)
	Direction	Doctor ⇓ Patient	Doctor ⇕ Patient	Doctor ⇓ Patient
	Type	Medical	Medical and personal	Medical
	Minimum amount	Legal requirement	Anything relevant for decision-making	Anything relevant for decision-making
Deliberation		Doctor alone with other doctors	Doctor and patient (plus potential others)	Patient (plus potential others)
Who decides what treatment to implement?		Doctors	Doctor and patient	Patient

The Paternalistic Model ('Traditional Medical Model')

The paternalistic model dominated the approach to making decisions concerning medical treatment for many decades (Charles *et al.*, 1999a; Llewellyn-Thomas, 1995). Within this model the physician is regarded as the sole treatment decision-maker and the patient is regarded as passive, dependent on the physician and is presumed to be compliant with the decision made. The model assumes that the doctor will make the optimal decision for the patient (Charles *et al.*, 1999b). The patient's role within this model is limited, although they are given the opportunity to express their preferences and attitudes toward treatment. The interactions that the doctor and patient have within this model are said to ensure that patients receive the interventions that best promote their health and well-being, with the doctor articulating what is best for the patient from the professional perspective.

In discussing this model of decision-making, Emanuel and Emanuel (1992) emphasised the role of the doctor as an information provider, providing the patient with selected information to encourage them to agree to the treatment that is considered optimal by the professional. The paternalistic model assumes that the doctor's imperatives are critical and they have the power to exert control over any decisions that are made (Charavel *et al.*, 2001). In considering the best possible treatment the doctor's main emphasis is on the patient's health and well-being rather than their autonomy and choice.

It has been argued that the paternalistic model can only be applied in extreme situations (such as emergencies) where it is impossible to obtain the patient's informed consent. Outside such situations, the paternalistic model would mean assuming that physician and patient share precisely the same values (Emanuel & Emanuel, 1992). However, it can be argued that this model is not truly one-sided if the patient actually asks for this type of decision-making. In this sense there exists a partnership within the paternalistic model and there is a wealth of literature that suggests that many patients actually prefer that decisions are made by the doctors on their behalf (Arora & McHorney, 2000; Rotar-Pavlic *et al.*, 2008). Furthermore, within a stepped care model of service delivery a paternalistic model may prevail. When patients want access to a longer, more intensive treatment, professionals are being encouraged to increase throughput and efficiency, and the whole ethos behind stepped care is that access must be limited.

The Informed Model

The informed model differs from the paternalistic model in that a partnership exists between the doctor and the patient. The role of the doctor is still one of an information provider but instead of making the definitive decision on behalf of the patient they communicate enough information on all risks and benefits, to allow the patient to make a final, informed decision. The model emphasises a clear distinction between diagnostic and therapeutic information and the patient's values, but assumes that the patient is not equipped with the information that would be required for an autonomous decision. Within this model it may be argued that if information is not communicated effectively then the patient may be disadvantaged in their decision-making as they are not 'fully equipped' with all of the relevant information required to make an informed decision.

According to Emanuel and Emanuel (1992) this model of treatment decision-making is no more adequate than the paternalistic one and, as Dowie (1997) highlights, the doctor is relegated to the role of a 'technician' who delivers medical information and acts as directed by the patient. The informed model also inhibits the incorporation of the doctor's values and their understanding and judgement of those of the patient.

The Shared Decision Model

Shared decision-making has been defined as:

> *'a process in which patients are involved as active partners with the clinician in clarifying acceptable medical opinions and in choosing a preferred course in clinical care'*
>
> (Sheridan, 2004, p59)

In contrast to the informed and paternalistic models, this model proposes that the decision is made in partnership, considering the expertise of both the doctor and the patient. To the partnership the doctor brings knowledge surrounding diagnosis, causes of disease, treatment options and preventative strategies whereas the patient complements this with knowledge of their own experience of the disease, their social circumstances, values and preferences.

This model requires a partnership to be developed between the patient and the doctor. In doing so the doctor must establish the amount and type of information that the patient wishes; provide them with that information in an unbiased, understandable way; ensure that the patient feels valued by responding to their ideas, concerns and expectations and additionally assist the patient in exploring treatment options to ensure choice (Charles *et al.*, 1997). In contrast to the informed model, this model is interactional with both the doctor and the patient simultaneously contributing (Charles *et al.*, 1997; Charles *et al.*, 1999a). The model considers the patient and the doctor as partners who come to the relationship with different sources of knowledge and awareness. Charavel et al (2001) emphasised patients may be limited in their awareness of medical issues but have the lived experience of illness, while doctors need input from the patient in order to understand other factors.

Depending on the doctor's skill and the quality of the relationship that they have with the patient, the degree to which decision-making is shared can differ. Doctors using this model of decision-making need to be able to define the boundaries of their role, and constraints within health care provision may directly affect success. For example Gafni *et al*. (1998) pointed out that even if transfer of information from the doctor to the patient is feasible, transfer of the patient's preferences to the doctor is much more complicated and time-consuming and may prove unfeasible.

It is clear that within clinical practice the professional–patient interaction is much more complex and the models represent points on a continuum of decision-making (Benbassat *et al.*, 1998).

Evidence Related to Models of Decision-Making Roles

Studies have indicated that primary care patients suffering from depression have strong preferences for one form of treatment over another (Cooper *et al.*, 2003; Dwight-Johnson *et al.*, 2000; Priest *et al.*, 1996; Raue *et al.*, 2009; Unutzer *et al.*, 2002). A study using qualitative interviews and scales to assess preferences for decision-making style in a sample of thirty patients with severe mental health problems (Adams *et al.*, 2007), indicated that although involvement in decision-making varied, many patients preferred an active or collaborative role. Additional studies have also found that the patients desire

involvement in treatment decisions (e.g. Hill & Laugharne, 2006; Adams et al., 2007; O'Neal et al., 2008; McKinstry, 2000). One study looking to determine whether preferences varied by age, found that older people with severe mental health problems expressed a greater desire to be involved (O'Neal et al., 2008). Hamann et al (2003) claimed that although there can be difficulties involving people who have more severe forms of mental health problems, with less severe forms of depression or anxiety there should be no such limitations.

It has been argued that if health care professionals involved patients in decision-making then this would increase adherence to treatment provided their preferences and choices are taken into consideration (Clever et al., 2006; Ludman et al., 2003; Dwight-Johnson et al., 2000), with a potentially positive impact upon outcomes. In a longitudinal cohort study conduced in a community mental health service, Lasalvia et al (2008) found that outcomes improved where staff and patient agreement about treatment was high. This finding was consistent among patients regardless of their diagnosis, severity or level of functioning. However, it has also been shown that being given choice may not necessarily impact upon levels of adherence or indeed satisfaction (Clever *et al.*, 2006; Eisenthal *et al.*, 1979; Fairhurst & Dowrick, 1996; Rokke *et al.*, 1999; Bedi *et al.*, 2000; King *et al.*, 2000; van Schaik *et al.*, 2005). One study which examined the specific effects that shared decision-making can have, indicated that a patient-centred relapse prevention program utilising shared decision-making only had moderate effects on depressive symptoms (Von Korff et al., 2003). In line with these findings, Ludman et al (2003) found that whilst shared decision-making can have an impact upon improving patient behaviours such as self-management and self-efficacy, clinical outcomes are not necessarily affected. Hamann and colleagues (Hamann *et al.*, 2003), however, argued that these studies had design flaws and thus the conclusions that can be drawn are limited. For example in the study by Bedi et al (2000) patients were only offered a preference if they declined randomisation and thus there may have been a number of patients in the randomised group who would have expressed a preference had they been given the opportunity to do so.

Summary of Models of Decision-Making Roles

- Three general models of decision-making have been proposed within clinical decision-making. These are:
    - The Paternalistic Model
    - The Informed Model
    - The Shared Decision Model
- Each model has advantages and disadvantages.
    - In the paternalistic model the health care professional makes the optimal decision for the patient. This, however, is based on the assumptions and views of the health care professional and patients have little opportunity to be involved.
    - The informed model allows the patient to have control over the decision made and thus allows for the incorporation of patient choice, however this may be disadvantageous to patients who do not possess all of the required information.
    - The shared model, allows patients and health care professionals to work together as 'active partners' and uses the expertise of both when making decisions. Factors such as the patients' ability to express their concerns, needs and preferences may limit the model's effectiveness.
- Studies exploring decision-making roles in health care have highlighted variations in the amount of involvement patients express they would like, the potential impact upon outcomes, and disparities between patients reported preferences for involvement and what occurs in practice.

Theoretical Models of the Psychological Process in Decision-Making

Scientists and researchers have long been interested in investigating the processes that occur when a decision is made and over the years a number of influential models of decision-making have been proposed. Although these models may not be specific to decision-making in mental health care they highlight a number of important issues that can help us to understand decision-making.

Psychologists' views on decision-making have been varied (Svenson, 1996; Beach, 1990; Gollwitzer, 1990) but the general consensus is that four discrete phases are present. Prior learning can influence each phase. Betsch et al (2002) described such a model (see Figure 6) and stated that the four phases involved when making a decision were – the start phase, the pre-selectional phase, the selectional phase and the post selectional phase. The model suggests that when one identifies a situation that requires a choice to be made a number of decision alternatives are acknowledged. In situations where multiple options are available a process of editing, drawing on knowledge or upon previous experiences takes place in order to reduce the options available and simplify the decision to be made. These options are then subjected to evaluation, which ultimately has an impact upon the person's behavioural intention to carry out certain behaviour. Finally, the person is able to make a conscious choice or decision.

Figure 6: Stages in the decision-making process (adapted from Betsch et al, 2002)

Start Phase	Identification of selection problem, options and criteria
Pre-Selectional Phase	Information search, editing operations
Selectional Phase	Evaluation of criteria, application of a decision rule
Post-Selectional Phase	Behaviour implementation
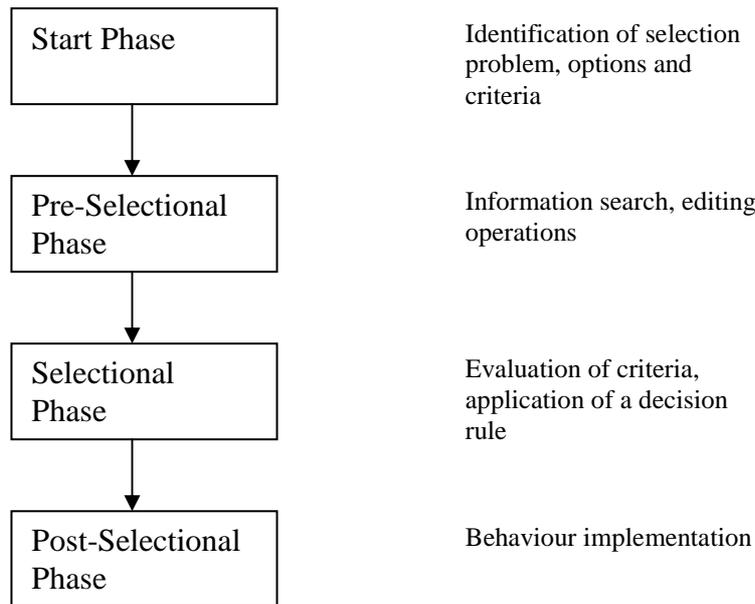
The next section describes a number of influential models that assist in demonstrating how decisions are made.

Subjective Expected Utility Model

The Subjective Expected Utility (SEU) model dates back to the 1700s. It was originally designed by mathematicians and determined what one should do in a particular context (i.e. it is a normative model) rather than helping to predict what people will actually do (i.e. a descriptive model) (Slovic *et al.*, 1988). The model provides the conceptual and computational framework that is most often used to analyse decisions under uncertainty. This model specifies that there are two basic components of decisions – expectations and values (Edwards *et al.*, 1965). An expectation is said to be a belief about the likelihood of a particular outcome, whereas a value is defined as the judgement about the desirability of that outcome. In facing uncertainty, decision-makers are said to rank the decision options in terms of preference according to the combination of expectancy and value. The optimal choice is that which maximises both likelihood and desirability and thus provides the greatest expected utility.

The SEU model is not without its critics. It has been argued that the model has a low predictive adequacy (i.e. it is unable to predict behaviour well) and poor explanatory

adequacy (i.e. it is unable to explain why people choose the option that they do) (Byrnes, 1998). Known important factors in decision-making including motivation and knowledge are absent from the model. In addition the SEU model can only be applied after someone has developed a full set of options: it fails to take into account the major processes that occur during the first stages of decision-making when people are generating these options.

The Theory of Reasoned Action

The Theory of Reasoned Action (TRA) was developed by Ajzen and Fishbein (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and aimed to examine predictors of behaviours and their relationship with attitudes (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1970; Fishbein, 1967). It is essentially an extension of the expectancy value models underlying SEU. Like SEU, TRA assumes that decision-making is a rational process involving expectancy value calculations, but takes into account other factors. This model suggests that a person's behaviour is determined by their intention (or motivation) to perform the behaviour and that this intention is, in turn, a function of:

i.   attitude towards the behaviour

ii.   beliefs about how significant others would want them to perform the behaviour (subjective norm)

The formulation of an intention helps us to understand how an unobservable attitude is translated into the actual behaviour (Conner & Sparks, 2007) See Figure 7.

Figure 7: The Theory of Reasoned Action (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980)
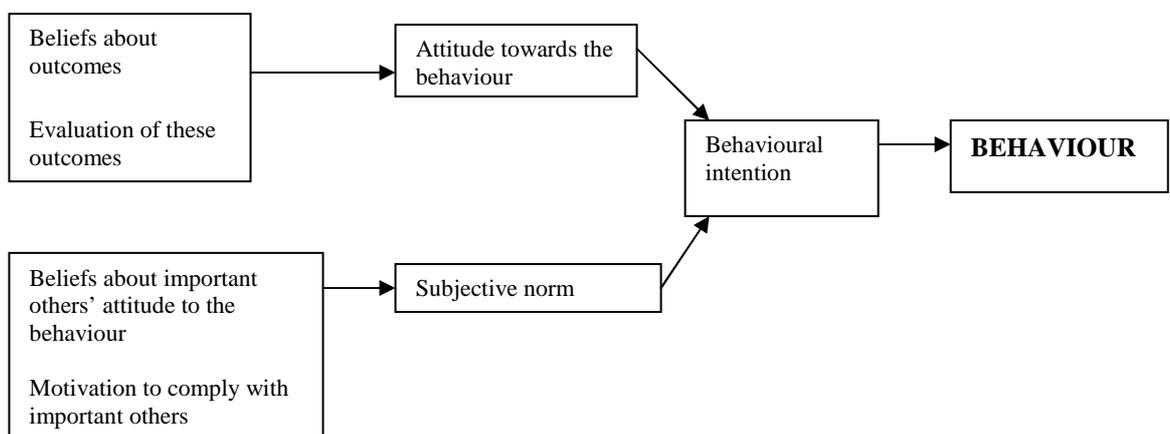
Incorporating social norms into the model reflects how a person's behavioural intention can be shaped, altered or influenced by significant others such as family, friends or health professionals. Thus it is a reflection and evaluation of other people's beliefs as well as one's own that lead to an attitude about a particular behaviour (de Wit & Stroebe, 2004).

Fishbein and Ajzen (Fishbein & Ajzen, 1975) originally assumed that the majority of the behaviours people carry out are within their abilities and suggested that people are unlikely to attempt ones that are not. It has been argued that such a view is too restrictive because it only helps to predict volitional behaviours, (Becker & Randall, 1995). In order to overcome these problems and increase its applicability the theory was modified.

The Theory of Planned Behaviour

As there were indications that behavioural intention does not necessarily lead to actual behaviour (Fishbein, 1993) it was argued that where a person does not have total control over their behaviour that behavioural intention alone cannot exclusively determine behaviour The Theory of Planned Behaviour (TPB) was developed to explain such circumstances (Ajzen, 1988; Ajzen & Madden, 1986; Ajzen, 1985). This modified model introduced the component of perceived behavioural control, a concept which originated from self efficacy theory (Bandura, 1977), see Figure 8.

Self efficacy was defined by Bandura (1994, p71) as:

> *'People's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives.'*

Such beliefs, related to perceptions of control, are thought to have an influence over how people think, feel and behave and account for more complex goals and behaviour without the mediating effect of behavioural intentions. This effect, however, is said to be different to the influence that intentions have on behaviour. Perceived behavioural control is said to have a causal effect upon intentions whereas it is the actual lack of control that one has that has a direct impact upon behaviour.

Figure 8: The Theory of Planned Behaviour (Ajzen, 1985; Ajzen & Madden, 1986; Ajzen, 1988)
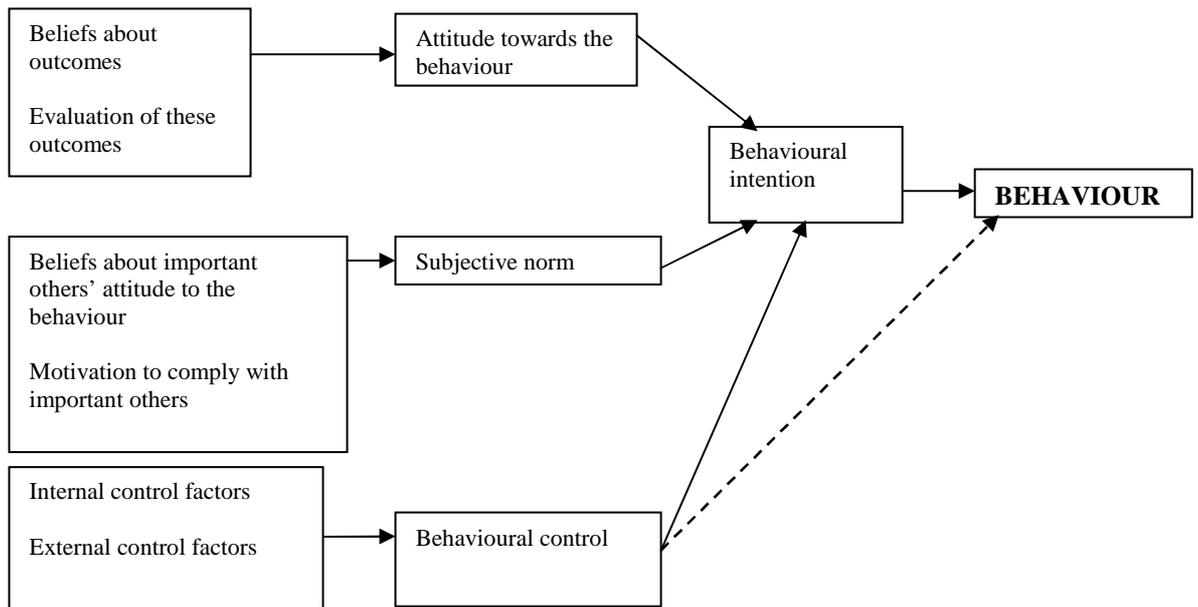
The TPB assumes that perceived behavioural control is determined by a set of control beliefs that can be internal or external. Internal factors may include level of information, skills, abilities and emotions whilst external factors refer to the extent to which the individual is given the opportunity to engage in the behaviour and to which it involves the inclusion of other people (de Wit & Stroebe, 2004). The strength that each control belief exerts is said to be weighted by the strength that the external and internal factors have. For example, if a professional has little confidence in their ability to manage a particular problem they may be more likely to refer to another professional that they perceive to have that ability.

The TPB has been used successfully to assess and predict a number of health-related behaviours such as engaging in breast and testicular self-examinations (Brubaker & Wickersham, 1990; McCaul *et al.*, 1993); health screening attendance (Sheeran *et al.*, 2001) and exercise (Godin & Kok, 1996; Hagger *et al.*, 2002). However effects have often been regarded as modest (Sanderson, 2004). Although this model can account for differences in peoples' attitudes, beliefs and intentions, through its attempts to assess normative factors, it is unable to provide evidence relating to the order of the beliefs or the direction of causality (Schwarzer, 1992). Additionally, evidence has suggested that where a

situation is a novel one e.g. making a treatment decision that has not had to be made before, that the intention to carry out the behaviour is weaker (Sheeran *et al.*, 1999). As there is no explicit role identified for emotion some perceive it as limited in assisting with the understanding of rational behavioural decisions only (Oliver & Berger, 1979).

Bentler and Speckart Model

Betch et al (2002) argued that many decisions are recurrent. That is to say that once a solution to a decision is established by an individual they build up a set of decision routines that can provide them with knowledge and potential solutions when faced with a similar decision in the future. The experiences of prior choices can have a systematic impact upon future decision-making (Betsch *et al.*, 2001; Oulette & Wood, 1998; Verplanken B & Aarts H, 2008). Many psychologists have acknowledged the fact that routines affect subsequent decisions and have defined the concept of routine in decision-making as:

> *'An option that comes to mind as a solution when the decision maker recognises a particular decision problem.'*
>
> (Betsch *et al.*, 2002, p456)

It is suggested that highly routine people are prone to collect less information than those classed as having a weak routine. It has been argued that routines have an impact upon the evaluation of new information an individual is faced with when making new or novel decisions. Betsch et al (1998) emphasised that a number of contextual factors have an impact upon routinised decision-making. One of these factors is time pressure. One model that has been proposed to address routine decision-making is the Bentler-Speckart model of attitude-behaviour relation (Bentler & Speckart, 1979). This model was based on the underlying assumptions of the TRA but elaborates on it by addressing the direct and indirect influences that past behaviour(s) and attitudes can have upon future behaviour. Unlike the TRA, they proposed that behaviour can be influenced by past behaviour or attitudes without intention as a mediator. Their model is illustrated in Figure 9.

Figure 9: Simplified Bentler and Speckart Theory (Bentler & Speckart, 1979)
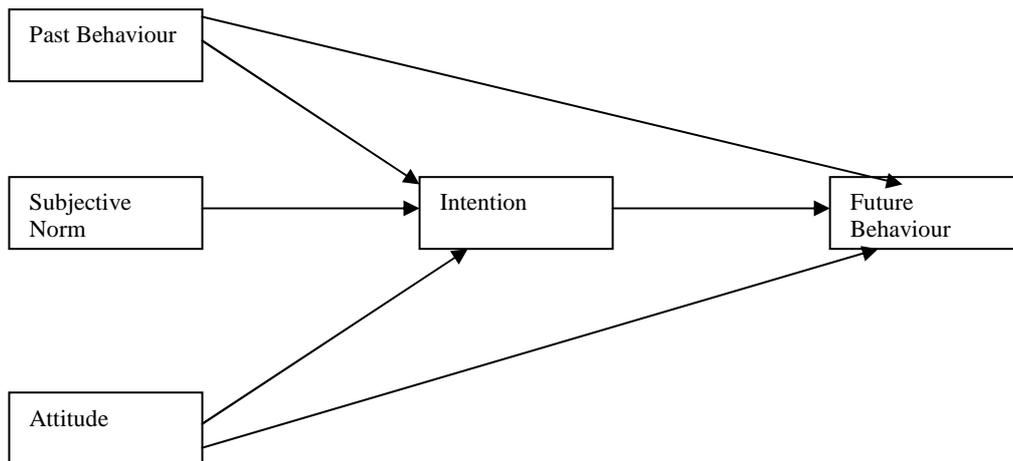
Bentler and Speckart (1979) argued that their model was superior to the TRA, and the inclusion of past behaviour assisted with explaining a larger amount of variance than previous models could. However it has been suggested that the claims made are limited due to the nature of the studies that they conducted to assist with exploring the models assumptions. Fraser and Burchell (2001) argued that the behaviours Bentler and Speckart explored - smoking and drug use - could not be considered as thoughtful and intentional behaviours due to their habitual characteristics. In addition, as past behaviours were retrospectively measured, it has been suggested that elements of response bias may be present in their evaluations, particularly due to the illegal nature of some of the behaviours explored (Fredricks & Dossett, 1983).

Integrated Social Cognitive Model

In addition to the TRA and TPB a number of other social cognitive models exist that are essentially extensions of expected utility theory. Such models include the Health Belief Model (Rosenstock, 1966; Becker, 1974); Protection Motivation Theory (Rogers, 1975; 1983; Maddux & Rogers, 1983) and the Health Locus of Control theory (Wallston, 1992; Norman & Bennett, 1995). Across these models there exists a basic set of social cognitive variables that are said to account for the majority of variance in behavioural outcomes (Fishbein *et al.*, 2001). These are:

- Environmental constraints that may have an impact on the ability to carry out the behaviour;
- Intention to conduct the behaviour and
- An evaluation of the skills that are required to carry out the behaviour

The above variables have been regarded as those that potentially have the largest impact upon behaviour directly. In addition there are a number of other variables that have been highlighted in social cognitive models as having either a direct impact on behaviour or indirect impact through intention such as self-image, social pressure and emotional reactions. Researchers recognised the similarities and overlap between many of the social cognitive models and their underlying assumptions and saw them as amenable to assimilation. They proposed an integrated model that is presented in Figure 10.

Figure 10: Integration of social cognitive models (Fishbein *et al.*, 2001)
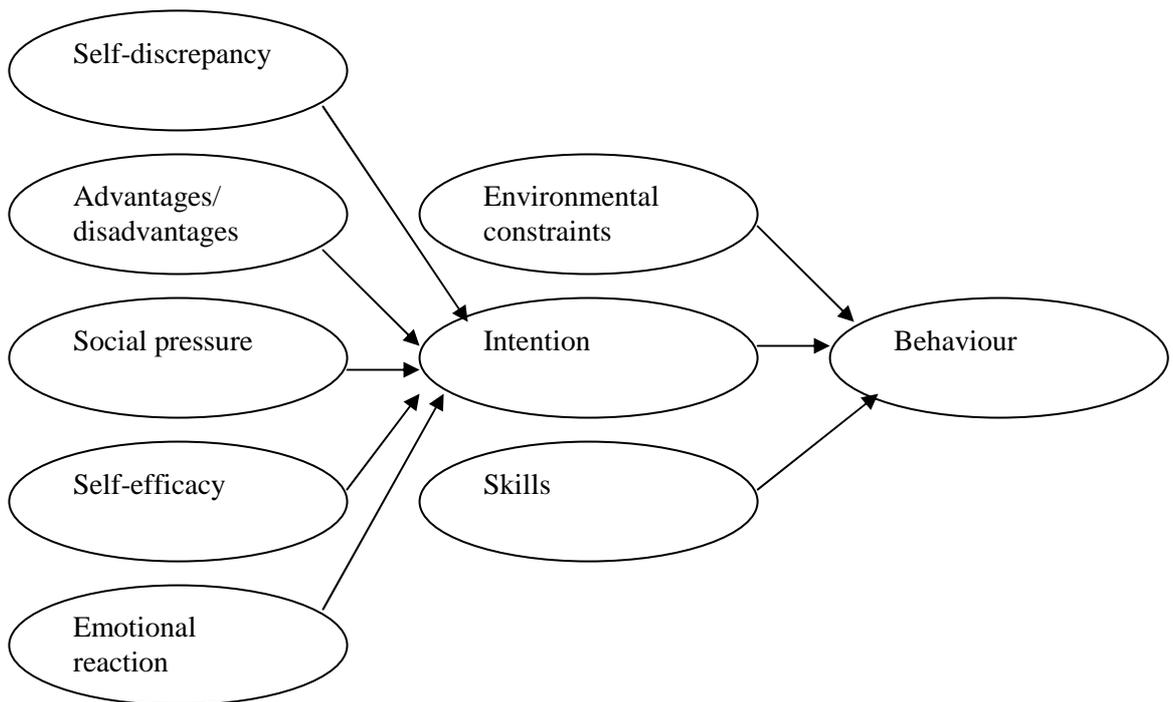
The model highlights there are a number of variables that can (1) directly impact upon behaviour – intention, skills and absence of environmental constraints. These variables were considered by Fishbein et al (2001) as sufficient by themselves to determine behaviour and/or; (2) indirectly influence behaviour by influencing the intention to carry out a particular behaviour.

Of particular importance for decision-making in mental health are the concepts of self-discrepancy and emotional reaction:

- *Self-discrepancy* is the gap between internalized representations of the self. It is proposed that three representations of the self are in existence – the 'actual self' (an individual's perceptions of their own attributes and abilities); the 'ideal self' (the attributes that an individual or other individuals would like the individual to possess) and the 'ought self' (the attributes that an individual or other individuals believe the individual ought to possess). Imbalances in these representations are said to lead to emotional vulnerabilities, particularly when individuals fail to live up to their own or others' expectations (Higgins, 1987). This may be of relevance to professional decision-making when there are tensions between professional and personal values and contextual pressures.

- *Emotional reactions* are often activated when individuals experience situations they perceive they should be able to manage but in which they doubt their ability (self-efficacy). Emotions such as fear, anxiety, stress or dissatisfaction or guilt may be triggered. In turn these provide the individual with indications of their anticipated performance. The intention to carry out the behaviour may therefore be highly influenced by the emotions activated. Again, this may be of relevance to decision-making among health professionals if there are tensions between their self-efficacy and the demands of service delivery.

The model, however, fails to take into account individuals' perceptions of susceptibility and severity that are key constructs in the health belief model and the protection motivation theory. Whilst the focus of these concepts within these models are explained in terms of an individual's belief about the chances of getting a condition, perceived severity and consequences, they may help to explain how health professionals make decisions. Based

on their beliefs about the likelihood of a patient's problem developing and the severity of the problem presented, a health professional may be inclined to make a particular treatment decision. Additionally, and as is previously recognised (Fishbein et al, 2001) some of the indirect concepts may also potentially have a direct impact upon behaviour but the model fails to demonstrate these possible relationships.

Within mental health it is unlikely that the integrated social cognitive model can explain the entirety of decision-making process in mental health. There are a number of influences that may impact upon this process that may not be encompassed by the concepts within these models alone. In essence, social cognitive models assume that individuals make conscious, rational decisions. In reality, however, this is highly unlikely to be the case for all decision-making and often individuals make decisions that are inconsistent with rational processes. The benefit of considering both rational and other approaches is therefore imprortant (Bazerman & Tenbrunsel, 1998) in aiding understanding and exploration. This broad model will not drive the the exploration of health professional experiences in making treatment decisions but will be drawn on to discuss themes identified in the analysis.

Dual Process Cognitive Model

Many theorists have proposed that reasoning occurs by means of dual processing (Sloman, 1996; Evans & Over, 1996; Shafir & LeBoeuf, 2002). Although primarily related to research on reasoning, these theories have been considered to have equal relevance to studies of decision-making (Kahneman & Frederick, 2002; Fisk, 2002; Gilovich & Griffin, 2000). Dual theories of social cognition provide a link between rational models of decision-making and what health professionals actually do in practice (Balla *et al.*, 2009).

In considering the commonalities between different theories, Stanovich and West (2000) reasoned that they all drew attention to two different cognitive modes of processing that were present. They labelled these system one and system two. System one is characterised as being rapid, automatic and unconscious, whilst system two is regarded as slow, controlled and conscious. Within the literature these 'systems' have been referred to using a variety of terms such as 'rule-based' and 'associative' (Smith & DeCoster, 2000), 'experiential' and 'rational' (Sladek *et al.*, 2006), 'intuitive' and 'reflective' (Kahneman & Frederick, 2002) or 'intuitive' and 'analytic' (Hammond, 1990). The distinction between

the application of the systems relate to the way in which a task is construed (Stanovich & West, 2000), and other factors such as the individual or the time available for deliberation (Finucane, 2000; Kahneman, 2003). They suggested that that tasks triggered by system one are more contextualised and personalised than those triggered by system two. Table 2 provides an overview of the characteristics of each system.

Table 2: Characteristics of system one and two of the dual process cognitive model (adapted from Croskerry & Norman, 2008)

Characteristic	System 1 (intuitive)	System 2 (analytic)
Conscious control	Unconscious	Conscious
Automaticity	Automatic	Controlled
Flexibility	Inflexible	Flexible
Speed	Fast and effortless	Slow and effortful
Cognitive style	Associative and/or heuristic	Rule-based
Context	Highly contextualised	De-contextualised
Emotional valence	High emotion	Low emotion

In trying to understand how the two systems are implemented two proposals have been implied. One suggests that both systems work in parallel and can interact. To rely on one system for all decisions is considered inefficient (Epstein, 1994). It has been suggested that the role of system one in this relationship is to quickly propose a response to a problem, while system two has the role to monitor the response made in terms of its quality. This monitoring process may have a number of outcomes including retaining, making amendments to, or overriding the original response made by system one. Kahneman and Frederick (2002) stated that where the monitoring by system two results in no change or small modification of the original response then the response is regarded as being intuitive. In relation to clinical situations it is thought that a system one approach may fail (Eva & Norman, 2005; Croskerry & Norman, 2008). In such circumstances where an automatic response is not triggered by the information or situation presented a system two approach will be triggered.

However, an alternative argument is that the two systems have the ability to be independent of one another (Booth-Butterfield et al., 1994). System one is thought to be utilised in circumstances when a judgement is considered to have low importance, while system two is said to prevail when the importance placed on a situation was greater. The underlying assumption of importance was thought to be the level of motivation associated with making a judgement or decision. Other researchers have proposed that when under time pressure (Schroyens *et al.*, 2003), or in situations when a great amount of information has to be cognitively processed (Roberts & Newton, 2001), that system one may be activated. Repeated exposure to making the same decision over time is thought to result in the behaviour becoming experiential and moving to system one. Support for dual process theories have been widely reported (Sloman, 1996; Stanovich & West, 2000; Evans & Over, 1996; Balla *et al.*, 2009) but criticism for the lack of direct support for system one has been voiced (Sahlin *et al.*, 2010). Although distinct from the social cognitive models described previously, where the emphasis is more on the actual construction of the way in which decisions are made, they nevertheless share some common features such as the influence of emotion or context.

Summary of Theoretical Models of Decision-Making

- Decision-making can be described in terms of four stages – identification of a situation where a decision is required, the searching of information that will assist with the decision-making process, evaluation of the information gathered and behavioural implementation once the decision has been made
- A number of influential models, which propose how decisions are made when uncertainties are present, assist in demonstrating these processes. These are:
    - Subjective Expected Utility (SEU)
    - Theory of Reasoned Action (TRA)
    - Theory of Planned Behaviour (TPB)
    - Bentler and Speckart Model
    - Integrated Social Cognitive Model
    - Dual Process Cognitive Model/Theory

- Social cognitive models demonstrate how social factors can have an influence over decision-making such as the individual's beliefs about the outcomes, their motivation to comply, the social pressures and their capabilities about their ability to carry out the required behaviour.

- Although decision research and social cognition research have different orientations there are a number of benefits to utilising the strengths of each approach in order to better understand the factors that have an influence over how a person ultimately makes a decision.

Drivers of Health Professional Decision-Making

In making decisions, health professionals are driven by a number of factors. One may be the importance of involving patients in the decision-making process. However, there are a number of other factors that may be taken into account. Of particular relevance is information based upon reliable external research evidence.

Evidence-Based Medicine

Within UK health care there has been a shift from decisions being made on clinical intuition towards one based on the best available research evidence (Higgit & Fonagy, 2002). This is most often associated with the term 'evidence-based medicine' (EBM). Sackett et al (1996, p71) defined EBM as:

> *'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patient/clients'.*

This shift has been a key driver for the development of clinical guidelines (Pilling, 2008) and there has been an unprecedented rise in the number of clinical guidelines which have been developed and implemented (Woolf *et al.*, 1999).

Limitations of Evidence Based Medicine

An evidence-based approach thus assumes that research evidence should be rationally implemented where a treatment or intervention is demonstrated to have an effective impact for a particular patient population. However, evidence is often derived through generalisation from randomly allocated sample population data. Thus, whilst an evidence-based approach assists with the identification of which interventions may be most applicable, they do not necessarily take into account the individualised nature of a patient's problem. It is thefore argued that EBM may not always be considered to be in the best interests of individual patients.

Tonelli (1998, p1237) stated that EBM can lead to:

> *'devaluation of the individual, a shift in the focus of medical practice from the individual to society at large, and the failure to appreciate and cultivate the complex nature of sound clinical judgment.'*

In applying an evidence-based approach to mental health, stepped care standardises care, and therefore decision-making, where it is assumed that patients will 'fit' into the treatments provided at each step of the model. However, in reality, decisions about patients' treatment on an individual level can prove much more complicated.

Patient-Centred Care

Subsequent to the publication of the NHS Plan (2005) increasing focus has been placed on moving a service that does things to and for its patients to one which is patient led. This is supported by the work of Levenstein et al (1986) who stated that the role of the health professional is not only to understand the diesease but also to understand the patient who has the disease. Patient-centred care holds a common resemblance to the concept of shared decision making and can ultimately impact upon the ways decisions are made and/or the actual decision made. While a definitive definition of patient-centred care has not yet been established, a widely-accepted definition has been provided by the Institute of Medicine:

> *'providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions'* (Institute of Medicine, 2001, p6)

Furthermore, in reviewing the literature on patient-centredness, Mead & Bower (2002, pg 51) suggested that there are five distinct dimensions that need to be considered:

1. The biopsychosocial perspective - a perspective on illness that includes consideration of social and psychological (as well as biomedical) factors.
2. The 'patient-as-person' - understanding the personal meaning of the illness for each individual patient.
3. Sharing power and responsibility - sensitivity to patients' preferences for information and shared decision-making and responding appropriately to these.
4. The therapeutic alliance - developing common therapeutic goals and enhancing the personal bond between doctor and patient.

5. The 'doctor-as-person' - awareness of the influence of the personal qualities and subjectivity of the doctor on the practise of medicine.

Within patient-centred care there is a great importance placed upon acknowledging a possible distinction of the health professionals understanding of patients' problems and the patients' personal experiences and values (Department of Health, 2001; Edwards & Elwyn, 2001; Charles et al., 1999). In adopting a patient-centred approach these issues need to be taken into consideration, as does the extent of patients' desire to partake in treatment decisions (Say et al 2006; Barnett et al 2008)

Tensions between Practicing Patient-Centred Care and Adhering to an Evidence-Based Approach

Whilst patient-centredness has gained prominence within mental health care and health care in general (Sackett 1996) and is central to government policy research, evidence indicates uncertainty about the impact of patient-centredness upon patient outcome (Mead & Bower 2002, Bensing 2000).

Levenstein et al (1986) stated that there are two agendas in play when managing patients' problems – that of the health professional and the patient – however, it may be argued that the agenda of services (which may not necessarily correlate with that of the health professional) also present an influence. Whilst attempting to adopt a patient-centred approach in developing an understanding of a patient's problem, from their own and the patient's perspective, the public health orientation of the stepped care model that standardises decision-making, rather then individualising it, presents a large challenge to health professionals. Balancing these potentially competing tensions between adopting an individualised patient-centred care approach (biopsychosocial model) whilst adhering to the culture of evidence-based medicine (biomedical model) is an ongoing challenge to health professionals.

Clinical Guidelines

Clinical guidelines are a way of standardising routine decision-making and have been defined by the Institute of Medicine as:

> *'systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.'*
>
> (Field & Lohr, 1990, p53).

They provide health care professionals with appropriate treatment recommendations for specific medical diagnoses. They are essentially tools to assist with the implementation of healthcare and aim to improve routine clinical decision-making by taking into account the best available evidence. They are not, however, said to replace the skills and knowledge that health care professionals already possess (NICE, 2007c). The importance of guideline recommendations compared with clinical decision-making varies. For example, there is an argument that guidelines are to be used as the default decision, with clinical decision-making looking at exceptions that for various reasons do not fit the guideline recommendations (Fonagy & Target, 1996). In these cases the clinician is expected to justify deviation from the guideline.

Guidelines are developed using a variety of methods. While a development group comprising of professionals and service users develops NICE guidelines through systematically synthesising available evidence, many previously developed guidelines involved a group of 'experts' offering opinion rather than evidence. Within mental health, guidelines developed by NICE have been adopted for a range of mental health problems including depression (NICE, 2009) and anxiety (NICE, 2010).

It is argued that clinical guidelines have a number of potential benefits for health care service delivery, health care professionals and patients (Kendall *et al.*, 2004a) including :

- Improvement of consistency of care among health care professionals and geographic sites (Department of Health, 1996).
- Improvement in the quality of health care professional decisions by providing reassurance about the appropriateness of treatment policies and decisions (Woolf et al., 1999) and a rational base for which decisions can be made (Thompson & Dowding, 2002).

- Making decisions about treatments simpler and more streamlined (Rycroft-Malone *et al.*, 2009).

There are a number of potential drawbacks associated with clinical guidelines:

- As the guidelines are produced by a development group they are influenced by the group's composition, attitudes and opinions (Kane, 1995) which may not reflect the population that are subjected to them (Parry *et al.*, 2003).
- Guidelines are often regarded as placing too much priority on cost-effectiveness, and fail to consider the patients' perspective (Speight & Reaney, 2009; Gilbody, 1999).
- As guidelines are based on the needs of the 'average' patient they fail to acknowledge variability among patients, and their individual circumstances and preferences (Hurwitz, 1999).

The publication and dissemination of clinical guidelines does not ensure that they are adopted (Woolf et al., 1999). This can be due to a number of reasons such as the nature of the disorder, an unsupportive environment and whether or not there are systems in place to manage implementation (Greenhalgh *et al.*, 2005; Feder *et al.*, 1999).

Stepped Care

The incorporation of the stepped care model raises completely different issues to that of EBM. While EBM bases treatment decisions upon the best available evidence to ensure optimal outcomes, implementation of stepped care means patient progress must be monitored and decisions about treatment provision need to be made effectively. Decisions about outcomes in stepped care are based upon an empirical approaches e.g. based on actual measurement of outcomes in relation to the individual patient. In order to assist with the decision-making within stepped care standardised outcome measures have been adopted.

Standardised Outcome Measurements

Outcome measurement involves measuring health outcomes of patients who are in receipt of health care. There are two main aims of outcome measures – one is to standardise the way in which dimensions of health are regarded, thus allowing for comparisons across individuals or groups of individuals, the second is to quantify a particular dimension to judge whether that dimension has changed over time. The use of outcome measurements in mental health services can help to 'inform decisions about whether to continue, change or curtail treatment' (Sheldon et al., 2004, p20), to assist with ensuring efficient decisions are made in terms of service resources (Slade, 2002b) and it is argued that the incorporation of these measurements can ultimately have a significant impact upon increasing the quality of services provided within the NHS (Kind *et al.*, 2005). It has been indicated that outcome measurement is effective across a number of mental health problems (Department of Health, 2005b) and that it leads to more efficient and reliable ways of planning and evaluating treatment (Roth & Fonagy, 1997), by providing a consistent record of progress of individuals (Marks, 1998). These issues have particular relevance to the provision of services within a stepped care model (Care Services Improvement Partnership, 2006) on a political level, in relation to monitoring the efficiency of services, but also on a patient level where they can be used in the monitoring of patient progress and thus assist with the decision as to whether a patient needs 'stepping-up' to a more intensive treatment (Bower *et al.*, 2006).

Whilst outcome measurements can be completed by the patient or the health care professional there is increasing emphasis on a more 'patient-based approach' to ensure that the health care system is addressing the patient's needs by determining how the illness is impacting upon their day-to-day life (Gilbody *et al.*, 2003). A number of outcome measurements thus aim to determine the patient's subjective experiences of the illness. Within mental health care there are a number of measures that are routinely utilised (Table 3).

Table 3: Routinely used outcome measurements in mental health care

Focus of Measure	Name of Measure and Reference
Generic Health	Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) (Barkham et al., 2001) The Social Functioning Scale (SFS) (Remmington & Tyrer, 1979) Social Adjustment Scale (Weissman & Bothwell, 1976)
Depression	Beck Depression Inventory II (BDI-II) (Beck *et al.*, 1996) Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001)
Anxiety	Generalised Anxiety Disorder Assessment (GAD-7) (Spitzer et al., 2006)
Anxiety and/or Depression	Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983)

Four large-scale studies by Lambert et al (2005) collated evidence which found that patient outcomes improved when psychotherapists adopted methods to monitor and predict treatment failure using outcome measures. In a review looking to establish the impact of outcome measures on routine practice, Marshall et al (2006b) found that outcome measures had a beneficial effect on processes of care such as diagnosis and management of patient conditions. This finding has also been demonstrated in a study that looked specifically at the use of outcome measures within mental health (Dowrick *et al.*, 2009). Furthermore, the incorporation of outcome measures has been found to improve the quality of health care by improving aspects such as treatment effectiveness and patient involvement (Steele et al., 2004; Maxwell, 1984).

Despite the literature that suggests that using outcome measurement in mental health is beneficial, a number of researchers and clinicians have described limitations. For example measures have been developed within clinical research and may not be feasible for routine use in health care (Valderas et al., 2008). Many studies evaluating their use in clinical practice have also been found to be methodologically flawed (Slade, 2002b). Measures routinely used to measure effectiveness tend to focus on symptoms and it is argued

therefore that often the patient as 'whole' is not considered, failing to take into account other issues that affect the patient such as social functioning and satisfaction (Davison, 2000; Dowrick *et al.*, 2009). Furthermore, some studies have shown very little impact upon health professional agreement and behaviours (Detmar *et al.*, 2002; Gilbody *et al.*, 2001; Wasson *et al.*, 1992). Concerns have been raised over how acceptable, applicable, practical and reliable such measures are (Andrews *et al.*, 1994) and have additionally expressed concerns about the time it takes to collect, manage and feedback the data collected (Slade, 2002a; Walter *et al.*, 1998).

In a relatively recent study conducted in Australia, Callaly et al (2006) found that many health care professionals viewed the incorporation of outcome measures as motivated by economic considerations rather than patient benefit. These views were consistent with those of Harrison who described the incorporation of outcome measures into the healthcare system as '*scientific-bureaucratic medicine*' (Harrison, 2002, p466). In UK general practice the quality and outcomes framework (QOF) contract was been introduced whereby GPs are provided with incentives to measure patient outcomes using standardised measurements (British Medical Association & NHS Employers, 2006). However a study by Kendrick et al (2009) revealed that while older patients were screened for depression they were less likely to be referred for treatment. This may indicate that such patients are being screened to simply achieve QOF points. Dowrick et al (2009) highlighted that in order to overcome and address such possibilities that a better understanding of how measures are used in practice and the impact they have upon patient management is required. Other studies have additionally highlighted that in order for a service to benefit from the adoption of outcome measures there is a need to ensure beforehand that it is discussed how they will be incorporated into the existing service and any adjustments to that service that may need to be made (Greenhalgh, 2009; Donaldson, 2008). Whilst outcomes measures can be extremely useful in terms of gaining further information about the patient's problem and improving the treatment provision through monitoring, issues such as the acceptability and practicalities of incorporating such measures must be addressed.

Summary of the Drivers of Health Professional Decision-Making

- Health professional decision-making is driven by a number of factors that include the principles of EBM (through clinical guidelines), patient-centred care and the stepped care model (through standardised outcome measures).

- Clinical guidelines have a number of benefits such as potentially improving consistency of care and ensuring the efficiency of services. However, they may lack flexibility and thus not take the individual patient into consideration.

- In contrast to clinical guidelines, outcome measures assist with the decision-making process by considering the outcome of individual patients. Their applicability and the time it takes to administer and analyse them, however, has been questioned.

- Tensions exist between practicing patient-centred care and adhering to an evidence-based approach

Empirical Studies of the Drivers of Decision-Making in Mental Health

In the area of mental health, studies that have investigated decision-making generally fall into two distinct categories – those which look at evidence related to the type of decision-making models that are used or preferred and those that are concerned with identifying factors that affect the decision-making processes of health care professionals.

Health Care Decision-Making Literature

While studies looking at decision-making in stepped care are only just emerging (see Chapter 1 for an overview of the literature) the evidence base for decision-making processes in mental health care in general is more established. The vast majority relates to the decisions that GPs make in the management of patients who present with mental health problems.

Factors That Impact upon GP Decision-Making

As the part that GPs play within mental health services is vital, a number of studies have explored how GPs manage these problems, according to three main groupings: patient-related factors, GP-related factors and service-related factors. These are summarised in Table 4.

Table 4: Summary of factors influencing GP decision-making

Patient-Related	GP-Related	Service Related
Severity of patient's presenting problem	Relationship with patient	Availability of services
Patient characteristics	GPs insecurities and experiences of treating mental health problems	Accessibility of services
Patient attitudes	Relationships with other mental health care professionals	Quality of available services
Patient preferences		Time available to address patients' mental health Problems
		Quality and Outcomes Framework (QOF)

Patient-Related Factors

Patient factors focus mainly on diagnostic and resource factors and include: the severity of the problem that the patient presents with; the presenting patient's characteristics, and their attitudes and preferences.

A consistent link between the problem that the patient presents with and decisions made has been found in a number of studies (Pilgrim *et al.*, 1997; Kendrick T *et al.*, 2005; Knight, 2003; Verhaak, 1993; Burton & Ramsden, 1994). In a study by Kendrick et al (2005) that looked at antidepressant prescribing patients considered to have more severe levels of depression were considerably more likely to be offered antidepressants than those with mild depression. In addition to severity, having a previous history of depression also appears to have a significant impact upon the likelihood of prescription (Kendrick et al., 2009). It was also found that older patients and those experiencing a co-morbid physical illness were less likely to receive treatment. Investigations into symptom severity and its impact upon how it is viewed by GPs, however, show inconsistencies with differing levels of importance placed on factors such as high risk and suicidal intent by different GPs (Smith *et al.*, 2003; Robertson, 1979). In a study by Hyde et al (2005) it was revealed that while approximately half of the patients diagnosed with a common mental health problem were offered an active treatment those presenting with anxiety or chronic mixed anxiety and depression were significantly less likely to be offered treatment than patients with a diagnosis of depression. In addition it was found that those provided with an active treatment were significantly more likely to be suffering from more severe forms of mental health problems.

GP decisions are also said to be affected by their patients' characteristics. These findings, however, are inconsistent across studies. Whilst some show that male patients are more likely to be referred for treatment (Verhaak, 1993; Hyde et al., 2005) others indicate that women are more likely (Kisely *et al.*, 2000). Qualitative studies have also revealed that male patients who present in general practice are perceived by GPs to be more in need of treatment as the severity of their problems is perceived as greater than that of their female equivalents (Hyde *et al.*, 2005; Anderson *et al.*, 2001). In analysing medical antidepressant prescribing and referral to specialist services record data in three general practices, Kendrick et al (2009) found that patients over 65 were more likely to receive a referral than

those patients presenting with chronic problems such as diabetes or coronary heart disease and were less likely to receive a referral to specialist services or be prescribed an antidepressant. Further evidence supporting the influence of patient characteristics upon GP treatment decisions is found in a study conducted in the USA by Young et al (2008). In analysing physician consultation data they found that physicians were more likely to involve patients in treatment decisions who were younger and more active in expressing their preferences. In contrast to other findings, no impact of the severity of the patients' presenting symptoms on involvement was found.

Knight (2003) conducted a mixed methods pilot study to determine how GPs make mental health referral decisions. Structured interviews allowed for exploration of the process and a rating-scale questionnaire was used to further identify the priority that the GPs placed on particular patient and service-related factors when making their decisions. Interviews consisted of nine case studies where following presentation, GPs were asked to state what their decision would be and why, and the outcomes they would expect. Factors relating to the patient, service and GP were found to influence referral decisions. A large number of the GPs interviewed emphasised that they would take into consideration their patients' preferences and wishes and that they viewed this process as a generally positive one. However it was unclear to what extent these interactions have in terms shaping or changing the GPs decision. Furthermore, GPs were said to consider the patients' experiences with different or previous treatments and indicated that they would refer to a different treatment if their experience had been negative or, in line with the stepped care model's principles, had shown no signs of improvement. Service-related factors included the perceived quality of services available to refer patients to, their availability and cost. Their own lack of expertise and confidence was also reported as a factor influencing treatment referrals. While the study provided further insight into the way GPs make decisions the limitations of presenting GPs with structured case scenarios and failing to take into account how patients' experience the process must be noted.

Comparable findings were found in a recent qualitative study that used matched-pair scenarios involving one patient who the GP referred to a mental health professional and a similar patient where the decision had been not to refer (Stavrou *et al.*, 2009). GPs from two urban practices were asked to compare and contrast the patients in each matched-pair and to identify what had influenced the decision that they had made. Three interrelated

themes were found to distinguished referrals from non referrals. Patients who showed initiative in requesting or showing interest in a referral were more likely to be referred as were those who were perceived to have the capacity to benefit from a referral. Additionally GPs took into account their own capacity to help the patient, where they lacked skills, expertise or time a referral was more likely. Service waiting lists were also discussed as an overall influence on their referral patterns. This study provides useful information about how referrals are made in relation to those which have been made previously in practice, however the retrospective nature of task may be prone to bias and may not have had the ability to capture all aspects of the decision-making process.

GP-Related Factors

GP referral decision-making has been shown to be variable. Factors such as the GP-patient relationship, the GPs confidence in managing mental health problems and their relationships with other professionals have been suggested to contribute to the decisions made.

The nature of the relationship that a GP holds with a patient has been found to be an important factor. It has been suggested that when a relationship with a patient becomes difficult that a GP is more likely to evoke a referral to other services (Knight, 2003; Morgan, 1989). This relates to overcoming frustrations (Nandy *et al.*, 2001) and other negative emotions such as fear of losing the patient and dissatisfaction on the patients' part (Knight, 2003).

Where patients present with notable social problems, particularly in areas of low socioeconomic status, they are less likely to be offered pharmacological treatments. With little time to deal with these problems GPs feel frustrated with the burden that such problems have and often recognise the importance of referring to active psychological therapies that best reflect the patients' needs (Chew-Graham *et al.*, 2002; Sleath & Shih, 2003). Decisions GPs make may also be influenced by the discussions they initiate with patients (Di Caccavo *et al.*, 2000). In analysing audiotaped consultations Di Caccavo et al found that a decision to prescribe medication was more likely when GPs had discussed social support, coping strategies and treatment options with the patient in comparison to those referred or given advice. Although the study did not exclusively look only at patients

with mental health problems, the findings suggest that discussing multiple aspects of patients' problems influenced the decisions that were subsequently made.

A number of the decisions that a GP makes regarding treatment referral are said to be governed by the relationships that they hold with mental health specialist colleagues (Pilgrim et al., 1997). These relationships link closely to service provision and related factors. Exchanges with other professionals have also been found to influence the attitudes that GPs have, the way in which they address and treat a patient's problem (Sigel & Leiper, 2004) and ultimately lead to the provision of more effective patient care (Epstein, 1995). Relationships with mental health care professionals are impacted upon by the services available and the links that a GP has with these services. Where closer links are present a greater number of referrals to such services occur (Ross & Hardy, 1999) and it has been indicated that this increase mainly involves an increase in referrals for people with mild psychological disorders, specifically depression (Jackson *et al.*, 1993; Warner *et al.*, 1993). A number of studies have shown that larger practices are more likely to have a consultation-liaison type of relationship with mental health services and additionally higher levels of patient referrals that require more intensive treatment (Hull *et al.*, 2002; Melzer *et al.*, 1999).

When a GP feels uncomfortable, uncertain or not comfortable treating a patient because the scope of the mental health problem is viewed as being beyond their capabilities and expertise, the consideration of a referral is greater (Sigel & Leiper, 2004; Stavrou *et al.*, 2009; Anthony *et al.*, 2010; Kravitz *et al.*, 2006; Chew-Graham *et al.*, 2008). A study conducted in the United States that looked at family physician referral rates for a number of health conditions including mental health problems showed that approximately twenty percent of referrals were made on the grounds of uncertainty surrounding the diagnosis or suitable treatment for their patient (Forrest *et al.*, 2002). The study also showed that perceptions of the problem being out-with their job specifications and incorporating patient preferences also informed the referral decision process. Similar findings are found in relation to the GPs interests, their views of psychological problems and their confidence in treating such problems (Hendryx *et al.*, 1994; Robertson, 1979; Byng *et al.*, 2003; Ross & Hardy, 1999).

Service-Related Factors

A number of service-related factors have been shown to influence the decision-making behaviours of health professionals. A questionnaire and interview-based study conducted with GPs within an NHS trust explored their priorities when making referrals (Ghiacy, 1995). It was found that decisions were based on whether the services are available, the quality of the service and the time that the patient would have to wait to access that service. Ghiacy (1995) further demonstrated that where long waiting lists were prevalent patients were likely to be referred to services out-with the NHS. Other studies have additionally highlighted the lack of confidence that GPs have in accessing psychological therapies, particularly CBT, and that this often resulted in them being unable to make decisions based on the recommendations of NICE (Ward *et al.*, 2008; Toner *et al.*, 2010). Furthermore, in a study conducted in the United States to explore referral decisions of family physicians for a variety of health conditions including anxiety and depression, it was also found that concerns about the time and resources they had influenced their decisions to refer (Forrest et al., 2002).

In exploring GPs perceptions of the availability of a counselling service within their practice one study identified that GPs perceived the on-site service to influence the decisions that they made (Schafer *et al.*, 2009). Many reported prescribing less anti-depressants and having increased awareness and confidence in managing patients presenting with mental health problems. The quality of the service being delivered was also stressed as important when making decisions, as was having a good relationship with the counsellor. Their findings are in line with those of Knight (2003) and resonate with those of Cape & Parham (1998) who found that having access to on-site counselling reduced referrals to secondary care. The finding that decisions to prescribe medication may be reduced by improving access to a counselling service has, however, not always been found (Pharoah & Melzer, 1995).

The impact that QOF has had upon GP decision-making has also been explored. Within this framework, individual GPs are provided incentives for implementing good practice within their surgeries. In mental health one of the indicators of this is measuring the severity of diagnosed depression with a validated questionnaire. In analysing patient medical data collected, Kendrick et al (2009) found that whilst GPs were utilising the

standardised outcome measures in their assessment of patients, their decisions were not based simply on the basis of these measures alone. While decisions about antidepressant treatment followed guidance, with antidepressants significantly more likely to be prescribed to those suffering from moderate to severe depression, levels of prescribing were not consistent with the proportions of patients who were considered to have such levels of depression. It was thus argued that GPs must be attending to other factors when making their decision. For example the age of a patient was found to significantly influence whether a referral to psychological therapy was made. It therefore appears that whilst the implementation of QOF may have some impact upon the ways that decisions are made in primary care mental health, it is not necessarily sufficient for all decision-making situations.

Summary of Factors That Impact upon GP Decision-Making

- A significant literature has looked how GPs make decisions about patients with mental health problems.
- Issues concerned with individual patients, their own personal attitudes and beliefs and the service they are working in may contribute to the decisions that they make about patients' treatment.

Factors that Impact upon Mental Health Professional Decision-Making

Mental health professional decision-making, in some circumstances, can be very comparable to that of GPs and the majority of the factors described previously can similarly have an impact upon the decisions that a mental health care professional is faced with. However, it is also important to recognise the differences between mental health professional and GP experiences. One of the main challenges facing GPs is the sustained relationship that they have with patients over time. While mental health professionals build-up a relationship with a patient, the nature of the relationship is essentially a short-term one, generally existing for the length of the treatment that they deliver. GPs, on the other hand, often continue to see patients throughout the course of their lifetime and may be continually faced with making treatment decisions about patients' problems. One of the difficulties often faced is trying to meet the needs of patients following referral to a treatment that has ended in a poor outcome.

Early research into how mental health professionals make decisions suggested a YAVIS way of thinking (Schofield, 1964), where patients with particular personal qualities are favoured by mental health professionals and are characterised as – Young, Attractive, Verbal, Intelligent, and Successful (YAVIS) individuals. Where a patient is perceived to be attractive, talkative, more spontaneous and compliant it is argued that that they are more likely to have access to mental health services (Lewis *et al.*, 1981). These perspectives were supported by Bartak et al (2007) who stated that therapists are more likely to want to help patients who present with characteristics indicative of a low burden of disease and thus necessity of treatment. In accordance with these views the way that a therapist first perceives a patient is said to have a large impact upon the diagnosis that the patient will receive, their prognosis, treatment choice and ultimately the outcome of any treatment that they are given (Wills, 1978).

The influence of patient characteristics upon decision-making were also found in a study conducted in Sweden looking at how people prioritise patients for subsidised psychotherapy (Sandell & Fredelius, 1997). Sandell and Fredelius (1997) provided separate groups of clinicians, decision-makers and laymen a number of vignettes based on actual patient cases. Each group, whilst thinking-aloud were asked to prioritise half of the patients to receive subsidised therapy. Where agreement was found between the groups,

patients were more likely to have had traumatic past histories and were highly motivated for psychotherapy. In contrast, those who consistently were not recommended for referral did not have traumatic histories and demonstrated lack of motivation. The findings showed that clinicians valued the patients differently as compared to laymen and decision makers. Clinicians were seen to place more weight on socio-demographic variables, preferring to refer women, those who had a humanistic or artistic profession, those engaged in post-graduate studies and those with previous experience of psychotherapy. Their study, however, is limited in a number of ways. During the prioritising task, participants were asked to think-aloud, however this data was not presented. While the authors accept that this is a limitation, it still does not make it possible to look at the actual process of decision-making, only the outcome. It is unclear why particular characteristics lead to a patient being prioritised. Additionally, as individuals were aware that decisions made would not bear directly on decisions made about the individual patients in practice consequently the decisions they made may not be an accurate reflection of the way decisions would necessarily be made.

Similar to the study detailed above, Visintini et al (2007) were also interested in the potential influence that patient characteristics have, particularly upon clinicians decisions to refer to group psychotherapy. They conducted a study to explore previous decisions made by clinicians, including psychiatrists, to refer patients to a specialist mental health unit in Italy. While referral was not linked to diagnosis or sociodemographic characteristics, patients were more likely to be referred if they presented with lower confidence levels or higher hostility as measured using self-administered questionnaires. However, as the study was a retrospective account of referral decisions, it is unclear why such individuals attracted referrals to group psychotherapy or whether any additional factors clinicians had taken into account when making their decision.

More recent research has explored a number of additional factors that may influence decision-making in this group of professionals. Within mental health practice there is an increased interest in the degree that evidence is being translated into clinical practice, the impact that evidence has on decision-making, the extent to which decisions are based on personal judgements, intuition or instincts (Abidin & Robertson, 2002; Rycroft-Malone et al., 2009), and the effects that this is having on the services provided (Kam & Midgley,

2006). A number of key papers have addressed decision-making by mental health professionals.

Prioritisation of patient referrals was considered by McEvoy et al (2000) who explored the ways in which community psychiatric nurses dealt with referrals from primary care to community mental health teams. They recognised the important gate-keeping role the nurses undertook in ensuring patients most in need of prioritisation accessed services effectively. Their role was similar to that which low intensity workers now play within IAPT and the stepped care model. A retrospective cohort of the nurses' patient assessment records was surveyed and the type of referral made and patient characteristics extracted. Statistical analysis was then conducted to determine if there were any associations or interactions between these factors. It was found that patients with a previous history of mental health problems, problems due to substance misuse or suffering from a personality disorder were more likely to be referred to specialist services. Severity of presenting problem, which included an evaluation of risk in addition to symptoms, was also associated with referral for ongoing support. Almost a third of patients were referred back to their GP as they were not considered to have appropriate needs. The study revealed the impact of factors such as diagnosis, severity and history on prioritising referral decisions, however, it failed to take into account other potential influences such as patient or service factors which may have driven the decision-making.

Kam and Midgley (2006) conducted a small qualitative study in order to explore the referral process of young people to psychotherapy within a large Child and Adolescent Mental Health Service (CAMHS) service in the UK. Five CAMHS team members with varying job roles and clinical experience took part in a semi-structured interview that explored their referral experiences. Analysis revealed referral decisions were based on three main factors. The first related to the perceptions that the mental health worker held of psychoanalytic child psychotherapy. Some saw it as a positive treatment modality that assisted in understanding childrens' behaviour in an individualised way. Others, however, evaluated it negatively arguing it offered little flexibility and was unjustifiably perceived as more value than other approaches. Secondly, decisions appeared also to be made on the particular features of the child or their family. It was reported that 'certain kinds of children would be appropriate candidates for individual psychotherapy' (p36). These perceptions did not necessarily relate to the child's diagnosis or severity of disease but

rather to the specific difficulties and experiences that the child had encountered. Embedded within this factor was also the realisation and awareness that the treatment was limited and thus valued. Finally, what had been achieved through therapeutic work to date with the family and this was often related to a recurrence or inflation of previous difficulties.

Another small qualitative study looking to evaluate interpersonal influence upon referrals to psychotherapy was conducted with four intake workers, three of whom were experienced and one trainee (Helstone & van Zuuren, 1996). Each took part in two semi-structured interviews discussing the appraisal of their encounter with two patients. Analysis of the interview recordings revealed that referral decisions were based mainly on the presenting patient's characteristics. It was highlighted that the perception of a patient and their views of how a patient would respond to a particular treatment, had a large impact upon the treatment offered. Intake workers were more enthusiastic about patients' abilities to show benefit from individual psychotherapy if they were regarded as being affectively open or accessible, e.g. if they displayed signs of trust in them or displayed interested in managing their problems. Uncertainties surrounding what treatment to offer a patient, however, occurred where the encounter was not so positive and the patient showed signs of keeping their distance irrespective of the intake worker remaining calm and understanding. Additionally, patients were regarded as having a 'false façade' where they displayed characteristics such as being unappealing, boastful or arrogant. This caused tensions to arise in the relationship that impacted upon the ability for intake workers to feel warmth towards them. This subsequently impacted upon the decisions they made where individual therapy in comparison to group therapy was considered most suitable, as it was perceived there was still a lot needing to be discovered about the patient. Comparisons between workers found that the trainee found answering questions more difficult than their experienced colleagues. There may be many reasons for this although one explanation may be with experience an improvement in the understanding of the decision-making process occurs.

In addition to the factors indicated previously, the members of the CAMHS team also emphasised the importance of working alongside other members of the team (Kam & Midgley, 2006). Working within a multidisciplinary team was highly valued for assisting with decision-making. These findings are in line with work that has been conducted looking at decision-making occurring in teams rather than at the individual level (Cook *et*

al., 2001; Department of Health, 2007b). There are said to be a number of benefits to making decisions about treatment within a team environment such as a better co-ordinated service (Bennett-Emslie & McIntosh, 1995) and a reduced decision-making time period . Working within a multidisciplinary team was also reported by Cook et al (2001) as being more focused on the individual patient and was thus regarded as a method for ensuring that the needs of patients are best met.

Summary of Factors that Impact upon Mental Health Professional Decision-Making

- Similar to GP literature, studies exploring mental health professional decision-making highlighted the impact that having a history of mental health problems, high severity and particular diagnoses had upon the decision to refer a patient to particular treatments.

- Patient characteristics were additionally found to guide decision-making, particularly those not necessarily directly related to the patient's presenting problem such as personality.

- Mental health professionals were found to use such characteristics to make judgements about the suitability of treatments.

Chapter Summary

- The amount of involvement a patient has, and desires to have, in the decision-making process can vary. Disparities between patients reported preferences for involvement and what occurs in practice have been found. Evidence suggests the amount of involvement a patient has can potentially impact upon outcomes.

- Tools to aid decision-making including clinical guidelines and outcome measures have been developed to aid decision-making within health care. The appropriateness and ability of using and applying their recommendations and assumptions, however, has been questioned.

- In order to better understand the process of decision-making a number of influential theoretical models may be considered. These models attempt to explain how decisions can be made under uncertainty, the types of processing that occur and the contribution that social cognitive variables may have.

- Currently, as there is a small evidence base available for decision-making in stepped care it is important to draw on literature exploring decision-making within mental health care in general.

- Literature highlights that decisions made in mental health are influenced not only by outcome measures and guidelines but a variety of other factors including patient characteristics, attitudes and preferences, health professional and patient relationships, health professional confidence and perceived abilities and relationships health professionals have with similar others.

- The literature, however, is limited in a number of ways, and the generalisability of many of the studies is questionable, particularly for studies designed to look at a specific population (e.g. children or a particular setting). Additionally it is unclear how applicable studies conducted out-with the UK are due to the fact that health professional roles vary and service structures and aims may differ considerably.

- Exploring decision-making from a number of angles – the tools available in health care, the evidence base for how decisions are made on clinical practice and theoretical models that assist in understanding the process of decision-making – will assist with identify with the process of how decisions are being made within the mental health stepped care model.

CHAPTER THREE: A REVIEW OF TECHNIQUES FOR THE MEASUREMENT OF DECISION-MAKING

Introduction

This chapter will provide a general introduction to the measurement of decision-making. A discussion of structural and process approaches will be presented followed by a critical appraisal of some of the existing techniques and their applicability in the context of the current study. The chapter will finally conclude with an overall summary of the main issues presented.

Measuring Decision-Making

Decision-making is regarded as the cognitive processes that result in a choice being made or an action being carried out. Since the mid-1950s there has been a considerable interest in capturing the cognitive processes of individuals to understand and explore how decisions or judgements are made (Hogarth, 1974). Most early research focused on more structural, mathematical approaches (Edwards, 1954) whilst methods aiming to capture the decision-making by measuring underlying psychological processes have been prominent in more recent research.

Structural Methods

Approaches using structural processes were prominent in early research (Edwards, 1954) where investigations focused on making decisional choices or ratings. The structural approach focussed on the mental product e.g. the decision or diagnosis made. Studies incorporating such methods involve describing the relationship between the input (the information provided about each decision alternative), and the output (represented by the decision made) (Ableson & Levi, 1985). These studies followed the principles of subjective expected utility models (see Chapter 2) that state when facing uncertainty

decision makers rank the options in terms of likelihood and desirability, and the choice made is one which maximises both likelihood and desirability and thus provides the greatest expected utility. However, it was argued that such methods did not allow the process of decision-making to be revealed (Einhorn & Hogarth, 1981; Slovic *et al.*, 1977), and that the structural approach was '*…unsatisfactory both on account of its frequent lack of theoretical considerations and its failure to capture the selective and sequential aspects of cognition…*' (Hogarth, 1974, p298).

Process Methods

Newell (1966) emphasised the importance of understanding how a person arrives at a decision rather than the decision itself. A process-driven method is regarded as a procedure that '*typically attempts to focus directly on the sequence of cognitive events that occur between the introduction of information stimuli and the decision outcome.*' (Kuusela & Paul, 2000)

There has been support for the use of process methods within decision-making and judgement research. Svenson argued that using process-driven methods was '*essential in the exploration of regularities of human decision-making*' (Svenson, 1996, p253) and Elstein et al (1990) stressed the importance of moving '*toward a systematic effort to gain insight into the plans, intentions and understanding of the problem solver*' (p7)

Process methods have made significant contributions to individual decision-making. They have assisted with the exploration of medical performance (Rimoldi & Raimondo, 1998), exploring the cognitive processes of decision-making by health professionals (Offredy & Meerabeau, 2005) and ways in which patients are prioritised for specialist psychological therapy (Fredelius *et al.*, 2002). Process studies can allow the identification of the steps that people take to make a decision (Payne *et al.*, 1978; Harte & Koele, 1997) and assess directly the specific information that is used and the order in which it is processed. It has been highlighted that using process-tracing studies can be useful when it is exploratory (Quelch, 1979). At their simplest level by observing the order in which attributes are attended to, such methodologies help to uncover the relative importance that individuals' place upon specific attributes (Fishbein, 1971; Ryan & Etzel, 1976) .

A description of key approaches for capturing decision-making processes will now be presented.

Cognitive Interviewing

From the late 1960s onwards cognitive approaches became more of a focus in studies of individual decision-making (Williamson *et al.*, 2000). Cognitive interviewing techniques were developed during the 1980s in response to the need to validate individuals' responses to survey questions by uncovering usually unobservable cognitive processes (Knafl et al., 2007). Cognitive interviewing has been described as:

> *'the administration of survey questions to a participant while collecting additional verbal information relevant to survey responses.'*
> (Beatty & Willis, 2007, p289)

Such techniques vary but the most common is 'think-aloud' or 'verbal probing' which can be used alone or concurrently (Collins, 2003; Jobe & Mingay, 1989).

Think-Aloud

The think-aloud method is used when investigators want to elicit data on participants' thought processes as they conduct a particular task (Knafl et al., 2007). During the task participants are asked to verbalize what they are thinking as they make their response, this may be to a problem presented or to an item on an outcome measure or survey. Eliciting thought processes in this way provides insight into how individuals' process and use information to make their decision and to determine, for example, whether information that is stored in memory is of importance to particular tasks.

Ericsson & Simon (1998) argued that the think-aloud approach can be applied in a variety of circumstances as a method to successfully capture unaltered sequences of thought processes. Following the think-aloud task the participant can be asked some follow-up questions to assist with gaining a fuller picture of the reasoning process or to clarify any issues that arose during think-aloud particularly where the participant has had difficulty with the demands of the task (Branch, 2000a; Branch, 2000b; Fronteyn *et al.*, 1993).

Similar to standard qualitative interviews, think-aloud sessions are audio taped and transcribed.

Many people were initially cautious about using this approach, particularly in relation to its validity. Some argued that individuals do not have conscious access to the mental processes that are operationalised when making decisions (Nisbett & Wilson, 1977; Turner, 1988) and that what appears in consciousness is '*result of thinking, not the process of thinking*' (Miller, 1962, p56). Others have claimed that eliciting verbal protocols can result in selective, and potentially biased, pieces of information being presented (van Raaij, 1977; Willis, 1994). It is thought that this can lead to rational decision processes being reported and the likelihood of thoughts relating to decisions or choices that have been discarded being less likely to be reported. Furthermore, participants may feel compelled to provide additional information where reports are incomplete or forgotten (Nisbett & Wilson, 1977). Others have reported that the approach may be valid in principle but some people may be confused about what they are being asked to do (Stratman & Hamp-Lyons, 1994) and as a result may be resistant to the task (Willis, 1994).

Support for collecting data by verbal report whilst the participant is conducting the task was summarised by Ericsson and Simon (Ericsson & Simon, 1980) who believed collecting data in this manner was consistent and provided a complete report of the knowledge and cognitive processes utilised. Additionally, they stated that should the task be performed retrospectively it eliminated incomplete recall or recall bias. It was further suggested that concurrent verbalisation should not effect the speed at which the participant completes the task nor interfere with ongoing cognitive processes should the investigator avoid questioning.

However, it has been argued that think-aloud methods do not meet a satisfactory level of standardisation and that they may not generalise well to real-world clinician decision-making which includes issues such as time constraints (Williamson et al., 2000). It has also been emphasised that, as the task to verbalise thoughts is a novel one for most individuals, the amount of guidance given to participants in such a study must be reflective of their needs (Cotton & Gresty, 2006).

Verbal Probing

Verbal probes can be used as an alternative to think-aloud or can be used alongside them. When used alone within qualitative interviews their role is to delve further into participants responses to further explore or understand better information collected.

Most think-aloud tasks use some verbal probes to encourage verbalisation, but some use more specific probes to meet the following functions.

- Gather additional information
- Clarify information
- Explore reasons or motivations
- Explore feelings, views or reactions
- Challenging opinions
- Returning to previously discussed issues
- Inviting further responses

Verbal probes are regarded as useful in guiding interviews without disturbing ongoing processing (Willis *et al.*, 1991). Studies have highlighted the potential for verbal probing to assist in evaluating the perceived accuracy of the individual's response or to clarify issues that they have raised (Williamson *et al.*, 2000; Davison *et al.*, 1997; Drennan, 2003). Additionally, in survey testing, probes have been used to uncover any problems with individual survey items, thus contributing to their validity and reliability (DeVellis, 2003). However, probes have been criticised on the grounds that if presented in a leading way, may lead to a biased focus in interviews (Willis, 1994).

The purpose of verbal probes in think-aloud techniques is to invite further responses. When necessary, such as when there are large gaps in verbalizations, the investigator may use some neutral probes such as 'keep thinking aloud' to encourage participants to continue (Ericsson & Simon, 1993). Probing participants to continue verbalising their thoughts helps to maximise the amount of data collected (Willis *et al.*, 1999). There is a clear distinction between the use of probes within traditional qualitative interviews and in think-aloud techniques. Where verbal probes are used, some researchers argue that they may influence the information subsequently reported by participants, for example by focusing

on elements of their response that they may not have considered or by asking for the verbalisation of information that cannot be accessed (Conrad *et al.*, 1999). However, as researchers often fail to report the exact wording used it is difficult to determine the actual impact that they have (Ericsson & Simon, 1993).

Application of Verbal Probing to Health Care

The think-aloud method has been used successfully within decision-making in health care to explore patient treatment priorities (Cheraghi-Sohi et al., 2007), the factors which influence the way patients are prioritised for subsidised psychotherapy (Fredelius *et al.*, 2002), the reasons why GPs make particular diagnoses (Skaner *et al.*, 2005) and differences between health professionals' diagnoses and treatment decisions (Offredy, 2002; Offredy & Meerabeau, 2005).

Information Display Board

Information display board approaches emerged from studies in diagnostic problem solving in the 1950s, and within marketing research during the 1970s and 1980s that explored decisions made by consumers (Bettman & Jacoby, 1976; Jacoby *et al.*, 1974). Researchers wanted to be able to effectively quantify the process by which people make decisions and to standardise the procedures by which that quantification occurred. Information display board experiments were developed in which participants were required to ask questions to obtain information that they deemed relevant for them to solve the problem (Rimoldi, 1955; Cowles, 1954). Although the methodology can be modified to meet the needs of the research, in general it involves presenting the participant with a 'problem' where they need to make a decision (Svenson, 1996). The format in which information is presented on the board is flexible and can be readily modified (Quelch, 1979).

In early studies, questions that participants may ask were pre-determined and written on a card. All cards were presented to the participant and, should a question be selected, the answer was found on the back of the card. Other researchers, however, have adopted alternative presentations such as gummed stickers (Rimoldi, 1955; Rimoldi, 1960; Rimoldi & Raimondo, 1998; Holbrook & Maier, 2009), dividing alternative options into separate

matrices to enable the participant to participate in a more 'real world' environment (McNeil & Wilkie, 1978) or through the use of a computer (Cardozo *et al.*, 1972). Common to all information display board experiments, regardless of presentation, is that the aim is to have participants make a decision or solve a problem in as natural a way as possible.

Although participants are presented with a limited amount of information that they can access they are informed that they can obtain as little or as much of that information that they require for making a decision. Should the participant want to make a decision based on the problem initially presented alone they need not obtain any information. Furthermore it is emphasised that participants can access information in whichever order they would like and that they need not obtain information in relation to the order in which it is presented on the board. Researchers have also adopted a number of other methods such as offering participants incentives for their chosen brand to ensure that they make decisions as they would do in a real-life situation Jacoby et al (1976).

A number of marketing studies asked participants to make a decision about which brand they would purchase from a range. Jacoby et al (1976) highlighted how the information available to participants is presented and the procedure by which participants select information. In their study they utilised a matrix to display the questions that may be asked. Figure 11 provides an example of what the matrix looked like.

Figure 11: Example of the matrix used by Jacoby et al (1976)

INFORMATION	BRANDS					
	A	**B**	**C**	**D**	**E**	**F**
Bleach content	Quite low	high	moderate	Very high	low	Quite high
Enzyme content	high	moderate	Very high	high	moderate	Very high
Fabric softener content	Quite low	low	Quite high	low	Very high	Very low
Phosphate content	low	Very high	low	moderate	Quite high	low
Price	67¢	95¢	39¢	$1.09	81¢	$1.23
Quantity required per wash load	½ cup	2/3 cup	1 cup	¼ cup	¾ cup	$1^{1/4}$ cup

The actual form of information in a matrix can and does vary but as this example shows, general information relating to the different brands (options) is arranged across and down the matrix. Brand choices are listed across the top of the matrix while the attributes of the brands are listed down the left hand side of the matrix. Each of the cells within the matrix contain what Jacoby (1974; 1975) termed the 'value' of the information for the particular brand relating to the attribute with which it relates to within that particular cell. In the majority of information display board studies the actual 'value' of the cell is not visible until the participant requests that piece of information whilst the options and attributes relating to those are which enables participants to judge which pieces of information they wish to obtain.

Data gathered throughout the task can be analysed in a number of ways such as in terms of the sequence that information is acquired in, the content or depth of the information that is acquired by the participants. The data collected can help to uncover the importance individuals place upon certain pieces of information. Information acquired and not acquired (Jacoby *et al.*, 1976), the sequence by which information was enquired about and the amount of information enquired about specific to particular features (Holbrook & Maier, 2009) can be explored.

Some have regarded the information display board as inexpensive, easy to administer, useful for the presentation of a variety of problems and useful at facilitating the aggregation of data collected from a number of participants (Rimoldi, 1960). Others have focused on its versatility inferring its use for application to virtually any public policy research issue (Quelch, 1979). Lehmann and Moore (1980) also emphasised that as the nature of the task lends itself well to modifications of presentation etc that information display board studies provide researchers with good opportunities to investigate how the changing of variables impacts upon the choices that individuals make.

However, some researchers have argued that there are a number of methodological issues that may jeopardise its validity. These include how the task is displayed and the procedures that are utilised throughout the task. Russo (1978) criticised it for the quality of the data generated from its highly structured approach and others have further criticised the structure of the task by stating that where matrices are used it may lend people to work in a left to right fashion over the matrix, thus not necessarily allowing for the capture of the

information that may be regarded as most important (Holbrook & Maier, 2009; Bettman & Kakkar, 1977).

Painton & Gentry (1985) determined that the information that participants obtain is influenced by the manner by which information is presented to the participant. Participants are more likely to obtain more information when information is presented in a traditional way (as was described above) in comparison to other presentations that have been employed such as memory, pictorial or through computer interaction. Supporting their argument, a study conducted by Bettman and Kakkar (1977) which looked at the effects that presentation (e.g. where the presentation of information favoured the 'brand' or where attributes were randomly presented) highlighted that the way in which acquired information was strongly influenced by presentation. Other studies have further substantiated these claims (Painton & Gentry, 1985; Bettman, 1979; Johnson & Russo, 1978). Furthermore it was identified that as unintentional information acquisition that may become of relevance within real-life decision-making is not addressed e.g. gathering unexpected information inadvertently whilst addressing other issues with a patient, that this may further limit the approaches validity (Lehmann & Moore, 1980).

Of particular relevance to note here is that it that within information display board studies it is the researcher who decides what information the participant is to have access to, that which the researcher thinks will be relevant to the case. This is potential detrimental to the decision-making process in two ways. Firstly the participant may wish to have access to information that has not been anticipated by the researcher. Secondly as the questions that the participant may wish to ask are all visible this may result in the participant asking questions that they may not have initially thought as important to their decision-making process. The generalisability and validity of studies adopting this method are therefore compromised.

Application of IDB to Health Care Research

Whilst the information display board approach has not specifically been utilised to look at decisions made about health treatments, this method has been applied to comparable decision-making. Studies conducted within marketing such as that by Cardozo et al (1972) where participants were required to acquire information in order to make a decision about

whether they would accept a new product highlight similar processes to that which health professionals are faced with in order to make the decision about a patient's treatment. The lack of interaction with others during the task does not reflect real life - in making decisions about a patient's treatment a health professional frequently engage with patients. The information display board approach does not provide the participant with any interaction opportunities and therefore does not take into account these interactions may occur.

While the marketing example provided is not directly comparable to the decisions faced in mental health the concept of presenting an individual with a stimuli and identifying how they react to that stimulus is of use. The example given presents an individual with multiple stimuli with several options available to help them make a decision. In mental health there is a single stimuli (the patient) which may vary in terms of characteristics, and multiple options to choose from (the treatment options available). Using this model can assist with to exploring and understand how a stimulus is judged and thus in the exploration of decision-making in a standarsised way. It allows for a certain level of conceptualisation about which factors health professionals find salient, which they spontaneously use, and what other factors they may wish to explore if the opportunity is presented to them.

Active Information Search (AIS)

The method of Active Information Search (AIS) was originally developed to identify which pieces of information people are interested in when making a decision (Huber *et al.*, 1997) and to 'trace people's thoughts', as they think about decisions (Ranyard & Williamson, 2005). AIS, involves a decision maker being presented with a short description of a decision situation. The participant reads the information and is then given the opportunity to ask the researcher questions in order to gather more information to make their decision. The description presented has to be one that is short enough to evoke questions from the participant (Huber *et al.*, 2001).

Questions that the participant may ask are pre-determined and thus when a participant asks a question the answer is given in a non-verbal way e.g. printed on a card, in order to avoid

any verbalising influences. In response to any questions that were not pre-determined the experimenter must improvise a response, recording that response to ensure that should the same question be asked by another participant that their response is consistent. Huber et al (1997) argued that AIS method allows for decision-making to be measured in a more naturalistic way than structured laboratory tasks including the information display board.

Data collected from an AIS task can be used in a number of ways. The types of questions that are asked, or indeed not asked, give an indication of the factors that the participants consider to be of most importance in decision-making. Uncovering the order that participants seek information to come to their decision can help to infer priorities. Furthermore the number of questions asked may give a useful insight into the difficulty of making the decision.

Huber et al (1997) recognised that when making a decision individuals may cognitively access particular pieces of information without asking questions related to that information. They suggested that this was a potential limitation of the AIS approach and highlighted that in order to capture such instances there is a need for AIS to be complimented by another approach such as think-aloud. In doing so the whole decision-making process could be more readily captured (Williamson et al., 2000).

Application of AIS to Health Research

Similar to the information display board approach, the AIS approach is flexible and researchers have modified the method. Whilst the AIS technique has been applied in a variety of fields, the focus of the research has been on risky decision-making scenarios such as lotteries, gambling or bets (Huber et al., 2001; Bar & Huber, 2008; Huber et al., 1997; Huber & Huber, 2008) and consumer choices (Ranyard *et al.*, 2006). Few health studies have incorporated the AIS method and those that have have utilised modified versions. One study looked at variability in uncertain medical decisions for patients with chronic obstructive pulmonary disease in an intensive care unit (Kostopoulou & Wildman, 2004). Doctors were asked to make a decision about the suitability of ventilation for six patients. Results found that doctors asked different types of questions, attached importance to different pieces of information and interpreted information differently. The modified AIS approach adopted might, however, impact upon the validity of the findings. As

participants were presented with a list of information that was available there was no scope to ask questions about other elements of patients' presentation. This limitation links to the criticisms of information display board approaches. It is therefore unclear the extent to which they reflect doctors' real-life decision-making.

A study by Kostopoulou et al (2008) used a computerised version of the task to look at the ways in which information is gathered to make difficult diagnosis and subsequent treatment management. They were interested in exploring the family physicians' cognitive processing to examine if it had an influence upon diagnostic accuracy. Each physician was presented with ten patient scenarios on a computer screen and was given the opportunity to ask questions. The researcher would then select the relevant cue from a drop-down menu where the answer would be displayed. If the participant asked for information that had not been pre-determined then the researcher would select a generic response such as 'no', 'no I haven't' 'the test is normal' etc. Physicians chose to end the 'consultation' when they had made a diagnostic or management decision and were asked to state what that decision was. Findings revealed that patient cases that were most difficult attracted more incorrect diagnoses but no relationship between accuracy and experience was found. The use of the AIS assisted with the way in which decisions were made, however, as the interaction between the researcher and participant was unnatural, it is difficult to gauge how applicable the findings are to routine practice. Although not unambiguous, an approach utilising conversational or think-aloud elements may have enhanced the data collected.

Another study conducted in health explored genetic-counselee information needs when faced with risky decision-making situations (Shiloh *et al.*, 2006). In this study instead of providing participants with a pre-prepared decision situation, participants were asked to think of a specific decision that they were presently faced with and then ask the researcher any questions that they would like answered before they made their decision. Unlike standard AIS tasks the participants were not presented with the responses to the questions at the point of answering the questions but instead were given these at a later time point. Although the method was used in this way to maintain standardisation this may have impacted upon the findings as not taking into account the initial automatic thoughts of the participant, thus order effects are altered. Additionally as participants were not faced with the same decision situation the reliability of the findings may be questioned.

No other health studies that use AIS have been identified and thus evidence for its use is limited. However, this method may have potential benefits for measuring decision-making in mental health and could be a valuable method to provide insight into what kinds of information people require in order to make a decision and what pieces of information people place most importance on. In evaluating the AIS method Ranyard and Williamson (2005) highlighted that it may be limited in its application as it may require a more experienced decision maker to understand and engage with it, whilst this may be true, in health care health professionals are faced with making decisions about a person's treatment and thus not necessarily 'experienced' decision makers they should be able to apply the same rules and knowledge that they do in real-life situations to such a task.

Importance of Combining Methods

There are disadvantages and limitations of each method in their ability to successfully capture decision-making processes of individuals and a combination of methods may maximise the data gathered. It could be argued that different methods have the tendency to measure different aspects of decision-making. Researchers have suggested that verbal protocols may attend to learned semantic representations (Chestnut & Jacoby, 1978) where the retrieval of relevant information may be facilitated by the of associated information irrespective of it being discussed. For example, a health professional may make a prediction about a suitable treatment when provided with information such as a diagnosis that subsequently initiates related concepts such as suitable treatment. It has been additionally suggested that verbalisation of a behaviour may not reflect reliably the actual processes that have occurred (Nisbett & DeCamp Wilson, 1977) but that this disparity may be partially overcome by the incorporation of concurrent verbal monitoring (Bettman, 1979). Thus adopting an approach that capitalises on each of the methods and meets the needs of the research more readily may be advantageous. Factors such as timing of information acquisition and use of prompts also need to be considered. Jacoby et al (1976) claimed that obtaining verbal reports from participants concurrently whilst conducting a decision-making task may be disruptive and interferes with the way participants subsequently acquire information. However, others have regarded concurrent verbalisation as a vital part of the research process (Lussier & Olshavsky, 1979; Bettman, 1971; Payne, 1976).

Summary of Techniques to Measure Decision-Making

In summary, each of the techniques described have advantages and disadvantages. Of relevance to health research, factors such as the inability to reflect decisions made under time pressure and the lack of interaction and social elements of the decision-making process limit their validity.

Information display boards are potentially less flexible and externally valid than AIS. Conversely, while the AIS displays flexible qualities, it suffers in terms of standardisation. Thus no 'gold standard' technique exists and it is important to consider the strengths and weaknesses of each approach to determine which will meet the needs of the research best. Whilst standardisation is important in capturing the decision-making process, its adoption may mirror little of the decision-making processes that health professionals endure in practice. Allowing for the inclusion of some interaction e.g. where they can ask questions and obtain responses, may better reflect the way that they interact with patients.

While no one approach is perfect, in consideration of the benefits and limitations of each, for this particular study a conversational AIS with the incorporation of thinking-aloud will be adopted. This method will be used alongside qualitative semi-structured interviews (discussed in Chapter 5), to complement and further establish the decision-making processes of health professionals.

Chapter Summary

- Structural and process approaches are well-established as methods within decision-making, problem solving and judgement research.

- Both approaches have advantages and disadvantages, however it is argued that early structural approaches do not address the psychological processes that occur when one makes a decision and the processes by which people actually make decisions based on the information that they utilise is largely ignored. As the purpose of this study is to explore such processes adopting a process approach instead of a structural one appears most applicable.

- A number of methods to capture the process of decision-making have been proposed. These include cognitive interviewing techniques such as think-aloud and use of verbal prompts, information display board and AIS. Each demonstrate the ability to capture the decision-making process but by incorporating elements of the varying approaches the benefits of each can be capitalised upon.

- Whichever approach is used the identification that one must always keep in mind the subjective nature of the information collected in participant verbalisations is recognised.

- The incorporation of the AIS approach within health care research is limited but its value appreciated. The incorporation of a conversational think-aloud AIS within this study is thought to be the first within the health care field.

CHAPTER FOUR: **METHODOLOGY**

Introduction

This chapter will begin by outlining the aims and objectives of the study. A discussion of the methodological foundations for the thesis will then follow. An overview of research paradigms and a rationale for the approach adopted in this study will be provided. Subsequently, specific details will then be provided about the characteristics of the researcher and approaches implemented to enhance methodological quality. Finally details regarding ethical and research governance approval and the identification of study sites will be outlined.

Research Aims and Objectives

The main aims of the research are:

 i. To explore patients' experiences of decision-making within a stepped care model of service delivery.

 ii. To explore health professionals' experiences of decision-making within a stepped care model of service delivery.

 iii. To synthesise health professionals' experiences with those of patients' and to discuss findings in relation to the implications for the implementation of the stepped care model and in wider health care policy issues.

There were two studies conducted within this piece of research:

Study 1: Exploration of patients' experiences of decision-making and the overall treatment process within a stepped care model through the use of an in-depth semi-structured interview

Study 2: Exploration of health professionals' experiences of decision-making in stepped care. Within study 1 two different methodologies were used

  2a. In-depth semi-structured interview

  2b. Active Information Search (AIS) think-aloud process tracing task

Figure 12 provides an outline of different aspects of this thesis in relation to the aims described above.

Figure 12: Study flow diagram
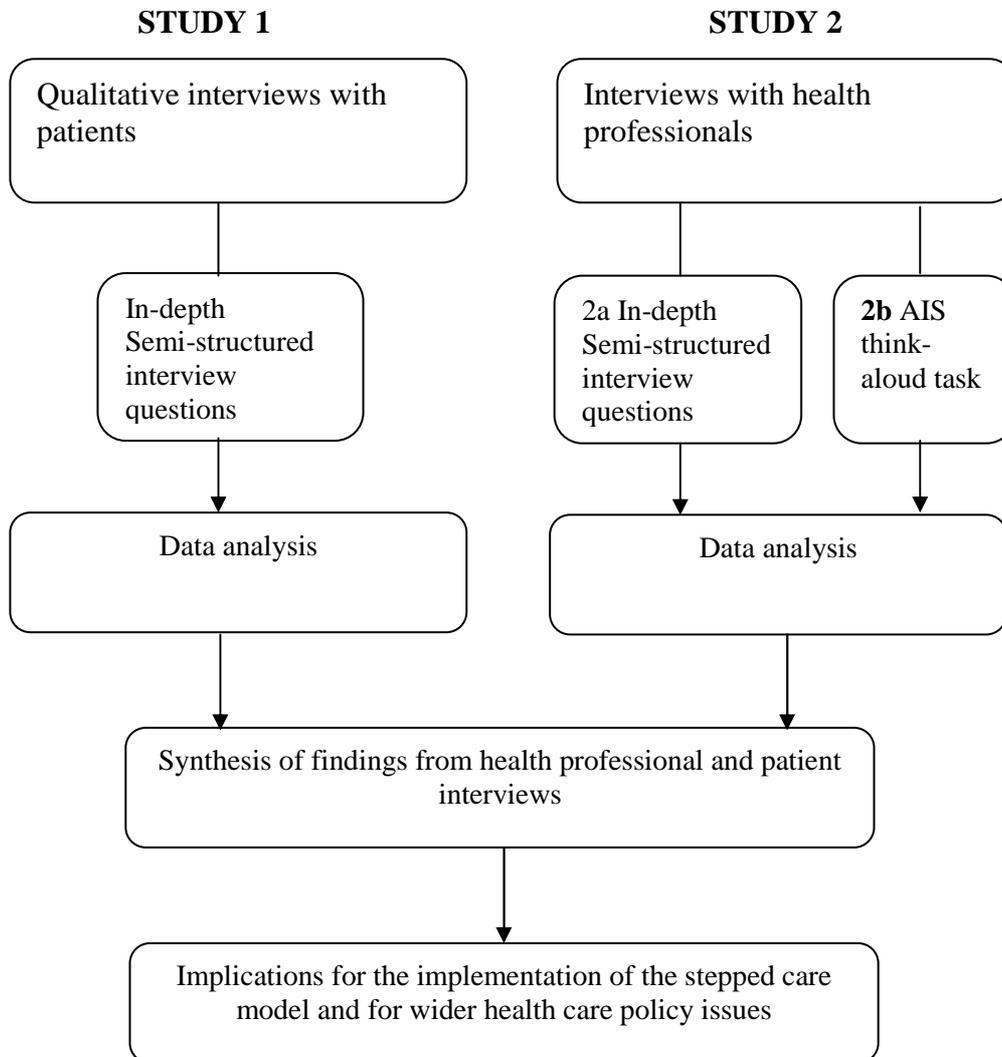
The methods associated with study 2b (AIS think-aloud process tracing task) are presented in Chapter 8.

Briefly, within this piece of qualitative work I conducted interviews with patients with common mental health problems and with health professionals responsible for making decisions about patients' treatment within a stepped care framework. This chapter will focus on the discussion of the chosen methodology and the subsequent chapter, Chapter 5, will discuss in detail the ways in which this methodology was adopted in the current study.

Methodology

In choosing appropriate methods, researchers are presented with a number of challenges (Blaikie, 2000). Researchers can adopt a variety of fundamentally different strategies to generate new knowledge. One approach involves starting from a theoretical perspective and the assumptions that researchers bring to the research (Crotty, 1998). At the heart of this approach are the assumptions of epistemology and ontology. Epistemology has been described as 'the possible ways of gaining knowledge of social reality, whatever it is understood to be. In short, claims about how what is assumed to exist can be known.' (Blaikie, 2000, p8). Ontology focuses on the 'philosophy of reality' (Krauss, 2005) where

> '…claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other. Thus ontological assumptions are concerned with what we believe constitutes social reality.'
>
> (Blaikie, 2000, p8).

Thus epistemology can be described as an understanding of how we know what we know whilst ontology is the way we describe things and the relationships that exist between them.

Variations in the approach to research exist due to the underlying nature of the beliefs that researchers bring (Lyons, 1999). This set of beliefs were described by Kuhn as a paradigm (Kuhn, 1970). Paradigms represent a view of the world as we perceive it, where we 'fit' and how we interact with it (Guba & Lincoln, 1994). Paradigms are said to '[establish] *the parameters and [set] the boundaries for scientific research and, in the ordinary course of events, scientific enquiry is carried out strictly in line with it*.' (Crotty, 1998, p35).

Historically, research has been influenced by two major paradigms – positivism and interpretivism, which in turn influence the methods by which data is collected.

Positivism – a Quantitative Approach

Objectivism is reality-orientated and posits that everything exists independent of consciousness. These assumptions underpin the positivist perspective which is often regarded as a 'scientific method' involving knowledge being gathered in ways that are not

subjective but are direct experiences (Crotty, 1998) and which are replicable involving logically deduced hypotheses and confirmed evidence (Charmaz, 2006). Reality is said to exist on cause and effect principles and that this reality can be measured. Positivists test casual explanations through the testing of theories and hypotheses, using variables quantified through methods that yield numbers and statistics such as questionnaires or surveys. Data collected in this manner is efficient in testing pre-determined hypotheses and the importance of the researcher remaining objectively separated from the subject under scrutiny is stressed. It has been argued such an approach fails to capture the complexity of human behaviour and social interaction (Jensen, 1989).

Interpretivism – a Qualitative Approach

Interpretivists believe that reality exists and can be measured, but recognise that interpretation of information cannot be wholly objective: rather we need to control or limit the biases present when collecting data (Hanson, 1958). It thus proposes that there can be multiple realities of phenomena, and that these realities can differ across time and place. Interpretivism aims firstly to understand the context and then to make an interpretation that is shaped by experience. Qualitative methods are frequently used when '*little is known about a phenomenon*' (Morse & Field, 1995) and where the investigator seeks to collect '*information rich*' cases (Patton, 2002). Qualitative research, broadly defined, means '*any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification*' (Strauss & Corbin, 1990, p17). Data is collected by qualitative means through interviews, focus groups or observations and analysis involves examining the words that are recorded during these interactions. Studies involving qualitative approaches are regarded as being subjective where the researcher's interpretation of the events recorded is paramount to address '*research questions that require explanation or understanding of social phenomena and their contexts*' (Snape & Spencer, 2003, p5).

During the 1970s, 80s and early 90s many debates concerning the opposing views of the differing paradigms took place (Gage, 1989). The notion that one must take one stance or another was held by many. However, a new era of research methods slowly emerged where it was considered by many '*that the struggle for primacy of one paradigm over others is irrelevant as each paradigm is an alternate offering with its own merits*' (Guba, 1990,

p27). From this a movement regarded as the 'third methodological movement' (Creswell, 2003) evolved. Whilst the philosophical issues were still of importance, there was less focus on trying to ensure that one method had primacy over the other and in turn it became more acceptable, to some researchers at least, to use mixed methods.

The Third paradigm - Pragmatism

The pragmatist approach is a theoretical stance that has been widely regarded as the 'third paradigm' (Johnson *et al.*, 2007; Creswell, 2003). Research conducted within health services research, where aims often reflect the priorities of funders (Murphy *et al.*, 1998) often adopt this viewpoint. Smith and Cantley (1985) argued that methodological approaches should follow the assumptions of rationality and of the desirability of research design. It has been argued that in the area of health care the choice between qualitative and quantitative approaches is likely to '*rest on the degree of knowledge of the phenomenon to be studied. The more that is known about a programme and its underlying theories, the more possible and logical it becomes to use experimental* [quantitative] *design. The less that is known, the more it makes sense simply to try to understand the basic components* [qualitative]' (Murphy et al., 1998, p221).

Pragmatists hold the belief that when making a decision about the method or methods to be adopted, the limitations and opportunities of the context in which the research is to be conducted are of primary importance (Greene *et al.*, 2001; Silverman, 1993). Patton (2002) stresses the importance of not getting 'bogged down' with the opposing differences that different paradigms present but to use a pragmatic approach, responding to the context in which the research is conducted. Pragmatism is closely associated with research using both quantitative and qualitative methods (Creswell & Piano-Clark, 2007; Tashakkori & Teddlie, 2003). Pragmatism, does not consider that a specific method be adopted although, simultaneously, is not an approach where 'anything goes' (Denscombe, 2008, p274), but one that is flexible in the approach to the collection and emergence of data (Feilzer, 2010).

The current study aimed to gather knowledge on the experiences of decision-making within a particular model of mental health care delivery. In achieving this aim consideration of methodologies and the methods that could be used took place. Morgan stated that while the theoretical underpinnings of a methodology and the methods

themselves should be considered of equal importance, '*we need to use our study of methodology to connect issues in epistemology with issues in research design rather than separating our thoughts about the nature of knowledge and from our efforts to produce it.*' (Morgan, 2007, p68).

Methodology Adopted Within this Study

Addressing the differences in the approaches revealed that to meet the main aims of the study, to explore health professional decision-making in the stepped care model, that an interpretive approach would be the most rational choice. Adopting such an approach would assist with identifying health professional's actions and beliefs and would allow for the process of decision-making to be explored. In line with the views of Chin Lin (1988) it was recognised that taking an interpretive qualitative approach, did not mean, however, that the data remained wholly within that paradigm. Qualitative work, it is argued, can also be positivist:

> '*It can attempt to document practices that lead consistently to one set of outcomes rather than another, to identify characteristics that commonly are related to some policy problem, or to find strategic patterns that hold across different venues and with different actors.*'
>
> (Chin Lin, 1988, p162)

This viewpoint highlights some of the issues that need to be addressed when incorporating process-tracing techniques. Such data can be taken as the actual content of the health professionals' thought processes and such casual relationships can lead to a better understanding about the decision-making process. While the interpretive (qualitative) approach helps to provide explanations for why there are connections between different factors (causal mechanism), exploring the qualitative data in a positivist (quantitative) manner assists with looking for patterns (causal relationships) in practice that lead to certain decisions being made for a particular problem. Thus looking at the data collected also from a positivist approach could help to provide more detail about the outcome and process of the decisions made. Chin Lin (1998) emphasised the importance of understanding both the causal mechanism and relationship within research in order to:

    i.   better understand the 'general phenomena'

    ii.   understand more about which factors are likely to cause particular outcomes

iii.   to evaluate the strength of the observations

Using different approaches to the analysis of data reveals different uses of the data and thus helps to address questions that may have remained unanswered.

Qualitative Interviews

Interviews are integral to interpretivist research that is conducted and were considered to be the most appropriate method for exploring health professional decision-making. Whilst in the past it has been argued that health service evaluations have failed to capture the types of information that such services need to be informed of (Dingwall, 1992), interviews are now widely used in health services research to help to capture the dynamic aspects of the service in order to understand what people do, believe and think (Britten, 1995).

Interviews have been described as a form of conversation that are '*initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused on content specified research objectives of systematic description, prediction or explanation*' (Cohen & Manion, 1989, p307). They provide the opportunity to explore ideas or concepts that cannot be directly observed (Patton, 1980) from the participants' point of view, not how they are perceived by the researcher (Marshall & Rossman, 1989). Interviews can take a variety of formats including unstructured or semi-structured, however it is argued that the flexibility of semi-structured interviews allows for the generation of '*rich and illuminating data*' (Robson, 1993, p229), which is particularly suited to studies investigating new ideas. In these interviews an interview schedule outlining open questions to be explored is used. In conducting a semi-structured interview the interviewer, based on their own perceptions, has the opportunity to modify the order in which questions are asked, change the way that they are worded, include additional questions should further exploration of a concept or idea be required or indeed leave out a question if it is regarded as inappropriate in order to enhance the context of the conversation. Robson (1993) argued that the benefits of such interviews can be strengthened even further by conducting them in a face-to-face manner where the interviewer has the ability to respond to the participants' non-visual cues or other responses by modifying their questions appropriately.

In conducting interviews, Britten (1995) emphasised the importance of not deferring from the participants own views and meanings and stated that:

> *'In a qualitative interview the aim is to discover the interviewee's own framework of meanings and the research task is to avoid imposing the researcher's structures and assumptions as far as possible. The researcher needs to remain very open to the possibility that the concepts and variables that emerge may be very different from those that might have been predicted at the outset.' (p251)*

Interviews, particularly those standardised in nature, have additionally been criticised for not acknowledging participants' views appropriately, taking into consideration the context in which they were generated (Mishler, 1979; Murphy et al., 1998). Adopting a semi-structured approach can help to overcome some of these issues but it is also important that researchers using a good interview technique. Building up a rapport with participants, listening and responding appropriately, asking questions in a straightforward, non-threatening, guiding or judgemental way are all ways that can help to ensure that data generated is as true a reflection of participants' views and opinions as possible.

Loftland et al (2006) argued that interviews should be recorded to allow for an in-depth analysis of the data to be conducted. Recording the interview additionally allows the researcher to be more responsive during the process, which is important when sensitive issues are discussed. Field notes are an important addition to enable the researcher to reflect upon any issues that may have impacted upon the way the interview was conducted.

Transcription

Transcription of interview data is one of the most common ways to prepare it for analysis (Bazeley, 2007). Whilst it was the initial intentions of the researcher to transcribe the interview data herself, due to time constraints, and the fact that data collection and analysis within the study were being conducted simultaneously, it was necessary to employ a transcriber. In order to ensure that the transcriber chosen was rigorous and professional in their approach advice was sought from colleagues about who would be suitable. They were advised that a post-doctoral researcher, a previous employee of the University, would be well suited to meet their needs. In line with the views of Waitzkin (1990) standardised rules of transcription were employed to ensure that participants' pauses, use of slang, notations of emotional content such as whispering were conserved ensuring that the

transcript reflected as true as possible the views of the participants and that possibility of misrepresentation was minimised. Standardised rules also ensured that transcripts followed the same presentational format. Schegloff (1997) described this as allowing the participants to speak for themselves.

Unfortunately, this transcriber was unable to complete all of the health professional and patient interviews and the final five patient interviews had to be sent to a professional transcriber, recommended by another colleague. In order to ensure consistency in the way that these remaining interviews were transcribed the transcriber was sent typing conventions in-line with the way that the previous interviews had been transcribed. It has been suggested that when working with transcribers it is useful to 'spot-check' a sample of the transcripts to identify whether there are any problems with the quality or content of the transcript that needs to be discussed (MacLean *et al.*, 2004). Thus to guarantee the quality of the transcription and to eliminate any errors it was decided that all transcripts were to be checked against the original interview recording. Although no problems were highlighted with the quality of the transcript provided by the transcriber, this was beneficial, not only to make any necessary amendments or corrections required due to poor recording quality, but also to re-familiarise with the data to assist with the data analysis process. All potential patient, health professional and PCT site identifiers were removed at this point to ensure participant confidentiality. In addition, to assist with the transcribing of the interviews the transcribers were sent a summary of the study's proposal to familiarise themselves with the content of the interviews and some of the terminology that they may encounter.

Computer assisted qualitative data analysis (CAQDAS)

In order to manage large amounts of qualitative data in a systematic way and to ensure efficient retrieval of that data a number of computer software packages have been developed. Whilst such packages help to assist with the data analysis process they are not an alternative to researchers' time, effort and skills but have been viewed as a means of enhancing the rigour of qualitative studies (Bazeley, 2007) and can encourage proximity of the researcher with the data (Pope *et al.*, 2000). For these reasons, following transcription of interviews into Microsoft Word, data was stored and managed using specialist software for qualitative data (NVivo-7).

Adopting Thematic Analysis as a Research Approach

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes the data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic (Boyatzis, 1998). Whilst it is a widely used approach in analysing qualitative research it is a poorly acknowledged method when compared to more prevalent methods such as grounded theory. It is argued, however, that what distinguishes thematic analysis from approaches such as grounded theory or discourse analysis is the fact that it does not rely on pre-existing theoretical frameworks and that it is therefore a more accessible approach (Braun & Clarke, 2006), with the ability to be used with a wide variety of frameworks. Thematic analysis lends itself to providing a rich thematic description of the whole data set and it is for this reason that it is a useful approach when exploring new or under-researched areas and is particularly relevant to health service studies. A well-conducted analysis involves some level of interpretation of the data. Using thematic analysis assists with this by providing clear links between themes and the aims of the study in order to guide the development of analytical claims.

Thematic Analysis Using Framework

Interviews were analysed following the principles of Framework analysis (Ritchie *et al.*, 2003). This method was designed to facilitate the exploration of the qualitative data in a systematic staged-approach moving from organising the data to summarising and finally to interpretation within a thematic framework.

Framework analysis was chosen for the following reasons (Roberts et al., 2009, p23):

1. It provides coherence and structure to otherwise cumbersome, qualitative data (i.e. interview transcripts).
2. It facilitates systematic analysis, thus allowing the research process to be explicit and replicable.
3. Despite the inherent structure, the process of abstraction and conceptualisation allow the researcher to be creative with the data.

Ritchie et al (2003) describe four key stages in the analysis process:

i. *Identifying initial themes or concepts* – similar to other analytical approaches to the analysis of data the researcher must become familiar with the data. This stage of familiarization involves revisiting the aims and objectives of the research, re-examining the sampling strategy to better understand the 'diversity' of the data, and thoroughly reading the transcripts to identify any recurring or key themes. Following identification of themes a conceptual framework can be developed. Further refinement of this framework allows for themes to be presented hierarchically with the grouping of broad themes under those considered to be the main themes.

ii. *Labelling or tagging the data* – In this stage of data analysis the raw data (e.g. interview transcripts) is systematically 'indexed' by applying the conceptual framework. Ritchie et al (2003) recognise this stage as different from coding where they define indexing as – *'when applying an index, it simply shows which theme or concept is being mentioned or referred to within a particular section of the data…'* whilst they consider coding to *'refer to a process of capturing dimensions or content that has already been more precisely defined and labelled'* (Ritchie et al., 2003, p224). Throughout the process of indexing there is the opportunity to refine the conceptual framework should it be deemed necessary

iii. *Sorting the data by theme or concept* – data is sorted in a logical manner to enable data of similar 'content' or 'properties' to be collated. Different methods can be adopted here to conduct this sorting whilst some researchers prefer to sort data manually others prefer to use computer programs such as NVivo to assist this process.

iv. *Summarising or synthesizing the data* – The aim of this final stage of data management is to make the data more manageable. Whilst researchers may choose to do this by different means, Richie & Lewis state that the following requirements should be met:

- the language of the participant is unchanged to ensure that key terms or phrases used by the participant are retained throughout analysis;

- interpretation, at this stage, is limited to allow for easy access back to the original data if required and;
- all data should be considered important regardless of whether or not its purpose or meaning is clear as its significance may become clearer at later stages of interpretation.

It is important to note that the Framework approach to managing and analysing data is not necessarily a linear, rigid process, it is possible to revisit earlier stages in the analysis should immersing oneself in the data reveal further key themes or issues. In line with the views of Mays and Pope (2000), with respect to ensuring that quality of the research conducted is high, the Framework approach assists with providing a clear account of the conceptual process by which interpretation of the data was developed.

Issues of Quality in Qualitative Research

Quality in qualitative research remains a *'complex and emerging area'* (Creswell, 1998, p193) and it has been argued that such research lacks scientific rigour. There is considerable debate as to whether the principles of validity, reliability and generalisability, which many consider to be deeply rooted within positivist research, can be applied effectively to studies adopting a qualitative interpretative approach (Stenbacka, 2001; Healy & Perry, 2000). Researchers have argued that alternative criterions are more applicable in qualitative research and new terms such as credibility, transferability, and conformability have been argued to better reflect the interpretivist outlook (Seale, 1999; Lincoln & Guba, 1985). Others, however, have argued that the same principles can be applied but that they need to be modified (Mays & Pope, 2000) to take account of the differing features and goals of qualitative research. Whilst the views of researchers such as Lincoln and Guba are acknowledged, the latter viewpoint is taken within this research study. The concepts of validity, generalisability (external validity) and reliability within qualitative research will be outlined:

Generalisability (External validity)

Morse (1999) stated that '*if qualitative research is considered not generalisable then it is of little use, insignificant and hardly worth doing*' (p5). Whilst qualitative studies are not, and do not consider themselves to be, generalisable in the traditional sense there are qualities of the research that have inherent value. As Ritchie and Lewis (2003) highlight there are a number of potential ways that the concept of generalisation can be applied. One of these was inferentially by generalising from one particular study context to another. To enable this to occur it is imperative that in reporting the research a 'thick description' (Geertz, 1978) of the original research process and setting is provided. The importance of representational generalisation is also highlighted where there is clear demonstration that the sample is a true reflection of the population studied and that the conclusions drawn are an accurate reflection of the data provided by the participants (Lewis & Ritchie, 2003; Murphy et al., 1998)

Within the context of this study the data collected was used appropriately and fully to strengthen the interpretation provided, this involved ensuring that the diversity of the dataset was encompassed within all reporting. The use of Framework analysis further facilitated the levels of interpretation at all levels of the analytic hierarchy. Furthermore scruitiny was placed upon the way in which the research was conducted and designed to further explore any features of the research, such as sampling, that may limit the way in which inferences can be drawn.

Validity

Joppe (2000) described research validity in terms of whether it:

> *'truly measures that which it was intended to measure or how truthful the research results are.'*

There are a number of methods to ensure that the research remains as truthful to reality as possible. Mays and Pope (2000) suggest that there are six main ways to improve validity – triangulation of results from different methods of data collection; asking participants to validate the researcher's interpretations; being aware of aspects of the research that may have influenced the way in which the data was collected e.g. researcher and participant

characteristics; taking into consideration participant data that may contradict other data collected by reporting fully and finally ensuring that the research takes into consideration a wide variety of perspectives.

For this particular study, triangulation was of particular significance:

Triangulation

Where a combination of different methods and study populations are involved, triangulation is an extremely important. Within this study the integration of different data sources (patient and health professional interview data) and different methods of data collection (qualitative interviews and AIS think-aloud process-tracing task) was required in order to produce a meaningful understanding of decision-making in stepped care from all avenues explored. While triangulation itself does not ensure validity is is regarded as *'a way of ensuring comprehensiveness and encouraging a more reflexive analysis of the data'* (Mays & Pope 2000, p51). Using triangulation in this study was a means to explore similarities between data collected through different sources and methods but in addition to identify if any contradictions arose. In triangulating the findings an overall interpretation of the findings was developed, this is presented in Chapter 10.

Reliability

Joppe (2000) defines reliability as:

> *'The extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable.'*

Determining reliability within qualitative studies can be challenging as the data collected is based often on face-to-face situations where participants are providing information on real-life experiences. Such methods are prone to elements of misinterpretation or personal biases. Therefore in demonstrating and enhancing reliability in qualitative research it is important to carefully describe each of the processes involved in the study. Several methods have been identified to assist with demonstrating the reliability of qualitative research such as conducting and reporting the research in a systematic way, ensuring that

any interpretations provided are supported by the data (Lewis & Ritchie, 2003) and asking for clarification when uncertainty is present (Shank, 2006).

Throughout the research process the concept of reliability was addressed to minimise any possible misinterpretation or bias. This involved conducting fieldwork using a consistent approach that allowed participants to readily portray their experiences, clarifying any ambiguities with participants during the interview, confirming interpretations of interview data by multiple assessments with supervisors and reporting the findings in a systematic manner with comparison to existing literature.

In order to ensure that quality was maintained throughout the research process various applications of these principles have been applied in context and demonstrated throughout this thesis.

The Researcher

On commencing this study I had been familiarised and immersed in mental health research for a few years. Being a volunteer for a mental health charity had also provided me with the opportunity to work clinically, by offering telephone therapy to clients with anxiety and depression. The work was supervised in-vivo by a trained and experienced CBT therapist and provided me with a good working knowledge of common mental health problems, and also the barriers and facilitators of the mental health care services within and outside of the NHS. I was aware of the recent developments in policy and developing research had a clear interest in how mental health services were evolving in practice and was keen to explore the impact that one development, the stepped care model, was having upon not only the mental health workforce but also the users of the services involved.

As the principal investigator, I completed all aspects of the study including recruitment of participants (patients and health professionals) involving attending meetings with PCT contacts and teams, gathering consent from participants, data collection (interviews with patients and health professionals) and all analysis od the data (utilising supervisors for data interpretation). Having a background in psychology and health psychology, but not being a registered health professional working within the NHS, there was concern that I would be considered as an 'outsider' to the populations of interest. It is regarded that having such a

position may influence the way in which the research study is approached, analysed and evaluated (Hockey, 1993). On one hand it can be an advantage having someone from the 'outside' who was not influenced by their role within the area being studied and instead can retain an objective outlook, impartial to any conflicting evidence (Schutz, 1976) which may be regarded as more valued (Robson, 1993). Conversely an 'insider' has the opportunity to access the complex social worlds of those involved in the research more readily and there is the potential that this may enhance the 'rapport' between themselves and the participants.

In qualitative research the researcher is regarded as the primary data collection tool and direct, personal contact with participants is a vital part of the process. Hammersley & Atkinson (2007, p16) acknowledged that within this encounter as researchers there is '*no way in which we can escape the world in order to study it*', as such it is assumed that the researcher has the potential to introduce bias and subjectivity to the data collected Although the influence that researcher's preconceptions, beliefs and experience can have upon the interpretation of data is accepted it is regarded as necessary that such influences are critically evaluated and recognised (Altheide & Johnson, 1994). In analysing data collected the researcher, informed by their theoretical position, interprets what participants have said rather than simply reproducing their meanings. In order to ensure that the data collected and explored is a true reflection of the participants' views or opinions researchers should make every effort to set aside their own preconceptions or assumptions by reflecting upon how such factors may influence the process.

PCT Supervision Observations

In order to understand better the context the researcher observed a few primary care mental health group supervision meetings at one of the primary care trusts sites. Participant observation has been defined as:

> '*a technique of unobtrusive, shared or overtly subjective data collection, which involves the researcher spending time in an environment observing behaviour, action and interaction, so that he/she can understand the meanings constructed in that environment and can make sense of everyday life experiences. These understandings are used to generate conceptual/theoretical explanations of what is being observed.*
>
> (Gribich, 2003, p123*)*

The supervision sessions were run by senior clinicians within the PCT to provide low intensity workers the opportunity to discuss their caseloads. This was beneficial for gaining an understanding about

- How patients are referred into the mental health system
- The roles of the different workers within the PCT
- The process by which they are assessed and assigned to a treatment e.g. what the role of the individual health professional is and how much influence the team have in the decisions that are ultimately made
- The process by which a patient is 'stepped-up'
- The role of outcome measures and guidelines

Interview Observations/ Field Notes

As it has been ascertained that making notes during interviews can lead to '*distraction or distrust*' (Hammersley & Atkinson, 2007, p142) and thus interfere with the interview process, observational field notes were made following all interviews. Issues such as the health professional's engagement with the think-aloud task, the researcher-interviewee rapport, main points raised by the health professional during the interview (taking into consideration any new points raised) and whether there was anything about the context or the environment that had an impact upon how the interview went were noted for each interview. The purpose of the field notes were:

i.   They allowed for reflection on the context of interview

ii.   They allowed for identification whether there were aspects of the interview that had gone well or indeed badly to inform the way that subsequent interviews were conducted

iii. They assisted with the beginning stages of identifying key themes or concepts that were emerging from the data. A standardised sheet was developed to record personal reflections.

In addition to the collection of field notes engagement with relevant literature continued throughout the collection of data. Consulting additional sources of information are said to enhance the data collection process (Tuckett, 2005). Following discussions with

supervisors it was agreed that engaging with literature throughout the course of the study would be more beneficial than detrimental.

Ethics and Governance Approval

The principles of the Department of Health's Research Governance Framework for Health and Social Care (Department of Health, 2005c) and the School of Nursing, Midwifery & Social Work's Safety Policy for Lone Workers underpinned planning and delivery of the study. The study protocol was approved by multisite Nottingham-2 Research Ethics Committee in May 2008 (REC reference number 08/H0408/79) and received research governance approval from the four PCTs. As each site required different documents, this process took longer than was initially expected. While applications were approved for three of the sites in June 2008, final approvals for the fourth site were obtained in November 2008.

Identifying and Accessing Study Sites

To identify potential sites for inclusion a number of strategies were adopted. Previous involvement in a study to develop a guided self-help intervention for depression had opened up opportunities to attend meetings of studies being conducted at established stepped care PCT sites. With these, and through attending national mental health conferences, the opportunity to network with well known academics involved in primary care mental health assisted with the identification of sites where stepped care was established. As the progress of stepped care implementation fluctuated nationally it was important to ensure any sites were reasonably well established. If implementation was in its very early stages at all sites it was anticipated that the experiences of patients being 'stepped-up' would be hard to capture as few would have flowed through the system. From discussions and networking opportunities four stepped care sites were approached.

Initially contact was made with a senior member of the primary care mental health team at each of the sites who included an IAPT primary mental health team manager, deputy director of public health, PCT clinical team lead, primary care mental health service lead and head of psychology. Following initial conversations the researcher arranged to meet to

discuss the project further and what their involvement would include should they agree to partake. During these meetings the primary researcher additionally provided a number of informal presentations highlighting the main aims and objectives, the rationale behind the study and the methods.

CHAPTER FIVE: **WORKING METHODS FOR STUDY 1 AND STUDY 2A**

Introduction

The interviews conducted with patients and health professionals in studies 1 and 2a will be discussed in terms of the methods used. This will include a discussion of the research aims and objectives, participant sampling and recruitment and methods used to generate, analyse and interpret the data collected. For the health professional interviews (study 2a) a pilot was conducted to test the potential benefits of asking professionals to reflect upon recent treatment decisions that they had made in practice and this will also be presented within the discussion of this study.

Study 1: Exploration of Patients' Experiences of Decision-Making

Overview

This study involved qualitative interviews to explore the views of patients, to develop a better understanding of their expectations and experiences of decision-making within the stepped care model.

Qualitative Interviews with Patients

In-depth, semi-structured qualitative interviews were used to gather the views and experiences of patients. Interviews were conducted face-to-face and by telephone, depending on patient preference and geographic location. The focus of the interview questions and the methods that were included in the interviews was determined from the literature review presented in chapter one.

Interview Question Content

Within the interviews with patients a standard semi-structured qualitative interview approach incorporating open-ended questions was employed.

Patient interview questions focused on the following issues:

    i.   their experiences of mental health services to date

    ii.   their experiences of decision-making within these services

    iii.   their decision-making preferences

    iv.   their expectations

    v.   their understanding of the stepped care model

See Figure 13 for the topic guide used in the patient interviews.

Figure 13: Interview topic guide used in patient interviews

INTERVIEW TOPIC GUIDE

TOPIC AREAS TO BE DISCUSSED:

➢ **General information about participant including**
  History of mental health problems
  - type of mental health problems experienced
- how long experienced mental health problems

➢ **Experience of mental health treatment to date**
  Ascertain stage of treatment
  Length of time on waiting list
  Number and type of treatments to date
  General experiences of treatment – explore the perceptions of a 'good' outcome?

➢ **Explore experiences of decision-making at various treatment stages**
  Explore how the participant was:
  - involved in decision-making
  - their role in the decision-making process

➢ **Explore decision-making preferences at various treatment stages**
  Explore preferences for involvement in treatment decision-making:
  - medically led
  - patient led
  - collaborative model

➢ **Ascertain information needs at key treatment stages**
  Explore information preferences:
  - what kind of information is favoured
  - timing of information
  - amount of information
  - format of information

➢ **Is there anything I have missed in our discussion that you consider to be important?**

As with the health professional interviews, the purpose of the topic guide was to guide the interview process and to ensure that the identified issues were discussed. At the outset of each interview, patients were asked to provide some general information about the history of their mental health problem(s) indicating the types of problems they had experienced and how long they had experienced them for. This gave patients the opportunity to 'tell their story', to ease them into the interview process and to assist with the understanding of the context of their experiences.

Following completion of the first few interviews with patients transcriptions were evaluated to determine whether any revisions were required. It was agreed, through discussions with supervisors, that it would be beneficial to include more specific questions about the actual stepped care model to gain a better understanding of how it was perceived by the patients, and the topic guide was amended to reflect this.

Demographic Questionnaire

Patients were also asked to complete a demographic questionnaire following the interview. Questions focused on whether they were currently (or previously) taking medication for their emotional problem, whether they were currently (or previously) receiving any form of psychological therapy and additional general demographics such as ethnicity, highest level of qualification obtained and current living situation. The demographic questionnaire used in this study is presented in Appendix 5.

Conducting Interviews by Telephone

It was decided to adopt a telephone approach after conducting the initial interviews face-to-face due to practical constraints. The major influence over this decision was one of time. Due to a very low response rate using the initial recruitment strategy identified by health professionals, a small amount of dedicated time remained within the study to complete the patient interviews. In addition travelling to the site, where a change in recruitment strategies proved successful was not only time consuming but costs were high, particularly when participants cancelled at the last minute. Some researchers have concerns about the use of the telephone in conducting interviews with some viewing it as less favourable to

conducting an interview face-to-face (Rubin & Rubin, 2005; Novick, 2008). One of the major criticisms with telephone interviews is that the interviewer is unable to pick up on visual cues indicating that the participant may be under stress or embarrassed, particularly when the topic being discussed is of a sensitive nature (Rubin & Rubin, 2005; Groves, 1990). They have also been criticised for the potential for participants to be distracted by their environment (Opdenakker, 2006), however it could be argued that there is the potential for this to occur in face-to-face interviews to the same extent, particularly as many are conducted in participants' homes. Additionally some researchers have argued that due to factors such as participant fatigue telephone interviews are generally much shorter in length than those conducted face-to-face (Sweet, 2000; de Vaus, 1991) but this claim is not supported by the findings of studies that have compared both modes of interview (Wilson *et al.*, 1998; Sturges & Hanrahan, 2004).

Although utilised by qualitative researchers less often than face-to-face approaches (Sweet, 2000), many researchers have identified that telephone interviews can overcome a number of practical problems, such as those faced within this study, and can be as effective at collecting data as face-to-face interviews (Sobin *et al.*, 1993; Greenfield *et al.*, 2000; Miller, 1995; Sturges & Hanrahan, 2004; Musselwhite *et al.*, 2007). Specifically practical concerns such as the geographical location of the participants (Sweet, 2000), the cost of conducting the interview face-to-face (Sturges & Hanrahan, 2004), the safety of the researcher (Hamm & Ferrell, 1998; Carr & Worth, 2001) and also the ease of organising a suitable time with the participant (Sturges & Hanrahan, 2004) have been alleviated through the use of telephone interviews. Furthermore De Vaus (1991) argued that the responses given by a participant in a telephone interview may be of a better quality than compared to a face-to-face interview as factors such as characteristics of the researcher have been partially removed (e.g. age, ethnicity, attractiveness) and the participant is less likely to be reactive towards such factors.

Whilst there may be differences in the mode utilised to collect the data it is argued that the major factor that can contribute to poor rapport and subsequent responses is the ability of the researcher to conduct an interview in a responsive manner. The researcher conducting the interviews had extensive training, was competent and confident in interviewing skills such as listening, controlling the interview dynamic, managing difficult interviews and being responsive to the participants' needs and also previous experience of conducting

qualitative interviews by telephone, and thus many of the issues highlighted in the literature were not regarded as having an impact upon the interview process and outcome.

Patient Sample

The aim was to include approximately five to seven patients from each of the four sites. Again, the total amount of interviews conducted, was flexible in order to maximise the depth of enquiry and was also dependent upon a sample size sufficient for reaching saturation of responses.

Mental health professionals and/or service managers at each of the sites were involved in identifying and recruiting a sample of individuals (this process is detailed on page 130). Patients were recruited based on the treatment(s) that they had received within the stepped care model. Of most importance was obtaining a sample that involved patients who had received treatments at different 'steps' of the model and that varied in gender, age and type and length of common mental health problem experienced. However, it was also stressed that patients who may have only accessed one step would also be valuable to the study.

Inclusion Criteria

Patients invited to participate were those who were currently receiving psychological therapy at one of the 'steps' of the stepped care model. Patients who had recently been discharged were also eligible to take part.

Exclusion Criteria

Patients were not recruited into the study if they:

- Are actively suicidal
- Are less than 18 years of age
- Have significant evidence of significant cognitive impairment
- Have bipolar disorder, schizophrenia or any other major mental health problem

Recruitment

Planned Recruitment Strategy

Patients were recruited into the study in-line with the 'opt-in' approach. This approach is commonly used in the recruitment of patients into research studies and involves only contacting patients who have indicated that they would like to be actively involved (Wilkie, 2001). It is the favoured recruitment method by research ethics committees who regard it as more acceptable than assuming that individuals want to participate. Patients were approached by the health professional who was delivering their psychological therapy. They were provided with a study recruitment pack that included an invitation letter accompanied by a study information leaflet with an attached expression of interest form (see Appendix 6).

Changes to Recruitment Strategy

This initial recruitment approach, however, did not prove successful and only a small number of participants in the first few months of recruitment indicated they would like to participate. To try and overcome these difficulties additional meetings and/or discussions were held with the primary contact at each of the sites to try to identify what the issues were and to identify different recruitment methods that may be applicable. Two of the sites stated that this method was most convenient for them and that they would continue to use it. At one site they suggested identifying suitable patients in their database and inviting them via a mass mail-out. Thus this strategy was adopted by this site, and potential participants were sent a study recruitment pack directly from the mental health team at that site.

Patients who returned the reply form were contacted by the researcher by the method that they had stated was most convenient (e.g. phone, email or post). All potential participants were given the opportunity to ask questions. If they wished to participate a date and time was arranged for them to take part in a single interview. The most convenient place for the interview to take place was also agreed at this point e.g. at the patient's home or GP surgery. For the initial three interviews a time was arranged to meet them in person to conduct a face-to-face interview, for the remaining interviews that were conducted by telephone a suitable time to call the participant was arranged.

Consent

At the interview the researcher discussed the study briefly and provided the participant the opportunity to ask any questions. All participants were assured that taking part was voluntary and that they could withdraw at any time. For all interviews, whether conducted face-to-face or by telephone, a discussion took place as to whether they were happy with the interview being audio-recorded. If they agreed for the recording to take place then they were also informed that if at anytime throughout the interview they would like the recording to be stopped that they were just to inform the researcher. As people suffering from mental health problems can be considered to be a vulnerable group it is important that the researcher can identify with and respond in an empathic manner, stopping the interview if needed, if and when any patient becomes distressed. In line with ethical procedures an identified protocol was produced to ensure that support was in place for any patient and also the researcher themselves in the event of distress arising.

For face-to-face interviews a small digital recorder was placed between the researcher and participant, and in telephone interviews the digital recorder was attached to a telephone recording device that linked directly to the researcher's office telephone. Recording equipment was not turned on until consent to record was given. Prior to recording, participants were asked if they consented to anonymous direct quotations being used in the reporting of the data. They were also informed that the health professional would not be informed of their subsequent involvement in the study. Patients were informed, however, that if they wished to discuss any aspects of the study with them that they were free to do so. All who agreed to take part signed the consent form (see Appendix 7). Participants were also asked to sign a second consent form which they were to keep for their information. Patients interviewed by telephone were sent consent forms following initial contact along with the demographic questionnaire. The researcher ensured that a signed consent form was returned before the interview.

At the time of consent, participants were allocated a study identification number. Only one list matching these identification codes to the participants' details was kept in a password-protected access database on the researcher's computer that was housed in a locked work-based office. Copies of consent forms were kept in a locked filing cabinet in the researcher's office separate from any interview data.

Study 2a: Exploration of Health Professional Decision-making through Semi-Structured Interviews

Overview

This study involved qualitative work using in-depth interviews to explore the decision-making of health professionals in the stepped care model.

Methods Adopted in Health Professional Study

In comparison to the patient study, it was thought that multiple methods were required to capture the differing elements of health professional decision-making. While exploring health professional decision-making experiences, the way in which they actually make treatment decisions was also considered to be of vital importance. Health professionals make decisions about multiple patients during the course of their work, and therefore their experience lent itself to the incorporation of a process-tracing task to explore consistency and variation across decisions.

Thus in exploring health professionals' decision-making thoroughly two different qualitative methods were adopted within the interviews:

    i.   to explore their decision-making experiences within the stepped care model through the use of semi-structured interview questions and asking them to draw on decisions that they have made recently about specific patients.

    ii. to further explore these experiences by asking them to complete an AIS think-aloud exploring what kinds of information health professionals need to make a decision and do they prioritise certain types of information over others (this is presented in Chapter 6)

The focus of the interview questions was determined from the review of mental health and stepped care literature presented in Chapters 1 and 2. All interviews were conducted face-to-face.

Interview Question Content

Health professional interview questions focused on three main issues:

    i.   how professionals make decisions about assigning patients to a treatment

    ii.   how professionals make decisions to 'step-up' a patient

    iii.   how patients are involved in this decision-making process

See Figure 14 for the topic guide used in the health professional interviews

Figure 14: Interview topic guide used in health professional interviews

INTERVIEW TOPIC GUIDE

TOPIC AREAS TO BE DISCUSSED:

➢ **General information about participant including**
  Job role
  Experience of working with patients with mental health problems

➢ **Explore how patients are assigned to a treatment**
  - investigate information that is considered e.g. service/patient factors
  - ascertain if measurements used
  - establish how decisions are made e.g. alone or in a team

➢ **Explore how decisions are made about moving patients between steps**
  - investigate information that is considered e.g. service/patient factors
  - ascertain if measurements are used
  - establish how decisions are made e.g. alone or in a team

➢ **Explore decision-making preferences and experiences at various treatment stages**
  Explore preferences for involvement in treatment decision-making:
  - medically led
  - patient led
  - collaborative model

➢ **Ascertain information providing at key decision-making stages**
  Explore:
  - what kind of information is provided to patients
  - timing of information
  - amount of information
  - format of information

➢ **Is there anything I have missed in our discussion that you consider to be important?**

The purpose of the topic guide was to guide the interview process and to ensure that the identified issues were discussed. At the outset of each interview health professionals were asked about their job role and experience of working with patients experiencing mental health problems. This was designed to ease them into the interview and to gather information that would help understand the context of their decision-making.

The topic guide was evaluated following the first few interviews to determine whether any amendments were necessary. In discussions with supervisors it was agreed that addressing issues of information provision at the end of the interview was somewhat disjointed and was integrated into the interview as a whole.

Last Five Cases

In addition to the issues covered in the topic guide, health professionals were also asked to identify and discuss the last five cases that they had seen, describing the treatment decisions that they made and the reasoning behind them. During this task the researcher allowed the health professional to speak freely and only asked questions in situations where clarification was required. The purpose of this exercise was to gather more information about how decisions were being made in the context of their service by making them reflect upon decisions that they had made in a retrospective manner. It provided a counterpoint to the methods used in study 1b (AIS think-aloud task as outlined in Chapters 3 and 8) where, although there was less control over the information presented and gathered, asking about specific recent experiences, rather than general principles of decision-making served to make the interviews more concrete and thus more generalisable.

Pilot of Last Five Cases

To evaluate the usefulness of asking health professionals to reflect on decisions that they had made in practice a small pilot with four health professionals (three GMHWs and one GP), not connected to the actual study sites, was conducted prior to the interviews. The observations, evaluation and potential amendments that could be made to enhance this part of the interview are detailed in Table 5.

Table 5: Last cases - observations, evaluations and potential ammendments

Observations from Pilot	Evaluation of Task & Possible Amendments Required
Researcher Observations	
This exercise went well but there were times where more information could perhaps have been collected	This task may therefore be enhanced by some additional questioning at the end to clarify points or obtain further information
Task went well, professional highlighted a number of issues that are important when making treatment decisions – covered work already done and things that were in progress	Asking about the health professional's last cases appeared to capture the changing nature of decisions over time well
Difficult to judge if professionals were discussing the patients that they had seen most recently or if they being selective in their choices e.g. providing a sample of those patients that were particularly memorable. Professionals did indicate that it was often difficult to remember who they had seen recently	Although there are issues surrounding this it is difficult to avoid – perhaps need to think of some strategies e.g. at the start of the interview state that it may be useful for the health professional to bring their diary with them so they can easily identify recent patients
Health Professional Observations/Feedback	
Professional said they found it difficult to think of cases 'on the spot'	Perhaps warn professionals before hand that I will be asking about this, however may introduce bias in reporting. May be best to inform just before the interview starts so they can bring their diary
Professional felt that this was a more natural task and found it easier talking about the decisions they made and the reasoning behind them. Professional stated that this was because the other methods involved an element of guessing as actually meeting the person adds something else	It seems that this task is beneficial in the sense that professionals are discussing previous real experiences. It does, however, include an element of bias – health professionals often identified patients that they had seen over a higher number of sessions than may be the norm - it may therefore perhaps better accompanied with another prospective decision-making task

Demographic Questionnaire

Health professionals were asked to complete a short demographic questionnaire, (presented in Appendix 2) following the interview. Questions were focused on determining their job title/formal role, the number of years they have worked in primary care and in mental health specifically. They were additionally asked to provide details of any psychological treatments they delivered to patients.

Health Professional Sample

Within qualitative research the number of participants required is not often determined rigidly at the outset but is established as the study progresses. It is very much dependent on when no new themes or explanations are emerging from the data (Marshall, 1996). This process was defined by Glaser (2001) as saturation:

> *'the conceptualisation of comparisons of these incidents which yield different properties of the pattern, until no new properties of the pattern emerge.'*

The number of interviews conducted, was therefore flexible to maximise the depth of enquiry and was also dependent upon a sample size sufficient for reaching saturation of responses.

Mental Health Professionals

In recruiting mental health professionals an approach involving a mix of purposive, and snowballing sampling was adopted. Purposive sampling involves choosing individuals on the basis of particular features or characteristics which are viewed as being central factors to the study's aims (Mason, 2002; Patton, 2002). For the purpose of this study while a strict purposive sampling frame was not adhered to, mental health professionals were recruited based on their role in stepped care. Of most importance was obtaining a sample at each site that involved health professionals directly involved in decision-making at different 'steps' of the model. These included mental health professionals in various roles within the model e.g. those delivering low and high intensity therapies, of varying gender, age and experience of working in mental health. As McLeod (1999) emphasised:

> *'The challenge in qualitative research is to ensure that each person interviewed or included is 'theoretically interesting' in that they represent as far as possible a different aspect of the phenomenon being studied.'* (p79)

It has been established that the sites included three or four 'steps' and the aim was to include approximately five to seven health professionals from each site to allow health professionals at different 'steps' to be recruited. However, it became apparent that as not all of the sites had fully implemented IAPT, some professional groups, for example high-intensity workers, were not present. Therefore it was agreed that at sites where specific

mental health professional groups were not present that ensuring that a representative sample from that site would be sufficient.

General Practitioners

As contacts at each site were situated within the PCT mental health teams there was little opoportunity to identify GPs who may be interested in taking part in the study. Thus, in order to achieve a sample of GPs a snowballing approach was implemented. Snowballing sampling involves identifying potential participants by asking those already involved in the study if they can identify individuals who they anticipate would be able to give an opinion on the topic. Thus mental health professionals who had previously participated were approached and asked if they could identify any GPs within their PCT who may wish to participate. Each site was able to readily identify at least one GP who was subsequently approached by the researcher or by the mental health professional who had identified them. Following their participation in the study initial GPs were then asked to identify any other GPs. Unfortunately, whilst this approach initially appeared successful, after recruiting five GPs into the study it was deemed unsuccessful. To try to overcome this problem another strategy was employed by identifying GPs within each of the PCTs through PCT websites and inviting them to participate via invitation letter. Particular attention was paid to those GP practices that provided mental health services. Unfortunately this recruitment strategy was unsuccessful and no additional GPs were recruited as a result

Recruitment

Mental Health Professionals

Handouts outlining the study rationale, aims, objectives and methods were provided to mental health team members at site meetings held to introduce the study. Following discussions and/or a formal presentation, team members were given the opportunity to ask any questions. Health professionals were informed that, being a participant involved taking part in a single interview and potentially assisting with patient recruitment. All potential participants were given a study recruitment pack by the researcher personally or via a team leader or a colleague where meetings were not held with the whole team. Within the packs an invitation letter was accompanied by an information leaflet with an attached expression of interest form (see Appendix 3). A pre-paid envelope was also included.

If health professionals chose to assist with the recruitment of patients a discussion was held about the most appropriate means of doing so to ensure that the impact upon them was minimal. All sites identified that the most appropriate way would be to give patients packs at the end of treatment sessions. All thought that this would give them the opportunity to inform the patient of the study. It was agreed that in order to maximise the potential of exploring patient experiences of decision-making that patients who had been 'stepped-up' or were about to be discharged would be targeted. Health professionals who returned the reply form were contacted by the researcher by phone, email or post. All potential participants were given the opportunity to ask any questions.

General Practitioners

GPs were approached to take part in a number of ways that was dependent on the way in which they were sampled. For those identified through snowballing techniques they were approached by the GP who had identified them or directly by the researcher via email or post. GPs identified through PCT websites were approached by post. In all cases GPs, like mental health professionals, were provided with a study recruitment that contained an invitation letter, information leaflet with an attached expression of interest form and a pre-paid envelope. GPs were not asked to be involved in the recruitment of patients.

Consent

At the interview the researcher provided each participant with the opportunity to ask questions. All participants were assured that taking part was entirely voluntary and that they could choose to withdraw at any time. A discussion also took place as to whether they were comfortable with the interview being audio-recorded. If they agreed to be recorded, they were informed that if at anytime throughout the interview they would like the recording to be stopped that they were just to inform the researcher. Permission was sought to use anonymous direct quotations in the reporting of the data. All who agreed to take part signed the consent form (see Appendix 4). Participants were also asked to sign a second consent form, which they were to keep for their records.

At the time of consent, participants were allocated a study identification number. Only one list matching these identification codes to the participants' details was kept in a password-

protected database. Copies of consent forms were kept in a locked filing cabinet in the researcher's office separate from any interview data.

CHAPTER SIX: **STUDY 2B - AIS THINK-ALOUD METHODS**

Introduction

This chapter will provide a description of the pilot study conducted to identify the most appropriate process tracing methods adopted for study 1b. There will be a discussion of the rationale for the pilot study, details of the development of the scenarios used, the methods piloted and an overall evaluation. Following this a description of the chosen method - AIS think-aloud task – will be outlined in addition to the process of data collection and data analysis.

Aims

As detailed in Chapter 3 a number of techniques exist that can be used to measure the process by which people make decisions. The purpose of including a process tracing task within the study was to look at decision-making using an approach that is less focused on the context, as such information is captured in the qualitative interviews, and more focused on understanding more about the manner by which health professionals make their decisions.

Process Tracing Pilot

Pilot studies can be used to pre-test or try out specific research instruments or methods (Baker, 1994). There are a number of advantages of conducting pilots such as testing the adequacy of research instruments, to allow for selection of the most appropriate method to be adopted and to reduce the number of unanticipated problems in applying particular methods or measures. Furthermore they are a vital part of good study design (van Teijlingen & Hundley, 2001) and important in ensuring methodological rigour (Lancaster *et al.*, 2004).

In order to choose the most appropriate process tracing method(s) to include in the interviews with health professionals a pilot was first conducted to test two of the identified techniques – think-aloud and AIS.

With particular relevance to using AIS methodology, Huber et al (1997) stressed the importance of conducting a pilot for two main reasons:

i.   to ensure the minimal scenario description is appropriate, applicable and optimal
ii. to identify as many of the possible questions that participants may ask during the task to allow for the preparation of answers to allow for the probability of unanticipated questions being reduced and thus preparing the researcher to a greater extent.

As the method is being applied for use within decision-making in a different field to that which it was developed, and is less structured than the study by Huber et al (2001) where participants were presented with a list of questions that they could ask the experimenter, rather than freely asking questions, conducting a pilot will additionally highlight whether it is suitable in terms of addressing the research study's aims.

The main aims of the pilot were:

i.   to test the appropriateness of each method for exploring health professional decision-making
ii. to try out the questions/ instructions for each method
iii. to test the appropriateness of the vignettes developed for the AIS think-aloud task
iv. to help to ascertain what types of qualitative questions may be asked in the other part of the interview with health professionals that forms study 1a and therefore adjust anything if necessary

The pilot study was conducted with three mental health workers and a GP from sites separate from the main study, but that had also adopted stepped care. Each health professional was asked to complete a number of tasks from the two process tracing

methods. The order that the tasks were presented was varied in order to determine whether there were any potential response effects resulting from the order the tasks were completed.

Development of Patient Scenarios for Pilot

Nine patient scenarios were developed for the mental health professional process tracing tasks. Each was designed to reflect a genuine patient encounter, although none were based on actual mental health patients. A mental health clinician was consulted during the development process in order to ensure the vignettes were realistic reflections of patients who present in primary care.

As the purpose of the AIS task was to determine the amount and type of information health professionals gather to make their decision the scenarios were limited in the nature of the content provided. The aim of this was to ensure that while there was ample information provided to give the health professionals something to work with, there was not too much resulting in little investigation of the patient's problem. The initial vignettes developed were therefore summarised to include only minimal aspects of the patient's presentation and problem, and none of these scenarios provided details of the severity of the problem.

The drafted vignettes were circulated to supervisors to establish whether they were appropriate and were reflective of the types of patients that would be presenting at the health professional sites. In addition to the development of the scenarios a comprehensive list of potential questions that may be asked by the health professionals during the AIS task and the responses that would be provided was prepared for each individual scenario. Please see Appendix 10 for an example of the vignettes and shortened AIS think-aloud scenarios.

At the outset of each scenario the patient's gender and age were presented. Five of the vignettes involved a female patient, whilst the remaining four were male. Ages of the patients varied from 24 to 72 years old. Information presented in addition to these factors differed between scenarios to determine if the presentation of certain types of information, at the outset, result in a particular decision or different patterns of questioning. Such information included the length of the patient's problem, the symptoms experienced, the diagnosis or risk factors. Some scenarios stated the diagnosis of the patient whilst others

did not. Outcome measure scores were developed for all of the scenarios but were provided at the end of the scenario for only half that were presented to the health professionals to look at whether presenting this information had a potential impact on the decision-making process.

Pilot Procedure

The following was asked of the health professionals for the two tasks:

i. Vignettes – Think-Aloud:

Participants were given a warm-up exercise to get them used to thinking aloud as this is not a method that we use routinely. This exercise was important to ensure the health professionals' understanding of the task and to maximise the potential data that would be subsequently collected. The warm-up exercise involved two parts – in the first the researcher explained the task and gave the health professional an opportunity to ask any questions if they needed to clarify anything, a few warm-up exercises then followed:

Explaining the Task

The researcher explained to the health professional that they were going to be presented with a series of short exercises and that they wanted them to talk aloud whilst completing them. They further explained that what they meant by thinking aloud was basically for them to say aloud everything that they would normally say to themselves or that they were thinking about silently whilst completing the exercises. The researcher emphasised that they were aware that this is not something you would normally do in everyday life but that its purpose was to help them to understand what they were doing, thinking and why they might make certain choices and to make them feel more comfortable with talking aloud.

The researcher reassured the health professional that they did not have to be concerned about making sense, and that the researcher was simply going to listen to what they had to say. It was also stated that if they were quiet for any period of time that the researcher would remind them to keep talking with a simple prompt such as 'continue', 'please keep talking' or 'don't forget to tell me what you are thinking'.

The researcher then checked that the participants understood what they were being asked to do and whether they had any questions. Participants were then asked to take their time, and to consider carefully all the information that they were presented with.

Warm-Up Exercises

The health professional was then presented with a number of cards with letters or numbers on them and was asked to do the following whilst thinking aloud:

1. Please put these letters into alphabetical order: *A G C E*
2. Please put these letters into alphabetical order: *D R P S*
3. Please add these numbers together: *3 8 5 10 6 2*
4. Please add these numbers together: *11 21 8 4 30 2*

They were then given a list of numbers and were asked:
What number comes next in this sequence *4, 7, 10, 13 ?*

Finally the researcher asked the health professional to tell them, whilst thinking aloud how many windows they have in their house. This task completed the warm-up exercises.

Following the warm-up exercises, health professionals were familiarised to the process of thinking aloud, they then completed the main task. They were given six different vignettes, one at a time, which presented some detailed information about a patient that they were to make a treatment decision about (half of which outcome measures were provided and half where this information was not). Whilst in the process of making their decision they were asked to 'think-aloud' so that their thoughts, views, opinions and beliefs about the decision could be collected.

ii. AIS Task

For this task participants were presented with three shorter versions of the vignettes used in the think-aloud task and, following the principles of the AIS method (as outlined in Chapter 3), they were asked to make a decision about the patient's treatment. The researcher informed them that they could ask for further information about the patient

should they require it. In instances where health professionals did ask for further information the researcher provided only the information asked for which had been prepared in advance to ensure consistent answers. If a question was asked that the researcher had not anticipated, and therefore not prepared in advance, a response was given and was recorded to ensure the same response was given, if required, to other participants.

The vignettes given to the health professionals for each task were different to those presented in the think-aloud to ensure that they had not previously been familiarised with the case presented. Additionally, the order in which health professionals were asked to complete the tasks was alternated to minimise any potential order effects.

Following the completion of the tasks each of the methods piloted were evaluated and verbal feedback from the health professionals that took part was gathered. There were a number of positives and negatives about each method. The observations and evaluation of the two methods piloted are detailed in Tables 6 and 7. In addition thought was given as to what amendments may be made in light of the observations made.

Table 6: Observations and evaluation of vignettes and think-aloud task

Observations from Pilot	Evaluation of Task & Possible Amendments Required
Researcher Observations	
Task quite short on occasions	Ensure prompts are being used when necessary to keep flow going. Perhaps when professional stops ask if there is anything else important that they would like to add
Think-aloud skills during task often not used	Again, ensure that prompts are used efficiently and effectively throughout task
Sometimes professionals struggled with think-aloud	Ensure clear information is given before task to maximise think-aloud aspect
Health Professional Observations/Feedback	
Vignettes at times seemed rather complicated	Professionals stated that this reflects reality and that the problems that they have with them in this task is not unusual. Therefore no real need to amend
One professional stated that the vignettes presented a number of social, biological and psychological factors that could lead to a number of different treatment decisions and that there is a need to understand these first	By presenting all of these it is harder to tease out if there are particular factors that are more important to the professional when making a decision. Perhaps need to limit this (maybe AIS is more appropriate here)
Professional stated that they felt that they had to make a decision based on ALL of the information that was presented when in reality this may not be the case	Again, this is a problem with this task – it is very difficult to determine exactly what professionals attend to and do not attend to
Professional mentioned that they were not necessarily voicing everything as they were having some 'politically incorrect' thoughts e.g. this is just normal for our PCT	Important to discuss issues of confidentiality etc and stress need to voice everything whether they think it is appropriate or not

Table 7: Observations and evaluation of AIS task

Observations from Pilot	Evaluation of Task & Possible Amendments Required
Researcher Observations	
Task went better than anticipated	
Need to ensure familiarity with cases and responses to respond to professional questions quickly and efficiently	Improve layout of already prepared responses. Read over all cases directly before interview takes place
On occasion professionals would be presented with more information than they had asked a question about	Need to ensure only giving information that is asked for
Although was useful in determining what types of information health professionals were interested in collecting it was not clear how they processed that information and thus how the collection of this information led to a treatment decision	Incorporating a think-aloud element into the AIS task may assist with collecting more detailed information
Task took longer to complete than was anticipated	Need to think about how many vignettes to present to avoid health professional burden but also to gather sufficient amounts of data
Health Professional Observations/Feedback	
Health professional stated that the small vignette presented here was similar to the information presented in a GP referral letter	Observation highlights that this task is face valid
Professional did not particularly like task as was always concerned if she was asking the right questions and that it seemed a bit unnatural	Important to state at beginning that there are no right answers and perhaps that questions may reflect the type that you would ask a patient or maybe a colleague to inform your decision-making. This may make the health professional feel more confident and comfortable about the task
Professional stated the task was harder than the others but that it was more like what they do in reality – much more information is collected at assessment	Observation highlights that this task is face valid
Professional stated could ask lots of questions and could go on forever	In reality this is not what happened for any of the professionals who took part

Evaluation of Pilot

Overall, the pilot was extremely useful in identifying how using such methods could complement the qualitative health professional interviews. One of the most important overall observations related to the presentation of outcome measures scores, indicative of the patient's problem severity level. In the vignettes used some presented the outcome measure scores, and others did not. Whilst no noticeable differences between the vignettes showing outcome measure scores and those that did not were found, one health professional stated that they considered these measures to be more of a service requirement and that they are often not a reliable measure of a patient's problem. Another health professional stated that by displaying the scores it helped to confirm their thinking by helping to suppress other things and look for what can be managed. From these findings it was decided not to include outcome measure findings in the study vignettes to better determine the influence that they have on health professional treatment decision-making. Furthermore, the cases presented to the health professionals in both tasks focused on patients who were presenting at initial assessment, it was identified that it may be important to adapt some of them to include patients who have previously started treatment.

The pilot also provided information to inform the qualitative interviews. It was identified that it may be of interest to ask the following direct questions in order to better understand the decision-making process and thus they were incorporated into the interview schedule:

- Can you describe factors that you think are most important to consider when making decisions about a person's treatment?
- What makes you decide when to stop treatment?

Following piloting, it was considered that the AIS task would be the most appropriate process tracing approach to meet the aims of this study. However, one of the most important observations made during the pilot was the fact that the AIS task as it stood was limited in the amount of information about the process of decision-making that could be collected. This observation was similar to that of Huber et al (Huber et al., 1997) who, as identified in Chapter 3, stated that the AIS task may be more beneficial when complimented by think-aloud methods, thus resulting in the task being a bit more conversational in style. In discussion with supervisors it was therefore decided, to merge

both the think-aloud task with the AIS task to produce one that would provide more information about how information is processed when within decision-making situations. Thus, within the interviews with the health professionals it was decided that in order to capitalise on the data collected from the more formal semi-structured interview health professionals would be asked to complete an AIS task whilst adopting think-aloud techniques that would assist with revealing how they are processing or evaluating the information.

Development of Scenarios for Study

Following the pilot of the two methods and the decision to use a combined AIS think-aloud task, scenarios were selected from the ones used in the pilot in-line with the observations made. It was decided that five scenarios would be appropriate. In making the decisions about the selection of the scenarios, discussions were held with supervisiors, in particular with the clinical supervisor, about the characteristics of patients and the symptoms they were presenting with. The health professional feedback gathered in the evaluation of the pilot was additionally drawn-upon when making these decisions. Again, each scenario was designed to reflect a patient encounter with face validity among health professionals.

At the outset of each scenario the patient's gender and age were presented. Two of the vignettes involved a male patient and the remaining three were female. In addition, two of the vignettes presented patients who were in the process of receiving ongoing treatment whilst the other three were attending their first appointment. Other factors included the duration of the patient's problem, the physical, behavioural or cognitive symptoms experienced, diagnosis, risk factors, length of time health professional had been seeing the patient, indication of any improvement in symptoms, the trigger, social circumstances such as information about the patient's family, length of time experienced the problem, impact and evidence of drug and alcohol use.

The drafted vignettes were circulated to supervisors to establish whether they were appropriate. In particular feedback from one clinical supervisor was sought to ensure face validity.

AIS Scenario Labels

The five scenarios used within the task are presented in Figure 15. For ease of reporting, and to aid the understanding of the findings, they have been labelled and these labels shall be referred to throughout.

Figure 15: Patient scenarios used in AIS think-aloud task

AIS1 - DEPRESSION (ONGOING TREATMENT) SCENARIO

A 65 year old male who you have been seeing once a month for eight weeks attends an appointment. He has made no significant improvements over the two months and still describes feelings of lack of motivation, low mood and poor sleeping and eating patterns.

AIS2 - STRESS/RAPE SCENARIO

A 36 year old female attends an appointment with you following a referral from her GP. She says she is suffering from stress, particularly being in social situations. She describes how these feelings started six months ago following an incident when she was attacked and raped.

AIS3 - WORTHLESSESS SCENARIO

A 44 year old Asian man, who works as an administrator in a local authority sports centre is referred to you from his GP. He lives with his wife and two young children in a nearby council house. When he comes to see you he is tearful and when asked describes feelings of worthlessness.

AIS4 - OCD SCENARIO

A 42 year old mother of two children with a twenty year history of obsessions and compulsions who you have been seeing for 6 weeks attends an appointment. She originally showed signs of improvement, however more recently her problems have gone back to the way they were when you first started seeing her. They are significantly interfering with her life.

AIS5 - RISK/DRUG AND ALCOHOL SCENARIO

A 28 year old Chinese female attends an appointment. She has suffered from panic attacks, poor impulse control and occasional self-harm. There are indications that she may also be abusing drugs and alcohol.

The Process of Data Collection

Participants were presented with the five short scenarios and asked to make a decision about the patient's treatment. The researcher informed them that they could ask for further information about the patient should they require it. Thus, prior to conducting the task, a comprehensive list of potential questions that could be asked by the health professionals and the responses that would be provided were prepared for each individual scenario. In instances where health professionals did ask for further information the researcher provided only the information asked using prepared answers to ensure consistency. If a question was asked that the researcher had not anticipated, and therefore not prepared in advance, a response was given and was recorded to ensure the same response was given, if required, to other participants. Responses prepared for the depression (ongoing treatment) scenario are presented in the Table 8 below:

Table 8: Responses to possible questions asked by mental health professionals about the depression (ongoing treatment) scenario

Possible Question	Response
Possible cause/trigger	He retired from a demanding job in the fire service
Additional symptoms	Cognitive - he feels like he has lost his self identity
Length of problem	6 months
Severity	Using an outcome measure – mild depression
Risk	He has never had thoughts of ending his life but often feels that life is not worth living.
Previous episodes/ Past history	Was prescribed antidepressants from his GP 4 months ago when he first presented in primary care. he is still taking them Outcome – he says that they help him get up in the morning but doesn't feel that the benefits are substantial
Patient needs/expectations	Doesn't know what he can do to make himself better
Patient preferences	he would like to see someone who can help him to get motivated again
Social circumstances	His wife and all his friends are still working and therefore he spends most days on his own.
Social support	Due to the way that he is feeling he has noticed that his relationship with his wife is suffering. She is extremely supportive but he says that it is very difficult to talk to her about the way he is feeling as he doesn't want to burden her with his problems.
Personality	Appears agreeable and cooperative
Substance abuse	He has noticed that he is drinking alcohol much more than he used to.
Medicine	Antidepressants Length of time – 4 months

See Appendix 11 for an example of the responses provided for all scenarios.

Data Analysis

The process of analysing the data collected in the AIS think-aloud task is detailed extensively in Chapter 9. In brief, data was tabulated in matrices, one for each scenario, to enable for the exploration of the numbers of questions asked, types of questions asked, order in which information was gathered and decisions made to be explored effectively using quantitative approaches. Additional information provided by the mental health professionals during the think-aloud aspect of the task lent itself to qualitative analysis. Within the matrices such data was included as free text to ensure this data was recognised alongside the quantitative data. Where appropriate, it was also incorporated into the analysis of the qualitative health professional interviews within study 2a (Chapter 8) using Framework to manage and summarise the data, as described in Chapter 4. Data collected from the task was therefore analysed by both qualitative and quantitative means.

Tashakkori and Teddlie (2003) described such a method of extracting quantitative data from data collected by qualitative means as multistrand conversation mixed method design. Inferences can then be made on the two types of data (qualitative and quantitative). The process described by Tashakkori and Teddlie is distinct from mixed methods designs in which multiple questions are asked by collecting and analysing data through qualitative *and* quantitative means. In multistrand conversation mixed method designs only one type of data is collected and analysed by means of qualitative *or* quantitative methods. Inferences made are developed/aided by complementing the main approach to the collection and analysis of data (qualitative or quantitative) with another approach. This process is outlined in Figure 16.

Figure 16: Multistrand conversational mixed method design (Tashakkori & Teddlie, 2003)
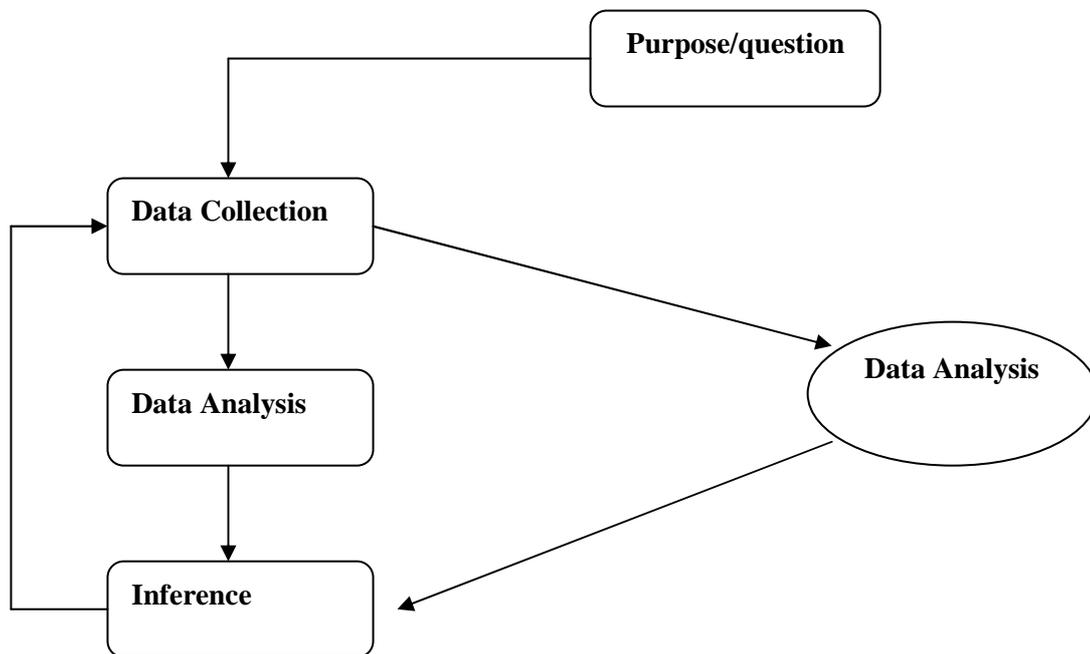
Such an approach fits with the methods adopted within this study, where a qualitative methodological approach is used to generate data about the process of prospective health professional decision-making but that the data generated is better understood by applying a quantitative data analysis approach as well. These principles were thus applied to the analysis of the data generated within the AIS think-aloud task.

A separate AIS think-aloud task was completed with GPs that took part in the study. For this task as GPs are concerned with a different level of decision-making different scenarios were used. However, there were substantial problems recruiting GPs into the study and only a small sample size was achieved (n=5). Strategies were put in place to try and improve GP recruitment such as sending out invitation packs in the post to GPs within the identified PCTs, a number of these GPs replied stating that they were not interested in taking part, while the majority failed to respond at all. For these reasons, and due to the fact that the main aims of the study were to explore what treatments patients get, not necessarily whether they were referred to mental health services, it was agreed, in discussion with supervisors, that the analysis of this data would not be conducted.

CHAPTER SEVEN: STUDY 1 – QUALITATIVE STUDY WITH PATIENTS

Introduction

The findings from the study presented in this thesis will be discussed in four interconnected chapters. This first chapter will present the findings from the patient in-depth qualitative interviews, which will be followed by the findings from the health professional in-depth qualitative interviews in Chapter 8. Chapter 9 will then present the findings from the health professional AIS think-aloud task. Finally, Chapter 10 will present a synthesis of the findings.

There are three key parts to the chapter. First, contextual information on the study participants is provided, followed by presentation of the key themes from the interviews, and a discussion of the findings.

The Study Participants

Recruitment took place from November 2008 to November 2009. There were some initial difficulties, resulting in slow recruitment. Additional strategies were initiated to try to overcome these which included the researcher attending PCT mental health team meetings to try to improve uptake. At one site it was suggested that a mass-mail out to suitable patients would be the best strategy to adopt. Therefore, at this site suitable patients were identified in the electronic patient records system by a PCT employee and invitation packs were sent directly to patients. This latter strategy proved successful and as a result the entire patient sample was recruited from this site only.

Fourteen patients agreed to take part in the study. Interviews were conducted face-to-face and by telephone and lasted between 25 to 89 minutes. Summary demographic data for participants is detailed in Table 9.

Table 9: Demographic data for the patient interview participants

ID	Age	Gender	Ethnic Origin	Marital Status	Highest Educational Qualification	Employment Status	Currently taking medication	Taken medication in the past	Steps accessed in current episode	Received psychological therapy in the past	Type of psychological therapy received[4]
Patient 01	40	Male	White	Married/co-habiting	GCSE A-C	Employed full-time	Yes	Yes	Step 2 – Step 3	Yes	CBT, BA
Patient 02	57	Female	White	Single	Higher education qualification	Employed full-time	No	No	Step 2 – Step 3	Yes	Counselling, anxiety management
Patient 03	34	Female	White	Single	Degree	Employed part-time	No	No	Step 2 – Step 3	Yes	CBT, graduate mental health worker
Patient 04	52	Female	White	Widowed	Higher education qualification	Self-employed	Yes	No	Step 2	Yes	Rehab for drug addiction
Patient 05	50	Male	White	Divorced	No formal qualifications	Unemployed	Yes	No	Step 2 – Step 3	No	
Patient 06	60	Male	White	Divorced	No formal qualifications	Unemployed	Yes	No	Step 2 – Step 3	No	
Patient 07	58	Female	White	Married/co-habiting	Higher education qualification	Housewife	Yes	Yes	Step 2 – Step 3	Yes	Psychiatrist, psychologist, mental health worker, psychotherapist
Patient 08	60	Female	White	Widowed	Degree	Retired	No	Yes	Step 2 – Step 3	Yes	Psychotherapy
Patient 09		Female	British - black African	Single	A-Levels		Yes	Yes	Step 2	Yes	CBT
Patient 10	42	Female	White	Single	No formal qualifications	Unemployed	No	No	Step 2	Yes	Low intensity
Patient 11	55	Male	White	Divorced		Unemployed	No	No	Step 2 – Step 3	No	
Patient 12	26	Female	Asian	Single	Degree	Self-employed	Yes	Yes	Step 2	Yes	For panic disorder
Patient 13	32	Female	White	Single	Degree	Employed full-time	Yes	No	Step 2	No	
Patient 14	32	Female	Mixed - white Asian	Single	Degree	Student	No	No	Step 2	Yes	counselling services

BA – behavioural activation; CBT – cognitive behaviour therapy; GSH – guided self help; LI – low intensity intervention

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[4] Psychological treatments received as described by patients

Themes from Patient Interviews

Using the principles of Framework analysis, five main themes and several sub-themes were identified. These are presented in Table 10.

Table 10: Conceptual framework outlining the main themes and sub-themes from patient interviews

Main Theme	Sub-themes
1. Expressed needs and expectations	1.1 Individual patient needs 1.2 Patient expectations 1.3 Information provision
2. Management of problem a) Personal decision-making process	a) Personal Decision-making Process i. Involvement ii. Choice
b) Patient-health professional relationship	b) Patient-Health Professional Relationship i. Patient-GP relationship ii Health professsional responsibility to patient iii. Therapeutic alliance/relationship iv. Confidence and trust in health professional judgement
c) Treatment process	c) Treatment Process i. 'Stepping-up' decision-making ii. Signposting iii. Outcome measures
3. Service-related issues (positive and negative)	i. Accessibility of treatment ii. Service resources iii. Waiting lists iv. Continuity of care
4. Views of step two treatment	i. Conceptualisations of step two ii. Negative views of step two iii. Positive views of step two
5. Outcome	i. Perceptions of a good outcome ii. Positive outcomes iii. Negative Outcomes

Five thematic charts were developed for each of the main themes and associated sub-themes. An example can be found in Appendix 9.

A discussion of these themes and sub-themes generated from the data will now be presented using this framework, which will include the identification of any relevant inter-relationships between these.

Theme 1: Expressed Needs and Expectations

Individual Patient Needs

Patients identified the importance of having their needs met and receiving assurance that these needs will be recognised by the health care system. This included the tailoring of treatment to suit the individual needs of the patient.

> *I suppose the information that I wanted – what I needed was to know that the, the kind of like there was somebody who would see me, you know like the psychologist or whatever, that was the information that I needed but the one I wanted was available, and in – and in the way that I would, would sort of need. So it was kind of like, can you tailor it to my needs, because I think particularly with mental health issues, they need a very, very individual need.*
>
> (Patient02, female, steps 2&3)

One patient recognised the level of treatment need that they had, but acknowledged that their level of need may change over time:

> *The preferred treatment that I am getting that was recommended by [GMHW] and now [Psychologist] has taken over I think [it] is a far...far better thing...for me personally. I mean they could turn around and say well... now we are sticking you in the big house and you know...But I don't feel that I need to go... I don't think I need to be put into there yet... I don't know... It might progress and I might have to but...*
>
> (Patient06, male, steps 2&3)

Whilst recognising their own needs, patients also expressed an understanding of the fact that the types of treatments used to manage their problem may not be appropriate for other individuals and vice versa. This was discussed in relation to other people needing 'more help' than they would or that they were 'quite low in level of need' in comparison to others. One patient discussed how the service a person is receiving would have to be changed should they be experiencing additional problems or the severity of the problem was higher:

...depends what the problem is doesn't it – as to the – if somebody is very, very – very, very depressed, it depends what degree of mental health issue you have and you know, obviously there's a lot about drink and drugs and, um, whether that was a problem and if that was a problem then you – I'd have needed a different sort of service – which I think's available.

(Patient08, female, steps 2&3)

One of the specific needs that some patients discussed was the need to talk to someone about their problems. One patient identified that the opportunity to 'tell their story' was limited within CBT-based treatments that they perceived as formulaic rather than personalised.

I think the problem is, when you're in crisis, you actually need much more individualised work, you know, it's, you know, I understand that you know a certain – some element of CBT is formula, but at the same time, you know, when I then go to X [current psychotherapist], I talk to X [current psychotherapist], about the specific issues that I have, he was able to help me to look at those again in another way, in a very concentrated way, which you can't get through that service I suppose, and that's the thing that I needed.

(Patient03, female, steps 2&3)

Patient Expectations

Several patients expressed uncertainty about what to expect from the mental health service and specific treatments. For some this was because this was their first encounter with mental health services and their uncertainty related to their expectations of the duration of the treatment they would receive in terms of outcome. One patient felt that the decision to end treatment would be based on them recovering from their problem. They did not indicate awareness of any other factors e.g. service restrictions that could influence this decision:

I assumed they would be there to kind of like help you until you didn't need any help. You know got to a point where you were dealing and you could see some way forward.

(Patient13, female, step 2)

In relation to the type of treatment that they were referred to, many patients' perceptions and expectations failed to match what they then received. One individual stated that they had their 'own idea' of what they wanted to gain from treatment while some discussed this in relation to other treatments that they thought they would receive:

I initially thought when she said you can see a mental health worker, I thought it would be kind of like counselling, but I thought I would be getting some form of treatment. I thought this was actually the first step towards the treatment. But when I got there, at my first appointment and she already said to me 'I will see you three times'.

(Patient14, female, step 2)

Individuals also identified their expectations of mental health services in relation to the ability to access treatment swiftly and at regular intervals:

And when you have mental health, you do need, you do need pretty much an instant response because of your you know, the, the effect of it…I think that was what I was hoping for…and because I've got stuff early I might not need it for very long. Where to me if it's delayed, then you need it for longer because you've gone further down, whereas if you get the response immediately, then you prevent yourself from, from, from dropping further…I think the older you get, and I'm getting older, the more set it is, like with everything else, the physical is more effort, the lifting yourself up is more effort.

(Patient02, female, steps 2&3)

Information Provision

Patients varied in their levels of satisfaction about the amount of information that they received about available treatments. Patient satisfaction with the level and type of information provided to them appeared to be greater during receipt of a treatment for their mental health problem in comparison to when treatment decisions were being made:

I would say that was, that was pretty well gauged because it didn't sort of get you all, the, yet, it was a very simple thing of cognitive distortions and…I thought that was very well gauged, yeh, nothing too – but enough to, you know, start you thinking, if you've got a bit of spare time to have a quick read, but also stuff to keep for the future. And there's not, it wasn't too simple that you were like, ahh. Straight away there was something there like you saw the common distortions. I mean I was just like, oh my god. So yeh, I thought they, I thought they were, the paperwork there was very good, yeh.

(Patient01, male, steps 2&3)

The same patient also highlighted the importance of taking the individual into account to ensure that the optimal level of information is provided without providing too much:

…I think not too in depth to frighten the person off, cos I think if you gave them too much, you know…I think, I think that is a difficult one because it's too little or too much. And I think again depending on the person type, because you might frighten

them off and they could benefit from it...but it's knowing what level of information to give to the patient at the time, that's what I, that's what I would say really.

(Patient01, male, steps 2&3)

In circumstances when patients expressed dissatisfaction, this generally related to difficulties in obtaining information about where to get help:

I think from the age of 17 I knew that I needed counselling but there was none, didn't know how to get it, didn't know how to ask for it and you felt inadequate and humiliated by even, you know, wanting it or needing it or feeling that you needed.

(Patient02, female, steps 2&3)

As a result of these difficulties, many patients sought information from a variety of sources such as friends or the internet:

I've had more information from friends than I've had from actual statutory health services...There, there's a raft of things out there, and you just don't get to hear about it. It's just luck if you get to hear about it...

(Patient03, female, steps 2&3)

Several patients thought that it was the GP's role to provide mental health information. Patients felt that having such information would reduce their levels of anxiety about potential treatments. But the limitations of the role that GPs could play were recognised:

I mean I don't think there's a big conspiracy, not by any means. But I do, you know, I think, you know, GPs have to learn a lot about a lot of things and I often think they're limited on the amount of information they can get their hands on themselves.

(Patient02, female, steps 2&3)

Some patients felt that having information was an important element in decision-making, but also felt that treatment decisions had to be made quickly with limited information:

It was like which one do you want...And you are like er... this one. And they don't give you any information to go away and read and decide from or anything like that. You know you can decide in the office do you want medication or do you want these two forms of therapy to therapy...I mean it was my choice <u>not</u> to go on the medication. It was my choice to pick the CBT but I didn't really understand what I was choosing because I have never been in a position where they have been offered to me before...

(Patient13, female, step 2)

Theme 2: Management of Problem

The second theme related to the way that their problem was being managed. Discussions revealed that many of the issues prevalent in general mental health care delivery were also present in stepped care. Three distinct aspects were identified (a) their personal involvement in the process; (b) their relationship with health professionals and; (c) the treatment process itself.

(a) Personal Decision-Making Process

Involvement

The majority of patients were satisfied with the level of involvement in their treatment. Patients expressed views about involvement in decision-making in relation to process and outcome. In terms of their personal experiences some patients talked about specific aspects of their involvement. They thought that time was taken to discuss different options with them and they were provided with a satisfactory amount of information to help make a decision. The existence of a partnership between the patient and the health professional was evident in many of the discussions, with patients being aware that it is not just the health professionals that ultimately make the final decision:

> *he's [patient's GP] been very good and he's kept me consulted. Uhm, yeh, and he's always got the time… it's never hurried…he doesn't force me into a decision, but he talks about the options and shows to me in everyday, everyday, you know, something that, something that everybody can understand.*
> (Patient01, male, steps 2&3)

> *…my doctor did - he did say to me if you'd sort – leave the ball in my court, um he did say to me, well you know, it is quite likely that prescribing something could help or would you like to go and talk about it. But, I, I've done the talking option first.*
> (Patient10, female, step 2)

There was recognition of what benefits being involved brought in terms of outcomes, most of which were not symptom-related but rather issues of control, and empowerment:

> *I did feel more empowered myself, you know, I had to make these decisions about my life, you know, it was not rammed down my throat. Uhm, the power, yes I was given the power, it wasn't that somebody was going to do it for me*
> (Patient04, female, step 2)

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However, some patients' experiences of involvement in decision-making were less positive:

I influenced perhaps the direction eventually, but I don't really think that it's fair to say that I was involved in it because erm... If I was involved in it I would have been getting CBT from ages ago

(Patient14, female, step 2)

I think that is tricky because it is not really clear cut. I think if erm... I mean the only time when you are kind of are involved is if there are options. And really for me there wasn't any other options...Had the situation been different and there was various options. Yes I definitely wanted to be... I wanted to be involved in the process and then it would have had to have been a different approach.

(Patient14, female, step 2)

Other patients expressed dissatisfaction with the way the decision-making process was approached. This was evident when health professionals were perceived to have adopted a more paternalistic approach:

...you're just feeling sorry for yourself. 'Cos I said right I think I need counselling and he said, no you don't...no, no you don't need it he said...and anyway it'll take too long to arrange.

(Patient02, female, steps 2&3)

Choice

Patient experiences regarding choice varied. Many had negative perceptions about the choices offered while some felt that no choices were available. Some recognised the potential difficulties that health professionals faced when attempting to provide patients with a choice. These included service issues such as waiting lists:

And he [psychiatrist] *said that... you know do you want individual or group? I said 'Well preferably individual because I have experienced of going to groups for therapy sessions'And he said 'Well the individual the waiting list is even longer....'*

(Patient14, female, step 2)

Other patients indicated that the process of referring initially to step two limited the choices that they could make:

here, I didn't give them an option, I just, I went and told them this is what I want, and again I suppose I didn't have a choice because – well I had a choice in that she said, did I want to take anything for it, and I said no...I had no choice in that [referral to

step two] *I had to see this worker and that there would be this waiting list, but I understand that, everybody faces that, you know, there is no choice.*

<div align="right">(Patient03, female, steps 2&3)</div>

When choices were available, several patients felt ill-informed. In some circumstances this resulted in them choosing what they felt was the 'wrong' choice. Having made a 'wrong' choice they then felt that no additional choices were available:

I mean it was my choice <u>not</u> to go on the medication. It was my choice to pick the CBT but I didn't really understand what I was choosing because I have never been in a position where they have been offered to me before…what I was finding is when I was out of the kind of situation where I am sitting there having to talk about it I then didn't want to deal with it. So I don't think CBT was the right way forward me because it is all about kind of like doing it on your own a little bit isn't it and taking the tools and learning to use them. I didn't want to do homework at home because at the end of the day I don't want to be spending my time... I have got kind to the point of where I am not thinking about it all the time. I don't now want to go back and think about it all the time again. So maybe if the kind of that, the different roles and being involved in them was explained in the first place that I might... I may well have taken a different option.

<div align="right">(Patient13, female, step 2)</div>

Patients felt the only choice available to them was to engage with the treatment they had been offered or to seek out more preferable treatments through alternative means:

Honestly. No [response to question asking if they felt they had had a choice]. *And I... I thought no to start with because I specifically asked for something and so then they thought well okay well she has asked for this and that... Whether it is just because they have nothing else to offer maybe. Em either way I... no I honestly don't feel like I had a choice. The only choice I have had is to pay for it myself because... Initially it was quite good because they said 'Well you know if you are not happy going on our waiting list I can refer you... you can go private'. But every time I see my doctor and talk about I'm frustrated about waiting and things like that, but the fact that I could go private is always mentioned at every single appointment.*

<div align="right">(Patient14, female, step 2)</div>

One of the important issues that patients discussed about choice was antidepressant prescribing. The majority held negative perceptions about medication, but some felt it was the only option available.

I didn't really want to be dependent on medication for my whole life. But then again, if I find that that's the only way I can do more normal, as possible, in fact to... as much of myself as I can, well then I willingly take something.

<div align="right">(Patient07, female, steps 2&3)</div>

Several initially made a decision to refuse medication and chose a psychological intervention. Those who subsequently did not achieve a positive treatment felt that medication was the only remaining option:

…in the first place I didn't want to take any tablets but now not talking to anybody and you know, I'm sitting here thinking, well, is that my only option now… I really don't want to take that option. Do you know what, I just, I just don't know. I mean, talking was good, I don't – I'm still ref – really refusing myself to go on any medication – <u>really</u> don't want to do that.

(Patient10, female, step 2)

(b) Patient-Health Professional Relationship

The patient-professional relationship influenced their general experiences in differing ways. Most of the discussions emerged from patients who had been 'stepped-up'.

Patient-GP Relationship

A few discussed how important the relationship with their GP was:

I would say she [GP] identified the problem to begin with because she has known me for a long time. She knows I've got... Obviously other problems erm... other health problems. But then I think she suddenly sort of realised there was more to me than what met the eye, and she sort of... She sort of got the ball rolling. So you know, I am very thankful to [doctor], she is a very good doctor and a very nice lady...I wouldn't change her for the world...without her I might be in a worse state probably than what I am at the moment.

(Patient06, male, steps 2&3)

One patient felt that GPs should take a more active role in helping the patient to manage their problem and emphasised the role GPs have in stepped care whilst patients are waiting for treatment:

I'm not expecting GPs to care, you know to show more attention to me compared to other patients. But at least basically, I think that is kind of the minimal requirement. Or if you really do want to take that stance of just giving practical advice, then do give practical advice. I mean when she said to me the waiting list was one month, she could have followed that up with as many options you can do yourself in-between or... you know just something.

(Patient14, female, step 2)

Health Professional Responsibility to Patient

Patients talked about the responsibility that health professionals have when managing mental health problems. With respect to GPs, one patient felt that they should ensure access to specialist help:

> *…you know, a GP is a, is a general practitioner, er, and they don't always have the understanding of, er, mental health conditions but largely they should refer you to somebody who has and he shouldn't make a judgement and a decision.*
>
> (Patient02, female, steps 2&3)

Another patient stated that GPs should be aware of appropriate services to provide patients with information. They also conveyed the need for the health service to work efficiently to ensure services are accessible:

> *I think GPs should be aware of that and be able to offer that information forward across the board, to everyone with other issues as well like Alzheimer's and dementia and they are not told about any of the societies or any kind of groups that are local to help…So I think we need more sort of collaboration between the Health Service and these charities in the community to make things a bit more efficient. Definitely.*
>
> (Patient13, female, step 2)

Therapeutic Alliance-Relationship

Patients viewed relationships with mental health professionals as generally positive. It was noted that good relationships were more likely to lead to better outcomes compared to if their relationship was poor:

> *…now I see [Psychologist] I feel a little bit more... He has got a good way of sort of... saying to me 'Well one thing is try it.' He doesn't say 'Do this or Do that. Why don't you try'…He is not one of those people that says 'Well I want you to do this.*
>
> (Patient06, male, steps 2&3)

Support was highlighted as contributing to a positive relationship with mental health professionals:

she [counsellor] listened to me and she was kind and caring...I think, yes, managing, I think, I saw, um, the counsellor yesterday, and I think and she gave me some support in being able to manage it.

(Patient08, female, steps 2&3)

Patients also identified factors that had a negative impact on their relationship with mental health professionals. One significant factor raised was when there was a perceived difference in personality types. When this happened they felt the relationship suffered and subsequent outcomes poorer:

That was on offer to me [step 2 – low intensity intervention] and I took the offer. But honest, I think more of that was, uhm, I just think personalities wise I think perhaps I didn't get as much out of that I was looking to get, that I feel I got out of the recent [step 3 – high intensity]. So, you know, I don't, you know, I don't bear any malice about – it just didn't work for me.

(Patient01, male, steps 2&3)

Where a good alliance was not achieved, they regarded it as important to have the choice of an alternative mental health professional:

I found the, um, what do you call it, the community psychiatric nurse, she was very good, they're more – it's very much a personal thing, I can get on with some people and not with others. And so, if, if, I'm not in rapport with the person, then it's not going to work at all...It's being comfortable with each other and I think in a sense you need to have the choice, if you, if you don't gel with the person that has been allocated to you, then you should then have the choice and be able to say, this isn't working, you know, us two in partnership, you know is there somebody else I can be referred to.

(Patient02, female, steps 2&3)

While there is the assumption in stepped care that 'stepping-up' is focussed on treatment outcome, it may also be important to take into account issues such as the importance of a good therapeutic relationship in making treatment decisions. Links can be made with this issue to those concerned with choice and having a more positive patient experience.

Confidence and Trust in Health Professional Judgement

One of the important elements in the relationship was being able to place trust in health professionals. Some patients regarded health professionals as knowledgeable about the decisions that needed to be made and were happy for them to lead the decision-making process:

…she's spent a lot of time learning her job so she knows what she's doing…It doesn't seem the right way to do things to me, but then I don't know how it's done…So I'm not sure if I actually agree with the way they do it, but like I say, they know better than me.

(Patient05, male, steps 2&3)

(c) Treatment Process

'Stepping-Up' Decision-Making

Several patients who had been 'stepped up' from a low intensity to a high intensity intervention identified their apprehension of changing treatments:

I was a little bit apprehensive like from going from one person to the other.

(Patient01, male, steps 2&3)

The actual process of being 'stepped-up' to another treatment was also discussed. One patient stated that they understood they were being referred on as the mental health worker had reached their limits in terms of the skills they had:

I think it was half hourly sessions, about three. I finished them. Uhm, and then the lady, the last one I saw – oh after that I was referred to another lady cos she, the lady involved with the first sessions was, couldn't see me any more because that's as far as she could go with me. And then she uhm, she referred me to another lady …what I understood was that she, she could only go as far as we did and then someone more qualified or whatever had to take, take it over. If that's the right reason, I can't remember. I couldn't tell you…I don't think I saw her that many times anyway, maybe once or twice. I didn't think we, we did anything much different to what I did with uhm the first lady.

(Patient11, male, steps 2&3)

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Another patient talked about the limited number of sessions provided at low intensity:

I knew I'd one see her for two sessions. There was the first one to get to know a bit about me…and then there was a second one booked, but I don't think I actually made the second one, I think I was referred on

(Patient05, male, steps 2&3)

In their understanding of 'stepping-up' one patient used the following analogy to illustrate the process:

..it's a positive it's like uhm, if you have a little tack you use a little hammer, if you go in with a big nail you use a big hammer. So you've got to work out which one you're going to need first haven't you?...So, you know, I'd sort of see the first person, if she can't help me then I'll be sent to see someone else. So yeh, that's got to be a good thing hasn't it?...Yeh I mean the big person coming in straight away I might not need them, I might just need someone to say, never mind, put a plaster on it and everything will be alright, you know.

(Patient05, male, steps 2&3)

This patient demonstrated an understanding of the reasons for 'stepping-up' by indicating that it would occur if no benefit was achieved. This understanding, however, was not universal. Other patients, although indicated they were aware of a sequence of treatments but did not speak about the reasons for 'stepping-up'. Their level of understanding about stepped care was unclear and many thought that they were being referred to a treatment that was simply a continuation of the first:

She [GP] was very forthcoming and she says 'Look you are not crackers or anything else like that, but you've obviously got a serious... a serious sort of problem so I am going to recommend you to see a lady called [GMHW]. And I saw her once... I think I saw her twice or three times. And then of course I was then referred to [psychologist]…well [GMHW] turned round and said 'Well with the conversations that I had had with you so far I feel that erm...I am referring you to [psychologist]. Er [psychologist] will probably be able to get... take over where I basically left off'.

(Patient06, male, steps 2&3)

Signposting

Several patients identified that being directed to non-NHS services such as charity or community-based psychological treatments or activities could be beneficial. They felt that accessing these services may help to meet some of their needs that were not being addressed within their current treatment. Some patients saw these services as more readily accessible and varied in their focus and others discussed the benefits of group-based approaches.

> *I think just because you see the doctor and he refers you for counselling, for therapy, that doesn't mean you're going to be, you're going to be better, you know, there's got to be a little bit of signposting sort of for all, all, you know, all different people to give them some sort of idea what, this is what we'd like to do for you, but this is what you're going to need to do if you want to go down this – so, a little bit of signposting I think really for, for the patient. And it's got to be gauged to the individual really cos, you know, it's OK to say, oh yeh sign me up for it, but it. It's the same with anything, you're only going to get out what you put in really aren't you I suppose.*

(Patient01, male, steps 2&3)

Outcome Measures

Only two patients discussed the use of outcome measures in making treatment decisions. It was therefore unclear the extent to which, if any, outcome measures have upon patient experiences within the stepped care. While they were not asked explicitly about these measures, the paucity of comments may indicate that they are rarely used in treatment decision-making or that little explanation is provided about the purpose of them. One patient revealed an understanding of the purpose of using measures including monitoring progress over time. However, another patient highlighted the difficulties in completing measures without assistance:

> *…he* [psychologist] *gives me this form to fill out. Well it is not a form, this is a thing with numbers on it which hopefully nine times out of ten my daughter helps me fill it in so... She reads the questions out to me because some of them I don't understand.*

(Patient06, male, steps 2&3)

Theme 3: Service-Related Issues

Patients discussed both positive and negative views of accessibility of treatment, service resources, waiting lists and continuity of care.

Accessibility of Treatment

Patients discussed the accessibility of treatment in terms of where it was delivered. They saw clear benefits in being able to receive the treatment within the setting of their own GP surgery:

Although they weren't actually based at the GP, they spent a certain afternoon therewith patients, seeing patients. And so... Although they are basically a different office, it is so accessible. Easily accessible. If I needed more support from them...

(Patient09, female, step 2)

The flexibility of the service was regarded positively, and some highlighted the benefits of treatment being offered by telephone or contact by email. One patient was very satisfied with the flexibility of the timing of sessions:

I think we planned four weeks in advance and yet, I mean, I couldn't have wished for better really, yeh, I mean all the appointments we mapped out together, it wasn't a case of uhm, I think at that point I was finishing at uh, I think at 1:30 and we were doing them for 2:15 which, you know, 30 minutes to walk, so 15 minutes just to chill before the appointment. So you're very, very flexible, and really, really flexible for my needs, you know, I mean, you know, if you're doing a nine till five a little bit easier to say, oh can I take that extra hour then, but no, it was very flexible. Yeh.

(Patient01, male, steps 2&3)

Two patients were less positive about accessibility, one stated that the site that it was delivered at was inaccessible to someone with physical problems whilst the other highlighted that helpful services that they had accessed in the past were no longer available:

The only thing I would say about it, it is not very accessible anymore, it has become too much part of the main mental hospital service. But it was very useful at the

time…Maybe not.. who are maybe not as an extreme case as some but like for instance someone like myself would have benefited from that…We need some proper support to get.. you know used to rebuilding your life. And now that isn't available anymore.

<div align="right">(Patient09, female, step 2)</div>

Although not an explicit aspect of stepped care some patients discussed the ability to re-access treatments in the future should they need to. They valued the ease with which they were able to access the service again if required:

I mean what I've agreed with X (current psychotherapist), now, cos I saw him monthly at first, then it went to two monthly, now it's gone to four monthly, and, well I'm on four months since my last one and my next one. And he's said that that will be the last one. But, if the shit hits the fan again, I can call him up... you know, it's just, it's a tough thing to go through [experiencing a mental health problem], and you just think, well whatever makes it easier... and having that here is, is, for your piece of mind it's really, really good, cos it's, you know, it's a very, you know, it's a scary thing to have and you just, you don't know what's around the corner and, and, you know, with a condition such as this that's affected by life stressors as well as a million billion things, you just, you know, it's good to know that you've got a safety net I think.

<div align="right">(Patient03, female, steps 2&3)</div>

Service Resources

A number of patients expressed negative views about the resources available to them. Some felt that they were given insufficient time to discuss their problems. This was distinguished from not being able to 'tell their story' by being solely focused on the time limitations of low intensity. One patient expressed the view that the availability of resources related to the reluctance for services to spend money. Another stated that due to the limited time that was available within treatment there were limits as to what outcomes could be achieved:

I: is that achievable [a positive outcome] within the kind of treatment that you are receiving?

R: Only possibly and maybe.

I: And can you explain a bit more why you say that?

R: Probably because my previous counselling experience was so good and was over years, a couple of years, and this is only going to be for six weeks.

<div align="right">(Patient08, female, steps 2&3)</div>

Waiting Lists

The issue of waiting lists for treatment were an important part of the treatment process discussed by all patients. Their experiences were mainly negative with only a small number who perceived that they had waited only a short time:

When I was handed over there was a long waiting list and I resigned myself to wait however long time. But apparently there was something coming up and there was a vacancy, so I got in quite quickly.

<div align="right">(Patient05, male, steps 2&3)</div>

The majority of patients discussed the long length of waiting lists and the lack of support whilst waiting for treatment:

It was about six months I think. It was a long time and I didn't get any support during that time…But I think I'd gone so long without support that, you know, it was hard, but it was doable.

<div align="right">(Patient03, female, steps 2&3)</div>

A small number of patients decided that they would seek out, or consider, additional private help on their own as the waiting list was long:

…I had counselling which I arranged myself because anything else takes so long.
<div align="right">(Patient02, female, steps 2&3)</div>

Waiting lists were also identified as impacting upon the way that health professionals approached treatment discussions with patients. An example of this is highlighted in the following quote:

And so I got my counsellor to write to her [GP] you know, we had previously discussed CBT, and she thinks it's a good idea, I think it's a good idea, I would like to try it. And my doctor kind of like well, you know, do you know the waiting list is like

nine months, and all that. It was like a sort of... I wouldn't say discouraging, but kind of... but she was... everything she was saying was kind of like well it might not be a problem like that, that you need to see someone about it.

(Patient14, female, step 2)

This example illustrates not only the impact that waiting lists have upon GP decision-making but also the potential impact it may have upon their relationship with patients.

Continuity of Care

Continuity of care was viewed by patients as an important aspect of the management of their mental health problem and the decisions that were made, particularly during the 'stepping-up' process. Only one patient highlighted that they had experienced good continuity of care:

I think it was quite a smooth transition, and also the graduate assistant was keeping in contact with the psychologist and she kept, she asked if she could give her an update how it was going, do that, that, you know, that was good.

(Patient01, male, steps 2&3)

Most patients had less positive views of communication between heath professionals:

I also saw a psychologist...but there seemed to be a confusion between her and my doctor, which seemed like they were trying to get one up on each other the psychologist or whatever she was would say one thing and when I got to my doctor and explained what went on and she'd seen me, she didn't actually agree with it. She's more someone, if you are feeling better then don't worry about what's caused it, you know, as long as you're feeling better. Whereas the other one was like the opposite way, so I think that was a bit of conflicting between the two of them...I was like in the middle I didn't want to say nothing to one in case it upset the other one, you know what I mean...then there was a little bit of confliction and it was every time I saw her was like once every two weeks or once a week...So when it was suggested that I saw someone local I felt, you know, it would be best all round because it stops the confliction...

(Patient05, male, steps 2&3)

Patients were uncertain about the way that their care was coordinated. For some this related to mental health professionals leaving the service and communication problems

with the patient and their treatment ensued, while for others it related to a general lack of information about the referral process:

> *I have not heard back from them again. So I don't know whether I've gone on the list because I have now been assessed for something else* [co-morbididity]. *I don't know how it works...If the GP or anyone coordinates to tell every single clinic whether I am going to be... I don't think there's communication between the departments because for example the other day, I got a letter that I had to confirm that I am still at my GP and I thought well I am right in your system at the moment...Why do you need confirmation?*

> (Patient14, female, step 2)

Theme 4: Views of Step Two Treatment

All patients provided views on their experiences of the low intensity interventions at step two. Perceptions of the treatments received, in terms of what they expected and what they received were raised.

Conceptualisations of Step Two

Low intensity interventions at step two were regarded by some as an option to access until their desired or required treatment was available.

> *...I went and asked for what I wanted* [CBT]. *I was offered this other service* [low intensity] *in the meantime.*

> (Patient03, female, steps 2&3)

One patient saw low intensity as having a preparatory role for higher steps rather than a distinct stage:

> *...it* [low intensity] *sort of got me in the right frame of mind to start thinking a bit deeper...you know, started me evaluating things I was doing and being aware of where things, you know, starting, not working right and how we could solve that and what the positives would come out of that and the same with uhm the negative situations and the reaction to those things...so I'd say, you know that both, I think,*

I'd call them like level one and level two really, that's how I sort of saw them. And level one got me ready for level two.

(Patient01, male, steps 2&3)

Related to this, while most patients understood the purpose of step two and saw it as distinctive to other treatments, some emphasised that they did not consider low intensity interventions as a form of 'therapy'. Rather it was seen as providing reassurance, practical advice and support, identifying opportunities in the community and someone to listen. These perceptions are in-line with the purposes of low intensity interventions and their function, which is predominantly self-help based:

It wasn't therapy as such but it, it, it does help to have uhm somebody listening to you and, and reassuring you and are pointing you in the right direction. So I would say that is what she did, it wasn't therapy in itself…I'm not sure how much [GMHW] could do really, you know, from what, what she's there to do, you know, because she's, well from what I understand, she's not there actually to give people therapy, but to advise people on how to get better.

(Patient04, female, step 2)

Negative Views of Step Two

Some patients expressed negative views of low intensity interventions. In particular these views highlighted the fact that treatment provided did not match their perceived needs:

I think for some people it'll be really good, uhm, my concern is that uhm, that by the time people are requesting GP's help, they're probably not well enough to benefit from it. I think it, you know, it's an excellent intervention for people who either aren't as ill as me, or are maybe coming out of the system the other end and aren't all, aren't as, you know, aren't in, basically that aren't in crisis. Whether it's – if they've been caught in time to stop it becoming crisis, or whether it's after they've had a period of psychotherapy and it's about actually then just sort of, you know, managing and establishing life patterns and so on. Uhm, at those points I could see how it would be really, really good, but for someone in crisis, uhm, it was good to know that once a month somebody was looking at me and seeing how I was, but that was basically all it was.

(Patient03, female, steps 2&3)

The following patient succinctly captured the issues that fed into a negative step two treatment experience:

…you are told that you only get three sessions. Which completely freaked me out and I... I was just like I don't see the point in me telling you any of this if... Well I thought I tell you this one, and we have two sessions and then... then I am out anyway. Where do I go from there because what can you do within sort of like... Like two hours sort of afterwards…She told me at the beginning but I was quite surprised by that…Three sessions I just found a bit of a joke. And actually that freaked me out more and made me more nervous about everything because I thought that if I had actually open up and go inside any of this then suddenly I am going to be dumped in that brief time. And then if I opened up other stuff and what do I do now?...She said that we would kind of review this, but I mean it was kind of like... it was three sessions and it would be pretty much what I got from it. I mean she may well have said more but I just didn't take it... I just wasn't... I am not kind of having a go at her but I just didn't... But yeah I mean... All that came out of it was just like... What is the point in this? I don't understand why I am doing this. I didn't see where, how it was going to help me.

<div align="right">(Patient13, female, step 2)</div>

Positive Views of Step Two

Regardless of the fact that many patients felt negatively towards step two treatments some spoke positively about the low intensity workers:

…she was a very very nice girl, she talked through things with me…She was there to refer me to different organisations that she felt might be of benefit. Which she did and she was very very good. She went through all this information about all different... You know loads and loads of information about all different groups that could be of benefit…she was able to give me quite comprehensive lists of what was available in our local area…The important thing to is that this girl and the next that I spoke to have very nice personalities so you felt quite relaxed with them. They were easy to deal with and easy to talk to, and very understanding.
(Patient07, female, steps 2&3)

Theme 5: Outcome

Perceptions of a Good Outcome

The analysis revealed that many patients had perceptions as to what they considered to be a 'good' outcome. Views tended to focus around their ability to function better in every-day life and getting back to 'normal' or their 'usual self' as opposed to achieving an improvement in the actual symptoms that they were experiencing:

> *I want to carry on and do my housework. Uhm, I don't want to feel guilty everyday, I don't want to feel useless and like I've done something wrong and this kind of thing, you know what I mean? I just, I just want to be back to me, because I was quite uhm, I'm the practical joker if you like, I was the one always in trouble in the class room, that kind of person, and I'm not like that any more. So I just want to get back to me, I don't want to be like this no more.*
>
> <div align="right">(Patient05, male, steps 2&3)</div>

One patient discussed how they felt they would not be rid of the problem but being able to cope better would be a good outcome:

> *…you can never completely recover. But learning to cope with it...learning to cope with my issues.*
>
> <div align="right">(Patient09, female, step 2)</div>

Positive Outcome

Several patients identified that the treatment that they had received, or were currently in receipt of, had been a positive experience that had benefitted them. The vast majority of these patients were those who had been 'stepped-up'. Again, as with perceptions of a 'good outcome', many of these views were about improvements in their overall daily functioning:

> *Even when I went to see the doctor right at the beginning, things changed, but yeh, since I've seen the psychologist , I mean she got me doing things that I don't want to do, you know, like I've got to do the housework and things like that.*
>
> <div align="right">(Patient05, male, steps 2&3)</div>

A small number of patients identified that the positive outcomes that had been achieved had been, primarily or at least in part to taking antidepressant medication:

> *Help wise the medication I think actually really levelled me. So even though I wasn't very confident about going onto them...I kind of wished that maybe I'd actually gone on them years ago.*
>
> (Patient13, female, step 2)

Poor/Negative Treatment Outcome

Limited Sessions

The limitations placed upon the number of sessions that a patient could receive were also highlighted by others:

> *I don't know what you feel about – I've never been under one before, but, um, you know, I just, you know, it was, it was quite a while ago now and I've not spoke to anyone else and I just seem like I just, you know, you've had your five sessions and you're alright now but I'm clearly not.*
>
> (Patient10, female, step 2)

Needs not met

Many patients felt that their needs were not/had not been met by treatment. Some patients discussed this in relation to their beliefs about the approach that had been taken to manage their problem where it was thought that the focus did not necessarily approach the problem effectively to produce positive outcomes:

> *No one has actually touched on on what I feel is the problem, and I don't know what the problem is to be fair, I can't actually get to it myself, I've tried to think about it, but I can't. Uhm, ?I wouldn't say any of this actually focused on what the problem is, unless I've got it totally wrong and the problem is I can't do my housework. But, you know, as far as I think no one's sort of like touched on it yet. So hopefully this next half of the treatment will do that.*
>
> (Patient05, male, steps 2&3)

Other patients identified that one of their needs was the time spent discussing their problem:

I don't want to walk out after seven minutes and think well I really didn't get a chance to say what I wanted to say. I find that a little situation for people who are really ill or stressed or whatever, they are going to see someone, they really need to talk to. And they are so aware that this doctor is talking really fast, looking at his clock, writing furiously on the computer and er then fairly standard making decisions and making another appointment. I'm here now, it makes more sense than coming back, so that is a very logical thing and also it makes more stress on the patient.

(Patient07, female, steps 2&3)

One patient highlighted did not feel that their needs were met at step 2 but were met when they were 'stepped-up':

when I started being referred to sort of different... On a higher level is the right expression, but a sort of more intense or more serious issue... erm when I was referred to them with that then that's when people to actually seeming to be more caring and sympathetic. What it was like to be on this end. I mean I think... Actually the mental health workers was great for that. She was very you know... It wasn't... Obviously that is her job and she was there to listen to you. But you just... She said they were making my appointment, for example she called me and said you have been referred. Please call me back. And then said you know, I know the waiting is long... It was just a more personal sort of...Because it did feel like well... I clearly said that CBT is what I need and you know now you are sending me to someone who cannot give me CBT and who is going to do a initial assessment and things like that. And I had to go through it all over again and... So it was kind of really frustrating.

(Patient14, female, step 2)

'Feeling Abandoned'

Many patients felt they had been 'abandoned' following their discharge from the treatment process. Those expressing such views were generally restricted to those patients who had received treatment at step two only. Some expressed uncertainty about what the 'next move was':

I just feel like I've had my five sessions and, I mean, I don't – I don't know what - if that's it, I don't know if I'm going to hear again, I know nothing, I just didn't, you know, just, I'm, I'm in the air somewhere I don't know what the next move is. I feel like I've been left...I don't see why that should be left with me [seeking out additional

help]…because you just feel like you're screaming and no one can hear you and that, and I don't like feeling like that.

(Patient10, female, step 2)

The findings thus provide evidence of the differing experiences of patients in terms of outcomes. Having a positive or negative outcome could not exclusively be determined by the steps at which treatment had been received.

Discussion

Interviews with patients revealed a number of factors that contributed to their experiences of decision-making within stepped care. These included their expectations of treatments, involvement in decision-making, treatment outcome and relationship with health professionals. Issues relating specifically to being 'stepped-up' also impacted upon some of the patients' experiences. Two key findings had particular relevance to stepped care – (i) patients do not necessarily have a good understanding and involvement in the stepped care process and (ii) there may be disagreement as to how outcomes are assessed.

Patients made a distinction between their involvement in the decision-making process and the choices available to them. These results are consistent with the findings of Simon et al (2006) who conducted qualitative interviews to explore patients' perceptions of depression and treatment decision-making in various primary and secondary care settings. They were generally satisfied with the way health professionals involved them in the decision-making process and stressed that having the opportunity to be involved related to issues of control, empowerment and outcome. These findings are well documented in the literature looking at patient involvement in their healthcare treatment (Ryan & Sysko, 2007; Jahng *et al.*, 2005), However, patients were not as satisfied with the range of choices that were available. This related particularly to their ability to choose high intensity treatments such as CBT that were not offered initially. In following a stepped care approach health professionals referred patients to step two low interventions first which many of the patients viewed negatively. The importance of being involved was detailed in Chapter 2 and links to models of involvement in the decision-making process where patients express a shared role is preferable. In the study by Simon et al (2006), however, it was highlighted that for patients with depression, the shared decision-making approach taken should also take into account the severity of patients' problem and their identified needs.

Although many of the patients valued the low intensity workers, some were frustrated about having to access a treatment that they did not think was pitched at the right level before getting to their treatment of choice. This is also is in line with the study by Simon et al (2006) who found that patients viewed more specialist treatments as ones that would result in most benefit. Additionally, some felt that in instances when a choice was presented, albeit a restricted one, when the chosen option did not subsequently result in

positive outcomes they felt that there were no other choices available to them. In relation to step two interventions, one of the issues raised was the fact that what patients received did not match their expectations. Some thought that they would be receiving a more counselling-focussed approach and identified that what they actually received was 'not therapy'. This mirrors the views of Kellet and Matthews (2008) who do not regard low intensity interventions as forms of therapy. Other qualitative studies have similarly highlighted the disparity between patients' prior expectations and what they actually receive at low intensity levels (Rogers *et al.*, 2003; MacDonald *et al.*, 2007). Rogers et al (2003) found that patients referred to a primary care self-help clinic commonly thought that they would be receiving a more counselling-based intervention.

Within this current study where expectations were not realised this often impacted upon outcomes. Many patients discussed what they regarded as a good outcome and the actual outcome from the intervention(s) that they received. In terms of a good outcome a number of patients focused on an improvement in functioning rather than the severity of their problem. This is consistent with Rogers et al (2003) where it was found that patients attending a self-help clinic were seeking help for problems related to their inability to function normally in their everyday lives. Furthermore, Simon et al (2006) found that patients lacked an understanding about severity of depression which delayed them seeking help. The lack of awareness about severity may, in part, help to explain why it is not frequently expressed when discussing outcome goals. MacDonald et al (2007) additionally highlighted that, whilst patients reported they had not recovered, that other benefits of the treatment were realised such as achieving a better ability to cope. Another relevant study explored both patient and health professional attitudes and treatments towards depression treatment (Cooper-Patrick *et al.*, 1997). They found that patient discussions focussed much more upon social functioning issues than health professionals did. The findings from this study, and comparison to previous literature, therefore provide some support for the importance of considering the contested nature of depression put forward by Dowrick (2004) (outlined in Chapter 1). In discussing their expectations of treatments, patients rarely distinguished depression from their social difficulties. Thus defining recovery or improvement using measures focusing on the medical symptoms of patients problems did not often result in a good outcome. Attention is thus drawn towards the disparities within the stepped care model between patient needs and service outcomes where 'recovery' is based on severity levels and diagnosis rather than functioning. Whilst outcome measures

have an important role within NICE guidance it is unclear what impact they have upon the patient stepped care experience.

While patients valued the low intensity workers they expressed a number of negative views about the step two interventions that they delivered. Some felt 'abandoned' following receipt of step two treatment following discharge when they were not subsequently 'stepped-up' to a higher intensity treatment. This, in part related to the previous issues raised regarding their perceptions of a good outcome. MacNeil et al (2010) stressed the importance of managing the conclusion of therapy sensitively, particularly when the patient does not feel 'cured'. Health professionals working in a stepped care approach are said to discharge (or 'step-up') a patient based on the level of improvement a patient has made (Bower & Gilbody, 2005b). For those patients who are discharged it is important to consider their individual needs. Kramer (1990) suggested that by ensuring the patient is aware of how to re-access treatment at a later date may be important. However, the incorporation of re-access raises important issues for the stepped care model. Decisions have to be made about how patients would re-access the model and whether it would be necessary to start with an initial assessment referral. The level at which they would initially re-access the model also has implications for the efficiency of stepped care. A number of patients in this study stated that they felt this was addressed. Others, who had received a stepped two intervention only, stated that the number of sessions received was limited. Patients' dissatisfaction with the time available time has been highlighted previously in primary care studies looking at GP consultations (Ogden *et al.*, 2004; Williams S.J. & Calnan, 1991), however it has been argued that this is as much related to patients' perception of time spent rather than the actual time allocated (Cape, 2002). Additionally, some patients who received low intensity that had or had not had been subsequently 'stepped-up' to high intensity did not regard the interventions as meeting their needs. Differing individual needs exist among people with the same common mental health diagnosis (Papworth & Walker, 2008) and thus this needs addressing.

The findings are also consistent with the recently completed evaluation of IAPT demonstration sites – Doncaster and Newham - in which the experiences of being an IAPT service user were explored (Parry *et al.*, 2010). Patients taking part in semi-structured interviews who had recently been discharged following step two or who were in receipt of or had completed step three following being 'stepped-up' provided insight into their

experiences. They reported low levels of satisfaction, indicated that the treatment they received was too short and lacked continuity and that it was often difficult to engage in low intensity work. Although some valued the structured approach adopted at step two some saw it as second best and not pitched at the right level to meet their needs. Some expressed disappointment in the treatments that they were offered, particularly when it did not meet their expectations. In relation to choice, however minimal, its value was expressed, but it was often felt that in ensuring that they got what they wanted that they had to be assertive and confident (Parry *et al.*, 2010).

Half of the patients interviewed in this study were 'stepped-up' to high intensity treatments. Although not all patients who had been 'stepped-up' to step three reported positive outcomes only those who had been 'stepped-up' identified they had benefited from the treatments they had received. Some reported uncertainty and apprehension about the 'stepping-up' process and many expressed negative views in relation to waiting for treatment. Additionally, whilst some indicated they understood the principles of why they were being 'stepped-up' some simply saw the second intervention they received as a continuation of the first rather than a distinct treatment in itself. This misunderstanding may relate to those people who were 'stepped-up' to high intensity CBT (rather than counselling) where the model of working adopted was viewed as similar to that in low intensity. The recent evaluations of the IAPT demonstration sites concur with these findings (Parry *et al.*, 2010; Horn, 2010). With respect to 'stepping-up' many patients felt frustrated and powerless, some were unaware of 'stepping-up' process while others felt that it was unnecessary to go through step two. In trying to make sense of 'stepping-up' patients reflected upon their journey, their experiences of the different interventions and the relationships they had with the health professionals.

Discussions surrounding the relationships that patients had with health professionals in this study varied. Those who were 'stepped-up' were more likely to talk about their relationships directly. Some patients who had accessed step two only talked about the qualities of the low intensity worker but provided little information about the actual relationship that they had with them. Patients valued having a good relationship with the health professional and identified that it played a part in achieving positive outcomes. Qualities of the health professional such as personality, being supportive and responsive to their needs were recognised as contributing to their evaluation of the relationship they had.

Others emphasised the confidence they placed in health professionals' judgements. In looking for common factors that are associated with improved outcomes in psychotherapy, the influence of a good therapeutic alliance has been demonstrated (Martin *et al.*, 2000; Loeb *et al.*, 2005; Orlinsky *et al.*, 2004). It has, however, been argued that the opposite may be true, that a good therapeutic alliance is the result of successful treatment effect rather than contributing to it (Halperin *et al.*, 2010; Barber *et al.*, 2000; Tang & DeRubeis, 1999). This may assist with understanding why patients who received a low intensity treatment only rarely discussed the therapeutic relationship. Whilst some indicated that they liked the low intensity worker many also expressed disappointment with the outcomes achieved from this level of intervention.

In conclusion, patients, regardless of the treatments and steps they had accessed within the model for the most part reported similar experiences. Patients expressed satisfaction with their level of involvement in the decision-making process, but reported discontent with other aspects of their experience. They reported that their choice was often limited, expectations were often not met and perceptions of a good outcome were not realised. Such issues have implications for the implementation of the stepped care model, ensuring that patient needs and not only service requirements are achieved. The findings highlight the need for the model to be better explained to the patients as few fully understood the process of referral and discharge. Additionally, as many patients reported that their perceived outcomes had not been achieved this highlights the disparity between what the service regards improvement or recovery and the patients' notion of a 'good outcome'.

CHAPTER EIGHT: STUDY 2A – QUALITATIVE STUDY WITH HEALTH PROFESSIONALS

Introduction

This chapter presents the findings of the qualitative interviews with health professionals. There are three key parts to this chapter. At the outset contextual information describing the research sites and the study participants is presented, followed by identification of key themes, and finally, a discussion of the findings is outlined.

The Research Sites

Initially, all four sites that were approached agreed to participate. One site withdrew due to ongoing organisational changes. The three remaining sites included one large urban city comprising of one PCT and one metropolitan borough comprising of one PCT, the third site consisted of two metropolitan city boroughs PCTs. Tables 11 and 12 provide an overview of the demographic characteristics and the features of stepped care at each site.

Table 11: Characteristics of stepped care sites

Characteristic	Site 1 (Foundation Trust – 2PCTs)	Site 2 (1PCT)	Site 3 (1PCT)
Key Demographics[5]	Inner city boroughs	Large urban city	Metropolitan borough
Population (June 2008)	PCT1 – 235,700 PCT2 – 190,900	770,800	221,300
Ethnicity (June 2007)			
White	PCT1 – 71.0% PCT2 – 75.4%	87.7%	92.0%
Mixed	PCT1 – 4.0% PCT2 – 4.3%	1.8%	1.4%
Asian or Asian British	PCT1 – 11.9% PCT2 – 6.5%	6.0%	2.9%
Black or Black British	PCT1 – 6.9% PCT2 – 9.6%	2.2%	1.5%
Chinese or other ethnic group	PCT1 – 6.2% PCT2 – 4.2%	2.3%	2.1%
Employment Rate (Jan-Dec 2007)	PCT1 – 68.2% PCT2 – 69.2%	73.9%	72.8%
Unemployment Rate (Jan-Dec 2007)	PCT1 – 6.6% PCT2 – 7.8%	5.7%	5.7%
Claimant count (Aug 2007)	PCT1 – 19.0% PCT2 – 13.0%	13.0%	21.0%

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[5] Data taken from the Office for National Statistics' most recent dataset

Table 12: Features of stepped care at each site

Stepped care feature	Site 1 (Foundation Trust – 2PCTs) Inner city boroughs	Site 2 (1PCT) Large urban City	Site 3 (1PCT) Metropolitan borough
What parts of the system are included in stepped care?	The low intensity primary care mental health service provided by the PCT provider arms and the high intensity psychological assessment and treatment service provided by the Foundation Trust	The PCMH service works in line with the IAPT stepped care model and therefore all parts of the system (i.e. treatment modalities) are organised according to steps 2 to 3	All parts of the system, in accordance with steps 2 and 3
How do patients access the stepped system?	Majority from GPs, some by self-referral and some from secondary care mental health services	GP referrals (approx 2/3) and self-referrals (approx 1/3)	Predominantly GP referrals (>95%), some self-referrals or referrals from other health professionals
Who conducts the initial screening/ assessment?	Either a low intensity or high intensity worker. Depends partly on where the referral was directed by the referrer and partly from looking at paper referral as to who is most appropriate to do initial screening and assessment. A clinical supervisor/coordinator may be involved in this process	All clinical staff have a role (low intensity and high intensity). A smaller proportion of cases are offered a further assessment appointment with a senior practitioner (band 6) in which a decision is made about allocation to therapy/step. A clinical supervisor may be involved in this process	Two Pathways: 1. Open clinics at GP surgeries – no screening 2. Referrals – LI workers conduct assessments
How is initial assessment conducted?	Face-to-face	Face-to-face and by telephone	Almost exclusively face-to-face
What low intensity treatments are offered?	Pure self help (books on prescription), guided self help, CCBT, psycho-educational groups, signposting	Guided self-help, CCBT, low intensity CBT. Cohort of staff that also deliver other treatment modalities such as solution focussed brief therapy	Guided self help, CCBT (available by signposting to local charity)
Number of sessions available at low intensity	'Standard' six in PCT1 and three in PCT2 ('standard' indicates guideline which would be expected for most cases to follow, but this was flexible)	Normally a limit of six sessions before discharge or stepping up (although some people may request further sessions at this review point)	Normally six sessions but can increase if clear rationale
Who delivers the low intensity interventions?	Primary care mental health workers	Graduate practitioners who have undergone specific training in this modality	Psychological wellbeing practitioners, graduate mental health workers, gateway workers

Stepped care feature	Site 1 (Foundation Trust – 2PCTs)	Site 2 (1PCT)	Site 3 (1PCT)
What high intensity interventions are offered?	Primarily CBT. Some counselling and referral on for individual and group psychotherapy	CBT, IPT, EMDR	structured psychotherapies CBT, psychodynamic therapy
Are there a limited number of sessions available at high intensity? How many?	'Standard' was 20 sessions in PCT2, no limit in PCT1	Up to 20 sessions, although most treatments work around a structured 16 session programme	Up to 20 sessions
Who delivers the high intensity interventions?	PCT1 - clinical and counselling psychologists and IAPT high intensity trainees PCT2 - clinical and counselling psychologists	Senior practitioners that are trained/accredited in these therapy modalities	Psychological therapy service in secondary care within Foundation Trust
How is patient progress measured?	IAPT standard measures (PHQ-9, GAD-7, WSAS and IAPT employment and phobia scales) session-by-session	IAPT standard measures (PHQ-9, GAD-7, WSAS and IAPT employment and phobia scales) session-by-session	IAPT standard measures (PHQ-9, GAD-7, WSAS and IAPT employment and phobia scales) session-by-session
What criteria are applied to 'step-up' patients?	If not clinically recovered, if patient would like to be 'stepped-up', and if it is judged by low intensity worker and their supervisor that there is a reasonable chance that patient would benefit from being 'stepped-up' to a high intensity intervention	If no significant improvement is evident following an initial period of low intensity treatment. Currently cut off scores for caseness on PHQ-9 and GAD-7 are used to determine clinically significant change	If no improvement
Can patients bypass lower steps?	Yes Dependent on initial assessment	Yes - If presenting with diagnoses such as OCD, PTSD, body dysmorphic disorder	Yes, stratified to high intensity if clear obvious need (not necessarily by diagnosis) e.g. if hearing voices or expressing intent to harm, then referred to CMHT.
How is supervision for Low and High intensity conducted?	One-to-one	One-on-one and groups. Trainees tend to have 1-1 supervision fortnightly. Trained staff arrange this flexibly with their supervisors	In-line with IAPT guidance. Main focus is group supervision but also have case management (mentor-PWP), caseload supervision, supervision based on techniques and formulation with a high intensity worker.

Data gathered highlights similarities between the three sites. Employment and claimant rates showed little variation between the sites as did the majority of the stepped care features such as how patients access the model, who delivers low intensity interventions, how progress is measured and the criteria used to 'step' a patient up. However, some differences were apparent. In terms of population characteristics more diversity in ethnicity was found in the inner city boroughs in comparison to the other sites, while the large urban city's population was considerable larger than the other sites. In terms of stepped care, one of the inner city boroughs provided less low intensity sessions compared with the other sites, the high intensity interventions available varied by site as did the criteria to 'step' a patient up to a higher step.

Study Participants

The recruitment strategy of health professionals (mental health professionals and GPs), is outlined in detail in Chapter 5. In brief, a number of purposive and snowballing techniques were adopted. GPs were wholly identified through snowballing techniques as they were not present during primary care mental health team meetings attended for the purposes of discussing the study.

Recruitment of participants took place from November 2008 to April 2009. A number of health professionals with varying roles within the stepped care model at each site were invited to participate, and 24 agreed to take part. Interviews were conducted face-to-face and lasted between 48-120 minutes (mean 77 minutes). Interviews were conducted at home or work according to interviewee preference. Summary demographic data is detailed in Table 13.

Table 13: Demographic data for the health professional interview participants

ID	Site	Job Title	Job Role[6]	Gender	Years in Primary Care	Years in mental health	Psychological Treatments Delivered[7]
01	1	PCMHW	LI	Male	1	3.5	GSH, CCBT
02	1	PCMHW	LI	Female	1.5	4.5	GSH, Community Links
03	1	Clinical psychologist	HI	Female	9	15	CBT
04	1	GP		Female	20	0	None
05	1	Clinical psychologist	HI	Female	0	11	CBT, brief psychodynamic, systemic/family therapy
06	1	PCMHW	LI	Female	1	3.5	GSH, psycho-education, community links
07	1	PCMHW	LI	Female	2	4	GSH, community links
08	1	PCMHW	LI	Female	1	1	GSH
09	1	Clinical psychologist/ HI trainee	HI	Female	6	4.5	CBT
10	1	GP		Female	20	0	None
11	2	CBT trainee	HI	Female	2	4	CBT, GSH
12	2	Clinical team leader	HI	Male	7	29	GSH, psychodynamic treatments
13	2	CBT therapist	HI	Female	0.5	12	CBT, mindfulness
14	2	GMHW	LI	Female	1.5	3	GSH
15	2	CBT therapist	HI	Female	5	5	CBT
16	2	GP		Female	3.5	0	None
17	3	GP		Male	11	5	None
18	3	Gateway worker	LI	Female	4	5.5	Brief CBT
19	3	GMHW (team leader)	LI	Female	0.75	4	GSH
20	3	Mental health service lead	LI	Male	4	20	GSH
21	3	PCMHW	LI	Female	2	3	GSH
22	3	GP		Male	15	0	Brief informal interventions
23	3	Gateway worker	LI	Female	0.25	6	Brief CBT
24	3	GMHW	LI	Female	1.5	1.5	GSH

CCBT – computerised cognitive behaviour therapy; CBT – cognitive behaviour therapy; GMHW – graduate mental health worker; GSH – guided self help; HI – high intensity; LI – low intensity; PC – primary care; PCMHW – primary care mental health worker; SC - secondary care

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[6] Based on the information about the types of psychological treatments mental health professionals stated they delivered they were categorised as low intensity or high intensity workers

[7] Psychological treatments as described by health professionals

While a representatative sample of mental health professionals working over the three sites was obtained, only five GPs were recruited into the study. While interviewing these GPs it was clear that those who had agreed to take part had a clear interest in mental health issues and some had taken on roles within primary care mental health services such as supervising low intensity workers and being an advisor for local IAPT services. While sampling issues are addressed in Chapter 10, the fact that there was a relatively small sample of GPs involved in the study and that the sample may be skewed towards those with a particular interest in mental health issues in primary care may limit the generalisability of the data gathered from this health professional group.

In addition, it is important to note that while four out of five of the GPs stated that they do not deliver any psychological therapies that this question may have been worded in a way that warranted this response. For mental health professionals answering the question 'what psychological treatments do you deliver' does not necessarily require much thought as their everyday role is to deliver well-defined psychological treatments such as GSH or CBT. As the role of a GP is not necessarily to deliver such well-defined treatments, the way in which the question was framed may have resulted in the responses attained. Within primary care it is clear that GPs often provide advice and support that may be considered as falling under the 'psychological therapies' definition. Elements of GSH or sleep hygiene therapies may be adopted while supporting their patients. Thus wording the question differently, such as 'would you consider any of the work you do could be considered as a psychological therapy and can you describe this' may have assisted in uncovering more about the emotional and psychological support role that GPs often undertake.

Themes from Health Professional Interviews

Interviews analysed using the principles of framework analysis resulted in the following final framework being generated which incorporated six main themes and several sub-themes (Table 14).

Table 14: Conceptual framework outlining the main themes and sub-themes from health professional interviews

Main Theme	Sub-themes	
1. Negotiating the stepped care model	i. Low intensity as a frontline service ii. Working at a higher level than low intensity iii. Patient's who don't fit iv. Waiting lists v. Outcome Measures vi. Guidelines	Service-related themes
2. Mental health service delivery issues	i. High demand for services ii. Service resource issues	
3. 'Holding'		Health professional-related themes
4. Sources of advice or support	i. Supervision support ii. Other health professional support iii. Multidisciplinary working	
5. Health professional role identity	i. Identity within model ii. Identity as defined by others	
6. Patient involvement in decision-making	i. Patient preferences ii. Patient choice iii Shared decision-making iv. Health professional-led decision-making	Patient-related theme

Six thematic charts were developed for each of the main themes and associated sub-themes. An example of one of these can be found in Appendix 8.

The themes identified from the interviews fell into three main categories – those related to the mental health service and stepped care (themes one and two), those specific to the health professionals (themes three, four and five) and those concerned with the patient (theme six). A discussion of these themes and sub-themes will be presented which will include the identification of any relevant inter-relationships.

SERVICE-RELATED THEMES

Much of the discussion within the health professional interviews focussed on issues within their services that impacted on the process and outcome of decision-making. Two main themes emerged from the analysis:

    i.   negotiating the stepped care model

    ii.   service delivery issues

Theme 1: Negotiating the Stepped Care Model

One of the major themes was concerned with the ways in which health professionals negotiated the stepped care model. There were a number of different factors that health professionals faced about stepped care that ultimately affected the decisions they made.

Two of the issues expressed related specifically to health professionals working within the low intensity service (step two). These were related to being at the 'frontline' of the service and when negotiating the model often having to work at a higher level than they should be.

Low Intensity as a Frontline Service

Stepped care was seen as being a front-loaded model which placed considerable pressure on the professionals working at this level. Health professionals delivering low intensity interventions from all sites viewed the model like this, describing themselves as 'gatekeepers' or being the 'first port of call'. They were often faced with introducing patients to the mental health service and, if necessary, had the responsibility of deciding where they should be referred. Often patients presenting for assessment had problems not suited to a low intensity way of working. A primary care mental health worker illustrated these views:

> *Occasionally I do see people that do need to be stepped up straight away and, you know, eating disorder, kind of inter-linked with depression and you know, GP's are putting pressure on you to see, see them for depression and they – you know, it's a bit like when they come to an assessment, it's clear the depression relates to eating disorder, for instance – that, that's happened to me quite a few times so it does*

happen, so part of my role is assessing where is the best place for someone to go, whether they need to be stepped up or, or I suppose if they are suitable for me.

(HP08, Site 1, Low Intensity Worker)

These views were highlighted by professionals working at lower and higher steps. A CBT trainee who had previous experience of working in the low intensity service stated:

I think that's possibly where it's importance lies as well, is that in low intensity often you're the first person client's had any experience with, uhm, and so basically you're giving them the, the, the emotional grounding, and the, the kind of intellectual and psychological groundwork is being laid and prepared with them. And you're helping them I guess just to feel at ease with psychological therapy.

(HP11, Site 1, High Intensity Worker)

One low intensity worker described their position in the service similar to a triage service, using an analogy to war, and the responsibility that that brings:

…especially by the front line thing that uh, we're assessing so many people we're kind of – and I think a lot of the GPs haven't really grasped stepped care and kind of treat us like a triage service… sometimes you just kind of feel like, oh my God!...it's very unprotected I think, that you just kind of get anybody coming through your door… you just kind of feel like, my God, you've got so much responsibility, you're kind of seeing this level of people, it does feel like you're just kind of, cannon fodder…You are on the frontline and although there are, you know, officers or psychologists behind you they're very much like not really seeing what it's like day to day, kind of getting a snippet for an hour a week.

(HP02, site1, low intensity worker)

Working at a Higher Level than Low Intensity

In low intensity services health professionals reported working at a level higher than that they were trained and/or employed to do. This was due to a variety of intertwining service and patient-related factors. Ensuring that the needs of the patient were placed before those of the service within the decision-making process were discussed. However, it was recognised that this had implications for low intensity workers potentially taking on patients who would be more appropriate for a higher-level service. This is demonstrated in the following quote from a GP who had an active supervisory role within the low intensity service:

…I mean it's frustrating for our service really, because, you know, we're not set up to really deal with these kind of patient, so, uhm, you know, so we're taking, we're taking on other people's work because of, uhm, access issues. So, so I do find it frustrating, but you, I, you know, I think the key thing is the patient not the system, so

you know, we try to do, to do our best to help the patient, and that sometimes means accepting patients who don't, who don't really fulfil the criteria possibly.

(HP17, site1, GP)

Many low intensity workers felt they often saw patients experiencing higher severity levels of mental health problems than is addressed in their remit and one clinical psychologist stated that 'if they only saw people who they were supposed to see then they wouldn't see anyone'. Many health professionals identified with the difficulties that patients faced in that many were being oscillated between different services, whilst others recognised that sometimes patients were left with nothing. Some identified that managing unsuitable patients could be beneficial, especially in terms of their own career progression.

It was unclear from the discussions how they actually managed these issues. One health professional highlighted that they would work with a patient who presented with severe depression if they could identify elements of their problem that they could address:

…generally we do have some quite severe scores on these questionnaires and people who might have other problems, uhm, I'd say like using drug or alcohol as well is part of their unhelpful behaviours. That doesn't necessarily mean that we wouldn't do any work with them, I think it might be kind of talking in supervision after that, like what else could help, but generally I'd still have a second session with those people to try and do a little bit of work, but looking at guided self help or linking them with another organisation.

(HP02, site1, low intensity worker)

Some of the low intensity workers identified that working at a higher level resulted in them feeling stressed. One recognised that this was a problem for all workers in their position:

'I think all the other graduate workers will have experience of managing patients who, who's difficulties are quite severe and, and they don't really feel that they've got the support that – or you know, they're trying to contain something and it's leaving them feeling really stressed and really anxious and they're not really sure what to do, but there isn't really anything to do.'

(HP01, site1, Low intensity worker)

Patients Who Don't 'Fit'

Health professionals managing patients at all levels were frequently faced with patients who did not 'fit' the stepped care model. Many argued that the model did not account for diagnosis, levels of severity, complexities surrounding their presenting problem or when the patients' environment was a significant contributor to their problem(s). They expressed

that where patients did not fit the model this resulted in them going back and forth between different services as the majority of services did not see themselves as appropriate. Such activity was viewed as highly time consuming:

…we play ping pong with them, um, I mean, I've got – I can remember writing hallelujah on one referral… she'd been to primary care psychology, they said there's nothing we could do in the time, could I refer her to ment – to community mental health, so I did, they said oh no, refer her back primary care, so we just played ping pong – in the end I got a letter from Head of Primary Care Psychologist – look there's nothing we can do you know, sent it back and they said, right fair enough we will see her and secondary psychologist but she stopped going because in the end when we started addressing the issues, she didn't want them addressing which is patient choice I suspect, but, in the end there's not a lot I can do about that.

(HP22, site3, GP)

At both high and low intensity levels there were problems highlighted concerning 'inappropriate referrals'. Some health professionals felt that inappropriate referrals were a result of 'desperate' GPs or GPs' lack of understanding about what the services provide. As a result of 'not fitting' into the model it was also recognised that in many cases there was nothing that could be done for the patient. Health professionals felt 'stuck' as services they deemed as being appropriate for the patient did not agree with their referral. Many recognised the limitations of the service they could provide. In contrast to situations where there was disagreement about appropriate services, on occasion it was accepted that the problems that some people encounter could not be managed successfully in any service. This was often detrimental to the patient as discussed by the following GP:

…She [the patient] *did agree to go to the mental health team and they gave her some sessions of counselling which she engaged with in terms of turning up. But they said that she wasn't really committed to talking through any of the issues. She didn't want group therapy because she didn't want to share her problems with other people. She struggled just to engage in anything at all, and eventually by mutual consent with them, was discharged from follow up. She then came to see us, and again these symptoms were escalating, so we referred her to psychiatry because the community mental health team intervention had failed. But psychiatry unfortunately rejected her and said she wasn't severe enough. And we're just stuck in a situation now where she's abusing medication. Abusing it, isn't abusing it, it's difficult cos she, she's so unwell. But she's obtaining it from A&E, from out of hours, she's coming to see us, struggling a great deal and wants to sort of, said she wants to get help, wants to help herself, but doesn't feel that the kind of simple measures that the, that they're offering are useful for her. And we sort of as a team, various colleagues have seen her, and we all thought psychiatry would be the most appropriate thing, but sadly they've rejected her. So we're stuck.*

(HP16, site2, GP)

Waiting Lists

> *There's waiting lists for <u>everything</u>.*

<div align="right">

(HP14, site2, low intensity worker)

</div>

One of the most influential factors that health professionals highlighted as having an impact upon their decision-making was service waiting lists. Health professionals stated that waiting lists were frequently present for services that they had made a decision to 'step' a patient up to. This impacted on their ability to follow the principles of stepped care model and resulted in making decisions that they would not necessarily have made. Some reported not referring to high intensity treatments even when they had been identified as most appropriate service, referring increasingly to low intensity treatments or signposting to services within the community as they could be accessed more readily:

> *…It's* [assigning a patient to a treatment] *also slightly been influenced by a long waiting list for high-intensity which is always quite hard because you've got your models and then you've got the reality and if someone's got to wait a year for a high intensity therapist, I mean you're not going to start with someone who's clearly inappropriate but perhaps on – when we have no waiting list for high intensity and people are perhaps more of the kind of – um, long-standing difficulties, but not particularly risky or severe, we might think about some of those going to high intensity first of all but while we've been operating with a - the worker's been able to see people within four weeks and high intensity not, you – that still tends to influence your care pathway for them.*

<div align="right">

(HP03, site1, high intensity worker)

</div>

Addressing the issues of waiting lists was concerning to health professionals. They identified a number of strategies within their services or that they themselves were adopting to try to combat waiting lists. These included more effective screening measures, making decisions in supervision about new referrals to 'step-up' patients more rapidly to relieve waiting lists for low intensity services and working flexibly to improve efficiency of managing referrals:

> *…the psychology service we 'step-up' to has started doing like an assessment first sort of bordering the waiting list. So I think that helps because we talk now about like setting them up for an assessment.*

<div align="right">

(HP02, site1, low intensity worker)

</div>

> *I do my session in a GP practice which is how – the way I prefer to work, so there's a lot, lot more flexibility in the system and I supervise and manage the low intensity worker in the practice and so I'm still going to have some waiting restrictions but*

I'm able to, um, slot people in much quicker than if I'd been at the psychology department and I, I think for me that's where the stepped care model works best...

<div align="right">(HP03, site1, high intensity worker)</div>

At times when waiting lists were high, health professionals involved patients in the decision-making process by informing them of the likely wait and referring them only if the patient expressed that they were happy with this. However, in-line with other factors concerned with negotiating the stepped care model, it appeared that many patients were left with nothing or decided to go elsewhere as they could not face the long wait to be treated:

...sometimes when people realise that it's going to take a year, they kind of lose heart or, or just say, don't bother.

<div align="right">(HP12, site2, high intensity worker)</div>

Outcome Measures

The use of outcome measures in making decisions about a patient's treatment was regarded both positively and negatively by health professionals. Outcome measures used due to service requirements, were generally not viewed as having a large impact on decision-making. Factors such as the need to take the individual patient into account, the fact that the scores obtained are often unable to capture the way that the patient is presenting and that often clinical judgements prevail over what is measured were reasons for this.

I think like I kind of see what that, that is being used for, is collecting data for IAPT, I don't see it as having a massive impact upon what's actually going on in the service, so it's kind of almost like a hoop that we're jumping through...'

<div align="right">(HP02, site1, low intensity worker)</div>

Some held the view that they did not reflect the actual experiences of the patient:

...I think, I just think that they're not always completely valid in the sense of what people are actually experiencing.

<div align="right">(HP06, site1, low intensity worker)</div>

A few professionals talked specifically about the outcome measures' inability to capture the level of distress that the patient was experiencing:

I mean obviously outcome measures are a good guide and sometimes they do seem to reflect what the patient's saying but sometimes they don't and the patients distress levels in, in sessions and things seem a lot higher than the measures would suggest

and, you know…I think they were like sort of five by the end of the sessions…but the distress was still there and it was still – she was preoccupied with it

<div align="right">(HP06, site1, low intensity worker)</div>

Others expressed that outcome measures were useful in the initial assessment for assessing severity, and perhaps have an influence on whether a patient is 'stepped-up' or 'stepped-down'. They also recognised that outcome measures can be useful for discussing progress of treatment with a patient:

I think that's important and it gives them [the patient] a bit more information and uhm, I mean it's obviously important too for our service to see what kind of people we're getting in and sort of like the difference in interventions and how the scores vary at the time, you know, and how to monitor the sessions and what's changed and what's helped.

<div align="right">(HP23, site3, low intensity worker)</div>

Guidelines

Whilst guidelines were not frequently referred to as having an influence on the decision-making process, on the occasions when they were discussed it was the lack of guidelines (sometimes local) as to how decisions should be made. One health professional talked about the lack of guidelines in relation to how their profession differed to that of other similar professions where guidelines played a pivotal role, and the implications that not having clear guidelines can have:

I'm not actually sure what kind of guidance we get. I don't think there is any guidelines, or if there is I've never seen them or heard of them or nobody's ever mentioned them, which I find quite appalling actually because for things like assistant psychologist there's, the Division of Clinical Psychology has guidelines for, you know, psych – anybody who's qualified, has got a core profession has guidelines, but for low intensity workers there are no guidelines and I think that is a huge, huge error. I think it's quite dangerous, especially when, uhm, I guess for a lot of low intensity workers tend to be younger, tend to have less experience, and so it's really important for their own learning and for client safety.

<div align="right">(HP11, site2, high intensity worker)</div>

Where guidelines did exist, for example NICE guidelines, difficulties in following these were stressed. Such difficulties related to the issues previously addressed such as waiting lists that sometimes made it impossible to make the decisions specified:

I know NICE guidelines said he shouldn't but we didn't before NICE guidelines came out so I [laughter] well not to a certain extent it must be said, um, but I, you know sometimes I would add a tric – a small dose of a tricyclic and that seems to work…It's, It's resource driven I'm afraid, um, my NICE guidelines, you know, which is a number one, level one diagnosis, level two, ignore it as far as I can see, but I think they're, they're fine as a what we ought to be aiming for but we do not have the resources.

(HP22, site3, GP)

Other health professionals expressed that where guidelines or protocols were in existence they are often not appropriate, as they do not take into consideration the individual nature of the patient's problem. The general feeling was that one treatment could not be regarded as 'one fits all':

…but, yeah, it does feel like a, quite a mechanical system which doesn't fit everybody so I just try to sort of use intuition and, and experience and supervision to the best of my ability to make things be moulded to clients rather than being very rigid and – 'cos I think ultimately you could get somebody with quite serious depression who could benefit greatly from the self-help and don't want to engage with higher services - in which case, it's a really valuable service for them if they are able to use it. So, yeah, I think as long as you do thorough enough assessment and use supervision, then you can work around that but it makes for quite a tiring, kind of frustrating experience sometimes.

(HP07, site1, low intensity worker)

However, whilst guidelines were generally viewed as insufficient, health professional decision-making was viewed as a less complicated process where patients presented with specific diagnoses.

I guess the other bit that I didn't specify clearly is within anxiety disorders, if someone's got OCD or PTSD, um, then they'll be stepped-up quickly. So PTSD, we can up – if we can see that on the referral we now tend to step that up straight away, um, OCD, I guess it depends 'cos there might be some things that low intensity workers could do, in terms of around stress management but OCD, um, we'd step up to high intensity.

(HP03, site1, high intensity worker)

Theme 2: Mental Health Service Delivery Issues

High Demand for Services

Health professionals, particularly those working in low intensity roles emphasised that the demand for mental health services was high, often exceeding what the service was capable of providing. Some expressed the impact that this had upon them personally:

> *…it's hard when you look back isn't it? you see that many people, just turn to a big fuzz in your head.*
>
> (HP11, site2, high intensity worker)

As a result professionals said that they had to be 'mindful' of the work that they were doing with patients to ensure they were managing their caseload effectively and efficiently. The need to provide consistently good quality care was stressed but with such high demand it was recognised that it would not always be possible:

> *We do what we can in with the, within the constraints that we've got. The way I look at it is that the before we were around people are experiencing the, the same kind of problems and there wasn't a service like this to support them. If the best that we can give is the equivalent of pretty good GP care, and we can ensure everyone gets that on a consistent basis then that's quite a big step forward. Anything beyond that then we're just like setting ourselves up to fail in terms of our expectations. The level of demand is so great that it's going to be impossible to achieve it.*
>
> (HP20, site3, low intensity worker)

Service Resource Issues

In delivering mental health services it was recognised that resources were often scarce and this impacted upon the health professional's ability to respond fully to patients' needs. As one GP stated:

> *…in primary care which is you've got somebody else sitting opposite you who's obviously distressed and poorly and you as a caring doctor want to help them and other than tea and sympathy - and yet being the NHS, you don't get the tea, the only thing we've got to – really to give them is our time and an anti-depressant and it might just be that time would be just as effective.*
>
> (HP22, site3, GP)

Thus the availability of resources directly influenced how treatment decisions were made. Some discussions highlighted the overlapping nature of resource availability with

'negotiating the stepped care model'. Health professionals discussed that when services were not available patients were not necessarily being referred to the treatment that had been identified as most appropriate. They believed that often decisions about where to refer patients to was based on what was available. At times this resulted in patients receiving treatments at lower levels than NICE guidance would suggest, mainly due to the fact that these services were more readily accessible:

> *…there are services that are available, and how quickly they're available, so, uhm, I might be more likely to send somebody straight through to CBT if the can be seen within two weeks, but if they're going to wait 6 months then it's more likely that I'd put someone in to the low intensity service where they'd be seen within the next two to three weeks. So availability.*
>
> (HP17, site3, GP)

Some of these issues were directly related to the implementation of IAPT and were therefore not only restricted to low intensity services. Where IAPT had not been implemented fully, low intensity or high intensity services may not have been available which resulted in patients sometimes being referred to lower or higher levels than would necessarily be required. A clinical psychologist who recognised this had happened previously did not regard these as 'proper referrals':

> *Now in* [PCT site] *there's, uhm, graduate mental health workers in all the practices, so uhm initially when there were only a few graduate mental health workers around we would get all the referrals because the GPs didn't have that initial step to refer to, but now they don't have that problem, so you know, normally the ones that we get are kind of proper like secondary level kind of referrals.*
>
> (HP05, site1, high intensity worker)

At times, where the treatments that were available were scarce or access was poor, health professionals were faced with making decisions about which patients should be prioritised. Whilst they recognised the NHS did not necessarily have the 'luxury of resources' and there were therefore limitations as to what patients could access, rationing referrals to services caused frustration among health professionals. One GP was particularly concerned about the rationing of services:

> *…perhaps I don't actually stand up for my patients enough, perhaps I'm take – you know, it's not for me to ration health care, um, and perhaps I'm doing the government's job for it by, you know, not referring when it's appropriate and making – beating the drum and making a case that well, sorry these people need psychology, then, you, you, if they said, if I make a five year queue, if that just shows that your*

provision is pathetic and you ought to increase it, so I do, did sometimes wonder, whether, whether he's right, I'm wrong and I ought to be referring more.

(HP22, site3, GP)

HEALTH PROFESSIONAL-RELATED THEMES

A number of issues that related specifically to the health professional themselves were discussed throughout the interviews. Three main themes emerged in relation to these issues:

    i.   'holding'

   ii.   sources of advice or support

  iii. health professional role identity

Theme 3: 'Holding'

Decision-making, particularly when related to 'stepping-up', was often described by the health professionals as 'babysitting', 'containment' or 'holding'. This theme is central to many of the other themes with 'holding' occurring as a result of many of the service-related factors, highlighted previously.

One of the health professionals' major concerns was the considerable time that patients often had to wait for the treatment that they had been referred to. They felt that with the prospect of patients having to wait, often for an unknown length of time, that they should offer patients 'something' and thus would keep working with the patient, even though they had already judged the level or type of treatment that they could provide as unsuitable. Health professionals recognised that 'holding' patients in this way was not necessarily appropriate:

> *…he was referred to me, um to do some guided self-help with, which I decided not to do guided self-help with him 'cos of the nature of his problem and seems it wasn't – didn't seem appropriate, so I've done some sort of community links and then, actually kind of referred him back to the GP to be referred on for psychotherapy. So I am still seeing him, um and I've seen him now for, I think, I've seen him face to face for two sessions and I've had a telephone session with him as well I think their waiting list for psychotherapy is about six months or something, so just trying to kind of do something in the meantime which is a bit bad to say but, I don't know…*

(HP06, site1, low intensity worker)

In discussing the reasons for 'holding' patients it was frequently reported that they felt that they had a sense of responsibility to the patient, and perceived their role as being responsive to the needs of the individual patients rather than be driven by service requirements:

> *…you know, cos he is, he is now my problem isn't he? He's sat in front of me and I'm responsible for him.*
>
> (HP17, site3, GP)

Health professionals also highlighted the impact that building up a good relationship with the patient had on the decision-making process. A team leader stated the influence that the development of the relationship had upon the likelihood of 'holding':

> *…I think sometimes it's, it's a bit, oh well I've seen you, um, but it's not a sort of cut off, generally if I'm referring people, if I've seen them for a couple of sessions already, I'll continue to see them for a few more sessions, you know, anyway, so that it's not just a sort of cut off and that's kind of it, bye bye, you know, um, 'cos we understand that people, that therapeutic relationship is probably, most important thing that, that we have as practitioners and, um, I think people, you know, obviously hold onto that and that's important to them often as important as the work that you're doing, um, but I think that, um, by talking it through with them and explaining sort of why you sort of feel that might be most benefit to them, most people are quite sort of receptive to it.*
>
> (HP19, site3, low intensity worker)

Health professionals were aware that the decision to hold a patient was not necessarily appropriate and was sometimes more about relieving their own personal tensions rather than the problems that the patient is experiencing. Not doing anything for the patient often impacted upon their emotional wellbeing with some stating that they felt 'anxious', 'stressed', 'demoralised' or simply uncomfortable about leaving a patient on the waiting list:

> *…I'd continue working with this person till I ran out of sessions, and then step her up to high intensity, yeh… Or I would hold on the this person, even though I'd run out of sessions. Cos I've been allowed to do that because we didn't know what to do with these people, till high intensity are free to take them on. I can just support them, and feeling demoralised, 'cause you feel like I can't help you.*
>
> (HP14, site2, low intensity worker)

It was recognised that 'holding' patients, whilst deemed to be a solution to relieve the time a patient is left with nothing, that doing so was not always beneficial to the patients or to

themselves. However, one clinical psychologist emphasised that regardless of waiting lists patients who were clearly not appropriate for a particular level of service should not be held within that service. They further emphasised the inappropriateness of commencing treatment with a patient they knew they should not be seeing.

Theme 4: Sources of Advice or Support

Many of the health professionals talked about the importance of advice and support from others when making decisions about a patient's treatment. There were generally three sources of gaining advice or support: from a supervisor, from other health professionals and from multidisciplinary working.

Supervision Support

The support provided to health professionals through supervision was regarded as playing a pivotal role in decision-making. These included gathering feedback about patients that they thought required 'stepping up', where there were uncertainties or complexities involved with the patient case (including making a formal diagnosis or where their professional judgement infers the patient is not appropriate) or where elements of risk were apparent. Different delivery modes of supervision were present across sites e.g. at two sites one-on-one supervisor-mental health professional supervision took place, while at the remaining site supervision was conducted in a group. However, views about support from supervisors were consistent.

One health professional stressed the benefits of talking about patients in supervision to get a more objective viewpoint:

> *…one of them* [low intensity worker] *had a patient that basically came in and said they, they were suicidal and they're going to hang themselves off a bridge, they've been to look at the place and all this kind of thing, um, so they're sort of saying, about what, what needs to be done, and, talking through the issues around are we in the best place to provide the service and sort, sort of getting the GP involved and that kind of thing, so it, it, sort of still very much clinical but then there's kind of that side of things where people talk through cases with me and, we can sort of , if they're stuck with somebody as well, we can maybe talk about, um, you know, what they've tried, what might, what else might help and that's not always just about being at a*

more senior level, it's just more objective, sometimes because you kind of on the outside and you can maybe see things a bit differently.

(HP19, site3, low intensity worker)

In terms of the advice provided at supervision about the decision-making process, health professionals stated that the process was a collaborative one between themselves and the supervisor and that the supervisor managed the situation in a way that was productive for the health professional's learning experience rather than feeling that their opinions have been overlooked:

…he [supervisor] doesn't really give me a second opinion but it just gives me - he gives me another sort of helps me think about it in a different way I suppose, um, but yeah, I don't think I've ever kind of left supervision thinking – oh, you know, oh no, you know I've – I was kind of wrong, my supervisor was right and, and then feeling uncomfortable…

(HP15, site2, high intensity worker)

Overall supervision was generally viewed as a positive avenue for support and assistance with making decisions. One health professional, however, highlighted a negative aspect of supervision in that it was time-restricted, pressurised and there often was limited opportunity to address all their concerns:

…I think if you've got an hour a week supervision where you've got like quite a few cases that have shown risk or that are really severe, like you need to discuss because you need to decide what you're going to do with them and kind of feel like, uhm, you've made a responsible decision with your supervisor, that actually that hour is kind of rushing through all those cases, like this one, what would you do? And the next one. So there's no time in that to kind of think about, well how am I managing my workload at the moment, how do I feel about this case that was really disturbing or, you know, I think that's what we mean…

(HP02, site1, low intensity worker)

Others felt that the limited time spent in supervision often meant that the difficulties that they were experiencing as professionals (such as managing their case load and not wanting to admit when they are struggling) were not always addressed. This was highlighted to be a problem particularly when the supervisor also had the role of line manager. It was recognised that this was not necessarily a universal problem but one that would be helpful to address.

Other Health Professional Support

Health professionals also sought advice and support from others within and outside their immediate team. The incentive to do so related to reducing isolation, gaining emotional support and to gain advice on treatment decisions from others that they considered had a certain level of expertise. Working within a team environment was particularly important in meeting these needs and some were reliant of such relationships:

> *...I suppose, the thing about is that you'd often make those decisions as a team anyway, so it's like, 'oh my God' what would I do if I didn't have a team.*
>
> (HP09, site1, high intensity worker)

Where health professionals did not have such team-working opportunities they found that they sought advice from specialists to help to clarify any difficulties that they were having:

> *...my particular job means time less and less part of the 'team' of high intensity and more, I do my stuff in my practice. Um, so I will be very aware of what the, the team policy is, um, and if I have, yeah, particular questions about that, would, um, find a, yeah, find a way of speaking to someone about it.*
>
> (HP13, site2, high intensity worker)

Multidisciplinary Working

Health professionals emphasised that they tried to work and communicate with other professionals involved in the patients care to ensure that they were making the best decision. GPs found it helpful to speak to the mental health professional to gauge the available treatments and for monitoring patient progress, whilst mental health professionals preferred to have the GP involved to keep them informed of the patient's condition and to relieve some of the responsibility in managing complex patients:

> *...for me, a lot of it is having another person involved. You know, if, if she's going to be up for supporting them through their anti-depressants and doing the odd phone call, it's a huge weight off my head. It makes a massive difference and you know we can, we can kind of liaise in six weeks and she'll tell me how she's doing and either it's going well and she's happy to go on or it hasn't really worked but, it, it's hugely helpful to share that, to share that initial stage with somebody and know that they're going to be able to see someone for an hour instead of 15 minutes. You know, it, it is really, that's what I find is, is that sharing, um, is brilliant.*
>
> (HP04, site1, GP)

Ultimately health professionals talked about liaising with others to ensure that patients were managed in an effective way and to overcome problems with poorly coordinated care:

> *I think what I did was feedback to the GP [about a patient not suitable as had psychosis] and talk to my supervisor and think about what's the best thing to do, and talking with the GP together about, and thinking what the person needs and I think he's going to go on for an assessment with uh a psychology assessment treatment service. So he's effectively been stepped up...*
>
> (HP02, site1, low intensity worker)

Theme 5: Health Professional Role Identity

The third health-professional related theme was concerned with roles. This related to the function and responsibility that health professionals had within the model and in the management of patients with common mental health problems. Two issues emerged in the data:

   i. health professional role identity within the model
   ii. health professional identity as defined by others

Health Professional Role Identity Within Model

A number of the health professionals stated that they worked within their remit and that of the stepped care model. Not being trained to provide certain treatments or advice did not necessarily mean that they did not work beyond their limits but there was a general recognition of where their role should end:

> *…I would not take on myself to either say yes or no, because actually that's not what my training is. Um, and I also think that I've got to work with this person for the next 30 years and it's not always best to the person who's actually said no, you know, they'll still be cross but maybe they'll go off and try using the self-help book find that actually it drives them nuts and CBT isn't for them at all. So that's, I would not probably make a categorical decision on that myself.*
>
> (HP04, site1, GP)

Flexibility could be found in relation to the severity of the problem rather than the diagnostic category the patient is presenting with:

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I think the only reasons which I would kind of say someone was inappropriate is if their difficulty didn't fall in my remit. Like I've had somebody who seemed to be at risk of early psychosis, but it just seemed like there's no way I can work with this. Whereas if it's severe, severe depression it's still along the same line that we're working on...

(HP02, site1, low intensity worker)

However, a distinction was made by health professionals between what they felt they could offer and what was expected of them by others. A GP expressed the need to often work beyond what they saw as their role in order to meet patient needs:

…people trust doctors, listen to doctors, this is a good opportunity – they have come for help, don't waste it. Especially blokes, you know, you – I might never see him again, it would not surprise me if I saw him once and he did or didn't want the primary health care worker, I might never see him again. So it's my one – and in fact, you know, what I might never see him again and what I'd hear is I'd hear from his wife how it had gone. She'd go 'oh, he's terrible' or 'oh that was really helpful'.

(HP04, site1, GP)

Health Professional Identity as Defined by Others

The way that health professionals' identity was viewed by other key stakeholders (e.g. health professionals and patients) was of particular concern to workers delivering low intensity treatments. Some had a clear understanding about the boundaries within the low intensity service in terms of the length and purpose of the service that is provided:

I guess, I guess the idea is that low intensity should be the thirty minutes, six to eight sessions of guided self help, based a lot around reading material. Orientating, orientating the person towards psychological therapy, uhm, uhm, and engagement, uhm, with the process. Uhm, and with the idea that they can help themselves.

(HP11, site2, high intensity worker)

Some health professionals remained uncertain about the role that low intensity workers play which can often have an impact upon what the patient expects when they present at that level. It was recognised that this was an issue within the service and can present challenges at the low intensity level:

…how do you help everyone get across the idea that low intensity isn't about doing brief CBT, it's about using materials, particularly where patients don't come in and say 'oh yes, I'd like you to help me use materials' [laughs]. They come in, they expect

it, um, something different in those sorts of issues, so I think it's a, it's a really, really
interesting time for low intensity.

<div align="right">(HP03, site1, high intensity worker)</div>

This issue was mirrored at a high intensity level where a CBT trainee identified the difficulties that they face when patients preconceptions of what they are to receive are very different to what they will be providing. This, in part, was often a result of other health professionals providing patients with inaccurate information. In such circumstances a great deal of work was required at the outset to establish a working relationship:

I think often the information can be kind of confusing for people. And I know that
GPs are forever telling clients that we're counsellors or they're coming for
counselling whatever. And then when they come, the client comes with these
expectations you haven't a – not only, you're not actually starting from scratch,
you're having to undo bad work to make it scratch, to then build up good work…it
can be a bit, uhm, it can feel a bit sort of defeating sometimes when people are
coming for, think they're coming for counselling and then you say to them, actually
we're not counsellors, we're not trained counsellors, this isn't a counselling service,
it's mental health workers and, you know, and then they're even more baffled and
they don't understand. So uhm it is, can be very difficult.

<div align="right">(HP11, site2, high intensity worker)</div>

It appeared that once again, low intensity workers were often faced with working beyond their role identity when the role that they played within the stepped care model was perceived differently by others:

…sometimes people sort of, managers and things, actually realise, um, including sort
of discharge letters, every time someone DNAs you have to send a letter out, you
know, letting the G –you know, sending letters, GP, letting them know what
happened. And also, you kind of – I get quite a lot of enquiries from the GP asking
me to sort of recommend things or do, you know, it's sort of extra stuff but in a way, I
feel slightly obliged to do it but also that if I don't, if I don't do it then I'm probably
just going to get referred that patient anyway so it's kind of helpful for me to do that
to sort of manage the workload as well.

<div align="right">(HP06, site1, low intensity worker)</div>

PATIENT-RELATED THEMES

Theme 6: Patient Involvement in Decision-Making

The final issues that were discussed within the health professional interviews related to the patients and the influence that they had on the decision-making process. Four main themes were present:

i. patient preferences

ii. patient choice

iii. collaborative working with the patient/ shared decision-making

iv. health professional-led decision-making

As the distinction between patient preferences and patient choice is not always clear a definition of each that was applied during the process of analysis is provided in Figure 17 to aid the discussion of these themes.

Figure 17: Defining patient preference and patient choice

PATIENT PREFERENCE
"Statements made by individuals regarding the relative desirability of a range of health experiences, treatment options, or health states"
                          (Brennan & Strombom, 1998, p259)

PATIENT CHOICE
"A decision made between a range of predetermined options (such as between different options for treatment) and is best viewed as an outcome"
                          (Protheroe & Bower, 2008, p603)

A distinction is therefore made between a preference which is regarded as the desirability that an individual associates with a particular treatment or outcome and choice that is conceptualised as the identified option chosen from a set of treatment options.

Patient Preferences

Most professionals indicated that taking patients' preferences into account was a vital part of the decision-making process, to ensure that the potential benefits of the treatment were maximised in terms of patient engagement and outcome:

> *…if someone says that, you know, they really don't want something then obviously you have to kind of work with, work with that and uhm, uh, yeh if you think – I think probably quite a good example of that might be someone who you think might benefit from psychotherapy, but they say I don't, I really don't feel like I'm ready to discuss early experiences, then there's no point because if someone doesn't want, you know, even if you think actually that person probably, you know, maybe in the – but you can't, so then you have to think about what else might be better. So yeh, I mean it [patient preference] has to play a role yeh.*
>
> (HP01, site1, low intensity worker)

> *Patient preference I think has a huge part to play in it because you can feel it's not relevant to prescribe medication, it's just relevant to pursue sort of simple measures. And if the patient's not willing to do that, and won't do it, and isn't getting better after weeks and weeks and weeks because they're not doing the things you advise, it's really hard not to be backed into a corner sometimes to, to give them what they want as such. So there's certainly the patient.*
>
> (HP16, site2, GP)

It was apparent, however, that allowing patient preferences to prevail could be, at times, difficult for the health professional. Sometimes patients were not willing to engage or try treatments that the health professional thought would be of benefit and instead preferred to remain under the care of the professional that they had established a relationship with:

> *…I mean a typical day like we typically don't see people with like a bereavement reaction and I see someone and refer them on to bereavement – for bereavement counselling and they've come back and said I don't want bereavement counselling I feel like in one session I got a relationship with you and I want to see you and I like well – we don't normally do that, so what do we do, do we leave this person who's clearly depressed – a year on from the bereavement even though it's very heavily related to the bereavement, what do you do?*
>
> (HP09, site1, high intensity worker)

Patient Choice

Patient choice in the mental health service was regarded as fundamental and of particular relevance in making decisions about patients' treatment. A distinction was made by a service lead as to the differences of the incorporation of choice in current primary care services rather than, historically, in secondary care:

> *I don't even think it's just like kind of important or not important, it's just like just the way it is, you know, it's their choice. Yeh, I don't even, that doesn't even enter my head I don't even conceptualise it like that. We're not here to – when I worked in secondary services sometimes we were in the situation where you got the troops out and you sectioned people and you brought people into hospital which was clearly against their, their will, and they called you everything for doing it. Well we're not in that game here.*
>
> (HP20, site3, low intensity worker)

However, the concept of choice was difficult to define and a number of issues stood in the way of allowing patients to have complete choice over their treatments. As one GP commented:

> *Well there's only one choice [laughter] but there's no choice... I mean yeah, we've got patient choice but there is no choice...*
>
> (HP22, site3, GP)

Difficulties of incorporating patient choice related to service issues such as 'stepping-up' to higher intensity services and ensuring that decisions made followed the principles of the stepped care model. It was clear that while patients had the opportunity to choose between treatments within steps e.g. choosing a treatment at the same level as the one they are currently receiving or tailoring that treatment to better meet their needs, the choice between steps e.g. choosing a different treatment at a higher intensity was not readily available:

> *…in terms of materials that we use, and whether they engage with the service, they have choice over that, how often they want to come to the sessions, how long the session is, they have a choice of that. I would again adapt it to what they want, um someone just wants one session, that's fine, or someone wants a shorter session that's fine, so, um, yeah, quite a bit of patient choice there definitely and I think that fits well with, um, the stepped care model is increased choice, definitely, and preference.*
>
> (HP08, site1, low intensity worker)

Patients were often not aware of a choice existing. Health professionals often withheld information about what is on offer, where they did not see it as appropriate or in situations where the availability of services was poor. A clinical team leader expressed their anxieties about this:

> *Sometimes, sometimes the impact is on whether or not I even mention it, you know, and that's imp - and that's got to be important. If I'm sort of sitting here thinking, you might, you know, you've reached the limit of where, where I can go with this, or where this, where our service allows, allows us to go. There's, you could, you could make further gains, as far as I can predict or forecast, uhm uh, but to do that I'd have to refer you to something that in effect is not available. And that's the thing isn't it? So sometimes I think, I suspect that, uhm, people are not offered a treatment, but may well be, they may well be entitled to in some way, if they knew about it, uhm, but I think in that way we are distorting something and I, which everybody feels uncomfortable about.*
>
> <div align="right">(HP12, site2, high intensity worker)</div>

It was also identified that many patients lacked an understanding of the service as a progression of steps and instead are satisfied that they are seeing someone regardless of their position within the mental health care system:

> *Generally patients aren't really that discriminative and that they're quite, they want –they really want the person that can see them quickest. Um, and we would, I don't think we'd ever get to saying 'well you really want to see high intensity, you realise you can but that's 12 months but I think patients often are quite, um, pleased to be contacted, to be able to, er, seen, um, quite soon and aren't that really aware of the differences in a stepped care model.*
>
> <div align="right">(HP03, site1, high intensity worker)</div>

Shared Decision-Making

With respect to making decisions health professionals identified that it was a collaborative process between themselves and the patient:

> *I think it's between me and the patient actually, 99.9% of the time.*
>
> <div align="right">(HP10, site1, GP)</div>

Incorporating patients into the decision-making process was regarded as a way to facilitate patients to feel empowered, allowing them to take more ownership of the decisions made. A gateway worker described the importance of ensuring that patients feel in charge:

I think ultimately just the talking through things is the main way we sort of facilitate decisions really, talking through things with people and trying to empower them to feel that they can take charge of their own life I suppose, 'cos when, when they're feeling that way, they often, feel, can feel completely out of control and sort of empowering them to feel, well I can, you know, take charge of this and sort of take control of kind of what's going on…it's a sort of constant, they're sort of re-visiting and sort of helping to empower them in, in some ways is kind of reflecting on where they've, they've come from.

<div align="right">(HP19, site3, low intensity worker)</div>

Health professionals also expressed the importance of including patients in treatment decision-making to ensure the most suitable treatment was identified. If a patient was not involved it was anticipated that this would impact upon the outcomes of the treatment they received:

…for them [the patient] to get the most benefit out of it, it needs to be joint so that you're offering some kind of sort of support to make these decisions, um, but it needs to come from them because they know themselves (laughs), you know, they know what, what they're like, what they like, what they don't like, what, you know, what fits into their life.

<div align="right">(HP19, site3, low intensity worker)</div>

I think it is important [collaborative decision-making] because if they're not on board at that stage, then they're not going to come and they're not going to benefit and well, yeah, it's, it's, so it's for your own sake and their sake, it's, I think it's really important to keep them, in, inv, involved as, as much as possible.

<div align="right">(HP09, site1, high intensity worker)</div>

On occasion, difficulties arose when patients presented with pre-conceptions about what treatment they required when these did not match what the health professional would recommend. Whilst acknowledging patient requests, health professionals were faced with discussing alternative options with the aim to allow the patient the opportunity to make a more informed decision. Such situations were said to be difficult and often compromised with the health professional's intention to incorporate patient choice into any decisions made:

…often the patient might say I want counselling and as we said earlier in here, that might not be effective for some things and clearly if someone has got different symptoms, and, we, we know we can do work, then I might advise that. This principle might work better than counselling and, and then again it's still their choice but obviously I, I feel I have a right to obviously, have a duty to advise people, er, but again it's their decision. Um, it's a collaborative approach, mean, meaning it's their

goals, what they want to work on, um and what material they might want to use, so I might have a range of different options.

(HP08, site1, low intensity worker)

Sometimes making decisions in collaboration with patients was also difficult when the options available were constrained by the services available.

…it's a balance, you have to have a balance between the two things and sort of be creative with the resources that you've got, kind of work hard to sort of manage those.

(HP21, site3, low intensity worker)

Therefore, while health professionals recognised the importance of involving patients in the process of making decisions this was distinguished from the ability to provide them with choices.

Health Professional-Led Decision-Making

A number of the health professionals stated that, at times, they felt it was necessary to take the lead on the decisions that were being made. They stressed that although at times they found themselves being quite directive about the treatment choice with the patient that ultimately the patient had the final choice. However, it appeared that this choice may be limited to accepting a treatment or not:

I would sometimes, we kind of override patient preference by, how could you call it, you could call it educating, you could call it kind of indoctrinating saying, we think this is the best thing to do, so this is where we think you should go, and then explaining it really well so they understand, they understand why you think that, and they can either say n – yes or no. I mean whether that's choice I don't know, is that choice?

(HP01, site1, low intensity worker)

In some circumstances, it was clear that patient choice was absent. For example when patient had a complex presentation (e.g. if they were regarded as being high risk, if they presented with drug or alcohol problems or when the health professional was unable to provide the treatment), health professionals took on a more paternalistic role:

…if they were like really high risk and they say 'I'm going to kill myself' then, you start, you're taking their choice out of their hands, if it was quite bad then you, you, er, you know might end up having to call an ambulance or you'd get in a social worker or a GP and they might end up having to be taken in so it's taking all the

choice out of their hands so in that case, yes, um, also, you know, it depends on the problems that if they come, I've had someone come in drunk, it, taken the decision out of their hands, you know, you can't be seen, so you make your decision there, um, I know and ultimately, you know the decision of whether someone's seen or not it totally down to myself, it is down to them as well, if they say I don't want to see you any more but, um, trying to think, I know that, everyone's different in the team and some people are more, are more – I think I'm pretty collaborative whereas they're, they're probably more, I don't know…

(HP18, site3, low intensity worker)

Discussion

The findings reveal that there are a variety of factors that have influence over the professional decision-making. These involve service, health professional and patient-related factors. Whilst the stepped care model is supposed to increase access, access issues impacted upon health care professionals' ability to follow the principles of the model. Of particular importance, it was highlighted throughout many of the themes that there were tensions between following the principles of the stepped care model whilst responding to patient need and negotiating service factors that they had very little control over. One of the factors that contributed to these tensions that had particular relevance to decision-making was the use of standardised outcome measures and guidelines.

Whilst regarded as a useful tool for the monitoring of patient progress, outcome measures were generally viewed as being more of a requirement for evaluating the impact of services rather than tools to purely assist with monitoring and making decisions about treatment. Some held the view that they did not reflect the actual experiences of the patient, and thus were not useful in the decision-making process. Although measures to capture subjective patient experience are in existence (Gilbody et al., 2003) treatment decisions within the stepped care model are very much related to measures that are standardised in nature. Guidelines aim to improve patient care but at the same time have a focus to ensure value for money and to reduce variation in patient care. It was argued that standardised measures and guidelines often posed difficulties when the individual nature of patients' problems did not fit with guidelines or service constraints such as waiting lists impacted upon the ability to adhere to recommendations. It is these standardised approaches which conflict with ensuring that mental health care is provided using a patient-based approach.

These findings are comparable to recent mental health literature that has highlighted the pessimism surrounding the use of outcome measures. This relates to the ability to address the multifaceted nature of patients problems, perspectives and outcomes (Gilbody *et al.*, 2002; Gilbody *et al.*, 2003), issues concerned with their interpretative benefits or validity (Garland *et al.*, 2003), and the view that their inclusion is driven by service agendas rather than having a patient management focus (Callaly *et al.*, 2006; Shumway *et al.*, 2003). While research has highlighted the overlap between meaningful patient outcomes and measurements that are used in practice (Perry & Gilbody, 2009) the emphasis placed on standardised measures such as those measuring severity levels is significantly greater. The

view that clinical judgement or intuition is required to make decisions alongside or independent of guidelines or outcome measures was also consistent with previous findings by Trauer et al (2009) who reported that mental health staff regarded outcome measures as a 'threat' to their clinical judgement. Whilst, the health professionals interviewed in this study did not necessarily regard them as a threat it was often reported that they were in disagreement with their clinical judgement. However, the clash of these contrasting approaches to decision-making has been addressed in the literature. Although clinical judgement is regarded as an important part of medical practice, unaided it is said to be prone to error, bias or misunderstanding (Dawes *et al.*, 1989). Therefore adopting one approach over another may have implications for the quality of the decisions made.

Studies specifically addressing outcome measure use and attitudes in GPs have shown similar findings and highlighted the importance of an individualised approach. While identifying the value that outcome measures add, such as improving assessments and helping to standardise practice, GPs saw them as only a part of the management of patients' problems. The importance of clinical judgement and gathering an understanding of patients' lives including their coping abilities and social situations in addition to the severity of their problem was regarded as an important aspect of managing patient problems from an individual perspective (Dowrick *et al.*, 2009) as was patients' age or the presence of a physical illness (Kendrick et al., 2009). The complexity of mental health decision-making by GPs and the influence of outcome measures was also identified in a qualitative study exploring GPs and female patients' experiences of depression (Maxwell, 2005). GPs reported that making decisions went beyond the use of such tools and often beyond their role boundaries. The duty to respond to their patients' needs was also stressed. In contrast, patients reported that they liked the measures, thought they helped them to understand their problems better but also identified the limitations of them when thinking about the needs and circumstances of individual people (Dowrick *et al.*, 2009). Health professionals identified the importance of involving patients in the decision-making process but in utilising outcome measures and guidance the patient's perspective may be lost (Speight & Reaney, 2009).

Evidence-based practice and guidelines are said to play their part in how mental health care professionals make decisions (Kendall *et al.*, 2004b), however it is suggested that there are times where adopting a more individualised approach are necessary, particularly when

patients present with complex cases where guidance is lacking. Decision-making within stepped care, although supported by available guidance and outcome measures, does not follow a standardised decision-making framework and thus the decisions that health professionals are faced with are complex. The impact that limited guidance has upon the management of mental health problems has been previously demonstrated in a study evaluating referrals to a community mental health team. Hilton et al (2008) found many referrals were inappropriate or the urgency of the problem was not addressed appropriately leading to difficulties in the service managing and responding effectively. Consequently, health professionals, at times, resort to other sources of information to assist with the decision-making process. A recent evaluation of two IAPT demonstration sites provided additional evidence that decisions are not made purely on the basis of these measures alone (Parry et al., 2010). For one of the sites it was revealed that patients who 'stepped-up' to step three CBT showed similar baseline scores to those who were 'stepped-up' to step three at the outset. This provides an indication that other factors are likely to have played a role in the decision-making process. The influence of factors such as patient characteristics has been demonstrated previously where it has been argued that an individualised approach is necessary when presented with complex patient cases (Welsh & Lyons, 2001; Hicks, 1998; Benner & Tanner, 1987). In such instances the importance of 'taking into account' more condition-specific factors alongside generic factors to improve sensitivity and to better capture what patients regard as being important, is stressed (Dowie, 2002). These findings were additionally supported by qualitative interviews conducted with key stakeholders at the demonstration sites (Parry et al., 2010). In discussing the ways in which the service was implemented they stressed the need to move away from a traditional '*silo*' (p58) way of thinking to a whole systems approach to ensure patients were provided with high quality care. Again, these findings provide evidence for the need for the move away from complete reliance of standardised measurements towards gathering a fuller picture of all aspects of patients' problems. Consideration of the ways in which decisions are made to ensure treatment pathways are efficient and responsive to patient needs was also of great importance.

In making decisions service issues such as long waiting lists resulted in many health professionals 'holding' patients. The issue of 'holding' patients until they can access the appropriate treatment is important and has implications for the functioning of the stepped care model. Previous literature has identified that GPs hold patients regularly and the most

commonly reported patients being held were those with mental health problems (Cocksedge, 2005; Cocksedge & May, 2005). 'Holding' was seen as a way to '*contain the situation' while the patient 'works' through the event'* (p71). For GPs it is clear that, in some instances, they have very little control over whether they hold a patient or not as they have a long-term role in caring for the patient. Mental health professionals, on the other hand, see the patient over a restricted time period. However, whilst not necessarily providing care over lengthy periods these professionals provided clear evidence of the instances where they felt the need to hold a patient. One of the most frequently reported reasons related to the presence of waiting lists. Professionals did not want to leave the patient with nothing during their wait and 'holding' was often said to be a result of needing to also contain their own emotional concerns. This was a particular problem for low intensity workers and resulted in frustration. The experiences of these workers mirror those of mental health triage nurses detailed in a recently published study (Sands, 2009). Through survey questionnaires and semi-structured interviews nurses revealed the problematic issues of having such a crucial role on the decision-making process. They emphasised the lack of resources, guidance and parameters impacted negatively upon their experiences and considered mental health triage as a 'grey area' in which they often worked beyond their professional remit. The difficulty of making decisions about newly referred patients whose diagnosis and/or levels of risk may not be clear (Huxley *et al.*, 1998) may also add to the complexity of decision-making at low intensity levels. Thus the driver for 'holding' by mental health professionals was related to service restrictions, whilst GPs were driven more by their '*contractually obliged*' (p74) role to continue caring for the patient.

A number of issues are raised with respect to 'holding'. One is the amount of involvement that patients have in the decision-making process. Health professionals identified the importance of involving patients in making decisions to ensure that their preferences and choices were taken into account. They recognised, however, that they are very often unable to provide patients with a choice, particularly when other options are not readily available. Patients may or may not be aware of instances where they are being held. 'Holding' may be viewed by health professionals as a way to enable patients to cope but not it does not necessarily provide positive outcomes and is often not focused on meeting their needs. Cocksedge (2005) described this as helping patients to '*keep ticking over*' (p67). A number of problems may therefore be associated with 'holding'. Davison (2000) highlighted that

patients may actually get worse if they receive ineffective treatments which may involve having a negative impact upon patients' self-esteem or motivation. This has implications for 'holding' where patients are being held in treatments that have previously been identified as not suitable in terms of the level, focus or content of a treatment that they require. Davison further explained that the time that a patient spends in receipt of an inappropriate treatment could have been devoted to a more appropriate one. Furthermore, a recently published study suggests that if decisions made about appropriate psychotherapy treatments are not made effectively they may potentially cause harm making the problem or other aspects of the patient's life worse (Dimidjian & Hollon, 2010). It has additionally been highlighted that it is possible some patients may feel a sense of failure if they cannot benefit from low intensity interventions which may cause them to disengage from treatment (Lucock et al., 2008). Thus 'holding' patients at treatments that have already been deemed as inappropriate may have potentially negative consequences upon outcome.

'Holding' is also refered to within the psychotherapeutic literature but has a very different meaning to the way in which it is discussed here within the stepped care model. Holding in the psychotherapeutic relationship refers to a therapeutic ambiance, setting or environment that permits the patient to experience safety and protection that can facilitate psychotherapeutic work (Modell, 1976). Within the stepped care model the role of 'holding'. With respect to the findings in this study, however, it is clear that the role of 'holding' is not equivalent to that in psychotherapy but that health professionals are 'holding' patients due to lack of service resources, long waiting lists and the need to manage their own anxieties. Thus the decision the health professional is faced with is not simply to refer to a more suitable treatment but instead to leave the patient on a long waiting list until their appropriately identified treatment becomes available. The stepped care model provides guidance about where the patient should be referred to and therefore, for the most part, it is not that the patient is receiving an inappropriate treatment due to poor judgement about suitability but instead because the health professional is aware that there is nothing else immediately available. Stepped care emphasises serving the needs of clients efficiently, but without sacrificing quality of care (Sobell & Sobell, 2000). If patients are not receiving the treatments that they require this may have implications for the fundamental propositions of the model. Health professionals are thus faced with complex decisions about how to manage such patient's problems which at times results in them 'holding' as no other option appears available.

In addition to lack of patient involvement and potentially providing patients with inappropriate treatment, other problems associated with 'holding' include health professionals' lack of skills or competency in managing patients with problems they have not been trained to deal with. This was highlighted within the interviews with health professionals and had particular relevance to low intensity workers. Links can also be made with the issues addressed within the role identity theme. Health professionals are aware of their role within the stepped care model and although there is a certain degree of flexibility within that remit they recognise the importance of being aware of the limitations of their capabilities. Low intensity workers frequently found themselves managing patients who were waiting to access treatments at higher steps of the model and identified that doing so may be unhelpful to the patient or themselves. The complex decisions that these workers were faced with impacted negatively upon them in terms of stress and frustration levels and may have implications for the retention of workers within IAPT. These findings are in line with recent literature looking at decision-making in mental health triage (Sands, 2009), a role that some low intensity workers felt they took on. This exploratory survey study of triage nurses identified the complexity of making decisions within mental health care, the responsibility that was associated with this and the anxieties that making such decisions brought. The study also identified the frustrations involved when services were not available and the need for more training to ensure that nurses feel more prepared in making such decisions. Also, in line with some of the issues addressed, Sands et al (2009), found that whilst training was provided it rarely covered all of the issues that health professionals were expected to manage and make decisions about. An earlier study highlighted 'the need for treatment decisions to be made by experienced clinicians and not by relatively untrained personnel or on the basis of questionnaires' within a stepped care approach (Sobell & Sobell, 2000), stressing the importance also of ensuring an individualised approach is adopted.

In helping to manage such difficulties health professionals in this study highlighted the supportive role that supervisors, team members and other health professionals have in easing the complex decision-making process. Recent mental health literature, with particular relevance to frontline workers, supports these findings and highlights the value placed upon such support (Parry et al., 2010). Parry et al's (2010) evaluation additionally highlighted that, at times, supervision was deemed insufficient. Whilst this was not revealed by the health professionals in this study, they did indicate that time was often an

issue and had negative implications for their capabilities of managing high case loads and their own emotions or problems. The importance of multi-professional team working has been drawn attention to in Department of Health Policy (Department of Health, 2000). Working within a team environment is associated with a number of benefits such as contributing to a more coordinated service (Cook et al., 2001) and opening up the opportunity to allow for a more holistic approach through the incorporation of multiple perspectives (Bennett-Emslie & McIntosh, 1995).

In exploring 'holding' further it is clear that while GPs and mental health professionals may face many similar issues, GPs may be faced with longer-term difficulties. Mental health professionals generally hold short-term relationships with patients and thus while 'holding' can cause many difficulties patients will eventually be 'stepped-up' or discharged. GPs, however, have the responsibility of managing and supporting patients in the long-term, they do not have the opportunity to discharge a patient and therefore where a referral to a psychological therapy or to a number therapies has not resulted in a positive outcome for the patient the GP has to take on the continuing role of managing the patient's mental health problems. An additional challenge for GPs is managing 'holding' without supervision, something that was reported by many mental health professionals as an important supportive mechanism. It is unclear from this study the mechanisms by which GPs gain support, whether they manage 'holding' essentially as an individual or if they utilise the support of peers.

In conclusion, a potential gap between the theory and implementation of stepped care was revealed. Central to the difficulties faced by health professionals when making decisions was adopting an individualised approach, which conflicted with standardised measures and guidelines. The clash between the 'caring' values of health professionals and the 'economic/public health' perspective underlying stepped care impacts upon the model's aims to maximise access to care and meet patient need. In trying to overcome some of these tensions health professionals often resorted to 'holding' patients who were facing long waiting lists for suitable treatment or for whom no other suitable treatment was available. In 'holding', the conflict between health professional values of what they are aware they should be delivering and what they are actually doing in practice is was recognised. 'Holding' has major implications for service delivery and efficiency. With patients being held at low intensity treatments prior to being stepped up these patients are

using up resources in terms of time that could be used to treat another patient. The potential impact that delaying patients' access to treatments may have or providing them with treatments identified as unsuitable, is also unclear. 'Holding' is thus a potential drain on resources, and has significant implications for the function of stepped care systems in their goals of maximising access to care.

CHAPTER NINE: STUDY 2B - MENTAL HEALTH PROFESSIONALS AIS THINK-ALOUD ANALYSIS

Introduction

This chapter presents the results of the AIS think-aloud task that was completed by mental health professionals. Details of the objectives of the analysis and the process by which the analysis was conducted are presented. The findings from the analysis are detailed, including the number and types of questions, the outcome of the decision-making process and the influence of factors (such as severity) on the decisions made.

Objectives of the Analysis

The analysis was designed to explore the following issues of relevance to modelling health professionals' decision-making:

i. *The number of questions asked to make a decision* – this aspect of the data may give an indication about the complexity of the decision e.g. when asking for more information this may indicate that the decision is more complex

ii. *The types of questions asked* – may help to understand what aspects of a patient's presentation have most influence upon a treatment decision. Thorough inspection of particular issues (e.g. repeated questions asked about a specific theme or sub-theme) may indicate that the health professional explicitly links information related to that issue with their treatment decision. There are a number of factors that we would predict would have particular relevance to decision-making within a stepped care model. For example, severity plays a major role in NICE guidelines, whilst patient preference is prevalent throughout policy.

iii. *The order in which information is gathered* – exploration of where certain issues are addressed within the decision-making process may indicate the perceived

importance of particular issues. Early inspection of particular issues may indicate greater importance.

iv. *The final decision* – reveals the actual disposal decision made e.g. what type of intervention does the professional think is most appropriate. Important issues concern the type of decision made, how it relates to other decision-making factors, and the consistency of the final decision across vignettes and health professionals.

v. *Automatic decisions*– exploring instances where an automatic decision is made may expose particular elements of a patient's problem that have a fundamental effect on the decision-making process.

vi. *Different decisions* – noting circumstances where health professionals would make a different decision may give more insight into what issues may influence reconsideration of their initial decision

Mental Health Professional Sample

Nineteen mental health professionals completed the AIS task. Mental health professionals were defined as low intensity workers or high intensity workers depending on the role that they were currently undertaking and the types of treatment that they were trained to deliver. Low intensity workers refer to mental health professionals who were delivering high volume-low intensity CBT self-management interventions such as guided self-help. High intensity workers refer to the mental health professionals who were delivering treatments of a higher intensity such as CBT. Table 15 outlines the way mental health professionals were defined, their job roles, gender and years worked within primary care and mental health.

Table 15: Health professional role, title, gender and experience

Defined Role Low Intensity (LI) or High Intensity (HI)	Job Title	Gender	Years in Primary Care	Years in Mental Health
LI	PCMHW	Male	1	3.5
LI	PCMHW	Female	1.5	4.5
LI	PCMHW	Female	1	3.5
LI	PCMHW	Female	2	4
LI	PCMHW	Female	1	1
LI	PCMHW	Female	2	3
LI	GMHW	Female	1.5	1.5
LI	GMHW	Female	1.5	3
LI	GMHW (Team Leader)	Female	0.75	4
LI	Gateway Worker	Female	4	5.5
LI	Gateway Worker	Female	0.25	6
LI	Mental Health Service Lead	Male	4	20
HI	CBT Trainee	Female	2	4
HI	Clinical Team Leader	Male	7	29
HI	Cognitive Behaviour Therapist	Female	5	5
HI	Cognitive Behaviour Therapist	Female	0.5	12
HI	Clinical Psychologist	Female	0	11
HI	Clinical Psychologist	Female	9	15
HI	Clinical Psychologist/ HI Trainee	Female	6	4.5

PCMHW – primary care mental health worker; GMHW – graduate mental health worker

Developing Matrices

Throughout the AIS-think-aloud task mental health professionals asked a wide variety of questions in order to gather further information about the cases presented. To examine this data in more detail a thematic analysis approach was adopted (Boyatzis, 1998). Following transcription of the recorded AIS-think-aloud task each individual transcript was broken down into segments where each segment represented one question. During this process initial themes and sub-themes regarding the types of questions being asked were developed.

To assist data collection, organisation and analysis it was decided that constructing a data matrix for each of the scenarios would be useful. In designing matrices, Miles and Huberman (1994) suggest that there are a number of factors that need to be considered to

ensure maximum benefit. Of particular relevance for this study was ensuring that the data was displayed and ordered in a way that allowed the core analytic questions (i.e. the order and types of questions) to be identified easily. Such detailed analysis of search patterns has been used in studies looking at how people process information in order to arrive at a judgement or a decision (Westenberg & Koele, 1994).

An example of the matrices can be seen below in Table 16 that presents an extraction of data from the depression (ongoing treatment) scenario.

Table 16: Extract from AIS analysis table - depression (ongoing treatment) scenario

	HEALTH PROFESSIONAL ROLE	
QUESTIONS ASKED	Low Intensity – Graduate Mental Health Worker	High Intensity - Clinical Psychologist
	Automatic decision	**Automatic decision -**Review why meeting so infrequently, look at patients views on appropriateness of freq. Continue to see at this level, set review point to see improvement occurs then think about what need to do
Engagement/ Compliance	12	
Patient Goals	2 3	Point at which decision was made
Patient Preferences	9 13 D (13): Continue to see at a low intensity. Look over what worked and didn't. Focus on the positive things from that. Link to other services that can provide things that may benefit him once completed sessions (as scores low) - patient preference. Keep working with if showing benefit	Decision made
Patient Social Circumstances		
Patient Support	5	
Diagnosis		Order in which question was asked
Impact of Problem		
Length of Problem		
Presenting Problem/ Symptoms	6 7	
Risk	4	
Severity	1	
Trigger	8	
Medication		
What Helps Improve Symptoms		
Work Already Done In Sessions	10 11	
Co-Morbidity		
Drug & Alcohol		
History Of Mental Health Problems		
Previous Treatment		

The Process of Analysis

Table 16 presents the data collected from two health professionals – one low intensity worker and one high intensity worker. Outlined in the table are the types of questions asked, the number and order of the questions asked (indicated by the numbers presented in the relevant question rows), the point at which a decision was made (indicated by the letter D), the actual decision made and instances where automatic decisions were made. Neither of the health professionals stated that there would be instances where their decision would be different and this is therefore not indicated in the above extraction.

The information that follows provides a detailed analysis of the data collected in relation to these issues.

Identified Outlier

Initial data analysis determined that one of the high intensity workers (CBT Therapist) was identified as an outlier due to the high numbers of questions asked for a number of the scenarios in comparison to the other health professionals. As the sample size was relatively small, including this health professional was found to have a large impact upon the quantitative findings. Thus the data collected from this health professional was excluded from the reporting of the data but is presented in footnotes to indicate the effect of its inclusion.

Categorising the Types of Questions Asked by Mental Health Professionals

Analysis revealed that the questions fell into three higher-level themes (each with a number of sub-themes). These were:

- the nature of the problem
- the management of the problem
- patient characteristics.

Whilst the majority of the questions were easy to group into themes a number of difficulties and ambiguities occurred throughout the process. In grouping the questions it was revealed that it was important to keep an open mind and avoid making assumptions about the purpose of the question when ambiguities may be present. An example of this relates to the question 'does he live on his own' asked about the patient presented in the depression (ongoing treatment) scenario. Initially, as an assumption was made that the health professional was interested about what help this patient may have and it was thus coded within 'patient support'. However, on reflection, it was not clear that this was indeed the reason that the question was asked and it was decided it would be better placed within the 'patient social circumstances' sub-theme.

Difficulties also arose in relation to questions that were categorised within a sub-theme as 'history of mental health problems', within the higher-level theme of 'management of the problem'. On further exploration of the actual questions it was revealed that these questions were actually focussed on two distinct issues – that of the patient's previous history of mental health problems and previous treatment that they had received for mental health problems. A decision was made to divide this into two sub themes – 'previous treatment' and 'history of mental health problems'. Additionally, on further inspection of the questions considered within the 'presenting problem/symptoms' sub-theme of the 'nature of the problem' theme, it was revealed that a number of these related specifically to the impact that the problem was having. This was regarded as being a distinct issue, so this theme was also split into two themes – 'presenting problem/symptoms' and 'impact of the problem'. There was also ambiguity between what was regarded as a 'goal' and a 'preference' and how these could be distinguished from each other. It was stated that whilst 'patient goals' related to what patients wanted to achieve from treatment, 'preferences' related more to what kind of treatment the patient would like to achieve these goals. It was agreed that in order to aid in the understanding of these categories that they would be better labelled – 'goals-outcome of care' and 'preferences-management of care'. The tables below provide definitions for, and examples of, the types of questions asked for each of the three categories of questions.

Table 17 presents the types of questions related to the 'nature of the problem' over all five AIS scenarios. Questions were related to:

- the patient's diagnosis
- the impact that the problem is having
- the length of time the problem has been experienced
- the way the problem is presenting
- whether there is any risk
- how severe the problem is
- whether the problem was triggered by anything. [8]

In relation to these factors, health professionals asked a high number of questions about 'risk' (71 questions) and the 'presenting problem/symptoms' (68 questions) and about whether there was an identified 'trigger' to the problem (67 questions). In comparison, far fewer questions focused on the 'impact of the problem' (28 questions), the 'severity of the problem' (19 questions) and the 'length of the problem' (19 questions). The 'diagnosis' of the problem attracted a very small level of questioning (7 questions).

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[8] Including data from the outlier would have altered the numbers of questions asked for the Nature of the Problem theme (363) and for the following sub-themes – impact of problem (33); length of problem (19); presenting problem/symptoms (94); risk (105); severity (22) and trigger (81)

Table 17: 'Nature of the problem' theme - outline of sub-themes, definitions and examples of questions asked

Theme label & sub-themes (no. of questions asked)	Definition	Example of Questions asked by health professionals during task
Nature of Problem (279)	Factors that are related to the problem(s) that the patient is having. These factors relate to the problem itself, the cause, how it is presenting and its impact.	
Diagnosis (7)	Determining if a medical label has been given to the problems that the patient is experiencing	'is she suffering from depression and anxiety?' 'we're thinking, you know, depressed, depression as a diagnosis, I suppose, or hinting towards that?'
Impact of the Problem (28)	Looking at whether the mental health problem is affecting aspects of the patient's life	'how much is it affecting her day-to-day life?' 'what effect does she think this is having on her children?' 'does panic/anxiety impact on studies?'
Length of the Problem (19)	Determining how long the patient has been experiencing the problems	'how long has she been experiencing the panic attacks?' 'when did this all start? Is it a recent thing?'
Presenting Problem/ Symptoms (68)	Understanding the problem more by identifying the physical, behavioural or psychological signs and symptoms	'what particular symptoms is she having?' 'what kind of behaviours is this woman presenting with?' 'does she avoid going to social situations?' 'what does she think the main problem is?'
Risk (71)	Issues related to identifying whether the patient poses any harm to themselves or to others, and if so the level at which it presents	'has he had any sort of suicidal thoughts?' 'occasional self-harm, how often, and what does it entail?' 'how about risk to others?' 'does she have any protective factors?'
Severity (19)	Level at which the problem is presenting, based on objective measurements such as PHQ9 (depression) or GAD7 (anxiety)	'what are his scores on the measures?' 'what kind of level is there of anxiety?' 'how depressed is this guy?'
Trigger (67)	Identification of any events or circumstances that may have elicited the problems that the patient is experiencing	'has there been anything that has prompted a change?' 'do we know where that's coming from, what was the trigger?' 'is there a particular triggering event?' 'were there any sort of life events that may have precipitated this?'

Table 18 presents the types of questions related to the 'management of the problem' in all five AIS scenarios. Questions were related to:

- management in general
- management of the problem with respect to factors that may influence the decision-making process. [9]

In relation to these factors, health professionals most often asked for further information about the level of 'drug and alcohol use' (28 questions), if any 'previous treatment' had been received (29 questions) and whether the patient had been prescribed 'medication' (25 questions). Fewer questions focused on 'what helps improve symptoms' (18 questions), previous 'history of mental health problems' (13 questions) and 'work done in previous sessions' (12 questions). Finally, 'co-morbidity' and 'disclosure of the problem' were asked about on only five occasions each.

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[9] Including data from the outlier would have altered the numbers of questions asked for the management of problem theme (182), general management of problem (56), problem in context (126) and the following sub-themes – what helps improve symptoms (19); disclosure of problem (11); drug and alcohol use (63), history of mental health problems (18); previous treatment (31); history of mental health problems (18) and previous treatment (31)

Table 18: 'Management of the problem' theme - outline of sub-themes, definitions and examples of questions asked

Theme label & sub-themes (no. of questions asked)	Definition	Example of Questions asked by health professionals during task
Management of the Problem (143)	There are two elements to the management of the problem: 1. factors that are concerned with specific treatments or interventions that have been applied and their outcome (general management) 2. factors that are considered to potentially impact upon the decisions to be made about the management of the problem (problem in context). These factors address additional elements of patients' lives such as behaviours or other health-related problems and also any previous experience of mental health problems or treatment.	
General Management of Problem (55):		
Medication (25)	Identifying if the patient has been prescribed, and is taking, medication for their problem e.g. antidepressants	'I would want to know if she was on any medication' 'has he been prescribed any medication?'
What Helps Improve Symptoms (18)	Looking to identify if there is anything that patient thinks makes their symptoms better. These may be behavioural or pharmacological	'what, in her opinion has been most helpful?' 'how helpful does she find the prozac?'
Work Already Done in Sessions (12)	When the patient is already in receipt of treatment, what the content has been in previous sessions	'what things have we done in sessions?' 'has he done any reading about depression?'
Problem in Context (88):		
Co-Morbidity (3)	Identifying if the patient is experiencing any other health conditions in addition to the mental health problems	'has he got any sort of physical health problems?' 'I don't know whether he's got like any health complications'
Disclosure of the Problem (5)	Identifying if the patient has told anyone else, health professional or not, about their problems	'has she told her GP about being attacked and raped?' 'I am the first person that she's told?'
Drug and Alcohol Use (38)	Determining if the patient is using or abusing drugs or alcohol, identifying if the level of use if above recommended levels	'is she using drugs and alcohol daily or is it just occasionally?' 'any sort of other issues like alcohol…?'
History of Mental Health Problems (13)	Establishing if the patient has experienced mental health problems in the past	'any previous history of these sorts of problems…?' 'does he have a long history of depression?'
Previous Treatment (29)	Determining if the patient has previously received treatment for the present or previous mental health problem	'has she had any counselling or anything in the past?' 'in terms of OCD has there been any psychology involvement?' 'has she ever seen any mental health workers?'

Table 19 presents the types of questions related to 'patient characteristics' in all five of the AIS scenarios. Questions were related to:

- patient's engagement/compliance
- goals for treatment outcome
- preferences towards the management of their care
- social circumstances and support. [10]

In relation to these factors, health professionals asked mostly about the patients' 'social circumstances' (32 questions) and about their 'preferences' towards how they would like their treatment to be managed (28 questions). The 'goals' that the patient held regarding treatment outcome were asked about less often (14 questions) and 'support' (12 questions). Little was asked about 'patient engagement/compliance' (7 questions) to assist with the decision-making process.

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[10] Including data from the outlier would have altered the numbers of questions asked for the Patient Characteristics theme (119) and the following sub-themes – goals-outcome of care (16); preferences-management of care (34); social circumstances (43) and support (24)

Table 19: 'Patient characteristics' theme - outline of sub-themes, definitions and examples of questions asked

Category label & sub –categories (no. of questions asked)	Definition	Example of Questions asked by health professionals during task
Patient Characteristics (88)	Factors identified as being specific to he individual patient. These factors relate to the Patients' individual beliefs, their life experience and their needs. The factors identified are not necessarily diagnosis related but provide a more holistic view of the patients' problems/experience.	
Engagement/ Compliance (7)	Identifying if the patient was adhering to the treatment and trying to identify why if not	'what efforts has he made?' 'what are the reasons that he hasn't been able to benefit from it, has he not engaged with it?'
Goals – outcome of care(14)	Looking at what the patient wants to achieve from seeing the health professional	'what are his goals? What does he want?' 'what's she specifically wanting to achieve from coming and asking for some help?'
Preferences – management of care (28)	Determining what the patient would like to do to meet their goals e.g. if they would like a particular treatment approach to another	'would he be interested in taking on any new hobbies?' 'does she want to talk about the abuse?' 'is it purely the social sort of anxiety and stress she wants to work on?' 'how does he feel about maybe upping or changing it (meds)?'
Social Circumstances (32)	Issues concerned with the patients personal life. This could relate to the impact of the problem on family members or work.	'I'd want to know a bit more about his home life, maybe if he has a wife and kids to support.' 'his living situation, is there anyone around?' 'has she got friends?'
Support (12)	Related to professional help that the patient is or has received for help with their problem(s). This could be form a health professional or from a union if problems are work related	'what help did she get after she was raped?' 'is he involved with any sort of services that are helping with his work problem at the moment?'

Process and Outcome of Decision-making

Following the identification of the types of questions that were asked, the analysis tried to capture the actual process and outcome of mental health professional decision-making. This involved looking at quantitative aspects of the data including:

i.   the numbers of questions asked (by all mental health professionals and split by low intensity and high intensity roles) and any automatic decisions that were made
ii. the actual decisions made.

Automatic decision-making was defined as a decision made by a mental health professional without asking for any further information in addition to the information presented in the patient scenario. A decision was also regarded as an automatic one should a health professional then go on to ask a number of questions but not alter the initial decision which they made.[11] A decision was not disregarded as an automatic decision if the health professional went on to ask a number of questions if the level of intervention in their final decision remained the same as their initial decision e.g. on two occasions (1 low intensity, 1 high intensity) for the OCD scenario an initial decision to refer to a high intensity intervention did not change after asking for additional information about a number of factors, however both health professionals stated that they would also ensure that the patient received a medication review. Such decisions were considered to be an important aspect of the data to investigate as they may provide insight into the types of situations where mental health professional decision-making was more straightforward or less ambiguous e.g. if particular presentations resulted in a more rapid decision being made.

The tables that follow present and summarise this data for all of the mental health professionals and by role.

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[11] Exploration of the data revealed that only one health professional made an automatic decision and then asked questions which subsequently changed their initial decision (high intensity worker for stress/rape scenario who initially decided that an high intensity intervention was appropriate but then changed it to low intensity potentially having a role after asking questions about patient preference and severity

Numbers of questions asked and Automatic Decisions

The numbers of questions that each of the health professionals asked to make a final decision for each of the five vignettes and by health professional role (low intensity – LI; high intensity – HI) are illustrated in Table 20[12].

Table 20: Numbers of questions asked for each scenario by health professional role

Scenario	Health Professional (HP) Role	Mean Number of Questions (SD)	Range of questions	Automatic Decisions
Depression (ongoing treatment)	All HPs (n=18)	5 (4.87)	0-12	3
	LI workers (n=12)	6 (4.83)	0-12	1
	HI workers (n=6)	4 (5.04)	0-12	2
Stress/Rape	All HPs (n=18)	4 (3.97)	0-12	7
	LI workers (n=12)	5 (4.38)	0-12	3
	HI workers (n=6)	3 (2.99)	0-7	4
Worthlessness	All HPs (n=18)	7 (5.02)	0-18	1
	LI workers (n=12)	8 (5.25)	2-18	0
	HI workers (n=6)	4 (3.92)	0-9	1
OCD	All HPs (n=18)	4 (3.66)	0-11	7
	LI workers (n=12)	5 (3.23)	0-10	5
	HI workers (n=6)	4 (4.73)	0-11	2
Risk/Drug & Alcohol	All HPs (n=17)[13]	9 (7.44)	0-24	3
	LI workers (n=11)	10 (7.22)	3-24	1
	HI workers (n=6)	7 (8.14)	0-20	2

The mean numbers of questions asked by all health professionals was generally consistent across the majority of the scenarios (depression, stress/rape and OCD scenarios) with 4-5

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[12] Including data from the outlier would have altered the mean number of questions asked standard deviations and ranges for all HPs to the following – depression (ongoing treatment) 6 (5.05) (0-13); stress/rape 5 (7.30) (0-31); worthlessness 7 (6.18) (0-23); OCD 5 (4.89) (0-19) and risk/drug and alcohol 12 (15.07) (0-65) and for HI workers only to the following – depression (ongoing treatment) 5 (5.76) (0-13); stress/rape 7 (10.99) (0-31); worthlessness 7 (7.97) (0-23); OCD 6 (7.13) (0-19) and risk/drug and alcohol 15 (23.15) (0-65)

[13] one LI worker, due to time restrictions placed upon the interview, did not have time to complete the risk/drug and alcohol scenario task and therefore data from only 17 health professionals is presented

being asked. The worthlessness scenario attracted slightly more (7 questions), and for the final risk/drug and alcohol scenario an average of 9 questions were asked.

Whilst low intensity workers asked more questions for all scenarios, the mean number of questions asked by role to make a final decision did not differ greatly for the majority of scenarios. The worthlessness scenario, however, attracted double the mean number of questions by low intensity health professionals than high intensity health professionals.

Table 21 gives an indication of the numbers of questions and automatic decisions made at an individual level.[14]

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[14] The outlier did not make any automatic decisions and asked the following numbers of questions for each scenario – depression/ongoing treatment (13); stress/rape (31); worthlessness (23); OCD (19) and risk/drug and alcohol (65)

Table 21: Numbers of questions (Qs) asked by individual health professionals and automatic decisions (AD) made

	Depression (ongoing treatment)		Stress/Rape		Worthlessness		OCD		Risk/Drug & Alcohol	
	No Qs asked	AD?	No Qs asked	AD?	No Qs asked	AD?	No Qs asked	AD?	No Qs asked	AD?
Low Intensity Workers										
Gateway Worker	3		7		13		3		24	
GMHW[15]	10		7		15		6		21	
Mental Health Service Lead	4		0	✓	7		3	✓	5	
GMHW	13		9		9		7		13	
Gateway Worker	1		0	✓	8		7		14	
GMHW	5		1		4		2		3	
GMHW	0	✓	1		3		0	✓	4	✓
GMHW	3		1	✓	2		2	✓	8	
GMHW	12		10		18		9		16	
GMHW	11		12		7		10	✓	8	
GMHW	4		1		3		5		5	
GMHW	4		6		3		1	✓	4	
High Intensity Workers										
CBT Trainee	3		6		7		9		20	
Clinical Team Lead	1		2		1		1		1	
CBT Therapist	6		7		9		11		9	
Clinical Psychologist	0	✓	0	✓	0	✓	0	✓	0	✓
Clinical Psychologist	0	✓	0	✓	1		1		0	✓
Clinical Psychologist/ HI Trainee	12		2	✓	7		2	✓	12	

At an individual level, there was a generally large variability in the numbers of questions

asked to make a final decision, suggesting that the number of questions that they asked was

dependent on the scenario rather than the health professional applying a consistent information gathering process across all scenarios. However, there were exceptions. A number of the high intensity workers showed more consistency in the questions asked across scenarios. For example one of the high intensity workers made an automatic decision for all scenarios and made their decision on the information presented without, on any occasion, asking for further information. Another high intensity worker also showed little variability in the numbers of questions that they asked making automatic decisions in three of the scenarios and asking only one question for the other two. In addition, whilst only making one automatic decision, another high intensity worker only asked two further questions for each to make a final decision for all the scenarios. Thus, for these high intensity workers very little additional information, to that which was presented, was required to make a treatment decision. In terms of the particular roles that the workers held, the clinical psychologists were more likely to make an automatic decision, whilst CBT therapists made none.

Automatic decisions

Automatic decisions were made in all scenarios, however the worthlessness scenario only attracted one automatic decision by a high intensity health professional. The highest number of automatic decisions related to the OCD scenario, which attracted seven automatic decisions, and the stress/rape scenario where six automatic decisions were made.

Low intensity and high intensity health professionals were generally inclined to make roughly the same number of automatic decisions apart from the OCD scenario where more than double the number of low intensity workers (n=5) compared to high intensity workers (n=2) made an automatic decision.

Outcome of Decision-making – Decisions Made

While the numbers of questions asked to make a decision is of importance, of particular relevance is the actual decision that the health professionals are making. In order to explore the decisions made for each of the scenarios, and to present this is in a meaningful way, the decisions made were categorised as being for low intensity or high intensity treatment.

Low intensity treatments included referrals to guided self-help, computerised CBT, psycho-education or similar community-based treatments and high intensity treatments included referrals to crisis teams, community mental health teams, psychology or to intensive CBT.

The decisions made for each of the scenarios by the health professionals (low intensity – LI; high intensity – HI) are detailed in Table 22.

Table 22: Treatment decision made for each scenario by health professional role

Scenario	Health Professional (HP) Role	Decision Made	
		Low intensity Treatment	**High intensity Treatment**
Depression (ongoing treatment)	All HPs (n=18)	14	4
	LI workers (n=12)	11[17]	1
	HI workers (n=6)	3	3
Stress/Rape	All HPs (n=18)	6	12
	LI workers (n=12)	1	11[18]
	HI workers (n=6)	3	3
Worthlessness	All HPs (n=18)	17	1
	LI workers (n=12)	12[19]	0
	HI workers (n=6)	5	1
OCD	All HPs (n=18)	0	18
	LI workers (n=12)	0	12[20]
	HI workers (n=6)	0	6
Risk/Drug & Alcohol	All HPs (n=17)	5	12
	LI workers (n=11)	3	8[21]
	HI workers (n=6)	1	5[22]

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[17] 4 would signpost to relevant community services
[18] 7 of these LI workers said they would hold in LI initially
[19] 1 LI worker would also signpost to MIND
[20] 1 LI worker said would hold in LI initially
[21] 4 LI workers would also hold in LI and 1 would signpost for alcohol or drug services initially
[22] 3 HI workers would signpost to alcohol or drug services initially

Overall, the decisions made were for the most part relatively consistent. Least consistency was found for the stress/rape scenario, with 67% of health professionals deciding this patient should be provided with a high intensity intervention. The most consistent decisions, made by both low intensity and high intensity workers were for the OCD scenario where all health professionals (100%) saw a high intensity intervention as most appropriate. The worthlessness scenario also attracted a high level of consistency in the decisions made with 84% of health professionals indicating that this patient should be seen at low intensity. Some consistency was found for the depression (ongoing treatment) and risk/drug and alcohol scenarios where moderate levels of 'stepping-up' were noticeable. Levels of 'stepping-up' to high intensity were highest for the OCD scenario and lowest for the depression (ongoing treatment) and worthlessness scenarios.

Impact of Severity on the Decision-making Process and Outcome

NICE guidance focuses on the role of severity when making treatment decisions and assigns patients to particular interventions based on the severity of their problem (see Figure 4 in Chapter 1). Severity would therefore be expected to play a central role in driving the decision-making process, and was thus examined in more detail.

Over all five scenarios only 19 questions were asked about the severity of the problem (less than 4% of the 510 asked in total). Nine health professionals asked about severity (67%, were low intensity workers). Table 23 indicates the number of questions that were asked for each scenario and the workers who asked them.

Table 23: Number of questions asked about severity for each scenario and by health professional role[23]

SCENARIO	NO. QUESTIONS ASKED	HEALTH PROFESSIONAL ROLE (total n=18, scenario 5 n=17) Low intensity (LI)	High intensity (HI)
1. Depression (ongoing treatment)	6	5	1
2. Stress/rape	3	2	1
3. Worthlessness	5	4	1
4. OCD	0	0	0
5. Risk/drug and alcohol	5[24]	2	1

The content of the 19 questions asked about severity, for the vast majority of health professionals, related specifically to the patients' 'scores' or 'measures'. Five questions were slightly less specific. For example health professionals asked 'how severely depressed' the patient was or what their 'level of anxiety' was.

Whilst severity was addressed by some health professionals in the decision-making process, the majority of the scenarios attracted very little questioning about this factor. Only a third of health professionals asked about severity in the depression (ongoing treatment), less than a third in the worthlessness scenarios and a small proportion of health professionals asked a question about severity for the stress/rape (17%) and risk/drug (18%) scenarios. No one asked any questions about severity of the patient's problem for the OCD scenario. Severity appeared to play more of a part in low intensity workers decision-making. With respect to the patient scenarios presented, severity has particular relevance for the depression (ongoing treatment) scenario in which the patient case presented has not made a significant improvement over the course of a couple of sessions. While this scenario attracted the highest numbers of questions about severity 72% of the health professionals did not address this factor.

The noticeably small numbers of questions asked about this factor is surprising particularly as severity was not explicitly stated in any of the patient scenarios. If severity is not

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[23] The outlier asked questions about severity for the following scenarios – worthlessness (2 questions); OCD (1 question) and risk/drug and alcohol (4 questions)

[24] 2 health professionals (1LI, 1HI) asked two questions

commonly addressed when making these decisions then it is important to explore why this is so.

Within the OCD scenario, where it is clear from the outset that the patient is suffering from OCD, health professionals may view this as a severe disorder and thus may not need to ask about severity. The number of automatic decisions made by the health professionals for this scenario provides evidence for this. Additionally, this was the only scenario where there was a unanimous decision among all the health professionals that this patient would need to receive a high intensity treatment. From these findings there is evidence that the diagnostic label of OCD drove the decision-making process without the need to ask about severity directly. While NICE guidelines suggest that low intensity treatments of up to ten hours should be offered for people with mild OCD (NICE, 2005a), these findings highlight that health professionals, although not asking about the severity of the problem, may have used other factors such as the length of the problem as predictors of the intensity of treatment required.

As well as diagnosis functioning as a proxy for severity, there are indications that other factors may also play such a role. Evidence for this can be found when exploring how decisions were made in two of the other scenarios. With respect to the stress/rape scenario, where there were some indications of the potential trigger of the stress, only three health professionals (2 low intensity, 1 high intensity) asked about severity. In this case the nature of the trigger of the problem (rape) may have played a pivotal role. As was stated previously, this scenario attracted six automatic decisions, with six health professionals (3 low intensity, 3 high intensity) not requiring any further information. Whilst the decisions made by these health professionals was not completely consistent (one high intensity worker saw a role for an low intensity intervention in the first instance) the findings suggest that the nature of the trigger may imply what level of treatment is required, regardless of the severity of the problem. However, this is not necessarily supported when looking at all of the health professional's decisions for this scenario as two thirds suggested a high intensity intervention and one third thought an low intensity intervention may be more appropriate. It is therefore unclear the extent to which the trigger of the problem has upon the decisions made, and it appears that other factors in addition to this may play a role within such situations. The impact that severity has when a specific trigger has been specified is still unclear when looking at the three health professionals who asked about

severity as consistent decisions were not made – two chose to refer to low intensity, whilst the other thought that a high intensity treatment was more appropriate.

The proxy role of risk is demonstrated in the decisions made for the risk/drug and alcohol scenario. Comparable to the stress/rape scenario only three of the health professionals (2 low intensity, 1 high intensity) asked about severity. It may therefore be that for this scenario issues about risk, may have played more of a central role in the decision-making process with 77% of the health professionals asking questions about risk in comparison to 19% of those who wanted more information about severity. Similar to severity, NICE guidance highlights the importance of urgently referring a patient to specialist services if considerable and immediate risk is apparent. Thus, it may be the case that where there are indications of risk, health professionals more readily consider this above severity as a means of making a treatment decision. Although the decisions made showed some level of consistency (among high intensity workers) and high levels of 'stepping-up', the indication that there were elements of risk did not strictly determine that high intensity or low intensity was more appropriate – this may be due to the nature of the questions that were subsequently asked about risk. Three health professionals who did not ask for further information about risk (1 low intensity, 2 high intensity) all decided that a high intensity intervention would be appropriate. An additional high intensity worker who also did not ask about risk, however, made the decision to refer to low intensity. From the findings although there are indications that risk may be addressed when making decisions over severity, it is not entirely clear the specific role that it has, it may be that a number of questions are asked about this factor to determine the level of risk that is prevalent which may be more important here rather than just the presence of risk.

There is similarly some evidence that drug and alcohol use may play a pivotal role over severity. There was only one scenario where drug and alcohol use was mentioned, and this was the factor that attracted the most questions, with 88% gathering more information. The two health professionals (2 high intensity) who did not ask questions had made automatic decisions to refer the patient to a high intensity treatment.

In summary, initial analysis highlighted that the prevalence of questions relating to severity was low, compared to what might be expected given the importance of this factor in the

NICE guidelines. Further analysis suggested that other factors (such as diagnosis, risk, and the presence of substance abuse issues) might serve as proxies for severity.

The following provides specific examples taken from the interview transcripts of when the mental health professionals in the task asked questions about severity and how that information was subsequently used. An interpretation/summary of how the information collected was used is provided following each excerpt. Further examples are provided in Appendix 12.

Depression (ongoing treatment) Scenario

HP15, site2, high intensity worker

HI worker:	*Right, OK. Um, well, I think, given that he's not made any improvement, well he, he, isn't he he's been seeing me (mumbling) and how do I know that he's not made any significant improvement, is that down to sort of his, his measures or?*
Interviewer:	*Well, in terms of measures, his measures show that he has mild depression and they haven't really changed very much.*
HI worker:	*OK, OK, I think I'd, I'd sort of also want, want to know, um, I'd maybe want to kind of know what he's - whether there's been anything in our sessions that he's actually found helpful, um, whether there has any – you know, ever been kind of any, you know, maybe, maybe, not kind of representing the measures but maybe if there was anything that we sort of did together that was, um, that had been particularly helpful*

…[additional questions then asked about symptoms, drug & alcohol use and trigger – no thinking aloud]…

| HI worker: | *Oh right, OK, OK, so I suppose I'm, I'm thinking, well we're talking about this that, that's of - if I've only seen him, if I've only seen him twice, I think it, it'd be too, it'd be too early to kind of to give up a step 2 level basically and I'd, I'd maybe hypothesise that if he's, um, if, if he's kind of recently given up quite a demanding job that, that then sort of lack of, lack of role and things has, has, has led to him feeling a little bit, a bit lost so I'd make – I'd probably, given that he's done, he's done sort of a, a diary sheet, I'd probably spend some time reviewing that with him and, and looking at kind of some of the changes that – and I after those do some behavioural activation maybe with this, with this guy but I do, I think I'd, <u>I'd stick with him</u>* |

at, at, at step 2 level and at least give it – I mean I suppose it's – I suppose it's one of those things I know, working at a step 2 level, that if by session 3 there haven't been any changes, in, in, in sort of his measures, then I think I'd consider stepping him up but I think because it seems like it's been sort of quite a long – 'cos it's been a quite long gap hasn't it between – yeah I'd, I think I'd maybe be minded to persevere with this person at, at step 2 and actually try some, some, some BA with him basically, um, that would be my, my thoughts on that.

When making their decision the health professional took severity into consideration but also considered the wider picture. The think-aloud aspect of the data captures that they understand that no change in severity score could indicate that the patient needed 'stepping-up'. However, from the text it is apparent that this is not the only factor that is taken into consideration, with factors such as length of time seeing the patient and the time-lag between appointments influencing their decision to continue to see the patient (at a low intensity level).

Stress/Rape Scenario

HP21, site3, low intensity worker

[previous questions – support, disclosure of problem, co-morbidity]…

LI worker: *So am I the first person that she's told?*

Interviewer: *Uhm, her mum knows and a few close friends know, but not anybody sort of medically or psychologically.*

LI worker   *What's she started noticing since, since it happened?*

Interviewer: *Uhm, on top of the sort of stress in social situations, she's got sort of a number of other symptoms, physical symptoms, such as knots in her stomach, sweating and feeling panicked all the time. She's frightened to leave her home and she feels permanently anxious and fears that she'll be att – she'll be attacked.*

LI worker: *OK. So I think I – OK, I would sort of do some education around anxiety and linking back to the frightening thing that happened to her. Uhm, quite a traumatic thing. What are her scores like for her measures, depression and anxiety?*

Interviewer: *They came up with severe anxiety and quite severe depression as well, sort of on the borderline of severe depression -*

LI worker: *And has she had any suicide or, or - ?*

Interviewer: *On one occasion she made plans to kill herself by overdosing on paracetamol, but in the end she couldn't go through with it.*

LI worker: *OK, and what would she like help with now that she's come to see me and opened up?*

Interviewer: *She just wants, uhm, someone to help her feel like she used to before all this happened. She was quite a sociable person, so she'd quite like to get back to sort of feeling comfortable in those situations again.*

LI worker: *OK. I think I'd do some normalising with her that it's quite a traumatic thing so, you know, she can't just flick a switch on and be back to normal, uhm, I mean it will take time to get through things, but, you know, she's made the first step by coming to seek help for it. Uhm, and I think I would, uhm, I would, I'd consider seeing this person myself before uhm, before sending to like psychology or something like that because there might be quite a lot of benefit that she can get just from the work on managing anxiety and looking at the sort of cycles that you can get into. And, but if, as the sessions went on it was quite clear that she, you know, was suffering really badly from the trauma then I would refer to the psychology service.*

While this low intensity worker asked about the severity of the patient's problems ultimately their decision was not necessarily affected by gathering this information. Again it appears that the health professional is following the principles of the stepped care model by providing the least intensive intervention first before considering another option but that these decisions are made irrespective of the level of severity – the stepped care model suggests that the lowest intensive treatment should be provided that will provide significant health gain for the patient but when considering NICE guidelines a patient with such severe levels of problem would not be considered at such a low level. In this scenario patient goals seem to prevail over the severity of the presenting problem.

Worthlessness Scenario

HP06, site1, low intensity worker

LI worker: *OK, um, thinking aloud, I'm just thinking there's not much information [laughs]. Um, what sort of brought him in and what was the kind of main triggers and that.*

Interviewer: *Yeah, he had a recent dispute at work which resulted in him becoming a subject of a complaint from a colleague because of his attitude towards her and he's now been suspended pending an enquiry.*

LI worker: *OK, and what are his scores, his risk?*

Interviewer: *Um, in terms of scores, he was found to have moderate depression and in terms of risk he denies any suicidal thoughts.*

LI worker: *OK, um, how is, I suppose, how is it affecting him sort of day to day, what is he kind of doing at the moment?*

Interviewer: *He, um, sort of feels that he's not really doing very much. He, um, doesn't go out very much because he doesn't have anything to go out for he says. He feels very sad a lot of the time, he said and he's got a tendency to wake up in the middle of the night and his appetite is poorer than usual.*

LI worker: *OK. And with the complaint at work, does he, I mean, is he, does he need help with that. I mean is it something that he feels has been unfair, does he need sort of support with that or is he getting support.*

Interviewer: *Oh I see, yeah, he feels it's unjustified but he hasn't really had any formal support from his work or anything, in terms of that.*

LI worker: *And first of all, I'm thinking that I'd refer him to MIND because I have a project where they support people with work disputes and things. Um, yeah, they've got a couple of projects that I think would probably be helpful. Um, and then sort of, I mean is it aff- is it affecting his relationship with his kids and his family and things as well?*

Interviewer: *Yeah, well he says that he's often sort – because his mood is quite low a lot of the time, he feels quite irritable and things around them so he feels that that's having an impact upon any relationship because he's been like sort of feeling so low and things.*

LI worker: *OK and what, what's his goals, what does he want, you know?*

Interviewer: *Um, he really just wants you to choose the treatment that's best for him. He doesn't really feel that there's anything that'll help him at the moment.*

LI worker: *Oh, a difficult one [laughs]. OK, well I'd offer him the sort of, as I said, the sort of, um, MIND project if he was interested in that and guess if he's not doing anything at the moment then just spending time sort of at home, um, and if he was interested in sort of trying to look at some increase in his activity and doing things during the day so he feels sort of more - like he's achieving things and he's, you know, doing enjoyable sort of things. Um, I'd look at behavioural activation, if he was - if he wanted to do that – sort of explain the rationality, um, so that would be my first, I think, sort of port of call if he was happy to do that and if he thought it'd be helpful.*

In this scenario, while the health professional asks about severity, they do not reveal any thinking about this and move quickly on to the next question. The impact that this information has upon their decision-making is unclear as they do not address it in any of their think-aloud processes (not any that are verbalised anyway) that are focused more on the specific problem that the patient is having and the patient's preferences.

Risk/Drug & Alcohol Scenario

HP11, site2, high intensity worker

[previous questions – symptoms, drug & alcohol, risk]…

HI worker: *OK, and uhm, the panic attacks, how long has she had the panic attacks for?*

Interviewer: *She's suffered from them for about, sort of really on and off since she was about nine.*

HI worker: *OK. Gosh that's a long time. OK and how, how frequent are they?*

Interviewer: *Uhm, she says she has them sort of the majority of the time and most days that she does have them, but not to the same extent everyday. She says at some point during the day she feels panicked, but a full blown panic attack perhaps maybe once or twice a week.*

HI worker: *OK, but she feels quite panicky a lot of the time.*

Interviewer: *Yes.*

HI worker: *OK, and uhm what, <u>what do her did she come out with the outcomes on? Has she got some completed?</u>*

Interviewer: *Uh, she's suffering from severe symptoms.*

HI worker: *Severe symptoms of panic, or anxiety, is there anxiety scores as well?*

Interviewer: *Uhm, yes, some sort of moderate to severe anxiety.*

HI worker: *And what kind of an impact has the panic and the anxiety had, has she uhm, has she, she's, is she a student or is she working?*

Interviewer: *She is a student at college and that has impacted on the time that she feels she often fails to attend because of the panic.*

HI worker: *OK and has that resulted in sort of any impact on her studies?*

Interviewer: *Yes, she finds that she's started to fall behind because she's not attending enough.*

HI worker: *OK, so she's got the panic attacks, the anxiety, they're impacting on her ability to attend college and study. She's got this self harm which has come up and there's potentially a drug and alcohol problem, and she's had the panic attacks for a long time. Has she had any previous treatment or support at all?*

Interviewer: *She, last year she was provided with some reading material, that's all she's had.*

HI worker: *And no follow up from that.*

Interviewer: *No.*

HI worker: *OK. Uhm, and has she made any indications that there's any concerns about her, her risk to herself, other than the self harm, like suicidal thoughts?*

Interviewer: *No, she hasn't, she doesn't have any suicidal thoughts.*

HI worker: *Uh, OK, so there's quite a lot going on and it's quite a long history of the panic attacks. Uhm, my, my concern's around, is around the drugs and alcohol, whether she'd be appropriate for primary care services, because they, they can really get in the way. I might be inclined to see her for another appointment and maybe ask her to keep an alcohol diary or something like that to try and get a bit more of an accurate reflection around that intake, uhm, because you don't know, it could have just been that she did just drink on that day because she was anxious and worried about having a panic attack or something like that. So I would be inclined to, to try and uh clarify that a bit more, and then obviously the result of that would would make a difference to what we did next. If there is drugs and alcohol I'd be thinking perhaps CMHT just to try and settle that down a bit and then bring her back to primary care, seeing as she hasn't really received any support in the past it might be worthwhile and, you know, trying the primary care for the panic attacks and the anxiety, and the self harm potentially as well because that's, that's fairly recent as well and that can be workable. Yeh, so I think I'd have to, I'd have to see her again to get an understanding of the alcohol. Yeh.*

The decision made by the health professional seemed driven by the potential drug and alcohol issues but also by actual problems that the patient is having – panic attacks and anxiety. No reference is made to the severity of these problems as having an impact upon the decision made.

Impact of Patient Preference on the Decision-making Process and Outcome

Giving patients more choice and control over their treatment, and taking into account their personal needs and preferences, is at the forefront of healthcare policy. As detailed in chapter 2, patients generally express a preference for an active role in decision-making and many possess strong preferences for particular treatments. Taking into consideration the preferences that patients have is therefore one important way to ensure that patient outcome is maximised.

Over all five scenarios 28 questions were asked about the patients' preferences about the management of their care (under 6% of the 510 questions asked in total). Twelve health professionals who asked about patient preferences (67% were low intensity workers). Only one low intensity worker asked about patient preferences for all scenarios. Table 24 indicates the number of questions that were asked for each scenario and the workers who asked them.

Table 24: Number of questions asked about patient preference for each scenario and by health professional role[25]

SCENARIO	NO. QUESTIONS ASKED	HEALTH PROFESSIONAL ROLE (total n=18, scenario 5 n=17)	
		Low intensity (LI)	High intensity (HI)
1. Depression (ongoing treatment)	5[26]	4	0
2. Stress/rape	10[27]	4	3
3. Worthlessness	4[28]	3	0
4. OCD	4[29]	3	0
5. Risk/drug and alcohol	5[30]	2	2

The content of the actual questions asked about patient preferences varied between scenarios. For the stress/rape and risk/drug and alcohol scenario the questions asked by the health professionals showed high levels of consistency. For these two scenarios health professionals were interested in determining what the patient wanted the focus of the management of their problem to be on e.g. for the stress/rape scenario if they wanted to look at the anxiety or stress that they were experiencing or the trigger of these problems (rape). For the three remaining scenarios less consistency was found in the types of questions asked with health professionals interested in identifying different aspects of patient preferences such as taking medication, what they would like to achieve and if they had any particular preferences about hobbies or activities that could be incorporated into the management of their problem.

All scenarios attracted questions from health professionals about patient preferences, albeit small numbers of questions for the majority. A minority of health professionals asked questions about preferences for the depression (ongoing treatment), worthlessness and OCD scenarios with (22%, 17% and 17% respectively). The risk/drug and alcohol scenario similarly attracted little questioning about patient preferences with just over a quarter of health professionals indicating that they would like more information. In contrast the

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[25] The outlier asked questions about severity for the following scenarios – depression-ongoing treatment (1 question); stress/rape (2 questions); worthlessness (2 questions) and risk/drug and alcohol (1 question)
[26] 1 health professional (LI) asked 2 questions
[27] 3 health professionals asked more than one question (1 LI and 1 HI asked 2 questions and 1 LI asked 3 questions)
[28] 2 health professionals asked more than one question (1 LI and 1 HI asked 2 questions)
[29] 1 health professional (LI) asked 2 questions
[30] 1 health professional (LI) asked 2 questions

stress/rape scenario attracted a higher number of questions (10) and more health professionals asking about the patient's preferences, with 39% asking about this factor. Overall patient preferences appeared to play a larger role in low intensity worker's decision-making with all scenarios attracting questioning about patient preferences by at least two low intensity workers. Questions about patient preferences were asked by high intensity workers for two of the scenarios only (stress/rape and risk/drug and alcohol). Only one health professional (low intensity worker) made their decision on patient preference alone (stress/rape scenario). Whilst not having a large noticeable role, following making a final decision, 50% of health professionals who had not previously asked about patient preferences stated that their decision would change should the patient prefer the focus of the treatment to be different. None of the scenarios gave any indication of what the patient may prefer.

In terms of providing an explanation for why patient preference is addressed most in the stress/rape scenario it may be that the trigger for the patient's problem, for some health professionals, has a significant influence over the importance of gathering information on deciding how they should go about managing the problem. As was stated previously, the questions that were asked in relation to patient preference for this scenario all related to what the patient wanted the focus of the treatment to be on. The health professionals were interested in gathering information about what the patient would like to address, for example, if they wanted to address the stress that they were experiencing or if they would prefer to explore the actual incident that triggered the problem. Scenarios which presented a patient with a problem that has a specific trigger such as rape or the problem is related to an accumulation of a number of differing factors appeared to impact upon the tendency for health professionals to ask about patient preference. An explanation for this may be that these are the situations where it is more important for health professionals to gather an understanding of patient preferences first in order to assist with making an informed decision about which treatment would be most appropriate.

While the trigger for the problem may have warranted questioning about patient preferences in the stress/rape scenario these claims are not supported in the risk/drug and alcohol scenario in which there was also a physical incident that triggered the patient's problems. There may be two explanations for this. The most obvious is that the trigger for the problem was not presented at the outset within the scenario. Therefore only by asking if

there was a trigger for the patient's problems would health professionals determine that the patient had been abused in the past. On the other hand it may be that as issues concerning drug and alcohol use and risk were conveyed in this scenario that these factors played more of a role within the health professionals' decision-making process than did patient preference. Within guidance it is clearly indicated that due to reasons such as engagement with treatment that when a patient presents with substance misuse issues that they should be directed towards services to help them to address these issues first before commencing any psychological treatment.

An interesting observation is the fact that, for the majority of scenarios, high intensity workers did not ask about patient preference. A number of interpretations are possible. One may be that there is perhaps less opportunity for treatment choice at higher steps. This essentially relates to the resource limitations within services. There may therefore be less of an opportunity for health professionals to incorporate patient preferences at higher levels. However, even if this is the case, there is presumably the opportunity for the patient to express a preference as to what the content or focus of the treatment is. Another interpretation relates to the flexibility of the therapists. Health professionals only have a limited repertoire of treatments that they can provide and therefore asking patients what they would prefer to receive when the options are limited may not be feasible. Health professionals' making decisions at lower steps of the model have more of an opportunity to refer to a larger variety of treatments and this may be a reason to explain why they were more likely to ask about this factor.

Within NICE guidance patient preference is stated as an important factor in the decision-making process at both low and high intensity. However, where decisions are affected by a number of factors such as a complex patient presentation (e.g. recurrent problems, long duration of problem or high risk) preference may have the tendency to be ignored. As information about such factors may provide some insight into treatment outcome, high intensity workers may place more focus upon these. In contrast, such circumstances may be of little priority when decisions are being made by low intensity workers. Within the literature, findings have revealed that while a number of factors influence the decisions made about the suitability of specific treatments there are few that correlate with a successful outcome. Although inconsistency is found, a large RCT investigating patient predictors of response to psychotherapy revealed that the severity or chronic nature of

patients' depression and level of functioning predicted treatment outcome (Sotsky et al., 2006). Being aware of such findings may make health professionals making decisions at high intensity less likely to focus on other issues such as patient preference. Alternatively, they may simply not see patient preferences as a core issue, either because they don't think they are important, or because they think they can work to engage patients who have other preferences.

In summary, analysis highlighted that the prevalence of questions relating to patient preferences was generally low, particularly in terms of those asked by high intensity workers. In-depth analysis revealed that this factor might play more of a role in situations where the patient's problem has a specific trigger that may have implications for what the treatment focus should be.

The following provides specific examples taken from the interview transcripts of when questions about patient preference were asked by the mental health professionals in the task and how that information was subsequently used. An interpretation/summary of how the information collected was used is provided following each excerpt. Further examples are provided in Appendix 13.

Depression (ongoing treatment) Scenario

HP07, site1, low intensity worker

[initial question – severity]…

LI worker: *Mild depression. OK, um, [pause] that's interesting, so, yeah I guess it would come back to, um, that's, that's a difficult one. I guess I'd want to know a bit about what he wants, is, is there any information about what he would want to do about this?*

Interviewer: *Yeah, he just wants to see someone to sort of help him get a bit motivated again because he's feeling sort of like he's not doing very much with his life.*

LI worker: *Right. OK, and in the work I've done with him, has he been focused on that already or?*

Interviewer: *Yeah, you started looking at sort of, um, sort of diaries and things and to try and get him to sort of think about the things that he did do, sort of plan his day out a bit better.*

LI worker: *Right and he didn't – did he come up with goals and things?*

Interviewer: *Well, he did but, um, because a lot of the goals are sort of doing things by himself, he still felt a bit sort of de-motivated.*

LI worker: *Right, OK, um, [pause] I guessed if anyone - what might – 'cos I wouldn't, kind of – I'm atypical for me to have seen somebody once – mind you once a month for eight weeks is only two or three times isn't it. OK, so I guess I'd be looking at, within my intervention, I'd be looking at the sort of next couple of months ahead and really reviewing why things hadn't changed yet and what he felt would be the change, the practice that would help him change, so is it that he would want somebody, like if it was that he wanted to go to a day centre or bingo or something, is there somebody he could kind of help support him to go – is there a friend or a family member who would go with him or if there was a community linked intervention that I could do where I could meet him to go somewhere initially to get him started, to motivate him, to go for the first one, then I could offer, offer to support him with that if that hel -felt helpful. Um, but given that if, if his mot – if his, um, depression levels are mild, even though his motivation's poor, I guess, I'd probably want to explore a bit with him about is it that he's – feels like there's more to sort of talk about, is it that – the given his life stage and he's probably recently retired, is it more to do with a kind of loss of role and a loss of identifying with activities that give him a sense of, of achievement or, or sort of encouraging to, to stay motivated in which case, I'd consider whether it was a, a guided self-help intervention with the right one or whether he actually wants to explore those feelings with counselling or something instead, given, given that he's not engaging with the guided self-help materials, I'd be reluctant to step him up with mild scores and an inability to engage I think at this stage. I'd want to sort of either give him another couple of months and some telephone appointments, to try and break his goals down into something that he will be able to start or is he really clear that that's not a helpful approach, then to think about other support options really.*

In making their decision this low intensity worker asked about what the patient wanted to do and discussed their decision to continue seeing the patient in relation to their stated preferences. This health professional was concerned not only with the patient's preferences for the type of treatment but also what preferences they had in relation to the components of the low intensity intervention that they were delivering. It was apparent, however, that patient preference was not the only factor that they would take into consideration. In line with the stepped care model principles, the indication that the patient was suffering from mild levels of depression appeared to be an influencing factor as to whether 'stepping-up'

would be considered. Patient preference alone did not appear to justify a decision to 'step-up'.

Stress/Rape Scenario

HP11, site2, high intensity worker

HI worker: *OK pause OK, so she's suffering from stress, particularly in social situations. Uhm, so at the time of being attacked and raped did she receive any support at that point?*

Interviewer: *Uhm, in terms of treatment?*

HI worker: *Yeh, well any kind of, kind of therapeutic support I guess.*

Interviewer: *She hasn't had any support in that way at all no.*

HI worker: *OK then. And uhm, what are, what are her uhm risk, what's her risk like? Has she had any thoughts?*

Interviewer: *On one occasion she made plans to kill herself by overdosing on paracetamol, but I the end she didn't go through with it.*

HI worker: *OK, and has she got much social support at the moment?*

Interviewer: *Uhm, she has a supportive mother and some close friends who know her problems -*

HI worker: *They're aware of the situation. OK, so uhm, so at the moment then, what, what, she's – what is she wanting to work on do you know? Do we know, she's got, suffering from stress, and obviously she's had this attack, what's she wanting to focus on?*

Interviewer: *Uhm, well she says that she just wants to sort of feel like she used to do, she wants to do the things she used to.*

HI worker: *OK, so has that had an impact on what she's doing, the stress, it says particularly being in social situations, has that resulted in avoidance?*

Interviewer: *Yes, she uhm, she tends to try and avoid going out more, although she does try because she knows that sort of doing those things might help her.*

HI worker: *OK, so it's the stress from doing it, that seems to be the main issue. OK, I think based on that again I would be inclined to, to start at a step two and with a review, and just see how, perhaps looking at the stress and the avoidance, maybe that can be, that would be enough,*

> *but I'd be aware of keeping an eye on uhm, whether she was starting to show any sort of traumatic stress symptoms, because perhaps a more counselling approach would be more appropriate depending on if her focus changed.*

Interviewer: *OK, so in that case, if her uh, if she did show signs of post traumatic stress, are those the occasions where you might - ?*

HI worker: *Yeh, I think for post traumatic stress you you'd need to refer to the specific service really, rather than primary care services, either psychology or there's specific, there's specific trauma services yeh, so checking for flashbacks and things like that, nightmares. Uhm, but if she's wanting to work on the, on the stress and the avoidance then I would be inclined to work, to look at primary care as appropriate, but just keeping an eye on, on that yeh.*

For this health professional, while patient preference was not immediately addressed, alongside support and risk it appeared to play a pivotal role in the decision-making process. The high intensity worker identified from the information presented in the patient scenario that they were suffering from stress when in social situations and felt that as this was the case that starting at step two was appropriate. However, they were mindful that other factors such as a PTSD diagnosis or if the patient's focus changed that a different decision to a higher intensity treatment may be warranted. Thus it appears that patient preferences played a role in guiding the health professional's initial decision but that there was scope to change the decision should certain circumstances change.

Worthlessness Scenario

HP19, site3, low intensity worker

[previous questions – length of problem, trigger, symptoms, social circumstances and support]…

LI worker: *OK, um, if there are other things that he does now, you know, to pass the time now that he's not at work, or …*

Interviewer: *Well, he, he's got two young children so he looks after them sometimes when his wife isn't there, and that's about it really.*

LI worker: *Are there things that, that he'd like to do that he might think might help?*

Interviewer: *He said that he just wants to get on better with his family because he's sort of feeling a bit irritable and things, he says that the relationships sort of suffering a bit.*

LI worker: *OK, um, is the, sort of issue within the relationship something where he feels that he needs specific attention on the, the relationship or is it more sort of himself that he …*

Interviewer: *He thinks sort of in general himself, because even when she's, his wife's not around he still feels sort of a bit irritable as well.*

LI worker: *Right, had they noticed anything that's made any sort of improvement, anything that's helped at all?*

Interviewer: *Not really, he hasn't, because he hasn't really been doing anything since it happened so …*

LI worker: *OK, I think they sort of finding out really what, what he wanted to be the focus in terms of, um, does he want to look at doing some more things so that he, he's more active other than just being at home and, and caring for the children, sort of from time to time and is that something he wants to focus on, sort of get some kind of enjoyment back, um, sort of day to day, um, or just generally sort of around the house are things quite difficult and sometimes that might cause a tension within a relationship, say he's at home and wife thinks he should be doing x, y and z and he's not so maybe finding out a bit more if he wants to focus on, on those kind of things or whether its more sort problem solving around the actual situation, work and, and looking at options and pros and cons for certain thing so, um, say returning to work, would he be happy with that or what are the alternatives if he didn't, just to see which is going to be sort of the focus really (OK), Um, I mean with, with eight weeks, they sort of not on any medication at the moment …*

Interviewer: *Well, his GP last week suggested that he may benefit from anti-depressants but he doesn't think that medication is useful for him.*

LI worker: *Um, so just be saying that, um, maybe at this time that's fine, um, but I'd keep sort of open-minded about it and that they can go along, um, working sort of therapeutically and guess sort of behavioural observation and problem solving, um, type of stuff but that if in a number of weeks he wasn't finding any improvement in that work, just being open minded about medication, just to help with alongside the, the sort of things that we're doing in sessions.*

This low intensity worker did not address patient preferences until quite late on in their decision-making process. However, once addressed the discussion of their decision related very much to what the patient wanted the focus of the intervention to be. Again the role of

patient preference was important but perhaps only after other factors that may have more of an influence over the decision made e.g. severity was addressed. This low intensity worker also addressed preferences towards taking medication. Although they were informed that the patient was adverse to taking medications they indicated that it may be appropriate to address with this with the patient if little improvement was achieved over a number of weeks.

OCD Scenario

HP06, site1, low intensity worker

LI worker: *Automatically I think step up [laughs] straight away. Apart that it's so chronic, 20 year history of it, um, and obsessions and compulsions, something quite difficult to work with anyway, um, and the fact that, you know, seeing her for six weeks is quite a long time anyway, I mean, we only see people for three sessions anyway so that would be kind of, I mean six, if say, six appointments that's what it adds up, limit of our – anyway, um, and the fact that it's, you know, significantly interfering with her life. I mean and just on this information I'd, I'd think about stepping up if she was happy, if she wanted to be stepped up, um, 'cos I wouldn't think that was that much that I'd probably do for her [laughs].*

Interviewer: *And who would you step her up to?*

LI worker: *Um, to CBT perhaps, from here, if, if that, if she was, again if she was happy to do that. Um, I don't, I don't know, is she on any medication?*

Interviewer: *Um, she's been taking Prozac on and off for the past 15 years.*

LI worker: *Has it ever helped her?*

Interviewer: *And, um, she said that it has some – it helps her a bit in terms of her mood but she feels like her OCD's still there, you know, it's not really helped her manage that bit.*

LI worker: *Does she have, so she has, does she have depression as well or –*

Interviewer: *Yes she's also got, she's got, um, moderate symptoms, so yeah, moderate symptoms of depression.*

LI worker: *OK, and she's happy taking Prozac and things or?*

Interviewer: *Um, she's happy taking it in the sense that she feels a bit better but she's not entirely sure if its effects are positive enough on her overall*

LI worker: *Goes along, to be taking it, so I think she maybe needs a medication review with her GP as well.*

[subsequent questions – drug and alcohol, social circumstances, risk]

LI worker: *OK. Um, and would she be happy to be stepped up to the CBT sort of approach is she?*

Interviewer: *Yeah, she said that that's something that she's going to try and perhaps it would help.*

LI worker: *OK. I would probably think of stepping up to CBT to start, definitely to start with. I don't know with kind of, her children, whether their symptoms are of – sort of bad enough that they need some kind of, sort of more family type therapy, I don't know, depending on that, maybe look at that, but, I think probably if it was, you know, if they'd sort of very, you know if, if she gets some help and she – her symptoms reduce and, and the kids sort of are modelling her and they reduce as well, they may not need that so probably, yeah, just, just CBT approach to start with.*

This low intensity worker made an automatic decision to 'step' this patient up to high intensity following the information presented in the scenario only. Their initial decision was based on the length and chronicity of the presenting problem, its impact and the limitations of low intensity in dealing with the problem. Following questioning about a number of factors, including patient preference, the health professional's initial decision did not change. For this health professional the preference for the type of treatment – CBT and medication – was important rather than the content of the intervention, presumably as they had decided that a 'step-up' was required. Although patient preference appears to play a very small role in making their decision, perhaps their decision would have altered if the patient had expressed a preference not to receive CBT.

Risk/Drug and Alcohol Scenario

HP15, site2, high intensity worker

[previous questions – symptoms, length of problem, drug and alcohol, risk and trigger]…

HI worker: *OK. Has she ever had any, um, therapy.*

Interviewer: *Um, she didn't really talk - she didn't really talk about it very much till – but last year she was provided with some reading material from her GP, um, but she didn't really engage with it.*

HI worker: *OK, um, does she, um, does she want to - talk about the abuse?*

Interviewer: *Um, she, she's not – a bit uncertain about what she wants to actually do but she just wants to – she's quite happy to do whatever will make her feel better really.*

HI worker: *OK, OK, I think my thoughts about this woman is that she wouldn't be –is that this woman wouldn't be suitable for primary care, I would be minded to refer, um, this woman for some counselling, for some specific counselling to deal with, with sort of childhood abuse, um, I might, as I'm saying this I might, I might be tempted to, to do some, some work before she went to, um, to do some counselling – but basically to look at, to look at some of these, these behaviours, I suppose and look at whether we could kind of, um, get her to, to a stage where, where she was sort of a, a bit more, bit more stable or you know looking at kind of the panic attacks, or looking at the sort of drug and alcohol – I don't know though, I suppose, I'd ask her how much she – with the drugs and alcohol how much she felt that was a problem, whether we needed to look at, um, at referring her on to a specialist service for that but it very much sounds like it's sort of, it's, it's an understandable sort of coping method for something for – you know for this trauma that she's experienced so I, yeah, my thoughts are that I might kind of offer her a few sessions where we maybe kind of looked at, um, some more helpful coping strategies and maybe just some, maybe literally just some kind of psycho-education on panic attacks but I don't – the – I think this woman would need to go to, to a very specialist, um, service really, um, yeah, to sort of talk about, talk about the, the abuse, um, [pause] I'm trying to think whether I think there's, there's anything particularly significant about her being Chinese, I don't [laughs] I'm trying to think whether, whether I should say she would need an interpreter but [laughter] just like what's coming into my mind, um, yeah, so I think that's what I'd do with her, well I don't think, I don't think this woman would just benefit from our service, I think she'd need to be, um - I think I'd probably refer her to sort of like a voluntary sector counselling service rather than sort of step her through the, um, the levels because, um, – yeah because there are specialist services who would work with people who've been abused as children rather than sort of sending them off to psychology, for example –*

Even when patient preferences were not clear, the high intensity worker indicated that the patient was not necessarily suitable for them. The influences of other factors such as the trigger and drug and alcohol use appear to play more of a role and indicate that the patient would be most suited to specialist high intensity services. The health professional appears to have identified a treatment that they think would be most appropriate and in their discussion about this do not indicate that patient preference would play much of a role. In this case it appears that the presenting problem and circumstances play a pivotal role in the decision-making process.

Chapter Summary

The following presents a summary of the findings in relation to the core questions stated at the outset of this chapter.

The number of questions asked to make a decision

The numbers of questions asked by health professionals to make a decision for each scenario did not generally differ much by role. The highest number of questions was asked for the risk/drug and alcohol scenarios. This may reflect the more complex content of these scenarios in relation to the number and nature of factors that are prevalent. Low intensity workers asked more questions than high intensity workers for all of the scenarios; however this difference was only marginally dissimilar in four of the scenarios. For the worthlessness scenario low intensity workers asked double the number of questions than high intensity workers did to make their decision. At an individual level there was generally large variability in the numbers of questions asked, this may suggest that the amount of information that a health professional gathers is dependent on the actual scenario rather than a consistent information gathering process being adopted.

The types of questions asked

The majority of health professionals considered various factors when making a decision relating to the nature or management of the problem or to patient characteristics. However, by far, most questions related to the nature of the problem, particularly in relation to the patients' symptoms, risk and the trigger of the problem. Detailed analysis of questions asked about severity and patient preference revealed that these factors were not addressed as frequently as was anticipated.

The final decision

Decisions made by health professionals to refer the patient to low or high intensity treatments were relatively consistent. A unanimous decision was found for the OCD scenario, where all health professionals thought the patient would be suitable for a high intensity treatment. NICE guidelines recommend that mild OCD can be treated at low intensity. As severity was rarely addressed evidence for the role of other factors on the decision-making process were identified. Conversely, less consistency was demonstrated with the decisions made for the stress/rape scenario. This may be reflective of a more

complex decision-making process where, due to a variety of factors present, a number of treatment decisions may have been deemed appropriate.

Automatic decisions

Automatic decisions were made for all scenarios. The prevalence was highest for the OCD and stress/rape scenario, while the worthlessness scenario only attracted one. The higher number of automatic decisions made for these scenarios suggests that these particular issues may have a fundamental effect on the decision-making process, providing clear indication to the health professional about the most suitable treatment option from the outset. The lack of automatic decisions made for the worthless scenario may reflect the fact that the patient's diagnosis in this scenario was not clear from the outset and thus it was necessary for more information to be gathered prior to a decision being made. Some health professionals asked questions following their initial decision. As the vast majority did not change their initial decision following gathering additional information the purpose of these questions may have served as a justification for their decision.

Discussion

The AIS think-aloud task was chosen for its flexibility and its ability, albeit limited, to reflect health care interactions to a better extent than the other methods reviewed. It facilitated a greater understanding of the way in which health professionals make decisions and the processes involved.

Links can be made from the findings to the models detailed earlier in Chapter 2. Of particular relevance, the AIS think-aloud task provides detailed information about two of the decision-making stages proposed in the model by Betsch et al (2002). Within this task it was possible to capture what information health professionals seek out (the pre-selectional phase) and inferences can be made about how they make a decision (the selectional phase). Betsch et al (2002) suggested that where multiple options are available an individual must go through a process to simplify the decision to be made. This process is demonstrated within the findings where health professionals asked a higher number of questions in circumstances where ambiguity about the appropriate treatment was present. In general, this was for scenarios where there was no clear diagnosis presented (e.g. worthless scenario) or a number of factors were prevalent which may have added complexity to the decision-making process (e.g. risk/drug and alcohol scenario).

Researchers have claimed that the initial feelings that a health professional has about a patient greatly influence the diagnosis that they make (Elstein *et al.*, 1978). This claim appears also to be relevant for treatment decisions and links with previous literature on clinical intuition (Polanyi, 1983). Findings from this study provide evidence for these claims. While the numbers of questions asked by health professionals did not vary considerably, there was variation in the numbers of automatic decisions made between scenarios. These findings are comparable with the dual theory of cognition proposed by Stanovich and West (2000) which provided a link between rational models of decision-making and what health professionals actually do in practice. The theory, which integrates non-analytic (intuitive) and analytic processes, may provide an explanation for the variability that was found in the numbers of automatic decisions made. Automatic decision-making has particular relevance to system one of their proposed model, which is said to involve fast and automatic reasoning. Past experience and theoretical knowledge

are said to result in a mental model being established. Thus when salient features of a problem are identified a solution can be instantly recognised with a limited search for more cues is required. The AIS think-aloud task was able to capture this process. In instances where health professionals made an automatic decision that was not associated with prior verbalisation of any of their thoughts it can be inferred that their decision was automatic and intuitive. A process whereby system one processing is utilised in isolation from system two may be apparent in these situations. Health professionals may have been able to adopt a system one approach where there are clear indications from the outset of the decision they should make.

These findings are also associated with literature looking at diagnosing medical problems that suggests that the process may be conducted unconsciously (Schmidt & Boshuizen, 1993) and are additionally in line with those of Balla et al (2009) who suggested that, following the identification of salient features of a patient's presentation, rapid decisions can be made. These assertions assist with providing an explanation for how decisions were made within the AIS think-aloud task. It was found that patient scenarios presenting particular factors e.g. diagnoses such as OCD or PTSD or when the trigger was rape attracted the most automatic decisions. The decisions made about these scenarios may, in part, be explained by the role that the identification of such salient factors has in the health professionals' decision-making process. Recognising such factors may have influence over the ability to make a rapid decision. It is acknowledged, however, that these claims must be taken with caution as they are made under the assumption that the health professionals were following the instructions of the task by verbally providing all of their thoughts throughout.

For the most part decisions made by health professionals were not necessarily made in this automatic, unconscious manner. The majority of health professionals adopted a more analytical processing approach to their decision-making and very rarely, if at all, made an automatic decision. Their approach was more in line with the process that is described in the second system of the dual process cognitive theory where a slower and more serial processing took place. In making their decisions a process of gathering and analysing information occurred prior to making their decision. An example of where this approach was most likely to arise was found in decisions made for the worthlessness scenario. For this scenario only one automatic decision was made with health professionals going

thorough a process of gathering additional information before making their treatment decision. This approach adopted may be related to the lack of salient factors providing a confirmed diagnosis and the need therefore for the health professional to adopt a more analytic approach.

Some of the data collected was supportive of the argument that rapid decision-making tends to be non-analytic and may be followed by a reflective (analytical) phase (Mamede *et al.*, 2007; Norman *et al.*, 2007). For a small number of health professionals this appears to have been the case where, following their initial automatic decision, they subsequently went on to ask further questions about the patient's presentation. Thus while originally making an immediate decision they then felt the need to ask further questions to validate or disconfirm their decision. This provides evidence of the interacting nature of the two different systems and links with previous allegations that in clinical situations it is thought that a system one approach may fail (Eva & Norman, 2005; Croskerry & Norman, 2008). Croskerry & Norman (2008) additionally propose that clinicians often make overconfident judgements and that when making intuitive decisions, emotions such as excitement and enthusiasm may be invoked. These emotions may consequently impact upon their perceived levels of confidence of the decision made. Links can therefore be made with social cognitive models and the concept of 'self-efficacy' where it appears that where rapid, often unconscious, judgements are activated that this may impact upon their subsequent behavioural intentions and accordingly the decision made.

In such circumstances where an automatic response is not triggered by the information or situation presented a system two approach is said to be triggered. The findings, however, do not necessarily support the assumptions of Sladek et al (Sladek *et al.*, 2006) that repeated exposure to making the same decision over time is thought to result in the behaviour becoming experiential and moving to system one. They argued that with repeated exposure to making such decisions that more experienced health professionals are likely to make more rapid decisions in an automatic fashion. Although this may be the case, it seems that the automaticity by which decisions are made may also be dependent upon the actual patient's presentation e.g. diagnosis and the clarity of guidance.

Elsewhere in the literature, it has also been suggested that health professionals may base their decisions on few critical cues (Kostopoulou et al., 2008). It was anticipated that

severity and patient preference would be considered as critical 'cues', however this assumption was not supported. While regarded by NICE and policy as the two core issues that should be taken into consideration in the assessment of patients and thus in deciding the suitability of treatment, they did not drive decision-making to the extent that was expected. These findings are comparable to the findings of Macleod et al's (2009) study, detailed previously in Chapter 1, which explored CBT therapists' opinions about particular patient characteristics that would most likely result in a positive outcome. Whilst they found that a high percentage of therapists identified mild levels of severity were likely to lead to a positive outcome, motivation, expectancy, adherence and self-efficacy characteristics were considered to be better predictors of outcome. Within this current study, diagnosis, trigger or risk were found to potentially play a proxy role in the decision-making process. These factors were found to influence the decisions made to more of an extent than severity and thus in circumstances where severity was not addressed such factors may have played a pivotal role. Links can be made with these findings to those of McEvoy and Richards (2007) who conducted a study exploring access to community mental health teams. It was identified that health professionals' decisions were based on a number of factors that indicated the level of priority a patient was perceived to have. Risk was viewed as an important factor in the decision-making process and was often closely associated with severity. Where a patient was perceived as high risk, a decision to increase their priority of accessing the community mental health team was made regardless of the severity of their problem. Other studies exploring decision-making priorities have also found that patients presenting with high levels of risk are more likely to be referred to specialist secondary care services (Chiesa *et al.*, 2007; Schwartz *et al.*, 2004).

There are a number of implications associated with the severity of patients' problems and their personal preferences not being addressed. Not attending to severity impacts upon decision-making on a number of levels. For stepped care, the utilisation of outcome measures to assist with identifying how severe a patient's problem is, and subsequently which treatment would be most appropriate, is a vital part of ensuring the efficiency and effectiveness of the stepped care model. However, as has been discussed, the treatments proposed at each of the steps and the need to follow an evidence-based approach presents a considerable challenge to health professionals who are recommended also to take into account the preferences of individual patients. Following recommendations based on severity, which have a population rather than individual-patient focus, often conflicts with

what patients want. From a patient preference perspective, there exists little evidence about the impact that it may have upon outcome. However, drawing on the therapeutic alliance research literature (Bordin, 1979; Cameron, 1996; Langer, 1999; Tryon and Winograd, 2002) provides an indication that in not taking into account the preferences and goals of individual patients their commitment and engagement with psychological therapy may be damaged. Patient preference is regarded by NICE as important in informing treatment choice, particularly where the research evidence-base is limited. In taking into account patient preferences, however, health professionals may be faced with referring patients to treatments that have a poor evidence-base for the problem they are presenting with, some of which may be of a higher intensity that they would regard as being appropriate to meet the patient's needs which, again, has implications for the successfulness of the stepped care model. The difficulties in meeting the needs of patients whilst attending to their own clinical expertise at the same time as using standardised outcome measures clearly needs addressing.

It also needs acknowledging that severity and patient preference may simply not have been addressed to the extent that was expected due to the nature of the AIS think-aloud task. The task was designed to give health professionals the opportunity to ask questions to explore any aspect of a patient's problem or their circumstances, but may have detracted from the realities of making decisions in practice. The patient scenario may have seemed very different from an actual patient encounter and thus very dissimilar to the interactions that they would have that may have caused health professionals to attend to the decision-making process differently.

While patient preferences and severity played only a small role in the health professional decision-making, questions related to other factors were consistently asked. On the whole these related to the nature of the problem and specifically addressed patients' symptoms, risk and the trigger of the problem. Addressing these issues may be viewed as being more in accordance with a medical-model rather than psychosocial approach to managing mental health problems. Models of psychotherapy are based on individualised treatment plans that are devised following initial patient assessments (Persons, 1991). However, these plans are not necessarily comparable to guidance or protocols that are provided to assist with decision-making. These are generally based more on a standardised approach, often focused heavily on diagnosis. The AIS think-aloud task helped to uncover the way

that health professionals are making decisions in practice and the way in which they deal with the conflicting focus of guidance and therapy-driven protocols. Persons (1991) argued that traditional outcome studies fail to address these issues as standardisation of assessment is generally imposed, focused on a single diagnostic criteria rather than taking an ideographic approach. The AIS think-aloud task provided some indication of the situations where a more standardised guidance-driven approach is taken and circumstances where such an approach is not utilised to the same extent. Findings revealed that the use of more standardised protocols appear to be limited to certain diagnosis e.g. OCD and more theory-driven individualised approaches (demonstrated in the health professionals' differing decisions) are taken when these diagnoses are not present. This may be more in-line with a case formulation approach which is said to take into account 'the chief features of the case as well as an encapsulation of the diagnosis, etiology, treatment options, and prognosis of the patient's problem' (Sim *et al.*, 2005, p289). Persons (1991) suggests that when evaluating the accuracy of a health professional's formulation whether all individuals arrive at the same formulation and if formulation is related to outcome can be explored.

Whilst the purpose of the AIS think-aloud task was not to look at accuracy (as it is thought a number of decisions may be appropriate) the decisions made may highlight the degree to which a standardised or individualised approach is taken. As different formulations can be generated (Crowe *et al.*, 2008), this may provide explanation as to why differing decisions were made by health professionals. Not all health professionals asked the same questions and thus their decisions were based on different pieces of information. The AIS think-aloud task may assist to understand more accurately psychotherapy in practice and thus help to lessen the gap between theory and practice. One of the problems in comparing this diagnostic literature with the findings of this study is that when health professionals are faced with making a diagnosis within research studies, there is often a pre-determined correct diagnosis. Within this study, the treatment decision is not pre-defined as there is the possibility that a number of decisions may be possible, depending on a variety of factors including the manner in which the health professional collects additional information or the model of management (stepped or stratified) that they adopt.

In conclusion, the findings from the AIS think-aloud task revealed a great deal about the process by which health professionals make decisions. A role for both clinical judgement

and guidelines was apparent. Clinical judgement, based primarily on experience, seeks to achieve efficiency, whilst clinical guidelines seek standardisation. Both are focused on limiting decisions to a few core factors. In considering the circumstances where automatic decision-making occurred insight into instances where clinical judgement prevails was gathered. The AIS think-aloud task additionally assisted with the identification of the situations in which a wider and more reflective search occurs. Each of these approaches were not necessarily exclusive, where at times it was clear decision-making involved a combination of both. However, it was revealed that the process by which health professionals made a decision was generally dependent upon the patient's presentation.

CHAPTER TEN: **SYNTHESIS OF FINDINGS**

Introduction

The main aims of this study as detailed earlier were:

i. To explore patients' experiences of decision-making within a stepped care model of service delivery.

ii. To explore health care professionals' experiences of decision-making within a stepped care model of service delivery.

This final chapter presents the synthesis of the key findings, and is structured as follows:

- Summary of the findings
- A discussion of how these findings relate to the wider literature
- Strengths and weaknesses of the studies
- Recommendations for future research
- Recommendations for policy and practice

Summary of Findings

Patient Interviews

Key themes in the decision-making of patients included the lack of clear understanding of the stepped care process, and low levels of satisfaction with access to choice. Furthermore, divergence between their treatment goals and those of the service were apparent.

Health Professional Interviews

Key themes in the decision-making of health professionals included negotiating the tensions between resource limitations (e.g. waiting lists), stepped care principles (e.g. standardised outcomes and 'stepping-up'), and patient needs. Many health professionals reported 'holding' patients when waiting lists were long or there was no clear treatment

identified for the patient. This has important implications for the functioning and efficiency of the stepped care model.

Mental Health Professional AIS Think-Aloud Task

The AIS think-aloud task allowed a more standardised exploration of the process of decision-making. Professionals sometimes made rapid decisions based on salient features of a patient's initial presentation, but usually, decisions followed a process of gathering additional information. Contrary to expectation, questions relating to the severity of the problem and patient preferences were not prevalent.

Synthesis

From the synthesis of the individual study findings, three core tensions were identified. These were:

    i.   Standardisation versus the individual needs of patients;

   ii.   The public health orientation of stepped care versus the therapeutic orientation of health professionals and;

  iii.   The rhetoric about patient choices versus the realities of shared decision-making in a resource-limited system.

Standardisation versus Individual Need

A key theme is the tension between individualisation and standardisation. Health professional interviews revealed the difficulties associated with meeting the needs of individual patients whilst following guidelines and using standardised outcome measures that did not necessarily reflect important aspects of the patient experience (a point verified by the patient interviews). The AIS think-aloud task further revealed the limited role that such measures play in the decision-making task.

However, in contrast to the health professional interviews, patient preference was not frequently addressed in the AIS think-aloud. Thus, whilst health professionals recognised the limitations with standardised measures, it is not clear that this necessarily leads to explicit attempts to understand the preferences and/or needs of patients.

These disparities highlight that when health professionals discuss individual care it is unclear if this always encompasses patient preferences. Health professionals stress the importance of identifying and recognising individual patient needs but, at least for a proportion, their focus may be upon individualised clinical assessments, drawing on their clinical intuition and experience. Making decisions in this manner is not bound by standardised outcomes, which many health professionals consistently discussed as having limitations. Thus whilst their decision is individualised, in the sense that decisions are designed around and for each patient, this is not necessarily based upon patient preferences. Some may simply not see patient preferences as a core issue, either because they do not think that they are important or because they think they can work to engage patients who have different preferences. The lack of consideration of patient preferences may also relate to the fact that they do not overlap with good quality care and that meeting their priorities is seen as essential but not necessarily sufficient (Elwyn *et al.*, 2007). Decisions may be made on the grounds that the health professional regards the patient to lack the necessary information and that following their wishes may actually be detrimental. Decisions made in this way are professionally-led and paternalistic which deviates with the more patient-centred approach health professionals reported as driving their practice. Health professionals can thus individualise via patient preference or via bespoke clinical formulation but each have different implications concerning the 'roles' that the health professional and patient are assigned.

Public Health Orientation versus Therapeutic Orientation

When faced with patients who needed 'stepping-up', but where resources were limited, health professionals often found themselves 'holding' patients. 'Holding' reflects a paradox that stepped care is designed to ease waiting lists, but waiting lists actually impact upon the health professionals' ability to work in line with the principles of stepped care. 'Holding' reflects the tension faced by health professionals trying to improve efficiency (in line with the public health orientation of stepped care) whilst attempting to meet the demands of patients and their own personal and professional values.

According to the stepped care model, health professionals should 'step-up' a patient when outcome is poor following treatment. A patient then moves onto the next level, waiting for that treatment if required. However, carrying out this behaviour was found to be influenced by a number of factors that resonate with the integrated social cognitive model as described in Chapter 2 and outlined in Figure 18.

Figure 18: Integration of social cognitive models (Fishbein *et al.*, 2001)
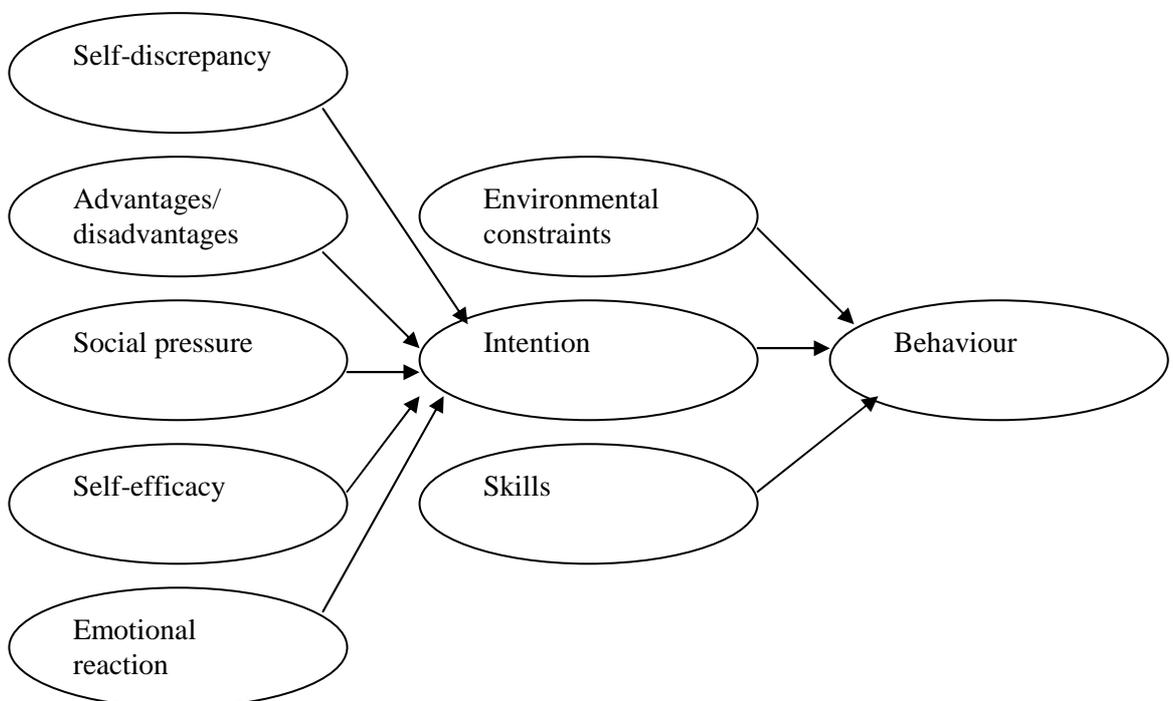
In making a decision to 'step-up' a patient, health professionals may be influenced by the representations they hold of themselves. Any discrepancies between these may impact

upon their perceived ability to manage the problems that a patient is experiencing. Their decisions may additionally be driven by perceived pressures to comply with guidelines, policy recommendations or the views of significant others, while the pressure to meet patient need may influence their intent to conduct a particular behaviour or make a specific decision.

A number of the concepts demonstrated within this model can also help to make sense of the phenomenon of 'holding'. The influence of emotional reactions may help to better understand some of the motives behind this behaviour. Once patients had been referred into the service health professionals reported their unwillingness to dispose of patients who were faced with long waits on waiting lists for higher levels of treatment or those who did not seem to 'fit' into the model. This was linked to their therapeutic values and professional anxieties. The intention to 'hold' was influenced by the emotions that were activated as a result of wanting to ensure patients were not left with nothing. 'Holding', however, conflicted with their awareness of their own abilities which links to the concept of self-discrepancy. Health professionals identified that 'holding' was not often beneficial to the patients or to themselves but the concerns that they had for patients appeared to override these values. Where they perceived themselves to have the ability to manage some aspects of patients' problems the intent to do so was perhaps greater. Health professionals appeared to also be driven by the pressures placed upon them by the service model and by their own evaluations of the advantages and disadvantages of carrying out this particular behaviour. In some cases, where professionals stated that it would be inappropriate to 'hold' a patient at a lower intensity level e.g. when patients presented with OCD or PTSD, this related to their recognition of their lack of skills and perceived inability to manage such patients.

The Rhetoric of Choice and the Realities of Decision-Making

Health professionals recognised that it was difficult to present patients with a choice due to resource limitations and waiting lists. They also identified the importance of involving patients in decision-making but acknowledged that the extent to which they can be involved is impacted upon by the choices that are available. These findings were mirrored in the patient interviews where a clear distinction was made by patients between being 'involved in decision-making' and 'having a choice'. They stressed that they were satisfied

with the extent to which health professionals involved them in the management of their problem by ensuring they were informed and consulted about the acceptability of the treatment process. However, they reported being given little opportunity to choose what they wanted. In contrast, the AIS think-aloud task revealed that preference was not considered to the extent that was anticipated. The collection of data using more standardised means thus highlighted that the importance of patient preference may be overstated in the interviews.

The key themes from each of the studies are presented in Figure 19:

Figure 19: Key themes from study findings and tensions identified

STUDY	FINDINGS	TENSIONS IDENTIFIED

HEALTH PROFESSIONAL INTERVIEWS (STUDY 1A)

Tensions between following stepped care principles whilst responding to patient need and negotiating issues such as waiting lists

'Holding'

PATIENT INTERVIEWS (STUDY 2)

Lack of choice

Poor understanding of stepped care process

MENTAL HEALTH PROFESSIONAL AIS THINK-ALOUD (STUDY 1B)

Importance of risk, presenting problem/ symptoms and trigger.
Automatic decision-making driven by salient features of patient presentation e.g. diagnosis or trigger
More analytical approach taken when salient features not present
Severity and patient preferences addressed infrequently

Public health versus therapeutic orientation

Choice versus realities of shared decision-making

Standardisation versus individual patient needs

Discussion of Findings in Relation to Literature

Studies are only now emerging looking at decision-making in stepped care (Parry *et al.*, 2010; Horn, 2010; Clark *et al.*, 2009; Richards *et al.*, 2010), but the next section considers the findings of the thesis in the context of this developing literature.

Standardisation versus Individual Patient Need

One of the relatively unexpected findings within this study was the limited role of severity in professional decision-making. The literature suggests it is unlikely that one single factor can reliably predict outcome (Clarkin & Levy, 2004; Seidenstucker & Roth, 1998), however the basis for the majority of decision-making within the stepped care model, particularly for 'stepping-up', is generally based upon standardised severity measurement. This supports some of the findings of Horn's review of primary studies and investigation of predictors of outcome and evaluation of patients 'stepped-up' at one of the IAPT demonstration sites (Horn, 2010) (as detailed in Chapter 1). In her evaluation, anxious patients were more likely to be 'stepped up', but no other associations were found. If decisions to 'step' a patient up are made on the basis that a clinically significant change has not been achieved it would be expected that those patients who were subsequently 'stepped-up' would be more readily recognisable in terms of their level of severity.

Horn (2010) concluded that as around half of the patients in her sample achieved a clinical change by their last session that that was indicative of the intervention matching their needs. This thesis might challenge that conclusion, in that a change in the severity of their problem is not necessarily what patients regard as a good treatment outcome. The issue of conflicting definitions of 'successful outcome' between patients and health professionals has also been found in other literature. MacDonald et al (2007) explored the attitudes of patients receiving guided self-help whilst waiting for more intensive psychological therapies using a qualitative interview approach. Their findings mirrored many of those found in this study. A lack of patient understanding, regardless of being provided with detailed information prior to receipt of guided self-help, was found and many reported that they had expected to receive a treatment more in-line with traditional psychological therapy. These expectancies influenced the way in which their perceived outcomes were met. Patients reported that improvements had been achieved but that they were not 'cured'

and felt that they needed more time, the opportunity to discuss their personal problems and to gain insight into why they were experiencing the problems they were.

Of particular significance for stepped care it is also important to note that more intensive treatments based on the same principles may also fail to meet these expectations (Addis & Carpenter, 1999). Williams and Martinez (2008) emphasised the value of understanding who low intensity interventions are most suitable for and in doing so an element of understanding patient preferences and choices is important. Giving patients the opportunity to choose their preferred treatment may, in part help to overcome poor outcomes. However, there is conflicting evidence about the impact that this may have (Swift & Callahan, 2009; Chilvers *et al.*, 2001; Howard & Thornicroft, 2006; King *et al.*, 2005; Bower *et al.*, 2005).

In considering the findings from this study and recent stepped care literature there are three identified means of making decisions – using standardised outcome measures, clinical formulation or patient preference.

Standardised Outcome Measures

At present decisions made about the effectiveness of treatments delivered in stepped care are based on standardised outcomes, where a large onus is placed on those measuring severity. Studies have highlighted the potential benefits of these such as improvement in patient outcomes (Lambert *et al.*, 2005), diagnosis and management of patient conditions (Marshall *et al.*, 2006a; Dowrick *et al.*, 2009) and in improving treatment effectiveness and patient involvement (Steele *et al.*, 2004; Maxwell, 1984). The literature, however, is not wholly positive and, in-line with the findings in this study, highlights concerns of their acceptability, applicability, and reliability (e.g. Andrews *et al.*, 1994; Davison, 2000) when taking into account the individual nature of patients' problems.

Patient Preference

Patients have expressed a desire to be involved in treatment decision-making (e.g. Adams *et al.*, 2007; Hill & Laugharne, 2006) and have strong preferences for one form of

treatment over another (Cooper *et al.*, 2003; Dwight-Johnson *et al.*, 2000; Priest *et al.*, 1996; Raue *et al.*, 2009; Unutzer *et al.*, 2002). The importance of incorporating patients in the decision-making process is also consistently reported in policy. However, there is little research exploring the impact that involvement has for people with mental health problems (Duncan *et al.*, 2009) and research that has been conducted is conflicting (e.g. Clever *et al.*, 2006; Fairhurst & Dowrick, 1996; Lasalvia *et al.*, 2008) and often associated with methodological limitations (Hamann *et al.*, 2003; Bower *et al.*, 2005).

Clinical Formulation

Literature relating to clinical formulation, viewed within psychotherapy as an alternative approach to obtaining a traditional diagnosis, emphasises the importance of health professionals working collaboratively with patients to derive a theoretically-based explanation that can be used to set therapy agendas (Macran *et al.*, 1999). It has been suggested that doing so may improve patient outcomes (Orlinsky *et al.*, 1994) and/or patient compliance (Fitzpatrick *et al.*, 1984). However findings exploring the benefits of a clinical formulation approach are mixed. While the associations between a good therapeutic relationship between the health professional and patient have been established (Trepka *et al.*, 2004; Ahn & Wampold, 2001; Saatski *et al.*, 2007) those present between patients' identified preferences and subsequent outcomes are less clear (Hardy *et al.*, 1998).

The literature surrounding these approaches is thus unclear and it is difficult to determine which approach, or combination of approaches, would best be suited to meet the needs of decision-making in stepped care. Exploring these approaches is important in order to improve the experiences not only of patients (by better addressing their needs) but also of health professionals faced with difficult decision-making situations.

Public Health versus Therapeutic Orientation

Health professionals in this study identified problems with availability of high intensity interventions and the difficulties of managing patients who did not 'fit' the model, which led to 'holding'. Horn (2010) recognised that health professionals may have made the

decision to 'step' a patient up early on in low intensity treatment but continued to see them until the high intensity intervention was available. Some of the patients interviewed in Horn's study stated that the low intensity intervention they received was focused on one problem (depression) and that they were 'stepped-up' for help to manage another problem (anxiety), which suggests that low intensity workers had identified the need for the patient to be 'stepped-up' but decided to work on an aspect of the patient's problem. As 'holding' patients or providing them with treatments that could be considered inappropriate may actually be damaging (Lucock *et al.*, 2008; Dimidjian & Hollon, 2010) this finding is of concern.

The phenomena of 'holding' was also identified by Richards et al (Richards *et al.*, 2010). While both types of workers were interviewed in Richards et al's (2010) study, the views presented reflected those of experienced health professionals and it was unclear from their report the impact that 'holding' had upon the workers at low intensity. This present study provided more insight into low intensity workers' experiences. In addition, particularly as a result of the incorporation of the AIS think-aloud, the ability to compare and contrast the decision-making experiences of low and high intensity workers was facilitated in this study.

Richards et al (2010) additionally found that patients alluded to the concept of 'holding'. On reflection, however the patient's focus was more about having a choice to access higher intensity interventions without having to access low intensity interventions first. These findings would be more in line with what the patients reported in this study where their apparent lack of awareness about the stepped care process would perhaps make them unlikely to conceptualise the treatment process as being 'on hold' unless this was explicitly discussed by the health professional with them.

Choice versus Realities of Shared Decision-Making

Health professional findings highlighted the importance of involving patients in the decision-making process but that achieving this was hampered by issues such as treatment availability and waiting lists. Patients confirmed the limited choices that were available to them. These findings build upon previous work focused on the patient experience within stepped care and IAPT evaluations (Horn, 2010; Parry *et al.*, 2010; Richards *et al.*, 2010)

where many patients felt that choice was limited. Laugharne & Priebe (2006) stated that limitations in choice may impact upon outcomes achieved. This was demonstrated by the patients interviewed by Parry et al (Parry *et al.*, 2010) who reported generally dissatisfied experiences, particularly with the outcomes they had achieved. Wilson et al (2000) raised important issues about the introduction of stepped care in relation to outcome. Where patients do not benefit from low intensity interventions they may become demoralised which could have an impact upon their likelihood to subsequently access higher interventions. This has specific relevance to the findings within this study that highlighted the relatively poor outcomes achieved by patients who accessed only low intensity interventions. Some reported that as they had not benefited from the treatment that they had chosen that the only option left was medication, which they had disregarded at the outset. The work by Parry et al (Parry *et al.*, 2010, p87) demonstrated similar findings where patients sometimes 'blamed themselves' if a positive outcome was not achieved. Policy and research emphasise choice as central to the provision of healthcare (Coulter, 1999) but these findings and supporting literature emphasise the difficulties of managing choice within stepped care systems. Health professionals appear to struggle to meet patient demand due to the availability of services. However, the AIS think-aloud task, in which decisions had been taken out of health professionals' service context, revealed that patient preference was rarely addressed. Thus while policy and health professionals themselves stress the importance of the incorporation of patient choices and preferences this study does not provide practical evidence that this actually occurs. In part this may be explained by the health professionals' inability to actually offer a choice, which may impact upon the likelihood that they address it with patients.

Strengths and Limitations

A number of strengths and limitations related to the methods adopted, sampling and researcher characteristics can be identified.

Methods

By adopting a multiple-methods approach, the exploration of different aspects of the process of decision-making was made possible. The choice to adopt a qualitative research approach allowed for the exploration of complex decision-making processes in detail. The addition of the AIS think-aloud task with mental health professionals was beneficial on a number of levels. Asking health professionals to make decisions using this task allowed for the collection of data of a higher degree of standardisation to complement that of the semi-structured interviews. It identified more about how decisions are made in practice by exploring the types of information health professionals were interested in and the timing at which participants asked for this information and made decisions.

A key advantage of the use of complementary methods was highlighted by the identification of conflicting findings. While health professionals highlighted the importance of patient preference and choice in their decision-making within the interviews this was found not to be a clear focus within the AIS think-aloud task. This disparity helped to reveal more about the decision-making process by capturing what they state that they do in theory that it reality may not be realised.

The AIS think-aloud task is not devoid of limitations, and cannot overcome participant response biases often found when conducting interviews. The standardised method might also be considered by some to be unnatural. The degree in which it reflected real-life practice situations was restricted and it is unclear if it fully captured the decision-making processes that health professionals would adopt with real patients. The majority of scenarios involved patients presenting for the first time. In practice, mental health professionals would have approximately 45 minutes to assess the patient's problems and make a treatment decision. While there was no time limit placed upon the task, all five scenarios were completed, by the majority, within 30 minutes. Thus, taking into

consideration the time allocated to the patient to provide information and for outcome measurements to be administered within normal practice, the totality of the decision-making process may not have been captured. It is also not possible to determine whether factors other than those asked about, such as patient behaviour or visual cues, would have had influence upon the decisions made. Furthermore, the quantitative data that was analysed was based on small numbers and therefore may also be limited. Observing actual consultations may have helped to overcome some of these limitations, although observation may alter the way in which the health professional interacts with the patient or the treatment decisions made, and considerations about how to avoid this would need to be made.

Sampling

Health Professional Sampling

The process of analysis involved focussing on health professional role differences and similarities. While there were no obvious differences between health professional experiences over the three sites, the numbers of health professionals recruited at each site were small and a decision was made that an analysis by site would have added little to the overall findings.

The health professionals who took part volunteered to do so, therefore those with a clear interest in decision-making within stepped care, who were willing to take time out of their busy work schedules may have been more inclined to participate. In particular, it was clear that the small sample of GPs who participated had a clear interest in the area of mental health problems and a few indicated that they actively engaged in the management of such problems within their PCT. It is therefore not known if those who declined the invitation to take part would have similar experiences of the decision-making process, and if their treatment decisions would have mirrored those found.

Patient Sampling

The small numbers of published studies that have been conducted exploring the views of patients have mainly interviewed those who have 'completed' treatment. These samples

may be biased towards those with more positive experiences of the service, particularly with respect to one study where the sample were made up of patients who had found high intensity treatment helpful (Horn, 2010). This may be a limiting factor as those who had not completed or did not attend may have had less positive views than those interviewed. The current thesis included patients at varying different stages of their treatment. Some had received a low intensity intervention and had been discharged, whilst others had been 'stepped-up'. Not all patients had been discharged and thus some views were reflective also of those still being treated within the stepped care model.

The relatively small patient sample size may be considered as an additional limitation. However, the emergent data was rich enough to cover a wide range of views and the recurrence of a number of themes provided indications of saturation. Additionally, although not all were satisfied with their outcomes, they had engaged with treatment and may have actually been more positive than those who did not engage. On the other hand however, as not uncommon with research studies, those who participated may actually represent a more negatively viewed sample that wanted the opportunity to air their views.

The age of the patients involved in the study may also limit the findings. While mental health problems are present in individuals of all ages, the study failed to recruit anyone over the age of 65. In inviting patients to take part health professionals were not told to exclude any patients on the basis of age (unless under the age of 18) and it is likely that a number of older patients would have been invited and declined. The issue of age could have been addressed within the AIS, but only one scenario presented an 'older-age' patient and thus the effect of age was not fully explored, although occasionally health professionals attributed patient problems to the 'stage of life' they had reached. It therefore may have been of interest to look at these issues in greater detail.

Site Sampling

Although the use of a limited number of sites is not in itself a limitation, as patients were all sampled from one stepped care site there is the possibility that if the study was repeated at other sites the findings may not be replicated. Differences in the way stepped care has been implemented may impact upon health professional and patient experiences. For example, in all of the sites sampled a mixed stepped-stratified approach was adopted where

patients initially assessed as having a clear need for an intensive service (on the basis of health professional judgement rather than patient preference) could bypass low intensity. Some sites may have adopted a wholly stepped care approach, where all patients must be treated at low intensity before decisions being made about their suitability for higher levels of treatment. In these circumstances the experiences of patients and health professionals may differ and thus it may be of interest to explore this.

Additionally, at the time interviews were conducted all sites were implementing IAPT but none had done so completely. As a consequence workforces were not fully established. As lack of high intensity services within this study were found to be a key driver for 'holding', health professionals and patients may have different experiences at sites that have completed implementation (e.g. where services are adequately resourced, the issue of 'holding' may not be so evident). This, in turn may impact upon patient experiences of waiting and of choice. Irrespective of potential biases, the findings were similar to those of recent evaluations and subsequent discussions with high and low intensity workers at one of the sites following full implementation revealed that the same issues persisted.

A more formal sampling process whereby all PCTs were invited to participate then a process of identifying whether they had adopted a stepped care model and how long it had implemented for may have been more beneficial. Adopting a different sampling strategy, however, would not necessarily guarantee that the sample that eventually agreed to participate would be any more representative.

Researcher Characteristics/Identity

An additional strength of the study was that the researcher was not a clinician and not involved with the stepped care sites in any other capacity. It is acknowledged that although the researcher may have held some preconceived ideas these were not necessarily the same as those with direct experiences of stepped care. While clinical insights were gathered by observing supervision sessions at one of the sites, the researcher attempted to be as objective as possible throughout data collection. It is thought these attributes of the researcher may have potentially influenced health professionals to feel more comfortable and talk openly about their experiences as their clinical competence would not be judged. Conversely, it has been argued that only individuals that are directly engaged as members

of a group can fully understand the experiences of those within that group (Hockey, 1993) and therefore the interpretations of an 'outsider' may diverge from those shared experiences. However, the involvement of an 'outsider' may actually prompt the exploration of issues in an objective way that may not have been considered by those experiencing these issues on a regular basis. The influence of the researcher's identity has been demonstrated in previous literature (Chew-Graham *et al.*, 2001). In two studies exploring the impact of using a GP-researcher to interview GPs they found that where a shared identity was identified participants were more likely to be open about their experiences and treated the GP-researcher as a 'professional peer or private confidant' (Chew-Graham *et al.*, 2001, p288). Whilst this may be considered an important part of the interview process Chew-Graham et al recognised the potential threats this may have upon data collection and analysis. Interviews may be guided by researchers' own experiences or opinions rather than driven by those of the participant. A concept referred to by Chew-Graham as a 'shared conceptual blindness' (p288).

Recommendations for Future Research

Now IAPT has been fully implemented at a number of sites, it might be anticipated that some of the tensions have been reduced, but ongoing discussions with one of the sites suggested that the same issues continue to prevail. While it is highly unlikely that mental health systems are likely to overcome all of these tensions fully e.g. access to services is always likely to be a problem, some of the issues may be addressed.

Two areas need to be addressed in future research exploring decision-making in stepped care:

   i.   identifying different methods that can be used to explore decision-making and;
  ii.   exploring the effectiveness of different ways of making decisions

In addition to interviews and the AIS, decision-making may be explored through observing actual consultations. This approach would allow for the exploration of decision-making in a more natural context than the methods used within this study. It may also have the potential to evaluate the indirect ways that patient preferences may influence decision-

making. For example, the interactions that health professionals have with patients is not restricted purely to their verbal communication but also may be influenced by non-verbal cues those patients may provide. However, such methods are not without limitations and incorporating more 'intrusive' measures may reduce the likelihood that professionals and patients will take part. Some of the problems, (such as having a third person present at the consultation), may be overcome by visually or audio-recording the interactions between the health professional and the patient.

One of the issues raised within this study relates to the different ways that decisions can be made, based on standardised outcomes, clinical formulation and patient preferences. However, the literature surrounding these does not provide a clear indication of which is best suited to decision-making in stepped care. The effectiveness of the different approaches therefore requires further exploration.

Work by Perry and Gilbody (2009) has highlighted some of the more user-defined outcome dimensions that could be incorporated within measures to address the issues recognised by health professionals and patients. They acknowledged the importance that patients placed on the importance of non-clinical and social outcomes rather than those focusing on severity. In considering one of the main findings from this study, the tension between individualisation and standardisation, further research could explore and trial the incorporation of new measures to complement those already routinely used.

Including idiographic measures (Shapiro *et al.*, 1961; e.g. Robinson *et al.*, 2006) that seek to 'capture individuals' phenomenological experiences ' (Bowling 2001) may be one way to assist with overcoming this tension. Identifying patient preferences and priorities alongside measures capturing significant clinical factors such as severity may reveal more about the outcomes that patients identify as important. Within this study, and previous literature, there is divergence between patient and service perspectives of when 'recovery' has been achieved. Identifying patients' needs and understanding better their perception of a 'good' treatment outcome may enhance patient satisfaction. However, while the incorporation of more patient-centred measures may have the potential to better meet patient need and obtain a more accurate assessment, the costs, including time and effort, associated with completing these may outweigh these identified benefits.

The concept of 'holding' additionally requires more research attention. At present the impact that 'holding' has upon patient outcome is unclear. Some researchers have suggested that 'holding' patients or providing them with treatments that could be considered inappropriate may actually be detrimental (Lucock *et al.*, 2008; Dimidjian & Hollon, 2010). A better understanding of the impact it has upon outcomes and whether any advantages of patients being 'held' can be identified, is of particular relevance.

Recommendations for Policy and Practice

The implementation of stepped care has been rapid and with a very small evidence-base surrounding its effectiveness it is not entirely surprising that subsequent issues and problems have arisen. NICE and IAPT need to consider the problems of decision-making in developing future guidance. Producing clearer guidance, particularly around what health professionals should do when faced with a patient that should be referred to higher steps may partly deal with this problem. In assisting with decisions around the management of such patients, the concern around 'holding' patients that are waiting for higher intensity services may be partly addressed.

Stepped care has been implemented to make service delivery more efficient. Although an important element of this is to reduce waiting lists in order to ensure its success, waiting lists need to be dealt with first. The paradox of implementing stepped care to improve waiting lists while waiting lists are high is prevalent. The inability to sort out adequate resourcing impacts directly on the functioning and effectiveness of the model and lack of resources impact upon the decisions that health professionals have the ability to make. As a consequence of poor resourcing, the decisions made may have potential detrimental effects upon the outcome of patients and their own well-being. 'Holding' patients due to lack of capacity results in increased waiting lists for low intensity which conflicts with the aim of rapid access. Ways to manage 'holding' patients more effectively between steps need to be identified.

Managing 'holding' more effectively to free-up capacity is important, as is improving capacity to alleviate 'holding' issues, to ensure the effectiveness of stepped care. 'Holding'

presents numerous challenges for health professionals on a professional and personal level. They are faced with managing the expectancies and emotions of patients, often at the same time as dealing with their own emotions and feelings of responsibility towards patients. GPs are faced with specific difficulties associated with holding where their role is of a long-term nature. Identifying and exploring the mechanisms or procedures that professionals in this role utilise to manage holding on a personal, professional and patient-level may assist with identifying the needs that they have. Without formal supervision, GPs are faced with seeking out support or guidance from elsewhere. As little to no formal guidance is available, this is an area of practice that could result in inconsistencies in patient care and put considerable pressure on the role of the GP. While mental health professional decision-making is, to an extent, supported through regular group or individual supervision the focus, for the most part, on case-management with little or no time to address the emotional impact that making decisions may have upon the professionals themselves. Incorporating time within supervision to address these issues is important, particularly for low intensity workers who frequently reported not having had sufficient training to deal with the complexity of many of the patients that they encounter. Training designed specifically around managing issues such as holding and the emotional consequences it may have alongside exploring the behaviours of health professionals may assist primary care mental health services to partly alleviate and/or support some of these difficulties.

The delivery of low intensity interventions can be difficult and often do not meet the expectations of patients. Managing patients' expectations and preferences is challenging within a service aiming to improve efficiency. Providing patients with clear information about the model at the outset may help to alleviate some of these challenges. The importance of ensuring that low intensity interventions are not communicated as short-term solutions to manage problems until higher intensity treatments become available is of paramount importance. Policy needs also to look at ways in which health professionals can be encouraged to take more account of patient preferences. This may include conducting patient needs assessments to guide treatment decisions or utilising patient satisfaction measures to assist with ensuring services are meeting the needs of patients and to explore areas that require improving where patients report their needs are not met.

The stepped care model may not operate efficiently if patients, professionals and services have different expectancies about outcome. The challenge is to meet patient need at the same time as ensuring an efficient service is being delivered. Findings have highlighted the need to consider a different way of evaluating the 'recovery' of individuals. Prioritisation of measures with a wider scope beyond symptoms, which may include individualised self-report measures in the evaluation of services, may help to better reflect patients' needs and perspectives. However, such measures are less standardised. Recent policy identifies the need to use such measures more widely to enable better personalisation of services (Department of Health, 2010) but this may present difficulties. Measures currently adopted, such as the PHQ-9, do not take into account patient preferences but are consistent, and may be argued equitable. Using more patient-centred approaches may capture individual patient needs more efficiently but could be potentially idiosyncratic and inequitable as different patients are likely to have very different expectations. These issues need to be addressed to ensure both the needs of patients and services are met.

An additional challenge to the efficiency of stepped care relates to the way in which decisions are made. Health professionals draw upon a variety of sources to make treatment decisions – the evidence-base, their own clinical experience and patient preference. With competing outlooks, priority is often placed on professional experiences (Kendrick REF). What is required within practice is to try to improve the use of of both the evidence available and the preferences patients hold. The difficulties in doing so have been outlined. One of the avenues that could be addressed is how QOF is being implemented. GPs are paid to make use of standardised questionnaires to measure patient outcomes. Exploration of their use, however, is varied. Some feel they are not objective enough and have questioned their validity (Kendrick et al, 2009) while others have highlighted that they can negatively impact upon the the relationship they have with patients (Dowrick et al, 2009; Leydon et al, 2011). Negative views of using outcome measures has resulted in some GPs avoiding categorising a patient as having depressive symptoms in order to avoid having to complete the measures and to save time (Kendrick et al, 2009). The implications of not using these measures effectively may mean that patients in need of a referral may not be identified and treated effectively. There are concerns as to whether services should 'force' GPs to use them by only allowing access to psychological treatments if they are utilised. This, however, has repercussions, competing with GPs views that decisions should take into account their experiences and intuition and an overall holistic outlook.

Final Conclusions

This thesis has identified 3 core tensions underlying decisions within the stepped care model:

i.   Standardisation versus the individual needs of patients;

ii. The public health orientation of stepped care versus the therapeutic orientation of health professionals and;

iii. The rhetoric about patient choices versus the realities of shared decision-making in a resource-limited system.

Future research needs to identify different methods to explore decision-making, the impact of these tensions, and how they can be ameliorated. In addition, the effectiveness of different ways of making decisions is in need of urgent evaluation. Developments within policy and practice need to focus upon ensuring that appropriate assistance is available to assist health professionals to make decisions, and to alleviate 'holding'. Additionally, more emphasis within practice is required to ensure patients' expectations and understanding of stepped care are better addressed, and to explore ways of making more patient-centred assessments of outcome that still function in the context of a system like stepped care.

By addressing these issues, the potential of stepped care to improve accessibility to psychological treatments and more effectively meet patient need, can be realised.

REFERENCES

Abidin,R. & Robertson,L. (2002) Stress, biases or professionalism: What drives teachers' referral judgements of students with challenging behaviours? *Journal of Emotional and Behavioural Disorders* **10**, 204-212.

Ableson,R.P. & Levi,A. (1985) Decision making and decision theory. In G.Lindsey and E.Aronson (Eds) *The Handbook of Social Psychology*. Random House, New York.

Adams,J.R., Drake,R.E., & Wolford,G.L. (2007) Shared decision-making preferences of people with severe mental illness. *Psychiatric Services* **58**, 1219-1221.

Addis,M. & Carpenter,K. (1999) Why, why, why? Reason giving and rumination as predictors of response to activation- and insight-oriented treatment rationales. *Journal of Clinical Psychology* **55**, 881-894.

Ahn,H. & Wampold,B.E. (2001) Where oh where are the specific ingredients? A meta-analysis of component studies in counselling and psychotherapy. *Journal of Counseling Psychology* **48**, 251-257.

Ajzen,I. (1985) From intention to actions: A theory of planned behaviour. In J.Kuhl and J.Beckham (Eds) *Action-control: From Cognition to Behaviour*. Springer, Heidelberg.

Ajzen,I. (1988) *Attitudes, Personality and Behavior*. Dorsey Press, Chicago, IL.

Ajzen,I. & Fishbein,M. (1970) The prediction of behaviour from attitudinal and normative beliefs. *Journal of Personality and Social Psychology* **6**, 466-487.

Ajzen,I. & Fishbein,M. (1980) *Understanding Attitudes and Predicting Social Behaviour*. Prentice Hall, Englewood Cliffs, NJ.

Ajzen,I. & Madden,T.J. (1986) Prediction of goal-directed behavior: Attitudes, intentions, and perceived behavioral control. *Journal of Experimental Social Psychology* **22**, 453-474.

Altheide,D. & Johnson,J. (1994) Criteria for assessing interpretive validity in qualitative research. In N.Denzin and Y.Lincoln (Eds) *Handbook of Qualitative Research*. Sage, Thousand Oaks, CA.

Anderson,I.M., Ferrier,I.N., Baldwin,R.C., Cowen,P.J., Howard,L., Lewis,G., Matthews,K., McAllister-Williams,R.H., Peveler,R.C., Scott,J., & Tylee,A. (2008) Evidence-based guideline for treating depressive disorders with antidepressants: a revision of the 2000 British Association for Psychopharmacology guidelines. *Journal of Psychopharmacology* **22**, 343-396.

Anderson,L., Lewis,G., Araya,R., Elgie,R., Harrison,G., Proudfoot,J., Schmidt,U., Sharp,D., Weightman,A., & Williams,C. (2005) Self-help books for depression: how can practitioners and patients make the right choice? *British Journal of General Practice* **55**, 387-392.

Anderson,S.J., Troein,M., & Lindberg,G. (2001) Conceptions of depressive disorder and its treatment among 17 Swedish GPs. A qualitative interview study. *Family Practice* **18**, 64-70.

Andrews,G., Peters,L., & Teeson,M. (1994) Measurement of Consumer Outcome in Mental Health: a report to the national mental health information strategy committee. Clinical Research Unit for Anxiety Disorders, Sydney.

Anthony,J.S., Baik,S.Y., Bowers,B., Tidjani,B., Jacobson,C.J., & Susman,J. (2010) Conditions that influence a primary care clinician's decision to refer patients for depression care. *Rehabilitation Nursing* **35**, 113-122.

Arora,N.K. & McHorney,C.A. (2000) Patient preferences for medical decision making. *Medical Care* **38**, 335-341.

Aveyard,H. & Sharp,P. (2009) *A Beginner's Guide to Evidence Based Practice in Health and Social Care*. Open University Press, Maidenhead.

Baker,T.L. (1994) *Doing social research*. McGraw-Hill Inc, New York.

Baldwin, D. S., Anderson, I. M., Nutt, D. J., Bandelow, B., Bond, A., Davidson, J. R., den Boer, J. A., Fineberg, N. A., Knapp, M., Scott, J., & Wittchen, H. U. (2005) Evidence based guidelines for the pharmacological treatment of anxiety disorders: recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology* **19**, 567–596.

Balla,J.I., Heneghan,C., Glasziou,P., Thompson,M., & Balla,M.E. (2009) A model for reflection for good clinical practice. *Journal of Evaluation in Clinical Practice* **15**, 964-969.

Bandura,A. (1977) Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review* **84**, 191-215.

Bandura, A. (1994) Self-efficacy. In V.S.Ramachaudran (Ed) *Encyclopedia of Human Behaviour*. Academic Press, New York.

Bar,A.S. & Huber,O. (2008) Successful or unsuccessful search for risk defusing operators: Effects on decision behaviour. *European Journal of Cognitive Psychology* **20**, 807-827.

Barber,J.P., Connolly,M.B., Crits-Cristoph,P., Gladis,L., & Siqueland,L. (2000) Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting & Clinical Psychology* **68**, 1027-1032.

Barkham,M., Leach,C., Lucock,M., Evans,C., Margison,F., Mellor-Clark,J., Benson,L., Connell,J., & Audin,K. (2001) Service profiling and outcomes benchmarking using the CORE-OM: toward practice-based evidence in psychological therapies. *Journal of Consulting and Clinical Psychology* **69**, 184-196.

Barnett, J., Ogden, J., & Daniells, E. (2008) The value of choice: a qualitative study. *Journal of General Practice* **58**, 609-613.

Barry,R. (2006) Delivery of psychological therapies: clinical governance implications for trusts. *Clinical Governance: An International Journal* **11**, 174-179.

Bartak,A., Soeteman,D.I., Verheul,R., & Busschbach,J.J.V. (2007) Strengthening the status of psychotherapy for personality disorders: An integrated perspective on effects and costs. *The Canadian Journal of Psychiatry* **52**, 803-810.

Bazeley P. (2007) *Qualitative data analysis with NVivo*. Sage, London.

Bazerman,M.H. & Tenbrunsel,A. (1998) The role of social context on decisions: Integrating social cognition and behavioural decision research. *Basic and Applied Social Psychology* **20**, 87-91.

Beach,L.R. (1990) *Image theory: decision making in personal and organizational contexts*. Wiley, New York.

Beatty,P.C. & Willis,G.B. (2007) Research Synthesis: The Practice of Cognitive Interviewing. *Public Opinion Quarterly* **71**, 287-311.

Beck,A., Steer,R., & Brown,G. (1996) *Manual for Beck Depression Inventory-II (BDI-II)*. TX, San Antonia.

Becker,M.H. (1974) The health belief model and sick role behaviour. *Health Education Monographs* **2**, 409-419.

Becker,T.E. & Randall,D.M.R.C.D. (1995) The multidimensional view of commitment and the theory of reasoned action: A comparative evaluation. *Journal of Management* **21**, 617-638.

Bedi,N., Chilvers,C., Churchill,R., Dewey,M., Duggan,C., Fielding,K., Gretton,V., Miller,P., Harrison,G., Lee,A., & Willians,I. (2000) Assessing effectiveness of treatment of depression in primary care. Partially randomised preference trial. *British Journal of Psychiatry* **177**, 312-318.

Benbassat,J., Pipel,D., & Tidhar,M. (1998) Patients' preferences for participation in clinical decision making: A review of published surveys. *Behavioral Medicine* **24**, 81-88.

Benner,P. & Tanner,C. (1987) Clinical judgement: how expert nurses use intuition. *American Journal of Nursing* **1**, 23-31.

Bennett-Emslie,G. & McIntosh,J. (1995) Promoting collaboration in the primary mental health care team: the role of the practice meeting. *Journal of Interprofessional Care* **9**, 251-256.

Bensing, J. (2000) Bridging the gap: the separate worlds of evidence-based and patient-centred medicine. *Patient Education and counselling* **39**, 17-25.

Bentler,P.M. & Speckart,G. (1979) Models of attitude-behavior relations. *Psychological Review* **86**, 452-464.

Betsch,T., Fiedler,K., & Brinkmann,J. (1998) Behavioural routines in decision making: The effects of novelty in task presentation and time pressure on routine maintenance and deviation. *European Journal of Social Psychology* **28**, 861-878.

Betsch,T., Haberstroh,S., Glockner,A., Haar,T., & Fiedler,K. (2001) The effects of routine strength on adaption and information search in recurrent decision making. *Organizational Behavior and Human Decision Processes* **84**, 25-53.

Betsch,T., Haberstroh,S., & Hohle,C. (2002) Explaining routinized decision making: A review of theories and models. *Theory & Psychology* **12**, 453-488.

Bettman,J.R. (1979) Issues in research on consumer choice. In W.L.Wilkie (Ed) *Advances in Consumer Research*. Association for Consumer Research, Atlanta, Georgia.

Bettman,J.R. (1971) The structure of consumer choice processes. *Journal of Marketing Research* **8**, 465-471.

Bettman,J.R. & Jacoby,J. (1976) Patterns of processing in consumer information acquisition. In B.B.Anderson (Ed) *Advances in Consumer Research*. Association for Consumer Research, Chicago.

Bettman,J.R. & Kakkar,P. (1977) Effects of information presentation format on consumer information acquisition strategies. *Journal of Consumer Research* **3**, 233-240.

Blaikie,N. (2000) *Designing social research*. Polity Press, Maulden, USA.

Booth-Butterfield,S., Cooke,P., Andrighetti,A., Casteel,B., Lang,T., Pearson,D., & Rodriquez,B. (1994) Simultaneous versus exclusive processing of persuasive arguments and cues. *Communication Quarterly* **42**, 21-35.

Bordin, E. S. (1979) The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice* **16**, 252-260.

Borkovec,T.D. & Costello,E. (1993) Efficacy of applied relaxation and cognitive behavioural therapy in the treatment of generalised anxiety disorder. *Journal of Consulting & Clinical Psychology* **61**, 611-619.

Bower,P. & Gilbody,S. (2005a) Managing common mental health disorders in primary care: conceptual models and evidence base. *British Medical Journal* **300**, 839-842.

Bower,P. & Gilbody,S. (2005b) Stepped care in psychological therapies: Access, effectiveness and efficiency. Narrative literature review. *British Journal of Psychiatry* **186**, 11-17.

Bower,P., Gilbody,S., & Barkham,M. (2006) Making decisions about patient progress: the application of routine outcome measurement in stepped care psychological therapy services. *Primary Care Mental Health* **4**, 21-28.

Bower,P., King,M., Nazareth,I., Lampe,F., & Sibbald,B. (2005) Patient preferences in randomised controlled trials: Conceptual framework and implications for research. *Social Science & Medicine* **61**, 685-695.

Bower,P., Richards,D., & Lovell,K. (2001) The clinical and cost effectiveness of self-help treatments for anxiety and depressive disorders in primary care: a systematic review. *British Journal of General Practice* **51**, 838-845.

Boyatzis,R.E. (1998) *Transforming qualitative information: thematic analysis and code development*. Sage.

Branch,J.L. (2000b) The trouble with think alouds: Generating data using concurrent verbal protocols. *Canadian Association for Information Science.*

Branch,J.L. (2000a) Investigating the information-seeking processes of adolescents: The value of using think-alouds and think afters. *Library and Information Science Research* **22**, 371-392.

Braun,V. & Clarke,V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**, 77-101.

Brennan,P.F. & Strombom,I. (1998) Improving health care by understanding patient preferences: The role of computer technology. *Journal of the American Informatics Association* **5**, 257-262.

Breslin, F.C., Sobell, M.B., Sobell, L.C., Buchan, G., & Cunningham, J.A. (1997) Toward a stepped care approach to treating problem drinkers: the predictive utility of within treatment variables and therapist prognostic ratings. *Addiction* **92**, 1479–89.

British Medical Association & NHS Employers (2006) Revisions to the GMS contract 2006/07. Delivering investment in general practice. Department of Health, London.

British Thoracic Society & Scottish Guidelines Intercollegiate Network (2009) British guideline on the management of asthma: A National Clinical Guideline. London.

Britten,N. (1995) Qualitative research: qualitative interviews in medical research. *British Medical Journal* **311**, 251-253.

Bromley C. & Hewton J. (2005) Trends in Attitudes to Health Care 1983 to 2003. Report based on the results from the British Social Attitudes Surveys. National Centre for Social Research, London.

Brubaker,R.G. & Wickersham,D. (1990) Encouraging the practice of testicular self-examination: A field application of the theory of reasoned action. *Health Psychology* **9**, 154-163.

Burton,M.V. & Ramsden,R. (1994) A survey of GP referral patterns to outpatient psychiatry, clinical psychology, community psychiatric nurses and counsellors. *Clinical Psychology Forum* **74**, 13-17.

Byng,R., Weaver,L., & Bury,C. (2003) GPs' beliefs about their management of depression and needs for supporting change in practice. *Primary Care Psychiatry* **8**, 121-125.

Byrnes,J.P. (1998) The nature and development of decision making: A self-regulation model.

Callaly,T., Hyland,M., Coombs,T., & Trauer,T. (2006) Routine outcome measurement in public mental health: results of a clinician survey. *Australian Health Review* **30**, 164-173.

Cameron, C. (1996) Patient compliance: recognition of factors involved and suggestions for promoting compliance with therapeutic regimens. Journal of Advanced Nursing **24**, 244-250.

Cape,J. (2002) Consultation length, patient-estimated consultation length, and satisfaction with the consultation. *British Journal of General Practice* **52**, 1004-1006.

Cape,J. & Parham,A. (1998) Relationship between practice counselling and referral to outpatient psychiatry and clinical psychology. *British Journal of General Practice* **48**, 1477-1480.

Cardozo,R.N., Ross,I., & Rudelius,W. (1972) New product decisions by merketing executives: A computer controlled experiment. *Journal of Marketing* **36**, 10-16.

Care Services Improvement Partnership (2006) Designing Primary Care Mental Health Services. National Institute for Mental Health in England, Department of Health.

Care Services Improvement Partnership & National Primary Care Research and Development Centre (2006) Primary care services for depression: A guide to best practice. National Institute for Mental Health in England, Department of Health.

Care Services Improvement Partnership North West Regional Development Centre (2007) Treating common mental health problems through stepped care.

Carr,E.C. & Worth,A. (2001) The use of the telephone interview for research. *Journal of Research in Nursing* **6**, 511-524.

Centre for Economic Performance's Mental Health Policy Group (2006) The Depression Report: A new deal for depression and anxiety disorders. The London School of Economics and Political Science..

Centre for Reviews and Dissemination (CRD) (2001) Undertaking Systematic Reviews of Research on Effectiveness: CRD's Guidance for those Carrying out or Commissioning Reviews. York Publishing Services, Ltd, NHS Centre for Reviews and Dissemination, University of York..

Charavel,M., Bremond,A., Moumjid-Ferdjaoui,N., Mignotte,H., & Carrere,M.O. (2001) Shared decision-making in question. *Psycho-Oncology* **10**, 93-102.

Charles,C., Gafni,A., & Whelan,T. (1999a) Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Social Science & Medicine* **49**, 651-661.

Charles,C., Gafni,A., & Whelan,T. (1997) Shared decision making in the medical encounter: what does it mean? (or, it takes at least two to tango). *Social Science & Medicine* **44**, 681-692.

Charles,C., Whelan,T., & Gafni,A. (1999b) What do we mean by partnership in making decisions about treatment? *British Medical Journal.319(7212)()(pp 780-782), 1999.Date of Publication: 18 Sep 1999.* 780-782.

Charmaz K. (2006) *Constructing Grounded Theory*. Sage Publications.

Cheraghi-Sohi,S., Bower,P., Mead,N., McDonald,R., Whalley,D., & Roland,M. (2007) Making sense of patient priorities: Applying discrete choice methods in primary care using 'think aloud' technique. *Family Practice* **24**, 276-282.

Chestnut,R.W. & Jacoby,J. (1978) Methods and concepts in consumer information processing: Toward an integrated framework. Research Paper 141A. Graduate School of Business, Columbia University.

Chew-Graham,C.A., May,C.R., & Perry,M.S. (2001) Qualitative research and the problem of judgement: lessons from interviewing fellow professionals. *Family Practice* **19**, 285-289.

Chew-Graham,C.A., Mullin,S., May,C.R., Hedley,S., & Cole,H. (2002) Managing depression in primary care: another example of the inverse care law? *Family Practice* **19**, 632-637.

Chew-Graham,C., Slade,M., Montana,C., Stewart,M., & Gask,L. (2008) Loss of doctor-to-doctor communication: lessons from the reconfiguration of mental health services in England. *Journal of Health Services Research Policy* **13**, 6-12.

Chiesa,M., Fonagy,P., & Bateman,A.W. (2007) Differences in clinical characteristics between patients assessed for NHS specialist psychotherapy and primary care counselling. *Psychology and Psychotherapy: Theory, Research and Practice* **80**, 591-603.

Chilvers,C., Dewey,M., Fielding,K.G.V., Miller,P., Palmer,B., Weller,D., Churchill,R., Williams,I., Bedi,N., Duggan,C., Lee,A., & Harrison,G. (2001) Antidepressant drugs and genetic counselling for treatment of major depression in primary care: randomised trial with patient preference arms. *BMJ* **322**, 722.

Chin Lin,A. (1988) Bridging positivist and interpretivist approaches to qualitative methods. *Policy Studies Journal* **26**, 162-180.

Clark,D.M., Layard,R., Smithies,R., Richards,D., Suckling,R., & Wright,B. (2009) Improving access to psychological therapy: initial evaluation of two demonstration sites. *Behaviour Research and Therapy* **47**, 910-920.

Clarkin J.F. & Levy K.N. (2004) The influence of client variables on psychotherapy. In M.J.Lambert (Ed) *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change*. Wiley and Sons, New York.

Clever,S.L., Ford,D.E., Rubenstein,L.V., Rost,K.M., Meredith,L.S., Sherbourne,C.D., Wang,N.Y., Arbelaez,J.J., & Cooper,L.A. (2006) Primary Care Patients' Involvement in Decision-Making is Associated with Improvement in Depression. *Medical Care* **44**, 398-405.

Cocksedge,S. (2005) *Listening as Work in Primary Care*. Radcliffe Publishing, Oxford.

Cocksedge,S. & May,C. (2005) Pastoral relationships and holding work in primary care: affect, subjectivity and chronicity. *Chronic Illness* **1**, 157-163.

Cohen,L. & Manion,L. (1989) *Action Research: Methods of Education*. Routledge, London.

Collins,D. (2003) Pretesting survey instruments: An overview of cognitive methods. *Quality of Life Research* **12**, 229-238.

Conner,M. & Sparks,P. (2007) Theory of Planned Behaviour and Health Behaviour. In M.Conner and P.Norman (Eds) *Predicting Health Behaviour*. Open University Press, England.

Conrad,F., Blair,J., & Tracy,E. (1999) Verbal reports are data! A theoretical approach to cognitive interviews.

Cook,G., Gerrish,K., & Clarke,C. (2001) Decision-making in teams: Issues arising from two UK evaluations. *Journal of Interprofessional Care* **15**, 141-151.

Cooper,L.A., Gonzales J.J, Gallo,J.J., Rost,K.M., Meredith,L.S., Rubenstein,L.V., Wang,N.Y., & Ford,D.E. (2003) The acceptability of treatment for depression among Afircan-American, Hispanic and white primary care patients. *Medical Care* **41**, 479-489.

Cooper-Patrick,L., Powe,N.R., Jenckes,M.W., Gonzales,J.J., Levine,D.M., & Ford,D.E. (1997) Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine* **12**, 431-438.

Cotton,D. & Gresty,K. (2006) Reflecting on the think-aloud method for evaluating e-learning. *British Journal of Educational Technology* **37**, 45-54.

Coulter,A. (1999) Paternalism or partnership? Patients have grown up - and there's no gowing back. *British Medical Journal* **319**, 719-720.

Cowles,J.T. (1954) Current trends in examination procedures. *Journal of the American Medical Association* **155**, 1383-1387.

Creswell,J. (1998) *Qualitative Inquiry and Research Design. Choosing among five traditions*. Sage, Thousand Oaks, CA.

Creswell,J. (2003) *Research design: Qualitative, quantitative and mixed methods approaches*. Sage, Thousand Oaks, CA.

Creswell,J. & Piano-Clark V. (2007) *Designing and Conducting Mixed Methods Research*. Sage, Thousand Oaks, CA.

Critical Appraisal Skills Programme (CASP) (2002) 10 Questions to Help You Make Sense of Qualitative Research. Milton Keynes Primary Care Trust, Milton Keynes.

Cronbach,L.J. & Snow,R.E. (1977) *Aptitudes and instructional methods: a handbook for research on interactions*. Irvington, New York.

Croskerry,P. & Norman,G. (2008) Overconfidence in Clinical Decision Making. *The American Journal of Medicine* **121**, S24-S29.

Crotty,M. (1998) *The Foundations of Social Research: Meaning and perspective in the research process*. SAGE Publications, London.

Crowe,M., Carlyle,D., & Farmar,R. (2008) Clinical formulation for mental health nursing practice. *Journal of Psychiatric & Mental Health Nursing* **15**, 800-807.

Davison,G.C. (2000) Stepped care: Doing more with less? *Journal of Consulting and Clinical Psychology* **68**, 580-585.

Davison,G.C., Vogel,R.S., & Coffman,S.G. (1997) Think-aloud approaches to cognitive assessment and the articulated thoughts in simulated situations paradigm. *Journal of Consulting & Clinical Psychology* **65**, 950-958.

Dawes,R.M., Faust,D., & Meehl,P.E. (1989) Clinical versus actuarial judgement. *Science* **243**, 1668-1674.

de Vaus,D.A. (1991) *Surveys in Social Research*. University College London Press, London.

de Wit,J. & Stroebe,W. (2004) Social Cognition Models of Health Behaviour. In A.Kaptein and J.Weinman (Eds) *Health Psychology*. BPS Blackwell, UK.

Denscombe,M. (2008) Communities of Practice: A research paradigm for the mixed methods approach. *Journal of Mixed Methods Research* **2**, 270-283.

Department of Health (2010) Equity and excellence: liberating the NHS. Department of Health.

Department of Health (2006) Our Health, Our Care, Our Say: a new direction for community services. HMSO, London.

Department of Health (2005a) Creating a Patient-led NHS: Delivering the NHS Improvement Plan. HMSO, London.

Department of Health (1999) A national service framework for mental health. HMSO, London.

Department of Health (2005b) Outcome Measures Implementation: Best Practice Guidance. HMSO, London.

Department of Health (2004a) Organising and delivering psychological therapies. HMSO, London.

Department of Health (2004b) Standards for Better Health: Health Care Standards for Services under the NHS. HMSO, London.

Department of Health (2005c) Research Governance Framework for Health and Social Care: Second Edition. HMSO, London.

Department of Health (2008a) IAPT Outcomes Toolkit http://www.iapt.nhs.uk/2008/01/30/improving-access-topsychological-therapies-iapt-outcomes-toolkit/ (accessed 13 January 2010).

Department of Health (2007b) Mental Health: New ways of working for everyone. HMSO, London.

Department of Health (1996) Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS. NHS Executive, Leeds.

Department of Health (2007a) Independence, choice and risk: a guide to best practice in supported decision making. The Stationery Office, London.

Department of Health (2008b) Improving Access to Psychological Therapies. Implementation Plan: National guidelines for regional delivery. National Institute for Mental Health in England. Department of Health.

Department of Health (2000) The NHS Plan: a plan for investment, a plan for reform. HMSO, London.

Department of Health (2001) The expert patient: a new approach to chronic disease management for the 21st century. London: Department of Health.

Department of Health (Research and Development Directorate) (2006) Best Research for Best Health - a new national health research strategy. HMSO, London.

DeRubeis,R.J., Hollon,S.D., Amsterdam,J.D., Shelton,R.C., Young,P.R., Salomon,R.M., O'Reardon,M.D., Lovett,M.L., Gladis,M.M., Brown,L.L., & Gallop,R. (2005) Cognitive therapy vs. medications in the treatment of moderate to severe depression. *Archives of General Psychiatry* **62**, 409-416.

Detmar,S.B., Muller,M.J., Schornagel,J.H., Wever,L.D., & Aaronson,N.K. (2002) Health related quality of life assessments and patient-physician communication. *Journal of the American Medical Association* **288**, 3027-3034.

DeVellis,R.E. (2003) *Scale Development: Theory and Applications*. Sage Publications, Inc, Thousand Oaks, California.

Di Caccavo,A., Ley,A., & Reid,F. (2000) What do general practitioners discuss with their patients? Exploring the relationship between content and medical consultations and treatment decisions. *Journal of Health Psychology* **5**, 87-97.

Dimidjian,S. & Hollon,S.D. (2010) How would we know if psychotherapy were harmful? *American Psychologist* **65**, 21-33.

Dingwall,R. (1992) Don't mind him - he's from Barcelona: qualitative methods in health studies. In J.Daly, I.McDonald, and E.Wilks (Eds) *Researching health care*. Tavistock/Routledge, London.

Donaldson,M.S. (2008) Taking PROs and patient-centred care seriously: Incremental and disruptive ideas for incorporating PROs in oncology practice. *Quality of Life Research* **17**, 1323-1330.

Dowie,J. (1997) Decision analysis in guideline development and clinical practice: the Clinical Guidance Tree. In H.K.Selbmann (Ed) *Guidelines in Health Care*. Baden-Baden, Nomos-Verlagsgesellschaft.

Dowie,J. (2002) Decision validity should determine whether a generic or condition-specific HRQOL measure is used in health care decisions. *Health Economics* **11**, 1-8.

Dowrick C (2004) Beyond Depression 1st edition. Oxford University Press, Oxford

Dowrick.C. (2009b) When diagnosis fails: commentary on McPherson & Armstrong's 'Negotiating 'depression' in primary care'. *Social Science and Medicine* **69**, 1144-1146.

Dowrick,C., Leydon,G.M., McBride,A., Howe,A., Burgess,H., Clarke,P., Maisey,S., & Kendrick,T. (2009a) Patients' and doctors' views on depression severity questionnaires incentivised in the UK study quality and outcomes framework: qualitative. *British Medical Journal* **338**, b663.

Drennan,J. (2003) Cognitive interviewing: verbal data in the design and pretesting of questionnaires. *Journal of Advanced Nursing* **42**, 57-63.

Duncan,E., Best,C., & Hagen,S. (2009) Shared decision making interventions for people with mental health conditions. *Cochrane Database of Systematic Reviews*.

Dwight-Johnson,M., Sherbourne,C.D., Liao,D., & Wells,K.B. (2000) Treatment preferences among depressed primary care patients. *Journal of General Internal Medicine* **15**, 527-534.

Edwards,W. (1954) The theory of decision making. *Psychological Bulletin* **41**, 380-417.

Edwards,W., Lindman,H., & Phillips,L.D. (1965) Emerging technologies for making decisions. In Newcomb T M (Ed) *New directions in psychology II*. Holt Rinehart & Winston, New York.

Einhorn,H. & Hogarth,R. (1981) Behavioral decision theory: processes of judgement and choice. *Annual Review of Psychology* **32**, 53-88.

Eisenthal,S., Emery,R., & Lazare,A. (1979) 'Adherence' and the negotiated approach to patienthood. *Archives of General Psychiatry* **36**, 393-398.

Elkin,I., Gibbons,R.D., Shea,M.T., Sotsky,S.M., Watkins,J.T., Pilkonis,P.A., & Hedeker,D. (1995) Initial severity and differential treatment outcome in the National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Journal of Consulting & Clinical Psychology* **63**, 841-847.

Elstein,A.S., Shulman,L.S., & Sprafka,S.A. (1978) *Medical Problem Solving: An Analysis of Clinical Reasoning*. Harvard University Press, Cambridge, MA.

Elstein,A.S., Shulman,L.S., & Sprafka,S.A. (1990) Medical problem solving. *Evaluation and the Health Professions* **13**, 5-36.

Elwyn,G., Buetow,S., Hibbard,J., & Wensing,M. (2007) Respecting the subjective: quality measurement from the patient's perspective. *British Medical Journal* **335**, 1021-1022.

Emanuel,E.J. & Emanuel,L.L. (1992) Four models of the physician-patient relationship. *Journal of the American Medical Association* **267**, 2221-2226.

Epstein,R.M. (1995) Communication between primary care clinicians and consultants. *Archives of Family Medicine* **4**, 403-409.

Epstein,S. (1994) Integration of the cognitive and the psychodynamic unconscious. *American Psychologist* **49**, 709-724.

Ericsson,K.A. & Simon,H.A. (1993) *Protocol analysis: Verbal reports as data (Revised edition).* MIT Press, Cambridge, MA.

Ericsson,K.A. & Simon,H.A. (1980) Verbal reports as data. *Psychological Review* **87**, 215-250.

Ericsson,K.A. & Simon,H.A. (1998) How to study thinking in everyday life: Contrasting think-aloud protocols with descriptions and explanations of thinking. *Mind, Culture, and Activity* **5**, 178-186.

Eva,K.W. & Norman,G.R. (2005) Heuristics and biases - a biased perspective on clinical reasoning. *Medical Education* **39**, 870-872.

Evans,J.St.B.T. & Over,D.E. (1996) *Rationality and reasoning*. Psychology Press.

Fairhurst,K. & Dowrick,C. (1996) Problems with recruitment in a randomized controlled trial of counselling in general practice: causes and implications. *Journal of Health Services Research Policy* **1**, 77-80.

Farrand,P., Confue,P., Byng,R., & Shaw,S. (2008) Guided-self help supported by paraprofessional mental health workers: an uncontrolled before-after cohort study. *Health and Social Care in the Community* **17**, 9-17.

Feder,G., Eccles,M., Grol,R., Griffiths,C., & Grimshaw,J. (1999) Using clinical guidelines. *British Medical Journal* **318**, 728-730.

Feilzer,M.Y. (2010) Doing mixed methods research pragmatically: Implications for the rediscovery of pragmatism as a research paradigm. *Journal of Mixed Methods Research* **4**, 6-16.

Field,M.J. & Lohr,K.N. (1990) *Clinical practice guidelines: directions for a new program. Institute of Medicine, committee to advise the public health service on clinical practice guidelines*. National Academy Press, Washington, DC.

Field,S., Layard,R., Farmer,P., & Clarke,J. (2010) GPs demand better psychological therapy services. Available at http://www.rcgp.org.uk/news_and_events/news_room/news_2010/gps_demand_better_psychologica.aspx (accessed 3 February 2010).

Finucane,M.L. (2000) The affect heuristic in judgements of risks and benefits. *Journal of Behavioral Decision Making* **13**, 1-17.

Fishbein,M. (1967) Attitude and the prediction of behaviour. In M.Fishbein (Ed) *Readings in attitude theory and measurement*. Wiley, New York.

Fishbein,M. (1971) Some comments on the use of models in advertising research. *Seminar on translating advanced advertising theories into research reality (Proceedings)*. European Society for Opinion and Marketing Research, Amsterdam.

Fishbein,M. (1993) Introduction. In D.J.Terry, C.Gallois, and M.McCamish (Eds) *The Theory of Reasoned Action: Its Application to AIDS-preventative Behaviour*. Pergamon, Oxford.

Fishbein,M. & Ajzen,I. (1975) *Belief, Attitude, Intention, and Behavior: An Introduction to Theory and Research*. Addison-Wesley, Reading, MA.

Fishbein,M., Triandis,H.C., Kanfer,F.H., Becker,M., Middlestadt,S.E., & Eichler,A. (2001) Factors influencing behavior and behavior change. In A.Baum, T.A.Revenson, and J.E.Singer (Eds) *Handbook of Health Psychology*. Lawerence Erlbaum Associates, Mahwah, NJ.

Fisk,J.E. (2002) Judgements under uncertainty: representativeness or potential surprise? *British Journal of Psychology* **93**, 431-449.

Fitzpatrick,R., Hinton,J., Newman,S., Scambler,G., & Thompson,J. (1984) *The Experience of Illness*. Tavistock Publications, London.

Fonagy,P. & Target,M. (1996) Should we allow psychotherapy research to determine clinical practice? *Clinical Psychology: Science and Practice* **3**, 245-250.

Forrest,C.B., Nutting,P.A., Starfield,B., & Von Schrader,S. (2002) Family phycisians' referral decisions: Results from the ASPN referral study. *The Journal of Family Practice* **51**, 215-222.

Frank,J. (1967) The dynamics of psychotherapeutic relationship. In T.Scheff (Ed) *Mental illness and social processes*. Harper & Row, New York.

Fraser,C. & Burchell,B. (2001) *Introducing Social Psychology*. Polity Press, Cambridge.

Fredelius,G., Sandell,R., & Lindqvist,C. (2002) Who should receive subsidized psychotherapy?: Analysis of decision makers' think-aloud protocols. *Qualitative Health Research* **12**, 640-654.

Fredricks,A.J. & Dossett,D.L. (1983) Attitude-behavior relations: A comparison of the Fishbein-Ajzen and the Bentler-Speckart Models. *Journal of Personality and Social Psychology* **45**, 501-512.

Friedli,L. & Parsonage,M. (2007) Mental Health Promotion: Building an Economic Case. Northern Ireland Association for Mental Health.

Fronteyn,M.E., Kuipers,B., & Grobe,S.J. (1993) A description of think aloud method and protocol analysis. *Qualitative Health Research* **3**, 430-441.

Gafni,A., Charles,C., & Whelan,T. (1998) The physician-patient encounter: the physician as a perfect agent for the patient versus the informed treatment decision-making model.[see comment]. *Social Science & Medicine* **47**, 347-354.

Gage,N. (1989) The paradigm wars and their aftermath: A "historical" sketch of research and teaching since 1989. *Educational Researcher* **18**, 4-10.

Garland,A.F., Kruse,M., & Aarons,G.A. (2003) Clinicians and outcome measurement: What's the use? *Journal of Behavioral Health Services and Research* **30**, 393-405.

Geertz,C. (1978) Thick Description: Toward an Interpretive Theory of Culture. In C.Geertz (Ed) *The Interpretation of Cultures: Selected Essays*. Basic Books, New York.

Gega,L., Marks,I., & Mataix-Cols,D. (2004) Computer-aided CBT self help for anxiety and depressive disorders: experience of a London clinic and future directions. *Journal of Clinical Psychology* **60**, 147-157.

Gellatly,J., Bower,P., Hennessy,S., Richards,D., Gilbody,S., & Lovell,K. (2007) What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. *Psychological Medicine* **37**, 1217-1228.

General Medical Council (2008) Consent: patients and doctors making decisions together. United Kingdom.

Ghiacy,S. (1995) GP Referrals. Primary teachers. *Health Service Journal* **7**, 27.

Gilbody,S., House,A.O., & Sheldon,T.A. (2002) Psychiatrists in the UK do not use outcome measures. *British Journal of Psychiatry* **180**, 101-103.

Gilbody,S.M. (1999) Potential and problems for psychiatry in the new National Health Service. *Psychiatric Bulletin* **23**, 513-516.

Gilbody,S.M., House,A.O., & Sheldon,T.A. (2001) Routinely administered questionnaires for depression and anxiety: systematic review. *British Medical Journal* **322**, 406-409.

Gilbody,S.M., House,A.O., & Sheldon,T.A. (2003) Outcome Measurement in Psychiatry: A critical review of outcomes measurement in psychiatric research and practice. Centre for Reviews and Dissemination, University of York.

Gilovich,T. & Griffin,D. (2000) Introduction - Heuristics and biases: then and now. In T.Gilovich, D.Griffin, and D.Kahneman (Eds) *Heuristics and Biases: The Psychology of Intuitive Judgement*. Cambridge University Press.

Glaser,B.G. (2001) *The Grounded Theory Perspective: Conceptualization Contrasted with Description*. The Sociology Press, Mill Valley, CA.

Gloaguen,V., Cottraux,J., Cucherat,M., & Blackburn,I. (1998) A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders* **49**, 59-72.

Godin,G. & Kok,G. (1996) The theory of planned behaviour: a review of its applications to health related behaviour. *American Journal of Health Promotion* **11**, 87-97.

Goldberg,D. & Huxley,P. (1980) *Mental Illness in the Community. The Pathway to Psychiatric Care*. Tavistock Publications, London.

Goldberg,D.P. & Gourney,K. (1997) The general practitioner, the psychiatrist and the burden of mental health care. *Maudsley Monograph* **Paper No. 1**.

Goldberg,D.P. & Huxley,P. (1992) *Common Mental Disorders: A Bio-Social Model*. Tavistock, London.

Gollwitzer,P.M. (1990) Action phases and mind sets. In Higgins E T and Sorentino R M (Eds) *Handbook of Motivation and Cognition: Foundations of Social Behaviour*. Guilford, New York.

Greene,J.C., Benjamin,L., & Goodyear,L. (2001) The merits of mixing methods in evaluation. *Evaluation* **7**, 25-44.

Greenfield,T.K., Midanik,L.T., & Rogers,J.D. (2000) Effects of telephone versus face-to-face interview modes on reports of alcohol consumption. *Addiction* **95**, 277-284.

Greenhalgh,J. (2009) The application of PROs in clinical practice: what are they, do they work, and why? *Quality of Life Research* **18**, 115-123.

Greenhalgh,T., Robert,G., MacFarlane,F., Bate,P., & Kyriakidou,O. (2005) Diffusion of innovations in service organizations: systematic review and recommendations. *The Millbank Quarterly* **82**, 581-629.

Gribich,C. (2003) *Qualitative Research in Health: An Introduction*. Sage, London.

Groves,R. (1990) Theories and methods of telephone surveys. *Annual Review of Sociology* **16**, 221-240.

Guba,E. (1990) *The Paradigm Dialog*. Sage, Thousand Oaks, CA.

Guba,E.G. & Lincoln,Y.S. (1994) Competing paradigms in qualitative research. In N.K.Denzin and Y.S.Lincoln (Eds) *Handbook of Qualitative Research*. Sage, London.

Haddad,P. (1999) Do antidepressants have any potential to cause addiction? *Journal of Psychopharmacology* **13**, 300-307.

Hagger,M., Chatzisarantis,N., & Biddle,S. (2002) A meta-analytic review of the theories of resaoned action and planned behaviour in physical activity: predictive validity and the contribution of additional variables. *Journal of Sport and Exercise Psychology* **24**, 3-32.

Halperin,D.M., Weitzman,M.L., & Otto,M.W. (2010) Therapeutic Alliance and Common Factors in Treatment. In M.W.Otto and S.Hofmann (Eds) *Avoiding Treatment Failures in the Anxiety Disorders*. Springer, New York.

Hamann,J., Leucht,S., & Kissling,W. (2003) Shared decision making in psychiatry. *Acta Psychiatrica Scandinavica* **107**, 403-409.

Hamm,M.S. & Ferrell,J. (1998) Confessions of Danger and Humanity. In J.Ferrell and M.S.Hamm (Eds) *Ethnography at the Edge: Crime, Deviance, and Field Research.* Northeastern University Press, Boston, MA.

Hammersley,M. & Atkinson,P. (2007) *Ethnography: principles in practice.* Routledge, London.

Hammond,K.R. (1990) Intuitive and analytic cognition: information models. In A.Sage (Ed) *Concise Encyclopedia of Information Processing in Systems and Organisations.* Pergamon Press, Oxford.

Hanson,N.R. (1958) *Patterns of discovery: An inquiry into the conceptual foundations of science.* Sage, Newbury Park, CA.

Hardy,G.E., Shapiro,D.A., Stiles,W.B., & Barkham,M. (1998) When and why does cognitive-behavioural treatment appear more efective than psychodynamic-interpersonal treatment? Discussion of the findings from the Second Sheffield Psychotherapy Project. *Journal of Mental Health* **7**, 179-190.

Harrison,S. (2002) New labour, modernisation and the medical labour process. *Journal of Social Policy* **31**, 465-485.

Harte,J.M. & Koele,P. (1997) Psychometric and methodological aspects of process tracing research. In R.Ranyard, W.R.Crozier, and O.Svenson (Eds) *Decision Making: Cognitive models and explanations.* Routledge, London.

Healy,M. & Perry,C. (2000) Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Marker Research* **3**, 118-126.

Helstone,F.S. & van Zuuren,F.J. (1996) Clinical decision making in intake interviews for psychotherapy: A qualitative study. *British Journal of Medical Psychology* **69**, 191-206.

Hendryx,M.S., Doebbeling,B.N., & Kearns,D.L. (1994) Mental health treatment in primary care: Physician treatment choices and psychiatric admission rates. *Family Practice Research Journal* **14**, 127-137.

Hicks,C. (1998) Barriers to evidence-based care in nursing: historical legacies and conflicting cultures. *Health Services Management Research* **11**, 137-147.

Higgins,E.T. (1987) Self-discrepancy: A theory relating self and affect. *Psychological Review* **94**, 319-340.

Higgit,A. & Fonagy,P. (2002) Reading about clinical effectiveness. *British Journal of Psychiatry* **181**, 170-174.

Hill,S.A. & Laugharne,R. (2006) Decision making and information seeking preferences among psychiatric patients. *Journal of Mental Health* **15**, 75-84.

Hilton,C., Bajaj,P., Hagger,M., Taha,S., & Warner,J. (2008) What should prompt an urgent referral to a community mental health team? *Mental Health in Family Medicine* **5**, 197-201.

Hockey,J. (1993) Research methods -- researching peers and familiar settings. *Research Papers in Education* **8**, 199-225.

Hogarth,R.M. (1974) Process tracing in clinical judgment. *Behavioral Science* **19**, 298-313.

Holbrook,M.B. & Maier,K.A. (2009) A study of the interface between attitude structure and information acquisition using a questionnaire-based information-display sheet. In H.K.Hunt (Ed) *Advances in Consumer Research*. Ann Arbor, Mich.: Association for Consumer Research..

Horn,R. (2010) Exploring stepping-up in a stepped care model of service delivery. Unpublished doctoral thesis. The University of Sheffield.

Howard,L. & Thornicroft,G. (2006) Patient preference randomised controlled trials in mental health research. *The British Journal of Psychiatry* **188**, 303-304.

Huber,O., Beutter,C., Montoya,J., & Huber,O.W. (2001) Risk-defusing behaviour: Towards an understanding of risky decision making. *European Journal of Cognitive Psychology* **13**, 409-426.

Huber,O. & Huber,O.W. (2008) Gambles vs. quasi-realistic scenarios: Expectations to find probability and risk-defusing information. *Acta Psychologica* **127**, 222-236.

Huber,O., Wider,R., & Huber,O.W. (1997) Active information search and complete information presentation in naturalistic risky decision tasks. *Acta Psychologica* **95**, 15-29.

Hull,S.A., Jones,C., Tissier,J.M., Eldridge,S., & Maclaren,D. (2002) Relationship style between GPs and community mental health teams affects referral rates. *British Journal of General Practice* **52**, 101-107.

Hunot,V., Churchill,R., Teixeira,V., & Silva de Lima,M. (2007) Psychological therapies for generalised anxiety disorder. *Cochrane Database of Systematic Reviews*.

Hurwitz,B. (1999) Legal and political considerations of clinical practice guidelines. *British Medical Journal* **318**, 661-664.

Huxley,P., Reilly,S., Mohamad,H., & Harrison,J. (1998) Severe mental illness: CPNs and social workers' input. *Mental Health Nursing* **18**, 14-17.

Hyde,J., Evans,J., Sharp,D., Coudace,T., Harrison,G., Lewis,G., & Araya,R. (2005) Deciding who gets treatment for depression and anxiety: A study of consecutive GP attenders. *British Journal of General Practice* **55**, 846-853.

Institute of Medicine (2001) Crossing the quality chasm: A new health system for the 21st century. National Academy Press: Washington, D.C.

Jackson,G., Gater,R., Goldberg,D., Tantam,D., Loftus,L., & Taylor,H. (1993) A new community mental health team based in primary care. A description of the service and its effects on service use in the first year. *British Journal of Psychiatry* **162**, 375-384.

Jacobsen,N.S. & Hollon,S.D. (1996) Prospects for future comparisons between drugs and psychotherapy: Lessons from the CBT-versus-pharmacotherapy exchange. *Journal of Consulting & Clinical Psychology* **64**, 104-108.

Jacoby,J. (1975) Perspectives on a consumer information processing research program. *Communication Research* **2**, 203-215.

Jacoby,J., Chestnut,R.W., Weigl,K.C., & Fisher,W. (1976) Pre-purchase information acquisition: Description of a process methodology, research paradigm, and pilot investigation. *Advances in Consumer Research* **3**, 314.

Jacoby,J., Speller,D., & Kohn,C.A. (1974) Brand choice behavior as a function of information load. *Journal of Marketing Research* **1**, 33-42.

Jahng,K.H., Martin,L.R., Golin,C.E., & DiMatteo,M.R. (2005) Preferences for medical collaboration: patient-physician congruence and patient outcomes. *Patient Education & Counseling* **57**, 308-314.

Jarrett,R.B., Schaffer,M., McIntire,D., Witt-Browder,A., Kraft,D., & Risser,R.C. (1999) Treatment of atypical depression with cognitive therapy or phenelzine: A double-blind, placebo-controlled trial. *Archives of General Psychiatry* **56**, 431-437.

Jenkins,R., McCulloch,A., Friedli,L., & Parker,C. (2002) Developing a national mental health policy.

Jensen,G.M. (1989) Qualitative methods in physical therapy research: A form of disciplined inquiry. *Physical Therapy* **69**, 76-84.

Jobe,J.B. & Mingay,D.J. (1989) Cognitive research improves questionnaires. *American Journal of Public Health* **79**, 1053-1055.

Johnson,E.J. & Russo,J.E. (1978) The organization of product information in memory identified by recall times. In H.K.Hunt and A.Arbor (Eds) *Advances in Consumer Research*. Association for Consumer Research, MI.

Johnson,R.B., Onwuegbuzie,A.J., & Turner,L.A. (2007) Toward a definition of mixed methods research. *Journal of Mixed Methods Research* **1**, 112-133.

Joppe,M. (2000) The Research Process. Available at http://www.htm.uoguelph.ca/pagefiles/MJResearch/ResearchProcess/home.html (accessed 8 June 2010).

Kahneman,D. (2003) A perspective on judgement and choice: mapping bounded rationality. *The American Psychologist* **58**, 697-720.

Kahneman,D. & Frederick S. (2002) Representativeness revisited: Attribute substitution in intuitive judgment. In T.Gilovich, D.Griffin, and D.Kahneman (Eds) *Heuristics of Intuitive Judgment: Extensions and Applications*. Cambridge University Press, New York.

Kaltenthaler, E., Shackley, P., Stevens, P., *et al* (2002) A systematic review and economic evaluation of computerised cognitive behaviour therapy for depression and anxiety. *Health Technology Assessment* **6** (22).

Kam,S.-U. & Midgley,N. (2006) Exploring 'clinical judgement': How do child and adolescent mental health professionals decide whether a young person needs individual psychotherapy? *Clinical Child Psychology and Psychiatry* **11**, 27-44.

Kane,R.L. (1995) Creating practice guidelines: the dangers of over-reliance on expert judgement. *Journal of Law, Medicine and Ethics* **23**, 62-64.

Katon,W., Von Korff,M., Lin,E., Simon,G., Walker,E., Unutzer,J., Bush,T., Russo,J., & Ludman,E. (1999) Stepped collaborative care for primary care patients with persistent symptoms of depression. *Archives of General Psychiatry* **56**, 1109-1115.

Keller, M.B., McCullough, Jr., J.P., Klein, D.N., Arnow, B.A., Dunner, D.L., Gelenberg, A.J., Markowitz, J.C., Nemeroff, C.B., Russell, J., Thase, M.E., Trivedi, M.H., & Zajecka, J. (2000). A comparison of nefazodone, the cognitive behavioral analysis system of psychotherapy, and their combination for the treatment of chronic depression. *New England Journal of Medicine* **342**, 1462-1470.

Kellet,S. & Matthews,L. (2008) Reflecting on the clinical, organisational and methodological implications of the Doncaster IAPT site. *Clinical Psychology Forum* **181**, 29-30.

Kendall,T., Pilling,S., Pettinari,C., & Whittington,C. (2004a) Clinical Guidelines in Mental Health I: The National Collaborating Centre for Mental Health. *Psychiatric Bulletin* **28**, 156-159.

Kendall,T., Pilling,S., Pettinari,C., & Whittington,C. (2004b) Clinical Guidelines in Mental Health I: The National Collaborating Centre for Mental Health. *Psychiatric Bulletin* **28**, 156-159.

Kendrick,T., King,F., Albertella,L., & Smith,P.W.F. (2005) GP treatment decisions for patients with depression. *British Journal of General Practice* **55**, 280-286.

Kendrick,T., Dowrick,C., McBride,A., Howe,A., Clarke,P., Maisey,S., Moore,M., & Smith,P.W. (2009) Management of depression in UK general practice in relation to scores on depression severity questionnaires: analysis of medical record data. *British Medical Journal* **338**, 750.

Kessler,D., Lloyd,K., Lewis,G., & Pereira-Gray,D. (1999) Cross sectional study of symptom attribution and recognition of depression and anxiety in primary care. *British Medical Journal* **318**, 440.

Kind,P., Hardman,G., & Leese,B. (2005) Measuring health status: information for primary care decision making. *Health Policy* **71**, 303-313.

King,M., Nazareth,I., Lampe,F., Bower,P., Chandler,M., Morou,M., Sibbald,B., & Lai,R. (2005) Impact of participant and physician intervention preferences in randomised trials: A systematic review. *Journal of the American Medical Association* **293**, 1089-1099.

King,M., Sibbald,B., Ward,E., Bower,P., Lloyd,M., Gabbay,M., & Byford,S. (2000) Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy and usual general practitioner care in the management of depression as well as mixed anxiety and depression in primary care. *Health Technology Assessment* **4**, 1-83.

Kirsch,I., Deacon,B.J., Huedo-Medina,T.B., Scoboria,A., Moore,T.J., & Johnson,B.T. (2008) Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *Public Library of Science Medicine* **5**, 260-268.

Kisely,S., Linden,M., Bellantuono,C., Simon,G., & Jones,J. (2000) Why are patients prescribed psychotropic drugs by general practitioners? Results of an international study. *Psychological Medicine* **168**, 164-168.

Knafl,K., Deatrick,J., Gallo,A., Holcombe,G., Bakitas,M., Dixon,J., & Grey,M. (2007) The analysis and interpretation of cognitive interviews for instrument development. *Research in Nursing & Health* **30**, 224-234.

Knight,L. (2003) How do GPs make referral and treatment decisions when patients present with mental health problems? *Counselling Psychology Quarterly* **16**, 195-221.

Kostopoulou,O., Oudhoff,J., Nath,R., Delaney,B.C., Munro,C.W., Harries,C., & Holder,R. (2008) Predictors of diagnostic accuracy and safe management in difficult diagnostic problems in famliy medicine. *Medical Decision Making* **28**, 668-680.

Kostopoulou,O. & Wildman,M. (2004) Sources of variability in uncertain medical decisions in the ICU: a process tracing study. *Quality and Safety in Health Care* **13**, 272-280.

Kramer,S.A. (1990) *Positive endings in psychotherapy: bringing meaningful closure to therapeutic relationships*. Jossey-Bass Publishers, San Fransisco, CA.

Krauss,S.E. (2005) Research paradigms and meaning making: a primer. *The Qualitative Report* **10**, 758-770.

Kravitz,R.L., Franks,P., Feldman,M., Meredith.L.S., Hinton,L., Franz,C., Duberstein,P., & Epstein,R.M. (2006) What drives referral from primary care physicians to mental health specialists? A randomised trial using actors portraying depressive symptoms. *Journal of General Internal Medicine* **21**, 584-589.

Kroenke,K., Spitzer,R.L., & Williams,J.B. (2001) The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine* **16**, 606-613.

Kuhn,T.S. (1970) *The Structure of Scientific Revolutions*. University of Chicago Press, Chicago.

Kuusela,H. & Paul,P. (2000) A comparison of concurrent verbal protocol analysis. *American Journal of Psychology* **113**, 387-404.

Lambert,M.J., Harmon,C., Slade,K., Whipple,J.L., & Hawkins,E.L. (2005) Providing feedback to psychotherapists on their patient's progress: clinical results and practice suggestions. *Journal of Clinical Psychology* **61**, 165-174.

Lancaster,G.A., Dodd,S., & Williamson,P.R. (2004) Design and analysis of pilot studies: recommendations for good practice. *Journal of Evaluation in Clinical Practice* **10**, 307-312.

Langer, N. (1999) Culturally Competent Professionals in Therapeutic Alliances Enhance Patient Compliance. *Journal of Health Care for the Poor and Underserved* **10**, 19-26.

Lasalvia,A., Bonetto,C., Tansella,M., Stefani,B., & Ruggeri,M. (2008) Does staff-patient agreement on needs for care predict a better mental health outcome? A 4-year follow-up in a community service. *Psychological Medicine* **38**, 123-133.

Laugharne,R. & Priebe,S. (2006) Trust, choice and power in mental health: A literature review. *Social Psychiatry and Psychiatric Epidemiology* **41**, 843-852.

Layard,R. (2005) Mental health: Britain's biggest social problem? Available at www.strategy.gov.uk/downloads/files/mh-layard.pdf (accessed 22 January 2010).

Lehmann,D.R. & Moore,W.L. (1980) Validity of information display boards: An assessment using longitudinal data. *Journal of Marketing Research* **17**, 450-459.

Levenstein, J.H., McCracken, E.C., McWhinney, I.R., Stewart, M.A. & Brown, J.B. (1986) The patient-centred clinical method. 1. A model for the doctor – patient interaction in family medicine. *Family Practice* **3***, 24 – 30.

Lewis,J. & Ritchie,J. (2003) Generalising from qualitative research. In J.Ritchie and J.Lewis (Eds) *Qualitative research in practice: A guide for social science students and researchers*. Sage, London.

Lewis,K.N., Davis,C.S., & Walker,B.J. (1981) Attractive versus unattractive clients: Mediating influences on counselors' perceptions. *Journal of Counseling Psychology* **28**, 309-314.

Leydon, G.M., Dowrick, C.F., McBride, A.S., Burgess, H.J., Howe, A.C., Clarke, P.D., Maisey, S.P. & Kendrick, T. (2011) Questionnaire severity: measures for depression. *British Journal of General Practice* **61**, 117-123.

Lincoln,Y.S. & Guba,E.G. (1985) *Naturalistic Enquiry*. Sage, Beverly Hills, CA.

Llewellyn-Thomas,H.A. (1995) Patients' health care decision making: A framework for descriptive and experimental investigations. *15th Annual Meeting for the Society for Medical Decision Making*.

Loeb,K.L., Wilson,G.T., Labouvie,E., Pratt,E.M., Hayaki,J., Walsh,B.T., Stewart,A.W., & Fairburn,C.G. (2005) Therapeutic alliance and treatment adherence in two interventions for bulimia nervosa: a study of process and outcome. *Journal of Consulting and Clinical Psychology* **73**, 1097-1107.

Lofland,J., Snow,D.A., Andreson,L., & Lofland,L.H. (2006) *Analyzing social settings: a guide to qualitative observation and analysis*. Wadsworth, UK.

Lovell,K., Bower,P., Richards,D., Barkham,M., Sibbald,B., Roberts,C., Davies,L., Rogers,A., Gellatly,J., & Hennessy,S. (2008) Developing guided self-help for depression using the Medical Research Council complex interventions framework: a description of the modelling phase and results of an exploratory randomised controlled trial. *BMC Psychiatry* **8**, 91-109.

Lovell,K. & Richards,D. (2000) Multiple access points and levels of entry (MAPLE): Ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy* **28**, 379-391.

Lovell,K., Richards,D.A., & Bower,P. (2003) Improving access to primary mental health care: uncontrolled evaluation of a pilot self-help clinic. *British Journal of General Practice* **53**, 133-135.

Lucock,M., Padgett,K., Noble,R., Westley,A., Atha,C., Horsefield,C., & Leach,C. (2008) Controlled clinical trail of a self-help for anxiety intervention for patients waiting for psychological therapy. *Behavioural and Cognitive Psychotherapy* **36**, 541-551.

Ludman,E., Katon,W., Bush,T., Rutter,C., Lin,E., Simon,G., Von Korff,M., & Walker,E. (2003) Behavioural factors associated with symptom outcomes in a primary care-based depression prevention trial. *Psychological Medicine* **33**, 1061-1070.

Lussier,D.A. & Olshavsky,R.W. (1979) Task complexity and ontingent processing in brand choice. *The Journal of Consumer Research* **6**, 154-165.

Lyons,A. (1999) Shaping health psychology: qualitative research, evaluation and representation. In M.Murray and K.Chamberlain (Eds) *Qualitative Health Psychology: Theories and methods*. Sage, London.

MacDonald,W., Mead,N., Bower,P., Richards,D., & Lovell,K. (2007) A qualitative study of patients' perceptions of a 'minimal' psychological therapy. *International Journal of Social Psychiatry* **53**, 23-25.

MacLean,L.M., Meyer,M., & Estable,A. (2004) Improving accuracy of transcripts in qualitative research. *Qualitative Health Research* **14**, 113-123.

MacLeod,M., Martinez,R., & Williams,C. (2009) Cognitive behaviou therapy self-help: Who does it help and what are the drawbacks? *Behavioural and Cognitive Psychotherapy* **37**, 61-72.

MacNeil,C.A., Hasty,M.K., Conus,P., & Berk,M. (2010) Termination of therapy: what can clinicians do to maximise gains? *Acta Neuropsychiatrica* **22**, 43-45.

Macran,S., Ross,H., Hardy,G.E., & Shapiro,D.A. (1999) The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health* **8**, 325-337.

Maddux,J.E. & Rogers,R.W. (1983) Protection motivation and self-efficacy: a revised theory of fear appeals and attitude change. *Journal of Experimental Social Psychology* **19**, 469-479.

Mamede,S., Schmidt,H.G., Rikers,R.M.J.P., Penaforte,J.C., & Coelho-Filho,J.M. (2007) Breaking down automaticity: case ambiguity and the shift to reflective approaches in clinical reasoning. *Medical Education* **41**, 1185-1192.

Marks,I. (1998) Overcoming obstacles to routine outcome measurement. *British Journal of Psychiatry* **173**, 281-286.

Marshall,C. & Rossman,G. (1989) *Designing qualitative research*. Sage, Newbury Park, CA.

Marshall,M.N. (1996) Sampling for qualitative research. *Family Practice* **13**, 522-525.

Marshall,S., Haywood,K., & Fitzpatrick,R. (2006b) Impact of patient-reported outcome measures on routine practice: a structured review. *Journal of Evaluation in Clinical Practice* **12**, 559-568.

Marshall,S., Haywood,K., & Fitzpatrick,R. (2006a) Impact of patient-reported outcome measures on routine practice: a structured review. *Journal of Evaluation in Clinical Practice* **12**, 559-568.

Martin,D., Garse,J., & Davis,M. (2000) Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting & Clinical Psychology* **68**, 438-450.

Mason,J. (2002) *Qualitative Researching*. Sage, London.

Maxwell,M. (2005) Women's and doctors' accounts of their experiences of depression in primary care: The influence of social and moral reasoning on patients' and doctors' decisions. *Chronic Illness* **1**, 61-71.

Maxwell,R.J. (1984) Quality assessment in health. *British Medical Journal* **288**, 1470-1472.

Mays,N. & Pope,C. (2000) Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal* **320**, 50-52.

McCaul,K.D., Sandgren,A.K., & O'Neill,H.K. (1993) The value of the theory of planned behavior, perceived control, and self-efficacy for predicting health protective behaviors. *Basic and Applied Social Psychology* **14**, 231-252.

McEvoy,P. & Richards,D. (2007) Gatekeeping access to community mental health teams: A qualitative study. *International Journal of Nursing Studies* **44**, 387-395.

McEvoy,P., Richards,D., & Owen,J. (2000) Selective access: prioritizing referrals at the primary care/community mental health interface. *Clinical Effectiveness in Nursing* **4**, 163-172.

McKinstry,B. (2000) Do patients wish to be involved in decision making in the consultation? A cross sectional survey with video vignettes. *British Medical Journal* **321**, 867-871.

McLeod, J. (1999) *Practitioner Research in Counselling*. Sage Publications, London.

McNeil,D.L. & Wilkie,W.L. (1978) Public policy and consumer information: Impacts of new energy labels. *Journal of Consumer Research* **6**, 1-11.

Mead,N. & Bower,P. (2000) Patient centredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine* **51**, 1087-1110.

Mead, N., & Bower, P. (2002) Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient Education and Counseling* **48**, 51-61.

Meeuwissen,J.A.C., van der Feltz-Cornelis,C.M., van Marwijk,H.W.J., Rijnders,P.B.M., & Donker,M.C.H. (2008) A stepped care programme for depression management: an uncontrolled pre-post study in primary and secondary care in the Netherlands. *International Journal of Integrated Care* **8**, 1-11.

Melzer,D., watters,L., Paykel,E., Singh,K., & Gormley,N. (1999) Factors explaining the use of psychiatric services by general practices. *British Journal of General Practice* **49**, 887-891.

Miles,M.A. & Huberman,M.B. (1994) *Qualitative data analysis: An expanded sourcebook*. Sage, Thousand Oaks, CA.

Miller,C. (1995) In-depth interviewing by telephone: Some practical considerations. *Evaluation and Research in Education* **9**, 29-38.

Miller,G.A. (1962) *Psychology: The science of mental life*. Harper and Row, New York.

Mishler,E.G. (1979) Meaning in context: is there any other kind? *Harvard Educational Review* **49**, 1-19.

Modell, A. H. (1976) "The holding environment" and therapeutic action of psychoanalysis. *Journal of the American Psychoanalytic Association* **24**, 285-308.

Moncrieff,J., Churchill,R., Drummond,C., & McGuire,H. (2001) Development of a quality assessment instrument for trials of treatments for depression and neurosis. *International Journal of Methods in Psychiatric Research* **10**, 126-133.

Morgan,D. (1989) Psychiatric cases: An ethnography of the referral process. *Psychological Medicine* **19**, 743-753.

Morgan,D.L. (2007) Paradigms lost and pragmatism regained: methodological implications of combinimg qualitative and quantitative methods. *Journal of Mixed Methods Research* **1**, 48-76.

Morse,J.M. (1999) Qualitative generalisability. *Qualtiative Health Research* **9**, 5-6.

Morse,J.M. & Field,P.A. (1995) *Qualitative research methods for health professionals*. Sage, Thousand Oaks, CA.

Murphy,E., Dingwall,R., Greatbatch,D., Parker,S., & Watson,P. (1998) Qualitative research methods in health technology assessment: a review of the literature. *Health Technology Assessment* **2**.

Murray, C.J., & Lopez, A.D. (1996) The Global Burden of Disease. Cambridge, Mass, Harvard University Press.

Musselwhite,K., Cuff,L., McGregor,L., & King,K.M. (2007) The telephone interview is an effective method of data collection in clinical nursing research: A discussion paper. *International Journal of Nursing Studies* **44**, 1064-1070.

Nandy,S., Chalmers-Watson,C., Gantley,M., & Underwood,M. (2001) Referral for minor mental illness: A qualitative study. *British Journal of General Practice* **51**, 465.

Newell,A. (1966) On the Analysis of Human Problem Solving. International Symposium on Mathematical and Computational Methods in the Social Sciences (Rome, Italy, July 4-9, 1966).

National Institute for Health and Clinical Excellence (2005a) Clinical Guideline 31 Obsessive Compulsive Disorder: Core Interventions in the Treatment of Obsessive Compulsive Disorder and Body Dysmorphic Disorder. Department of Health, London.

National Institute for Health and Clinical Excellence (2011) Clinical Guideline 113 Anxiety: Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. Management in primary, secondary and community care. Department of Health, London.

National Institute for Health and Clinical Excellence (2009) Clinical Guideline 90 Depression: The treatment and management of depression in adults (partial update). Department of Health, London.

National Institute for Health and Clinical Excellence (2009b) Clinical Guideline 91 Depression in adults with a chronic physical health problem: Treatment and management. Department of Health, London.

National Institute for Health and Clinical Excellence (2005b) Clinical Guideline 26 Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. Department of Health, London.

National Institute for Health and Clinical Excellence (2007) The Guidelines Manual. Department of Health, London.

Nisbett,R.E. & DeCamp Wilson,T.D. (1977) Awareness of higher mental processes. *Psychological Review* **84**, 231-259.

Nisbett,R.E. & Wilson,T.D. (1977) Telling more than we can know: Verbal reports on mental processes. *Psychological Review* **84**, 231-259.

Norman,G., Young,M., & Brooks,L. (2007) Non-analytical models of clinical reasoning: the role of experience. *Medical Education* **41**, 1140-1145.

Norman P. & Bennett P. (1995) Health locus of control and health behaviours. In M.Conner and P.Norman (Eds) *Predicting Health Behaviour: Research and Practice with Social Cognition Models*. Open University Press, Buckingham.

Norton,P.J. & Price,E.C. (2007) A meta-analytic review of adult cognitive-behavioral treatment outcome across the anxiety disorders. *The Journal of Nervous and Mental Disease* **195**, 521-531.

Novick,G. (2008) Is there a bias against telephone interviews in qualitative research? *Research in Nursing and Health* **31**, 391-398.

O'Neal,E., Adams,J., McHugo,G.J., Van Citters,A., Drake,R.E., & Bartels,S.J. (2008) Preferences of older and younger adults with serious mental illness for involvement in decision-making in medical and psychiatric settings. *American Journal of Geriatric Psychiatry* **16**, 826-833.

Office for National Statistics (2000) Psychiatric morbidity survey. London: ONS.

Offredy,M. (2002) Decision-making in primary care: outcomes from a study using patient scenarios. *Journal of Advanced Nursing* **40**, 532-541.

Offredy,M. & Meerabeau,E. (2005) The use of 'think aloud' technique, information processing theory and schema theory to explain decision-making processes of general practitioners and nurse practitioners using patient scenarios. *Primary Health Care Research and Development* **6**, 46-59.

Ogden,J., Bavalia,K., Bull,M., Frankum,S., Goldie,C., Gosslau,M., Jones,A., Kumar,S., & Vasant,K. (2004) "I want more time with my doctor": a quantitative study of time and the consultation. *Family Practice* **21**, 479-483.

Oliver,R.L. & Berger,P.K. (1979) A path analysis of preventative health care decision models. *Journal of Consumer Research* **6**, 113-122.

Opdenakker,R. (2006) Advantages and disadvantages of four interview techniques in qualitative research. *Forum: Qualitative Social Research* **7**.

Orlinsky,D.E., Grawe,K., & Parks,B.K. (1994) Process and outcome in psychotherapy. In S.L.Garfield and A.E.Bergin (Eds) *Handbook of psychotherapy and behaviour change*. Wiley, New York.

Orlinsky,D.E., Roonestad,M.H., & Willutzki,U. (2004) Fifty years of psychotherapy process-outcome research: Continuity and change. In M.J.Lambert (Ed) *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*. John Wiley, New York.

Oulette,J.A. & Wood,W. (1998) Habit and intention in everyday life: The multiple processes by which past behavior predicts future behavior. *Psychological Bulletin* **124**, 54-74.

Painton,S. & Gentry,J.W. (1985) Another look at the impact of information presentation format. *Journal of Consumer Research* **12**, 240-244.

Papworth,M. & Walker,L. (2008) The needs of primary care mental health service users: a Q-sort study. *Mental Health in Family Medicine* **5**, 203-212.

Parry G., Barkham M., Brazier J., Dent-Brown K., Hardy G., Kendrick T., Rick J., Chambers E., Chan T., Connell J., Hutten R., de Lusignan S., Mukuria C., Saxon D., Bower P., & Lovell K. (2010) An evaluation of the IAPT demonstration sites. Final Report. NIHR Service Delivery and Organisation programme.

Parry,G., Cape,J., & Pilling,S. (2003) Clinical practice guidelines in clinical psychology and psychotherapy. *Clinical Psychology and Psychotherapy* **10**, 337-351.

Patton,M. (2002) *Qualitative Research and Evaluation Methods*. Sage, Thousand Oaks.

Patton,M. (1980) *Qualitative evaluation methods*. Sage, Newbury Park, CA.

Paxton,R., Shrubb,S., Griffiths,H., Cameron,L., & Maunder,L. (2000) Tiered approach: matching mental health services to needs. *Journal of Mental Health* **9**, 137-144.

Paykel,E.S. (2001) Continuation and maintenance therapy in depression. *British Medical Bulletin* **57**, 145-159.

Payne,J.W. (1976) Task complexity and contingent processing in decision making: An information search and protocol analysis. *Organizational Behavior and Human Decision Processes* **16**, 366-387.

Payne,J.W., Braunstein,M.L., & Carroll,J.S. (1978) Exploring predecisional behaviour: An alternative approach to decision research. *Organisational Behaviour and Human Performance* **22**, 17-44.

Perry,A. & Gilbody,S. (2009) User-defined outcomes in mental health: A qualitative study and consensus development exercise. *Journal of Mental Health* **18**, 415-423.

Persons,J.B. & Silberschatz,G. (1998) Are results of randomized controlled trials useful to psychotherapists? *Journal of Consulting & Clinical Psychology* **66**, 126-135.

Persons,J.B. (1991) Psychotherapy outcome studies do not accurately represent current models of psychotherapy: A proposed remedy. *American Psychologist* **46**, 99-106.

Pharoah,P.D.P. & Melzer,D. (1995) Variation in prescribing of hypnotics, anxiolytics and antidepressants between 61 general practices. *British Journal of General Practice* **45**, 595-599.

Pilgrim,D., Rogers,A., Clarke,S., & Clark,W. (1997) Entering psychological treatment: Decision-making factors for GPs and service users. *Journal of Interprofessional Care* **11**, 313-323.

Pilling,S. (2008) History, context, process, and rationale for the development of clinical guidelines. *Psychology and Psychotherapy: Theory, Research and Practice* **81**, 331-350.

Polanyi M. (1983) *The Tacit Dimension*. MA: Peter Smith, Gloucester.

Pope,C., Ziebland,S., & Mays,N. (2000) Analysing qualitative data. *British Medical Journal* **320**, 114-116.

Power,A.K. (2009) A public health model of mental health for the 21st century. *Psychiatric Services* **60**, 580-584.

Priest,R.G., Vize,C., Roberts,A., Roberst,M., & Tylee,A. (1996) Lay people's attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. *British Medical Journal* **313**, 858-859.

Prins,M., Verhaak,P.F.M., Bensing,J.M., & van der Meer,K. (2008) Health beliefs and perceived need for mental health care of anxiety and depression - The patients' prespective explored. *Clinical Psychology Review* **28**, 1038-1058.

Protheroe,J. & Bower,P. (2008) Choosing, deciding, or participating: what do patients want in primary care? *British Journal of General Practice* **58**, 603-604.

Proudfoot,J., Ryden,C., Everitt,B., Shapiro,D.A., Goldberg,D., Mann,A., Tylee,A., Marks,I., & Gray,J.A. (2004) Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: a randomised controlled trial. *Journal of Psychiatry* **185**, 46-54.

Quelch,J.A. (1979) Measurement of the relative importance of product attribute information: A review of the information display approach. *Journal of Consumer Policy* **3**, 232-245.

Ranyard,R., Hinkley,L., Williamson,J., & McHugh,S. (2006) The role of mental accounting in consumer credit decision processes. *Journal of Economic Psychology* **27**, 571-588.

Ranyard,R. & Williamson,J. (2005) Conversation-based process tracing methods for naturalistic decision making: Information search and verbal protocol analysis. In H.Montgomery, R.Lipshitz, and B.Brehmer (Eds) *How professionals make decisions*. LEA Associates, Mahwah, NJ.

Raue,P., Schulberg,H.C., Heo,M., Klimstra,S., & Bruce,M.L. (2009) Patients' depression treatment preferences and initiation, adherence, and outcome: A randomised primary care study. *Psychiatric Services* **60**, 337-343.

Remmington,M. & Tyrer,P. (1979) The social functioning schedule: a brief semi-structured intervention. *Social Psychiatry* **14**, 151-157.

Richards,A., Barkham,M., Cahill,J., Richards,D., Williams,C., & Heywood,P. (2003) PHASE: a randomised, controlled trial of supervised self-help cognitive behavioural therapy in primary care. *British Journal of General Practice* **53**, 764-770.

Richards,D.A., Lankshear,A.J., Fletcher,J., Rogers,A., Barkham,M., Bower,P., Gask,L., Gilbody,S., & Lovell,K. (2006) Developing a U.K. protocol for collaborative care: a qualitative study. *General Hospital Psychiatry* **28**, 296-305.

Richards,D.A. & Suckling,R. (2008) Improving access to psychological therapy: The Doncaster demonstration site organisational model. *Clinical Psychology Forum*.

Richards,D.A., Weaver,A., Utley,M., Bower,P., Cape,J., Gallivan,S., Gilbody,S., Hennessy, S., Leibowitz,J., Lovell,K., Owens,L., Pagel,C., Paxton,R., Pilling,S., Simpson,A., Tomson,D., & Vasilakis,C. (2010) Developing evidence-based and acceptable stepped care systems in mental health care: an operational research project. Final Report. NIHR Service Delivery and Organisation programme.

Riedel-Heller,S.G., Matschinger,H., & Angermeyer,M.C. (2005) Mental disorders--Who and what might help? Help-seeking and treatment preferences of the lay public. *Social Psychiatry and Psychiatric Epidemiology* **40**, 167-174.

Rimoldi,H.J.A. (1955) A technique for the study of problem solving. *Educational and Psychological Measurement* **15**, 450-461.

Rimoldi,H.J.A. (1960) Problem solving as a process. *Educational and Psychological Measurement* **2**, 449-460.

Rimoldi,H.J.A. & Raimondo,R. (1998) Assessing the process of clinical problem solving. *Advances in Health Sciences Education* **3**, 217-230.

Ritchie,J., Spencer,L., & O'Connor,W. (2003) Carrying out qualitative analysis. In J.Ritchie and J.Lewis (Eds) *Qualitative Research Practice*. Sage Publications, London.

Roberts,M.J. & Newton,E.J. (2001) Inspection times, the change task, and the rapid-response selection task. *Quarterly Journal of Experimental Psychology* **54**, 1031-1048.

Roberts, S.A., McGowan, L., Hirst, W.M., Brison, D.R., Vail, A., & Lieberman, B.A. (2010) Towards single embryo transfer? Modelling clinical outcomes of potential treatment choices using multiple data sources: predictive models and patient perspectives *Health Technology Assessment* **14**(38).

Robertson,R.C. (1979) Variations in referral pattern to the psychiatric services by general practitioners. *Psychological Medicine* **9**, 355-364.

Robinson,S., Ashworth,M., Shepherd,M., & Evans,C. (2006) In their own words: a narrative-based classification of clients' problems on an idiographic outcome measure for talking therapy in primary care. *Primary Care Mental Health* **4**, 165-173.

Robson C. (1993) *Real world research. A resource for social scientists and practitioner-researchers*. Blackwell Pub Ltd, Oxford, UK.

Rogers,A., Oliver,D., Bower,P., Lovell,K., & Richards,D. (2003) Peoples' understandings of a primary care-based mental health self-help clinic. *Patient Education & Counseling* **53**, 41-46.

Rogers,R.W. (1975) A protection motivation theory of fear appeals and attitude change. *Journal of Psychology* **91**, 93-114.

Rogers,R.W. (1983) Cognitive and physiological processes in fear appeals and attitude change: A revised theory of protection motivation. In J.R.Cacioppo and R.E.Petty (Eds) *Social Psychology: A Source Book*. Guilford Press, New York.

Rokke,P.D., Tomhave,J.A., & Jocic,Z. (1999) The role of client choice and target selection in self-management therapy for depression in older adults. *Psychology and Ageing* **14**, 155-169.

Rosenstock,I.M. (1966) Why people use health services. *Millbank Memorial Fund Quarterly* **44**, 94-124.

Ross,H. & Hardy,G. (1999) GP referrals to adult psychological services: A research agenda for promoting needs-led practice through the involvement of mental health clinicians. *British Journal of Medical Psychology* **72**, 75-91.

Rotar-Pavlic,D., Svab,I., & Wetzels,R. (2008) How do older patients and their GPs evaluate shared decision-making in healthcare? *BMC Geriatrics* **8**.

Roth,A. & Fonagy,P. (1997) *What Works for Whom?* Guilford Press, New York.

Royal College of General Practitioners (2000) Provision of NHS Mental Health Services. Fourth report from the select committee on health. Department of Health, London: The Stationery Office.

Royal College of Psychiatrists & Royal College of General Practitioners (2008) Psychological therapies in psychiatry and primary care. London.

Rubin,H.J. & Rubin,I.S. (2005) *Qualitative Interviewing: The Art of Hearing Data*. Sage, Thousand Oaks, CA.

Rush,A.J., Trivedi,M.H., Wisniewski,S.R., Nierenberg,A.A., Stewart,J.W., Warden,D., Niederehe,G., Thase,M.E., Lavori,P.W., Lebowitz,B.D., McGrath,P.J., Rosenbaum,J.F., Sackeim,H.A., Kupfer,D.J., Luther,J., & Fava,M. (2006) Acute and Longer-Term Outcomes in Depressed Outpatients Requiring One or Several Treatment Steps: A STAR*D Report. *American Journal of Psychiatry* **163**, 1905-1917.

Russo J.E. (1978) Eye fixations can save the world: A critical evaluation and a comparison between eye fixations and other information processing methodologies. In H.K.Hunt (Ed) *Advances in Consumer Research*. Association for Consumer Research, Ann Arbor, Mich.

Ryan,J. & Sysko,J. (2007) The contingency of patient preferences for involvement in health decision making. *Health Care Management Review* **32**, 30-36.

Ryan J.E. & Etzel M.J. (1976) The nature of salient outcomes and referents in the extended model. In B.B.Anderson (Ed) *Advances in Consumer Research*. Association for Consumer Research.

Rycroft-Malone,J., Fontenla,M., Seers,K., & Bick,D. (2009) Protocol-based care: the standardisation of decision-making? *Journal of Clinical Nursing* **18**, 1490-1500.

Saatski,S., Hardy,G.E., & Cahill,J. (2007) Predictors of outcome and completion status in cognitive therapy for depression. *Psychotherapy Research* **17**, 185-195.

Sackett, D.L. (1996) The doctor's (ethical and economic) dilemma. London: Office of Health Economics.

Sackett,D.L., Rosenberg,W.M.C., Gray,J.A.M., Haynes,R.B., & Richardson,W.S. (1996) Evidence-based medicine: what it is and what it isn't. *British Medical Journal* **312**, 71-72.

Sahlin,N.-E., Wallin,A., & Persson,J. (2010) Decision science: from Ramsey to dual process theories. *Synthese* **172**, 129-143.

Sandell,R. & Fredelius,G. (1997) Prioritizing among patients seeking subsidized psychotherapy. *Psychoanalytic Psychotherapy* **11**, 73-86.

Sanderson,C.A. (2004) *Health Psychology*. Wiley, US.

Sands,N. (2009) An exploration of clinical decision making in mental health triage. *Archives of Psychiatric Nursing* **23**, 298-308.

Say, R., Murtagh, M., & Thomson, R. (2006) Patients' preference for involvement in medical decision making: a narrative review. *Patient Education and Counseling* **60**, 102-114.

Sayce,L. & Morris,D. (1999) Outsiders Coming in? Achieving social inclusion for people with mental health problems. Mind, London.

Schafer,T., Amoateng,G., & Wrycraft,N. (2009) An exploratory study of GP perceptions of the impact of a primary care counselling service on their practice. *British Journal of Guidance and Counselling* **37**, 1-15.

Schegloff,E. (1997) Whose text? Whose context? *Discourse and Society* **8**, 165-187.

Schmidt,H.G. & Boshuizen,H.P.A. (1993) On acquiring expertise in medicine. *Educational Psychology Review* **5**, 1-17.

Schofield,W. (1964) *Psychotherapy: The Purchase of Friendship*. Englewood Cliffs, N.J.: Prentice Hall.

Schroyens,W., Shaeken,W., & Handley,S. (2003) In search of counterexamples: Deductive rationality in human reasoning. *Quarterly Journal of Experimental Psychology* **56A**, 1129-1145.

Schutz,A. (1976) The stranger. In G.Bowker and J.Carrier (Eds) *Race and Ethnic Relations*. Hutchison, London.

Schwartz,R.C., Zarski,J.J., & Hilscher,R.L. (2004) Mental Health Counselors' Decision-Making Priorities Related to Inpatient Admissions for Anxiety Disordered Clients: A Pilot Study. *Journal of Mental Health Counseling* **26**, 283-293.

Schwarzer R. (1992) Self efficacy in the adoption and maintenance of health behaviors: Theoretical approaches and a new model. In R.Schwarzer (Ed) *Self Efficacy: Thought Control of Action*.

Scogin,F.R., Hanson,A., & Welsh,D. (2003) Self-administered treatment in stepped-care models of depression treatment. *Journal of Clinical Psychology* **59**, 341-349.

Seale,C. (1999) *The Quality of Qualitative Research*. Sage, London.

Seidenstucker,G. & Roth,W.L. (1998) Treatment decisions: Types, models and schools. *European Journal of Psychological Assessment* **14**, 2-13.

Shafir,E. & LeBoeuf,R.A. (2002) Rationality. *Annual Review of Psychology* **53**, 491-517.

Shank,G.D. (2006) *Qualitative Research: A personal skills approach*. Pearson, Upper Saddle River, NJ.

Shapiro,D.A., Harper,H., Startup,M., Renyolds,S., Bird,D., & Suokas,A. (1961) The high-water mark of the drug metaphor: A meta-analytic critique of process-outcome research. *Reassessing Psychotherapy Research*. Guilford Press, New York.

Sheeran,P., Conner,M., & Norman,P. (2001) Can the theory of planned behavior explain patterns of health behavior change? *Health Psychology* **20**, 12-19.

Sheeran,P., Orbell,S., & Trafimow,D. (1999) Does the temporal stability of a behavioral intentions moderate intention-behavior and past behavior-future behavior reactions? *Personality and Social Psychology Bulletin* **25**, 721-730.

Sheldon,T.A., Cullum,N., Dawson,D., Lankshear,A., Lowson,K., Watt,I., West,P., & Wright,J. (2004) What's the evidence that NICE guidance has been implemented? Results from a national evaluation using time series analysis, audit of patients' notes, and interviews. *British Medical Journal* **329**, 999-1006.

Sheridan,S.L. (2004) Shared decision making about screening and chemoprevention: A suggested approach from the U.S. Preventative Services Task Force. *American Journal of Preventative Medicine* **26**, 56-66.

Shiloh,S., Gerad,L., & Goldman,B. (2006) Patients' information needs and decision-making processes: What can be learned from genetic counselees? *Health Psychology* **25**, 211-219.

Shumway,M., Saunders,T., Shern,D., Pines,E., Downs,A., Burbine,T., & Beller,J. (2003) Preferences for Schizophrenia Treatment Outcomes Among Public Policy Makers, Consumers, Families, and Providers. *Psychiatric Services* **54**, 1124-1128.

Sigel,P. & Leiper,R. (2004) GP views of their management and referral of psychological problems: a qualitative study. *Psychology & Psychotherapy: Theory, Research & Practice* **77**, 3-95.

Silverman,D. (1993) *Interpreting qualitative data: methods for analysing talk, text and interaction*. Sage, London.

Sim,K., Peng Geww,K., & Bateman,A. (2005) Case formulation in psychotherapy: Revitalising its usefulness as a clinical tool. *Academic Psychiatry* **29**, 289-292.

Simon,D., Loh,A., Wills,C.E., & Harter,M. (2006) Depressed patients' perceptions of depression treatment decision-making. *Health Expectations: An International Journal of Public Participation in Health Care & Health Policy* **10**, 62-74.

Singleton,N., Bumpstead,R., O'Brien,M., Lee,A., & Meltzer,H. (2000) Psychiatric morbidity among adults living in private households. The Stationery Office, London.

Singleton,N. & Lewis,G. (2003) Better or worse: a longitudinal study of the mental health of adults living in private households in Great Britain. The Stationery Office, London.

Skaner,Y., Backlund,L., Montgomery,H., Bring,J., & Strender,L.-E. (2005) General practitioners' reasoning when considering the diagnosis of heart failure: a think-aloud study. *Family Practice* **6**, 4-13.

Slade,M. (2002a) Routine outcome assessment in mental health services. *Psychological Medicine* **32**, 1339-1343.

Slade,M. (2002b) The use of patient-level outcomes to inform treatment. *Epidemiologia e Psichiatria Sociale* **11**, 20-27.

Sladek,R.M., Phillips,P.A., & Bond,M.J. (2006) Implementation science: a role for parallel dual processing models of reasoning? *Implementation Science* **1**, 12.

Sleath,B. & Shih,Y.C. (2003) Sociological influences on antidepressant prescribing. *Social Science & Medicine* **56**, 1335-1344.

Sloman,S.A. (1996) The empirical case for two systems of reasoning. *Psychological Bulletin* **119**, 3-22.

Slovic,P., Fischoff,B., & Lichtenstein,S. (1977) Behavioural decision theory. *Annual Review of Psychology* **28**, 1-39.

Slovic P., Lichtenstein S., & Fischhoff B. (1988) Decision-making. In Atkinson R C and et al (Eds) *Steven's handbook of experimental psychology (Vol 2: Learning and Cognition)*. Wiley, New York.

Smith,B. & Sechrest,L. (1991) Treatment of Aptitude x Treatment Interactions. *Journal of Consulting and Clinical Psychology* **39**, 233-244.

Smith,E.R. & DeCoster,J. (2000) Dual-Process Models in Social and Cognitive Psychology: Conceptual Integration and Links to Underlying Memory Systems. *Personality and Social Psychology Review* 108-131.

Smith,G. & Cantley,C. (1985) *Assessing health care: a study in organizational evaluation*. Open University Press, Milton Keynes.

Smith,L., Gilhooly,K., & Walker,A. (2003) Factors influencing prescribing decisions in the treatment of depression: A social judgement theory approach. *Applied Cognitive Psychology.17(1)()(pp 51-63), 2003.Date of Publication: Jan 2003*. 51-63.

Snape,D. & Spencer,L. (2003) The foundations of qualitative research. In J.Richie and J.Lewis (Eds) *Qualitative Research Practice*. Sage, London.

Sobell, M.B., & Sobell, L.C. (1993) Treatment for problem drinkers: a public health priority.In J.S. Baer, G.A. Marlatt, & R.J. McMahon (eds) *Addictive Behaviours Across the Lifespan: Prevention, Treatment, and Policy Issues* 138–57. Sage.

Sobell,M.B. & Sobell,L.C. (2000) Stepped care as a heuristic approach to the treatment of alcohol problems. *Journal of Consulting and Clinical Psychology* **68**, 573-579.

Sobin,C., Weissman,M.M., Goldstein,R.B., Adams,P., Wickramaratne,P., Warner,V., & Lish,J.D. (1993) Diagnostic interviewing for family studies: Comparing telephone and face-to-face methods for the diagnosis of lifetime psychiatric disorders. *Psychiatric Genetics* **3**, 227-333.

Sotsky,S.M., Glass,D.R., Shea,M.T., Pilkonis,P.A., Collins,F., Elkin,I., Watkins,J.T., Imber,S.D., Leber,W.R., Moyer,J., & Oliveri,M.E. (2006) Patient Predictors of Response to Psychotherapy and Pharmacotherapy: Findings in the NIMH Treatment of Depression Collaborative Research Program. *Focus* **4**, 278-290.

Speight,J. & Reaney,M. (2009) Rationing: it would be NICE to consider patients' views. *British Medical Journal* **338**, b85.

Spitzer,R.L., Kroenke,K., Williams,J.B., & Lowe,B. (2006) A brief measure for assessing generalised anxiety disorder: the GAD-7. *Archives of General Psychiatry* **166**, 1092-1097.

Spitzer,R.L., Kroenke,K., Linzer,M., Hahn,S.R., Williams,J.B.W., deGruy,F.V., III, Brody,D., & Davies,M. (1995) Health-Related Quality of Life in Primary Care Patients With Mental Disorders: Results From the PRIME-MD 1000 Study. *JAMA: The Journal of the American Medical Association* **274**, 1511-1517.

Stanovich,K.E. & West,R.F. (2000) Individual differences in reasoning: Implications for the rationality debate? *Behavioural and Brain Sciences* **23**, 645-726.

Stavrou,S., Cape,J., & Barker,C. (2009) Decisions about referrals for psychological therapies: a matched-patient qualitative study. *British Journal of General Practice* **59**, 289-298.

Steele,N., Melzer,E., Shekelle,P.G., Wenger,N.S., Forsyth,D., & McWilliams,B.C. (2004) Developing quality indicators for older adults: transfer from the USA to UK is feasible. *Quality and Safety in Health Care* **13**, 260-264.

Stenbacka,C. (2001) Qualitative research requires quality concepts of its own. *Management Decision* **39**, 551-555.

Stewart,R.E. & Chambless,D.L. (2009) Cognitive-behavioural therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. *Journal of Consulting & Clinical Psychology* **77**, 595-606.

Stratman,J.F. & Hamp-Lyons,L. (1994) Reactivity in concurrent think-aloud protocols: Issues for research. In P.Smagorinsky (Ed) *Speaking about writing: Reflections on research methodology*. Sage, Thousand Oaks, CA.

Strauss,A. & Corbin,J. (1990) *Basics of Qualitative Research: Grounded theory procedures and techniques*. Sage Publications Inc., Newbury Park, CA.

Sturges,J.E. & Hanrahan,K.J. (2004) Comparing telephone and face-to-face-interviewing: a research note. *Qualitative Research* **4**, 107-118.

Summerfield,D. & Veale,D. (2008) Proposals for massive expansion of psychological therapies would be counterproductive acorss society. *The British Journal of Psychiatry* **192**, 326-330.

Svenson,O. (1996) Decision making and the search for fundamental psychological regularities: What can be learned from a process perspective? *Organizational Behavior and Human Decision Processes* **65**, 252-267.

Sweet,L. (2000) Telephone interviewing: Is it compatable with interpretive phenomenological research? *Contemporary Nurse* **12**, 58-63.

Swift,J.K. & Callahan,J.L. (2009) The impact of client treatment preferences on outcome: A meta-analysis. *Journal of Clinical Psychology* **65**, 368-381.

Tang,T.Z. & DeRubeis,R.J. (1999) Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting & Clinical Psychology* **67**, 894-904.

Tashakkori,A. & Teddlie,C. (2003) The past and future of mixed methods research: From data triangulation to mixed model designs. In A.Tashakkori and C.Teddlie (Eds) *Handbook of Mixed Methods in Social and Behavioral Research*. Sage, Thousand Oaks, CA.

Thompson,C. & Dowding,D. (2002) *Clinical Decision-Making and Judgement in Nursing*. Churchill Livingstone, London.

Tillett,R. (1996) Psychotherapy assessment and treatment selection. *British Journal of Psychiatry* **168**, 10-15.

Tonelli, M.R. (1998) The philosophical limits of evidence-based medicine. *Academic Meicine* **73**, 1234-1240.

Toner,R., Snape,C., Acton,S., & Blenkiron,P. (2010) Do general practitioners adhere to NICE guidelines for depression? Systematic Questionnaire Survey. *Primary Health Care Research and Development* **11**, 123-131.

Trauer,T., Callaly,T., & Herrman,H. (2009) Attitudes of mental health staff to routine outcome measurement. *Journal of Mental Health* **18**, 288-296.

Trepka,C., Rees,A., Shapiro,D.A., Hardy,G.E., & Barkham,M. (2004) Therapist competence and outcome of cognitive therapy for depression. *Cognitive Therapy and Research* **28**, 143-157.

Tuckett,A.G. (2005) Applying thematic analysis thepry to practice: A researcher's experience. *Contemporary Nurse* **19**, 75-87.

Turner,C.K. (1988) Don't blame memory for people's faulty reports on what influences their judgements. *Personality and Social Psychology Bulletin* **14**, 622-629.

Tryon, G. S., & Winograd, G. (2002) Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: therapist contributions and responsiveness to patients*. New York: Oxford University Press.

Unutzer,J., Katon,W., Callahan,C.M., Williams,J.W., Jr., Hunkeler,E., Harpole,L., Hoffing,M., la Penna,R.D., Noel,P.H., Lin,E.H.B., Arean,P.A., Hegel,M.T., Tang,L., Belin,T.R., Oishi,S., Langston,C., & for the IMPACT Investigators (2002a) Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. *JAMA: The Journal of the American Medical Association* **288**, 2836-2845.

Valderas,J.M., Kotzeva,A., Espallargues,M., Guyatt,G., Ferrans,C.E., Halyard,M.Y., Revicki,D.A., Symonds,T., Parada,A., & Alonso,J. (2008) The impact of measuring patient-reported outcomes in clinical practice: a systematic review of the literature. *Quality of Life Research* **17**, 179-193.

van Boeijen,C.A., van Oppen,P., van Balkom,A.J.L.M., Visser,S., Kempe,P.T., Blankenstein,N., & van Dyck,R. (2005) Treatment of anxiety disorders in primary care practice: a randomised controlled trial. *British Journal of General Practice* **67**, 361-370.

van Raaij,W.F. (1977) Consumer information processing for different information structures and formats. *Advances in Consumer Research* **4**, 176-184.

van Schaik,D.J.F., Klijn,A.F.J., van Hout,H.P.J., van Marwijk,H.W.J., Beekman,A.T.F., de Haan,M., & van Dyck,R. (2005) Patients' preferences in the treatment of depressive disorder in primary care. *General Hospital Psychiatry* **26**, 184-189.

van Straten,A., Tiemens,B., Hakkaart,L., Nolen,W.A., & Donker,M.C.H. (2006) Stepped care vs. matched care for mood and anxiety disorders: a randomized trial in routine practice. *Acta Psychiatrica Scandinavica* **113**, 468-476.

van Teijlingen,E.R. & Hundley,V. (2001) The importance of pilot studies. *Social Research Update* **35**.

van't Veer-Tazelaar,P.J., van Marwijk,H.W.J., van Oppen,P., van Hout,H.P.J., van der Horst,H.E., Cuijpers,P., Smit,F., & Beekman,A.T.F. (2009) Stepped-Care Prevention of Anxiety and Depression in Late Life: A Randomized Controlled Trial. *Archives of General Psychiatry* **66**, 297-304.

Verhaak,P.F.M. (1993) Analysis of referrals of mental health problems by general practitioners. *British Journal of General Practice* **43**, 203-208.

Verplanken,B & Aarts,H (2008) Habit, attitude, and planned behavior: Is habit an empty construct or an interesting case of goal-directed automaticity? In Stroebe W and Hewstone M (Eds) *European Review of Social Psychology*.

Visintini,R., Ubbiali,A., Donati,D., Chiorri,C., & Maffei,C. (2007) Referral to group psychotherapy: A retrospective study on patients' personality features associated with clinicians' judgements. *International Journal of Group Psychotherapy* **57**, 515-524.

Von Korff,M., Katon,W., Rutter,C., Ludman,E., Simon,G., Lin,E., & Bush,T. (2003) Effect on disability outcomes of a depression relapse prevention program. *Psychosomatic Medicine* **65**, 938-943.

Wailoo,A., Roberst,J., Brazier,J., & McCabe,C. (2004) Efficiency, equity, and NICE clinical guidelines. Clinical guidelines need a broader view than just the clinical. *British Medical Journal* **328**, 536-537.

Waitzkin,H. (1990) On studying the discourse of medical encounters. A critique of quantitative and qualitative methods and a proposal for reasonable compromise. *Medical Care* **28**, 473-488.

Wallston,K.E. (1992) Hocus-pocus, the focus isn't strictly locus: Rotter's social learning theory modified for health. *Cognitive Therapy and Research* **16**, 183-199.

Walter,G., Cleary,M., & Rey,J.M. (1998) Attitudes of mental health personnel towards rating outcome. *Journal of Quality in Clinical Practice* **18**, 109-115.

Ward,A., Polizzi,G., & Milovanovic,M. (2008) Psychological therapies provision: views from primary care. *Psychiatric Bulletin* **32**, 369-374.

Warner,R.W., Gater,R., Jackson,M.G., & Goldberg,D.P. (1993) Effects of a community mental health service on the practice and attitudes of general practitioners. *British Journal of General Practice* **43**, 507-511.

Wasson,J., Hays,R., Rubenstein,L., Nelson,E., Leaning,J., Johnson,D., Keller,A., Landgraf,J., & Rosenkrans,C. (1992) The short-term effect of patient health status assessment in a health maintenance organization. *Quality of Life Research* **1**, 99-106.

Weissman,M.M. & Bothwell,S. (1976) The assessment of social adjustment by self report. *Archives of General Psychiatry* **33**, 1111-1115.

Welsh,I. & Lyons,C.M. (2001) Evidence-based care and the case for intuition and tacit knowledge in clinical assesment and decision making in mental health nursing practice: An empirical contribution to the debate. *Journal of Psychiatric and Mental Health Nursing* **8**, 299-305.

Westenberg,M.R.M. & Koele,P. (1994) Multi-attribute evaluation processes: Methodological and conceptual issues. *Acta Psychologica* **87**, 65-84.

Wilkie,T. (2001) Public opinion may force researchers to seek "opt in" consent for all studies (commentary). *British Medical Journal* **322**, 1221.

Williams,S.J. & Calnan,M. (1991) Key Determinants of Consumer Satisfaction With General Practice. *Family Practice* **8**, 237-242.

Williams,C. & Martinez,R. (2008) Increasing access to CBT: stepped care and CBT self-help models in practice. *Behavioural and Cognitive Psychotherapy* **36**, 675-683.

Williamson,J., Ranyard,R., & Cuthbert,L. (2000) A conversation-based process tracing method for use with naturalistic decisions: An evaluation study. *British Journal of Psychology* **91**, 203-221.

Willis,G., DeMaio,T., & Harris-Kojetin,B. (1999) Is the Bandwagon Headed to the Methodological Promised Land? Evaluation of the Validity of Cognitive Interviewing Techniques. In M.Sirken, D.Herrmann, S.Schechter, N.Schwartz, J.Tanur, and R.Tourangeau (Eds) *Cognition and Survey Research*. Wiley, New York.

Willis,G.B. (1994) Cognitive interviewing and questionnaire design: a training manual (Working Paper No. 7). National Centre for Health Statistics, Hyattsville.

Willis,G.B., Royston,P., & Bercini,D. (1991) The use of verbal report methods in the development and testing of survey questionnaires. *Applied Cognitive Psychology* **5**, 251-267.

Wills,T.A. (1978) Perceptions of clients by professional helpers. *Psychological Bulletin* **85**, 968-1000.

Wilson,G.T., Vitousek,K.M., & Loeb,K.L. (2000) Stepped care treatment for eating disorders. *Journal of Consulting & Clinical Psychology* **68**, 564-572.

Wilson,K., Roe,B., & Wright,L. (1998) Telephone or face-to-face interviews?: a decision made on the basis of a pilot study. *International Journal of Nursing Studies* **35**, 314-321.

Wolstenholme E., Repper D.T.D., Monk D., & McKelvie D. (2006) Implementation of a stepped care approach to depression services in North West England. *Systems Dynamics Conference*.

Woolf,S.H., Grol,R., Hutchinson,A., Eccles,M., & Grimshaw,J. (1999) Potential benefits, limitations, and harms of clinical guidelines. *British Medical Journal* **318**, 527-530.

World Health Organisation (2008) *Integrating Mental Health Services into Primary Health Care* Mental Health Policy, Planning and Service Development Information Sheet (Sheet 3) Geneva: World Health Organization,
www.who.int/mental_health/policy/services/en/index.html (accessed 13th January 2010)

Young,H.N., Bell,R.A., Epstein,R.M., Feldman,M.D., & Kravitz,R.L. (2008) Physicians' shared decision-making behaviours in depression care. *Archives of Internal Medicine* **168**, 1404-1408.

Zigmond,A.S. & Snaith,R.P. (1983) The Hospital Anxiety And Depression Scale. *Acta Psychiatrica Scandinavica* **67**, 361-370.

APPENDICES

APPENDIX ONE: LITERATURE SEARCH STRATEGY

As the main aims of the study were conceptual as such the review required to address the main aims of the study did not lend itself to a formal systematic review. However, the principles of a systematic review (i.e. comprehensive searches, transparency and consideration of study quality) were adhered to (Critical Appraisal Skills Programme (CASP), 2002; Moncrieff *et al.*, 2001; Centre for Reviews and Dissemination (CRD), 2001).

The search was kept deliberately broad to encompass the complexities of the literature relevant to the following aspects of the study. Any study investigating these issues was considered relevant:

- stepped care for common mental health problems
- theoretical models of decision-making
- empirical studies of decision-making in mental health
- techniques for the measurement of decision-making.

The following databases were systematically searched in July 2008 and auto-alert searches set-up to ensure new literature was identified throughout the study's duration. A final search was conducted in September 2010:

- OVID to search MEDLINE, PsycINFO, and EMBASE
- CINAHL
- The Cochrane Library
- NHS Centres for Reviews and Dissemination

Other relevant sources of information were identified by sourcing related publications, reports, research studies or relevant policy documents:

- General search of NHS, Department of Health, IAPT and the Office of National Statistics websites
- Conference proceedings
- Reference lists of retrieved articles

- Manual search of relevant journals online and in The University of Manchester library
- Recommendations from experts in the field

The search was conducted using a mix of subject headings (see examples below) and free-text terms. Relevant terms were combined for different chapters.

Decision-making
Decision*
decision-making
choice*
choice behaviour
preference*
informed decision* choice*

Mental Health
mental-health
mental* ill*
psychiatr*
mental* disorder
anxiety
depression
stepped care

Theoretical Models
Experimental model*
Theoretic* model*
Theoretic* study

Several of the identified studies were not available in the University library and were retrieved using the inter-library loan system. References of literature were recorded and stored in Reference Manager 11.

The final Reference Manager database contained 883 records and included papers from a variety of sources. Detailed records of the exact number from each search were not kept as many papers were picked up by multiple methods and because the nature of the searches was iterative rather than being conducted all at one point in time.

The evidence retrieved through this strategy is presented in Chapters 1, 2 and 3.

APPENDIX TWO: HEALTH PROFESSIONAL DEMOGRAPHIC QUESTIONNAIRE

Health Professional ID ☐ ☐ ☐ ☐

DEMOGRAPHIC INFORMATION

Please complete the following questionnaire as fully as you can.
All of the information collected remains confidential.

1. Are you: Male ☐   Female ☐

2. What is the name of the site that you are currently working at?

3. What is your job title/ formal role?

4. What qualifications do you have?

5. Can you describe your professional background?

6. How many years have you been working in primary care? (if applicable)

7. How many years have you been working in mental health?

8. What psychological treatments do you deliver? (please provide details of each)

THANK YOU FOR ANSWERING THESE QUESTIONS

APPENDIX THREE: HEALTH PROFESSIONAL STUDY RECRUITMENT PACK -INVITATION LETTER, INFORMATION SHEET & REPLY FORM

Judith Gellatly
Tel: 0161 306 7672
judith.l.gellatly@manchester.ac.uk

Dear

Decision-making in Stepped Care
(Health Care Professionals)

We would like to invite you to take part in a study which aims to assist in the understanding of how treatment decisions are made within new mental health service configuration models (e.g. stepped care). Involvement in the study would involve taking part in a one-off face-to-face interview with a researcher to discuss your experiences of decision-making within mental health services.

Enclosed is an information sheet which provides you with further information about the study.

If you are interested in taking part please complete the reply slip enclosed and return in the freepost envelope provided, once we have received your completed slip a researcher shall contact you to arrange a convenient time to meet with you.

If you have any questions about taking part do please get in touch with us on the contact details found on the information sheet.

Thank you for taking the time to consider this invitation

Yours sincerely

Judith Gellatly
Department of Health Research Fellow

PARTICIPANT INFORMATION SHEET
(Health Care Professionals)

Decision-making in Stepped Care

Introduction

Although psychological therapy is provided within primary care, there is a huge disparity between need for services and their availability, leading to lengthy waiting lists and waiting times. More effective and efficient models of psychological therapy delivery need to be considered. Stepped care services (as recommended by NICE) are designed to increase the efficiency of service provision and improve access to psychological therapy. Although stepped care is an important part of current clinical guidelines, little is known about how treatment decisions are made in these new systems. For example, how do health care professionals make decisions about which patients go to each step? What factors determine whether a patient is stepped up? How much are patients involved in the decision-making process?

Researchers at the University of Manchester are interested in looking at how decisions are made within stepped care. They are speaking to a number of health care professionals and patients in order to understand their experiences of decision-making. This research study will be carried out by a researcher as part of a doctoral award.

What will I have to do if I take part?

We will arrange for you to meet a researcher at a time convenient to you, either at your place of work or a mutually convenient place. Our researcher will meet you to ask you some questions about your experiences of decision-making. For example, we will ask how patients are assigned a treatment and how are decisions made about moving patients between steps. The interview will last approximately one hour and with your agreement the answers you give will be tape-recorded.

What are the possible risks of taking part?

Interviews are a common way of finding out about people's experiences, and do not have any known risks. The study is insured by the University of Manchester.

Are there any possible benefits?

The information we get from you will help us gain knowledge about decision-making processes in mental health care and will potentially have an impact on the way decisions are made within the NHS by developing good practice guidelines for deliverers, providers and users in health care.

Do I have to take part?

No, taking part is entirely up to you. If you do not want to take part you will not be asked to give a reason for declining to be interviewed. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. All interviews are given a code, which means that information such as your name is kept separate from your answers. This means that you cannot be identified by audio-tape alone. All information will be securely stored for a maximum of ten years before being destroyed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (please see contact details below). If you remain unhappy and wish to complain formally, you can do this by contacting research governance at the Central Research Office on 0161 2758795 or by email at research-governance@manchester.ac.uk.

What will happen to the results of the research study?

At the end of the study, we will send you and the other health care professionals and patients that took part a brief summary of its results. We hope to use the findings to develop a set of guidelines that will encourage transparent, evidence based and shared decision-making. A report for the Department of Health who have funded the study will also be produced.

In addition we will publicise our findings more widely by means of articles in medical and psychology journals and through presentations at health-related conferences. We will ensure that it is not possible to identify you individually in any reports, papers or presentations that we produce.

What do I do now?

If you wish to take part, please complete the enclosed form and return it to us in the envelope (no stamp required). The researcher organising the study will then contact you.

Thank you very much for taking the time to read this and considering taking part in our research. If you have any questions about taking part do please get in touch with us on the contact details below.

Please feel free to discuss this information with your colleagues.

Judith Gellatly
School of Nursing, Midwifery & Social Work
University of Manchester
Rm 6.338
Block 3 University Place
Oxford Road
Manchester M13 9PL
Tel: 0161 306 7672
Mob: 07904868103
Fax: 0161 306 7707
Email: Judith.l.gellatly@manchester.ac.uk

PARTICIPANT REPLY FORM (HEALTH PROFESSIONALS)

Decision-making in Stepped Care for Common Mental Health Problems

Please complete the following information and return the form in the envelope provided (no stamp required).

Name: …………………………………………………………………………………………

Address:…………………………………………………………………………………………
                  …………………………………………………………………………………………………

Postcode: ……………………………………………………………………………………

		Is it OK to contact you using this information? (Please circle)

Telephone: Home: …………………………   Yes   No

                       Work: …………………………   Yes   No

                       Mobile: …………………………   Yes   No

E-Mail: ………………………………….   Yes   No

If you would prefer to be contacted on certain days/times please indicate here, thank you:

…………………………………………………………………………………………………

THANK YOU VERY MUCH FOR YOUR ASSISTANCE. IF YOU WISH TO DISCUSS ANYTHING WITH A MEMBER OF OUR TEAM, PLEASE CONTACT US USING THE INFORMATION BELOW.

Judith Gellatly
School of Nursing, Midwifery & Social Work, University of Manchester, Rm 6.338 Block 3 University Place, Oxford Road, Manchester M13 9PL.
Tel: 0161 306 7672   Fax: 0161 306 7707   Email: judith.l.gellatly@manchester.ac.uk

Karina Lovell
School of Nursing, Midwifery & Social Work, University of Manchester, Rm 6.322a University Place, Oxford Road, Manchester M13 9PL.
Tel: 0161 306 7853   Fax: 0161 306 7707   Email: karina.lovell@manchester.ac.uk

Peter Bower
NPCRDC, University of Manchester, Williamson Building, Oxford Road, Manchester, M13 9PL
Tel: 0161 275 7638   Fax: 0161 275 7600   Email: peter.bower@manchester.ac.uk

Linda McGowan
School of Nursing, Midwifery & Social Work, University of Manchester, Rm 5.321 University Place, Oxford Road, Manchester M13 9PL.
Tel: 0161 306 7841   Fax: 0161 306 7707   Email: Linda.mcgowan@manchester.ac.uk

APPENDIX FOUR: HEALTH PROFESSIONAL CONSENT FORM

PARTICIPANT CONSENT FORM
(Phase II - Health Care Professionals)

Title of Project: Decision-making in Stepped Care

Name of Researcher: Judith L Gellatly

Please initial box

1. I confirm that I have read and understand the information sheet dated 08/04/08 version 1 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I agree to have my views audio-taped and give permission for research team members to listen to the tape recordings of my views.

4. I agree to direct, anonymous quotations being used in the reporting of the study findings.

5. I agree to take part in the above study.

_____ _____ _____
Name of participant   Date   Signature

_____ _____ _____
Researcher   Date   Signature

APPENDIX 5: PATIENT DEMOGRAPHIC QUESTIONNAIRE

Patient ID ☐☐☐☐

DEMOGRAPHIC INFORMATION

Please complete the following questionnaire as fully as you can.
All of the information collected remains confidential.

1. What is your date of birth?   ☐☐☐☐☐☐
                                      D D M M Y Y

2. Are you: Male ☐   Female ☐

3. How would you describe your ethnic status?

White ☐
Black Caribbean ☐
Black African ☐
Black other ☐
Indian ☐
Pakistani ☐
Bangladeshi ☐
Chinese ☐
Asian ☐
Other (please state) ☐

3. Are you:

single/unmarried ☐
married/co-habiting ☐
divorced/separated ☐
widowed ☐

5. Do you normally live:

alone (with or without children) ☐
with your husband/wife ☐
with a partner ☐
with your parents ☐
with other relatives ☐
Other (please state) ☐

6. How many people live in your home?

No. of adults (aged 18+) ☐
No.of children (under 18) ☐

7. Do you live in

an owner-occupied flat/house ☐
a privately rented flat/house ☐
a flat/house rented from a housing association ☐
local authority etc ☐
Other (please state) ☐

8. What is the highest qualification that you possess?

Degree or equivalent (inc. higher degrees, NVQ level 5) ☐
Higher educational qualification (inc.BTEC, HNC/HND, NVQ level 4, teaching/nursing qualification) ☐
A-level or equivalent (e.g. SEB Highers) ☐
GCSE grades A-C or equivalent (e.g. O Levels; SEB Standard Grades) ☐
GCSE grades D-F or equivalent (e.g. CSEs; SEB Standard Grades) ☐
I have no formal qualifications ☐

9. At the moment, are you:

employed full-time ☐
employed part-time ☐
self-employed ☐
working in voluntary employment ☐
working in sheltered employment ☐
unemployed ☐
a student ☐
a housewife/husband ☐
retired ☐
Other (please state) ☐

10. If employed, what is your occupation? _____

11. Do you own a car   Yes ☐   No ☐

          If yes, how many cars do you own _____

12. Are you currently taking any medication your emotional problem?

                                 Yes ☐   No ☐

          If yes, what is it called (please also state dose) _____

          How long have you been taking them? _____

13. Have you previously taken any medication?   Yes ☐   No. ☐

          If yes, what was it called (please also state dose) _____

          How long did you take them for? _____

14. Are you currently receiving any form of psychological therapy?

                                Yes ☐   No ☐

          If yes, what type of psychological therapy are you receiving?

          How long have you been receiving it? _____

15. Have you received psychological therapy in the past?

                            Yes ☐   No ☐

          If yes, what type of psychological therapy have you received?

          _____

          _____

16. Have you ever had to stay in hospital because of emotional problems?

                              Yes ☐   No ☐

          If yes, when was this? _____

THANK YOU FOR PROVIDING THIS INFORMATION

APPENDIX SIX: PATIENT STUDY RECRUITMENT PACK – INVITATION LETTER, INFORMATION SHEET & REPLY FORM

<div align="right">

Judith Gellatly
Tel: 0161 306 7672
judith.l.gellatly@manchester.ac.uk

</div>

Decision-making in Stepped Care
(Phase II Patients)

We would like to invite you to take part in a study which aims to assist in the understanding of how treatment decisions for people suffering from problems such as anxiety and depression are made within your service. Involvement in the study would involve taking part in a one-off face-to-face interview with a researcher to discuss your experiences.

Enclosed is an information sheet which provides you with further information about the study.

If you are interested in taking part please complete the reply slip enclosed and return in the freepost envelope provided, once we have received your completed slip a researcher shall contact you to arrange a convenient time to meet with you.

If you have any questions about taking part do please get in touch with us on the contact details found on the information sheet.

Thank you for taking the time to consider this invitation.

Yours sincerely

Judith Gellatly

Judith Gellatly
Department of Health Research Fellow

PARTICIPANT INFORMATION SHEET
(Phase II - Patients)

Decision-making in Stepped Care

Introduction

A large number of people suffer from problems such as anxiety and depression and many of these are managed in primary care, however people who are referred for treatment often have to wait a long time due to long waiting lists. Services are looking at better ways to deal with these problems in order to improve the service that patients receive. Health care professionals have to make decisions about what type of treatment is most appropriate, and whether patients require additional treatment after they have received help. However, little is known about how these decisions are made and whether patients are involved in these decisions.

Researchers at the University of Manchester are interested in looking at how decisions are made within mental health care. They are speaking to a number of patients and health care professionals about their experiences of decision-making about treatments in order to examine issues such as choice and preferences. This research study will be carried out by a researcher as part of a doctoral award.

Why have I been chosen?

You have been chosen because we believe that the experiences that you have of your current health problems will have given you valuable insights into how treatment decisions are made and about your involvement in them. We are hoping to involve approximately 50 people, including health care professionals, in order to give us a wider picture of treatment decision-making.

What will I have to do if I take part?

We will arrange for you to meet a researcher at a time convenient to you, either at the doctor's surgery or at your home. Our researcher will meet you to ask you some questions about your experiences of decision-making in health care such as how much do you feel you have participated in decisions made around the treatment that you have received and how much information were you given about the treatment. The interview will last approximately one hour and, with your agreement, the answers you give will be tape-recorded.

What are the possible risks of taking part?

Interviews are a common way of finding out about people's experiences, and do not have any known risks. This study does not involve our taking any samples or specimens from you. It does not involve your taking any new medications or changing your treatment in any way. The study is insured by the University of Manchester

Are there any possible benefits?

The information we get from you will help us gain knowledge about how decisions are made about peoples' treatment in mental health care. By gathering information on this we hope to be able to develop good practice guidelines for deliverers, providers and users in health care.

Do I have to take part?

No, taking part is entirely up to you. If you don't want to take part you will not be asked to give a reason for declining to be interviewed. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not upset your doctor or health worker and your treatment would not be affected in any way, now or in the future.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Your doctor will not be told that you are involved in the study. All interviews are given a code, which means that information such as your name and address is kept separate from your answers. This means that you cannot be identified by audio-tape alone. All information will be securely stored for a maximum of ten years before being destroyed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (please see contact details below). If you remain unhappy and wish to complain formally, you can do this by contacting research governance at the Central Research Office on 0161 2758795 or by email at research-governance@manchester.ac.uk.

What will happen to the results of the research study?

At the end of the study, we will send you and the other health care professionals and patients that took part a brief summary of its results. We hope to use the findings to develop a set of guidelines that will assist with decision-making to improve patient care. A report for the Department of Health who have funded the study will also be produced.

In addition we will publicise our findings more widely by means of articles in medical and psychology journals and through presentations at health-related conferences. We will ensure that it is not possible to identify you individually in any reports, papers or presentations that we produce.

What do I do now?

If you wish to take part, please complete the enclosed form and return it to us in the envelope (no stamp required). The researcher organising the study will then contact you.

Thank you very much for taking the time to read this and considering taking part in our research. If you have any questions about taking part do please get in touch with us on the contact details below.

Please feel free to discuss this information with your family, friends or GP.

Judith Gellatly
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Rm 6.338
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Tel: 0161 306 7672
Mob: 07904868103
Fax: 0161 306 7707
Email: Judith.l.gellatly@manchester.ac.uk

PARTICIPANT REPLY FORM (PATIENTS)

Decision-making in Stepped Care for Common Mental Health Problems

Please complete the following information and return the form in the envelope provided (no stamp required).

Name: …………………………………………………………………………………………

Address:……………………………………………………………………………………

……………………………………………………………………………………………………

Postcode: …………………………………………………………………………………

Is it OK to contact you using this information? (Please circle)

Telephone:	Home: ………………………………	Yes	No
	Work: ………………………………	Yes	No
	Mobile: ………………………………	Yes	No
E-Mail:	……………………………….	Yes	No

If you would prefer to be contacted on certain days/times please indicate here, thank you:

…………………………………………………………………………………………………

THANK YOU VERY MUCH FOR YOUR ASSISTANCE. IF YOU WISH TO DISCUSS ANYTHING WITH A MEMBER OF OUR TEAM, PLEASE CONTACT US USING THE INFORMATION BELOW.

Judith Gellatly
School of Nursing, Midwifery & Social Work, University of Manchester, Rm 6.338 Block 3
University Place, Oxford Road, Manchester M13 9PL.
Tel: 0161 306 7672   Fax: 0161 306 7707   Email: judith.l.gellatly@manchester.ac.uk

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School of Nursing, Midwifery & Social Work, University of Manchester, Rm 6.322a University Place,
Oxford Road, Manchester M13 9PL.
Tel: 0161 306 7853   Fax: 0161 306 7707   Email: karina.lovell@manchester.ac.uk

Peter Bower
NPCRDC, University of Manchester, Williamson Building, Oxford Road, Manchester, M13 9PL
Tel: 0161 275 7638   Fax: 0161 275 7600   Email: peter.bower@manchester.ac.uk

Linda McGowan
School of Nursing, Midwifery & Social Work, University of Manchester, Rm 5.321 University Place,
Oxford Road, Manchester M13 9PL.
Tel: 0161 306 7841   Fax: 0161 306 7707   Email: Linda.mcgowan@manchester.ac.uk

APPENDIX SEVEN: PATIENT CONSENT FORM

PARTICIPANT CONSENT FORM
(Phase II - Patients)

Title of Project: Decision-making in Stepped Care

Name of Researcher: Judith L Gellatly

Please initial box

1. I confirm that I have read and understand the information sheet dated 08/04/08 version 1 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

☐

3. I agree to have my views audio-taped and give permission for research team members to listen to the tape recordings of my views.

☐

4. I agree to direct, anonymous quotations being used in the reporting of the study findings.

☐

5. I agree to take part in the above study.

☐

_____   _____   _____
Name of participant   Date   Signature

_____   _____   _____
Researcher   Date   Signature

APPENDIX EIGHT: HEALTH PROFESSIONAL THEMATIC CHART EXAMPLE

HEALTH PROFESSIONAL THEMATIC CHART NO.1 - NEGOTIATING THE STEPPED CARE MODEL						
	1.1	1.2	1.3	1.4	1.5	1.6
ID Site Job Title Level of Intervention	**Li as frontline service**	**Working at a higher level than Li**	**Patients who don't fit the model**	**Waiting lists**	**Outcome measures**	**Guidelines**
HP01 Site 1 GMHW LI	**1** - Feelings of being 'gatekeepers' of MH services in primary care		**1** - Pt not suitable for LI but also not psychology - symptoms not severe enough and functioning fairly well. **2** - Nowhere for personality disorders to go if not high levels of risk, difficulties not severe enough. 'Huge pool' of people there's not anything for which is difficult **3** - moderate levels of personality disorder only have community options **4** - all different sorts of completely inappropriate people for our service. Get used to kind of working out what you do with people who don't really fit.	**1** - WLs influences discussions about other alternative options e.g. private txs in community **2** - offering more sessions due to concern for Pt having to wait and manage their severe problems. Impacts on 'holding' **3** - having to tell Pts about long wait **4** - Lucky to have free services	**1** - obtaining quantitative data to assess severity **2** - don't play a huge role in the actual decision process	**1** - lack of guidance for 'stepping-up' from LI to psychology **2** - would be helpful for Pts if had a guide to give them about what psychology is and what to expect
HP02 Site1 GMHW LI	**1** - analogy to a war. Being at the frontline. GPs treating LI as triage service. Overcome by number of referrals, unprotected, too much responsibility in comparison to higher	**1** - when taking into consideration Pt factors such as motivation often people who should be 'stepped-up' (OCD) are kept on **2** - decision guided by way Pt presented and was dealing with problem rather than	**1 -** Doesn't fit service model but 'what the hell' but often continue to see people **2** - Wouldn't ever say 'you're not appropriate so I'm not going to see you you're too severe'. No where else to go, just back to the GP so might as	**1** - While waiting Pts can actually recover **2** - increase in referrals impacts upon service WL targets **3** - Strategies to help WLs e.g. assessment at higher levels before adding to WL	**1** - Level of severity on measures does not necessarily influence the decision of whether they are suitable for LI service **2** - have influence on SU **3** - play more of a service requirement role **4** -	

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	workers and challenging as can get 'anybody coming through the door' but can also be an enjoyable learning experience. **2**- Not enough support from the 'people behind you', those behind the frontline. No one containing you	diagnosis **3** - should be seeing Pts with mild-mod scores but generally see Pts who are severe or people with problems such as d&a, should be SU but will normally have a couple of sessions first **4** - identifying something that we can work on in LI, even if presenting with high scores. Introduce ideas, helpful for Pts who hasn't had information before **5** - even if severe if it fits with depression or anxiety can do some work	well see them.	**4** - difficulties discussing WLs with Pts	do not help to make decisions on an individual Pt basis **5** - helpful to determine symptoms but do not capture individual differences	
HP03 Site1 Clin psych HI		**1** - SU criteria most problematic, often know shouldn't be seeing Pts in LI	**1** - High levels of complexity pose problems, no where to go. CMHT generally more about, severe and enduring and risk issues, not about long standing depression and anxiety.	**1** - SC model assists with overcoming access and WL issues **2** - Higher services still have WLs **3** - WLs impact upon care pathway, if HI services not available may be seen in LI **4** - Pt pref is to see the person they can see quickest **5** - Wider service WLs have impact upon DM in SC	**1** - influence SU DM - Pts with higher scores more likely to be SU	**1** - as detached from team need to be aware of team policy and seek out advice if unsure about anything **2** - Taking into consideration NICE guidance when amending service limits
HP04 Site1 GP				**1** - Where Pts clearly don't fit LI then WL doesn't not have such an impact upon the decision made - Pts just have to wait **2** - WLs improving **3** - Pts referred for LI and HI at same time		
HP05 Site1 Clin psych HI				**1** - Pts reaching top of WL still having same problems as when put on WL. Impact upon potential to improve **2** - Service strategies to overcome WL problems - titrating referrals **3** - Pts at top of WL may not		

				need same level of intervention anymore but HPs unlikely to SD as they have waited - tailor intervention to Pt need		
HP06 Site1 GMHW LI		**1** - IAPT not fully implemented so LI seeing everybody. Severity not taken into account **2** - a lot of Pts are severe, doesn't play a large part on DM. Mild Pts in the minority		**1** - Service isn't supposed to have WLs - impacting upon access etc **2** - Service strategies - deciding when Pts can be referred straight on before assessment in LI **3** - decision made influenced by how long Pts are going to have to wait, more likely to SU if shorter wait	**1** - don't often reflect the way that the Pt is presenting **2** - use measures to a certain extent to make decisions but with level of caution alomgside how Pt presents **3** - Important factors in identifying risk issues and subsequent DM **4** - danger of being overused, too much DM made on the basis of OMs alone **5** - Service requirement - seeing things in more of an 'economic' way **6** - Consideration of Pt factors such as ethnicity - some Pts scoring high because of the way that their culture views MH **7** - if decision based on OMs alone would often make the wrong choice	
HP07 Site1 GMHW LI		**1** - 'ultimately you're not for providing the level of intervention that's recommended by NICE' so it can be quite difficult. Always option of SU, have support from GP.	**1** - Scores too low, not in clinical range, so difficulty in SU. Need to think of alternatives for Pt		**1** - severe in one measure does not mean that Pt will meet clinical range for any others	
HP08 Site1 GMHW LI	**1** - A lot of role spent gate-keeping as higher services see LI as more appropriate. 'Stepping-up' role in managing Pts **2** - pressure from GPs to see people that are not suitable for LI service and need 'stepping-up' straight away. Part of role is thereofres to determining			**1** - more likely to step up if shorter WL - continuity of care **2** - Pt motivation - if willing to do something immediately often best to provide with LI of long waiting time	**1** - High scores make SU or seeking advice from supervision more likely	

	best place for Pt					
HP09 Site1 Clin psych/HI trainee HI		**1** - sometimes providing LI interventions for Pts who have diagnoses - OCD - who should generally be seen at a higher level	**1** - Need to be specific about who we should see but its difficult. People who 'slip through the net'. Pt prefs do not match service model **2** - if we don't see them they won't see anyone due to context of problem (bereavement) rather than clinical presentation **3** - perhaps need to 'tighten our doors' but people fall through the net who need help and make use of it if they get it **4** - if we did tighten up so strictly that we only took on clear diagnoses, we wouldn't see anybody!		**1** - Scores can be zero but can often reflect under-reporting by Pt **2** - Influence at initial assessment but often accompanied by a discrepancy between what Pts are saying and what they are reporting **3** - use to target certain problems **4** - service requirement - 'another one of those things you've just got to damn fill in before they can jump through the hoop' **5** - Need to consider Pts on a case-by-case basis, not just on OM scores alone	
HP10 Site1 GP			**1** - issues with other services (CAHMS) not agreeing with decisions **2** - often urgent need for psychological input but issues as for adult service you have to be suicidal, in which case you're urgent, or you wait **3** - people crossing boundaries. Difficult to fit into anyone's priority group even though a concern **4** - Sometimes Pts consume a vast amount of service's time but can have positive outcomes	**1** - urgency of Pt need of psychological input influences DM when WL **2** - lag btwn assessment and delivery - if short sometimes not worth starting anything but Pts can often lose momentum **3** - IAPT hopefully will overcome overwhelmed service **4** - long WLs mean Pts are hard to contain **5** - WLs don't change decision about what Pts need but need to be able to explain to Pt	**1** - OMs have their place e.g. PHQ OK for AD tx but not for psych tx. **2** - service requirement issues **3** - doesn't really measure what want to understand e.g. distress	
HP11 Site2 CBT trainee HI	**1** - Role in LI to provide emotional grounding as often Pts first experience in MH	**1** - realised that a lot of the work doing in 30mins was actually HI work **2** - Probably working with people at a higher level than role title. Lack of clarity. Pt was classed as getting LI but was actually receiving much higher level tx **3** - had previous experience of working with more severe/complex cases. As		**1** - if Pts are managing sometimes better not to give them anything whilst waiting, Pt pref	**1** - High scores have implications as to whether a Pt will engage **2** - Scores obtained don't always reflect exact nature of problem	**1** - lack of guidance for LI and HI. Different to other services e.g. clin psych. 'Appalling, a huge error and dangerous' - LI less experienced, need guidelines for learning and Pt safety **2** - guidance suggests functioning must be impacted upon **3** - wouldn't 'step-down' as Pts shouldn't be at higher level than needed **4** -

		confident as a LI worker was capable of working higher so did **4** - support from managers and supervisors to work at high level. Boundaries btwn levels lost **5** - need to respect LI workers for ability to work at higher level. Can move people on faster than if 'holding' them cause of LI role **6** - Often working not outside but beyond remit as GMHW. manager actually encouraging to push training and learning **7** - start at lowest level even if not sure but be transparent with self and Pt				development of service leaflet which will help to improve decisions
HP12 Site2 Clinical team leader HI				decisions to refer, need to discuss WL with Pt, some lose heart and say don't bother	**1** - useful for checking symptoms **2** - sometimes 'entirely sufficient in their own right' but other occasions where additional information needs to be taken into account **3** - Pts can report feeling better even when scores have not changed **4** - From a service perspective scores do not help to infer where a Pt will 'end-up'	
HP13 Site2 CBT therapist HI				**1** - WLs impact upon Pt preferences for services - can't acces what they want in reasonable time. **2** - HP offering alternative options in community **3** - Need to be honest with Pts to allow them to have a picture of what's happening to make an informed decision, provide them with options **4** - when risk prevalent HPs have dilemmas about putting	**1** - used as a way of monitoring Pts symptoms over time	

				on WLs		
HP14 Site2 GMHW LI			**1** - Sig problems refering to CMHT - often keeping on Pts who are too severe and have risk issues as CMHT don't see them as approp for their service. Pts getting bounced back and forth **2** - Complex Pt presentations that do not fit the model, difficult to decide what to do **3** - where services aren't available (e.g. HI) tols to refer on but no point as Pt will just wait forever	**1** - Pts sometimes not willing to wait so need to think of alternative options **2** - HPs 'hold' Pts when WLs for appropriate service	**1** - high scores have indications that LI is not suitable **2** - assist on comfirming level of Pt symptoms	**1** - CBT model had good guidelines for managing different problems
HP15 Site2 CBT therapist HI			**1** - when Pts problems are realted to their environment they often don't fit **2** - when complicated inter-presonal issues most services don't know what to do	**1** - Aim to keep WL short as PC services will end up like psychology **2** - Pts shouldn't really have to wait **3** - More impact of WLs at step 2 or part-way through therapy. Not many places to refer when in step 3 **4** - More likely to refer to voluntary services than psychology due to WL **5** - decision of where to refer to sometimes influenced by who has shorter WL e.g. psych or counselling but not if wholly inapprop	**1** - Measures have little influence over whether to take a Pt on as don't capture what Pt is suffering from **2** - Useful for monitoring of progress, if not changed then indications that tx is not working and therefore may SU	
HP16 Site2 GP			**1** - when Pt not engaging with what's on offer refer to other services but they don't always agree and reject referral so PC stuck **2** - Pts end up 'going round in circles', get stuck in 'limbo', left struggling end up getting tx at LI **3** - services too strict and structured as to what they can offer and seem unable to 'bend' the rules for individuals **4** - Pts sometimes offered tx		**1** - Matching level of symptoms to tx **2** - Issues at GP level about inconsistency in recording btwn different GPs **3** - OMs viewed as a service requirement - QOF. More of an admin tool **4** - Lots of mis-coding and register of scores doesn't reflect what's going on **5** - Useful for agenda setting and monitoring Pt progress	**1** - issues when some GPs are following guidance and others arent - no consistency in Pt tx **2** - when making decisions guidelines are taken into account

			but don't engage or respond and end up getting nowhere **6** - often aware at point of referral that the Pt will be rejected but need to try **7** - take on board what other services say but need to keep in mind Pts needs and sometimes negotiate **8** - need to be honest with Pt when explaining why not being taken on in other services			
HP17 Site3 GP		**1** - It's frustrating, not set up to deal with Pts who don't fulfill criteria. Taking on other people's work cause of access issues	**1** - Frustration caused as having to accept Pts who don't fit the criteria	**1** - Tx decision to refer to HI likely to be changed to LI if WL e.g. to LI if CBT has long WL	**1** - help to identify any elements of risk **2** - Provides guidance but not all judgement is based on, need clinical interpretation **3** - Score can be high by Pt doesn't objectively present in that way	**1** - guidance suggests that atypical grief reactions need specialist counselling. Try as far as possible not to prescribe ADs until later **2** - local guidance suggests high severity - HI, but guidance not always followed if WLs
HP18 Site3 Gateway worker LI		**1** - Its stressful, various Pts - severe with lots going on but beneficial to see rather than just mild to moderate in terms of job prospects **2** - when had training in more complex things start to work at a higher level but have to 'pull self back' to remembering its LI			**1** - Scores alone aren't sufficient, have to use own instinct **2** - Good for monitoring change over time **3** - Time Pts are given then can impact upon scores e.g. if at beginning of tx Pt may be extremely anxious	
HP19 Site3 GMHW LI			**1** - Try and be as inclusive as possible but sometimes people just don't suit the way we work		**1** - Use as a guide, sometimes scores can be horrifying so need to be balanced out by what the Pt is saying **2** - 'If OMs were all that was taken into consideration we wouldn't bother assessing people, just get them to fill out a form' **3** - use to highlight progress to Pt	**1** - making decisions would be easier if guidance existed, rather than having to 'unravell and pick pieces together'
HP20 Site3 MH service lead LI	**1** - LI workers on 'front-desk' of service. Specialists behind to support the quite inexperienced	**1** - Emphasis progressed - Pt wanted to reflect on things. Did some work on PTSD, tried to apply it to LI	**1** - Things that are potentially achievable. Things that service isn't set up to provide - difficulties and problems that		**1** - useful for monitoring Pts progress over time **2** - Service benefits as help to monitor individual workers	

			people encounter in that nobody anywhere's likely to be able to do anything about.		practice, helps to make sure they aren't 'holding' all the burden **3** - 'OMs are not deterministic, what they can do is help - the're part of the jigsaw'	
21 NW GMHW LI			**1** - Often seeing Pts for too long - can get to the point when there's nothing else to offer **2** - Severity often not high enough for CMHT, thefore often faced with complex cases. Where d&a is an issue sometimes people don't want to address it so not really anything can do for them.		**1** - Scores do not always reflect the way the Pt is presenting **2** - can be helpful in leading a discussion about the problems the Pt is experiencing	
HP22 Site3 GP			**1** - Other services trying to get rid of Pts, now left doing not much apart from being nice **2** - Start to run out of options and end up doing things outwith job role e.g. contacting housing association **3** - Difficulties when other services do not match your line of thinking **4** - Some people are not helpable, they still turn up and can't do anything more for them. GPs unable to discharge Pts **5** - Sometimes referring people so you are doing something even though you know they will be sent back - playing 'ping pong' **6** - Pt preference sometimes doesn't match services **7** - 'hitting brick walls', nothing more can do so Pts just have to muddle along	**1** - Inability to follow NICE guidance due to WL, have to think of alternatives e.g. managing with ADs **2** - if referring all appropriate Pts to psych then WL would increase substantially so needs to be rationed - identifying Pts most difficult to deal with e.g. PTSD or phobias **3** - Fail to refer people because just not an option **4** - Pts needs not being met as WL long	**1** - 'easy to get someone into a score you would like' to refer on **2** - Helpful when the opinion of the HP does not match the Pts, but over-reporting often occurs **3** - Over-reliance on Oms can mean the most appropriate decisions are made as the HP may not know the Pt well-enough to judge what they need **4** - the way that questions are worded can impact on responses given **5** - Need to be pragmatic about how information is used	**1** - NICE guidance is 'pretty hopeless'. Often not applicable when WLs for services **2** - Following NICE would increase referrals and WLs so need to ration based on need/diagnosis **3** - Guidance overruled on occassion by personal preference (HP) **4** - Resorting back to way of working before NICE **5** - NICE in ideal world but resources not available **6** - Impact of NICE - reduction in AD prescribing **7** - NICE guidelines are imposed on some GPs **8** - Idiosyncratic nature of GP referrals, some more liberal than others, not limited to MH just GP nature
HP23 Site3 Gateway worker	**1** - LI are the 'first point of call' for Pts - role to decide about whether 'stepping-up' is required				**1** - useful for monitoring Pts progress over time e.g. fluctuations (for HP and Pt) **2** - useful for identifying how	

LI					Pt is feeling **3** - A high score alone will not be the justification for a referral decision	
HP24 Site3 GMHW LI			**1** - Pts don't neatly fit into service's boxes and end up in innapropriate services		**1** - Can help to identify underlying problems not disclosed by Pt **2** - Level of severity imfluences treatment decisions	

APPENDIX NINE: PATIENT THEMATIC CHART EXAMPLE

PATIENT THEMATIC CHART NO.1 - EXPRESSED NEEDS AND EXPECTATIONS			
	1.1	1.2	1.3
ID Gender Level of Interventions received	**Individual Patient Needs**	**Patient Expectations**	**Information Provision**
Patient 01 Male Steps 2 & 3	**1** - Being referred for therapy does not mean recovery, may also need additional help/support. Need to consider the individual patient in making these decisions. As an individual 'only going to get out what you are putting in' **2** - Treatment has to be pitched at right intensity/level for the individual. Factors such as age and people's perceptions may influence this.	**1** - Uncertainty about what to expect **2** - Unsure what was wrong. Could identify symptoms **3** - Have own ideas about what want to gain but unsure if the treatment will focus on that **4** - Thought would be focusing on whole experience - starting at the beginning **5** - If suffering from mental health problems, expect an immediate response to ensure don't get worse and won't need help for such a long time if delayed. Expected the PCT would be the place to get that	**1** - need to be given the right amount of information - different for different patients at different times **2** - Information provided with was good, well gauged, not too simple. Good for starting to think about things. Paperwork
Patient02 Female Steps 2 & 3	**1** - Need to know someone would see me and would tailor any intervention to meet my individual needs **2** - Individuals need to be sensitively diagnosed to ensure the service you receive is matched to your own needs. Undermining if not receiving right treatment **3** - Need assurance that your needs will be readily recognised. Need to know where can get help and that it can be quickly accessed **4** - Need to have someone to talk to and be reassured by them. Service needs to be responsive and identify that I may need that. Need assurance this would happen quickly		**1** - Lacked information about how to get help that needed **2** - Not provided with information, had to seek it out. Need information about treatments, given choices to see if suitable or can accessible **3** - GPs should have information readily available **4** - Information has to be positively presented so it is comfortable and reassuring
Patient03 Female Steps 2 & 3	**1** - If in crisis need individualised work. Useful to talk about the specific problems expereincing. Some CBT formula is useful but need more than just that	**1** - Didn't expect a recovery **2** - Negative expectations and outcomes of assessment	**1** - Lack of information provision about serivce. Information provided by friends rather than health service **2** - Given little information bar that about the service receiving treatment from **3** - Not enough done in NHS to provide people who need the information with it. Talk about it e.g. public involvement/engagement but don't act

			on it **4** - Awareness ofthe limitations of GP knowledge **5** - Internet information sources can be poor
Patient04 Female Step 2	**1** - In comparison to me some people have more severe depression. Important to get the right level of help **2** - Important to have insight into problem. Some people think that is just how they should feel **3** - Want someone to actually make suggestions about what I could try, not just someone listening	**1** - Expected more that what I got but 'it didn't really teach me anything'. **2** - All treatments should be made accessible for everyone **3** - Uncertain about what a 'good therapy' is, if knew that 'probably would have done it' **4** - HPs should offer a number of 'alternatives in the bag'	**1** - Got information but could always do with more
Patient05 Male Steps 2 & 3		**1** - Had no idea what to expect as no contact with psychologist previously **2** - Expectations of way treatment is delivered that don't necessarily follow what will be delivered **3** - Uncertain expectations as never experiences mental health problem before **4** - If not focusing on what need to then expect outcome would be poor	
Patient06 Male Steps 2 & 3	**1** - Importance of treatment level being pitched right. If intensity too high may have negative impact upon mental health state. Importance of own preferences being acknowledged		**1** - Low intensity worker explained what was happening when was referred and gave the psychologist information about me
Patient07 Female Steps 2 & 3	**1** - When making treatment decisions need to consider how things will fit into person's life **2** - Nice to have someone to talk to. Some people may find it even more helpful. Good to have someone that understands problems experiencing **3** - Just talking can be of benefit, naturally curious. These needs can be met through group work	**1** - Direction important, not allowed another solution **2** - Unsure of who being referred to - their role. Thought it would be like therapy **3** - What got was not what was expected, but helpful	**1** - Expectations of health professionals. Need to have readily available information e.g. leaflets for all problems **2** - Low intensity worker went through lots of information about different groups (signposting). **3** - Satisfied with amount of information **4** - Information e.g. leaflets help to relieve stress **5** - If have to look for information on own get 'lost' and just stop so helpful someone else is providing it
Patient08 Female Steps 2 & 3	**1** - Degree of mental health issue and additional problems such as drug and alcohol use need consideration as may influence the type of service needed **2** - Referrer needs to recognise individual aspects of the person's problem in order to identify correct level of intervention required	**1** - To talk to someone regularly	**1** - Satisfied with information given **2** - Mainly verbal in nature
Patient09 Female Step 2		**1** - More complex than anticipated **2** - Expect service to assist with coping and feeling more calm	
Patient10	**1** - Good to talk to someone out with the family,	**1** - Never 'been under one' so didn't know what	**1** - GP not providing enough information about

Female Step 2	put less stress on them **2** - Great need to speak to someone	to expect **2** - Expected to get more sessions **3** - If experiencing problems expect to get some help	where being referred to
Patient11 Male Steps 2 & 3		**1** - Didn't know what to expect. Just happy to speak to someone **2** - Assumed it was about talking about how you feel - not what imagined but let health professional drive treatment	**1** - Full explanations given
Patient12 Female Step 2	**1** - Expecting something more practical, what received didn't really work. Important to respect background of each individual **2** - Everyone needs something different, everyone has a different cause, different backgrounds. People experience things differently and have different symptoms so not everything will work in the same way for everyone **3** - Individual discussion about own background etc important as it is personal rather than general	**1** - Expected something more practical for my life, more personal **2** - Expectations of medications related to own beliefs	**1** - Lack of information provided to base decisions on **2** - Lack of information at outset=lack of understanding about what was choosing **3** - GPs should have information available e.g. booklets, about different options to enable informed choices to be made **4** - Focus of information on specific problems may be experiencing e.g. problems at work
Patient13 Female Step 2		**1** - Expected help until didn't need it any more **2** - Higher expectations of CBT in comparison to 'shrink-thing' **3** - Expectations of professionals/service to monitor medication not met **4** - Treatment received did not offer help that was expected **5** - Unexpected focus on CCBT programme rather than on self **6** - If identify problem and seek out help expect that would get help needed but not necessarily the case	
Patient14 Female Step 2		**1** - Expected treatment to be like counselling - but not like treatment	**1** - Informed about what was going to happen before attended appointment, information in post adequate **2** - Need to think more about how information about options are presented, particularly when not all are readily available

APPENDIX TEN: SCENARIOS USED FOR PILOT

THINK-ALOUD VIGNETTE 1
A 24 year old African male attends an appointment with you following a referral from his GP. He denies having an alcohol problem although he binge drinks every weekend with his friends. This has resulted in a number of serious fights and more recently he has assaulted his long-term partner. He feels angry a lot of the time and regrets the way that he acts when he feels like this as he does not understand why he does it. He wants help as his partner has told him she will leave him if he doesn't sort himself out.
Although there is no indication of risk to himself there is to others.
He refuses to complete an outcome measure on the grounds that it 'won't tell you anything'.

AIS SCENARIO 1
A 24 year old African male attends an appointment with you following a referral from his GP. He denies having an alcohol problem although he binge drinks every weekend with his friends. This has resulted in a number of serious fights and more recently he has assaulted his long-term partner.

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THINK-ALOUD VIGNETTE 2
A 65 year old male comes to see you following a referral from his GP. He describes feelings of lack of motivation, low mood and poor sleeping and eating patterns. He has recently retired from a demanding job in the fire service and feels like he has lost his self identity. His wife and all his friends are still working and therefore he spends most days on his own. He has never had thoughts of ending his life but often feels that life is not worth living. Due to the way that he is feeling he has noticed that his relationship with his wife is suffering but he says that it is very difficult to talk to her about the way he is feeling. He doesn't know what he can do to make himself feel better.
Following assessment using an outcome measure it is indicated that he is suffering from mild depression.

AIS SCENARIO 2
A 65 year old male comes to see you following a referral from his GP. He describes feelings of lack of motivation, low mood and poor sleeping and eating patterns.

THINK-ALOUD VIGNETTE 3

A 36 year old female attends an appointment with you who says she is suffering from stress, particularly in social situations. She describes how these feelings started six months ago following an incident when she was attacked and raped by someone that she had just met at a friend's party. She complains of feeling permanently anxious and describes physical sensations of knots in her stomach, sweating and feeling panicked all of the time. She is frightened to leave her home for fear that she will be attacked and has only managed to come today because her mum brought her. On one occasion she made plans to kill herself by overdosing on paracetamol but in the end she couldn't go through with it. She doesn't want to be of any bother but she doesn't know what she can do.

Following assessment using an outcome measure it is indicated that he is suffering from severe anxiety.

AIS ACENARIO 3

A 36 year old female attends an appointment with you who says she is suffering from stress, particularly being in social situations. She describes how these feelings started six months ago following an incident when she was attacked and raped.

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THINK-ALOUD VIGNETTE 4

You have diagnosed depression in a 44 year old Asian man, who works as an administrator in a local authority sports centre. He lives with his wife and two young children in a nearby council house. When he comes to see you he is tearful and when asked describes feelings of worthlessness. On enquiry, you elicit the following symptoms: persistent mood of sadness and a tendency to wake up briefly in the middle of the night for the past five weeks. His appetite is poorer than usual, although he has not lost weight. He denies early morning waking or mood fluctuations. His concentration is not disturbed and he is not lethargic. He denies any suicidal thoughts. There is no past history of self-harm. He says the way he is feeling is due to a recent dispute at work which has resulted in him being suspended, pending an internal enquiry. He feels lost without his work, but also says he feels he has been done an injustice and is resentful about the way he has been treated. He is finding it extremely difficult to adjust to staying at home all day and is particularly aware of his irritability when around his family, and mentions how guilty this makes him feel.

Following assessment using an outcome measure it is indicated that he is suffering from moderate depression.

AIS SCENARIO 4

You have diagnosed depression in a 44 year old Asian man, who works as an administrator in a local authority sports centre. He lives with his wife and two young children in a nearby council house. When he comes to see you he is tearful and when asked describes feelings of worthlessness.

THINK-ALOUDVIGNETTE **5**

A 54 year old female comes to see you. She is tearful and describes feelings of despair. Her mother has been suffering from Alzheimer's disease for the past three years but over the past few months it has gotten much worse. She cares for her 24 hours a day and although she says she usually manages okay she has started to 'drive her mad', so mad that she feels that she is very close to hitting her. She feels really guilty for feeling like this as she knows that it is not her mum's fault but that things are so difficult. She is divorced and her only close family is her teenage daughter who has taken a gap year in America. She feels very lonely and doesn't feel that she can cope much longer. She is fearful what she may do if things don't get any better. She suffered from depression three years ago when her mum was first diagnosed and at the time was given antidepressants which she reluctantly took for three months but claims that they 'did her no good'. She is not at risk of self harm, but is very distressed.

Following assessment using an outcome measure it is indicated that she is suffering from mild depression.

AIS SCENARIO 5

A 54 year old female comes to see you. She is tearful and describes feelings of despair. Her mother has been suffering from Alzheimer's disease. She feels very lonely and doesn't feel that she can cope much longer. She is fearful what she may do if things don't get any better.

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THINK-ALOUD VIGNETTE 6

A 72 year old female comes to see you. She has been suffering from post traumatic stress disorder since being involved in a car crash three months ago in which her husband died. She constantly experiences intrusive memories, bad dreams and flashbacks of the event and additionally experiences physiological stress reminders of the event such as pounding heart, sweating, muscle tension and rapid breathing. Sometimes these symptoms appear because they are triggered by something that reminds her of the event but often they appear out of the blue. She has difficulty sleeping and concentrating, is hyper-vigilant and feels 'emotionally numb and hopeless'. She is extremely frightened of driving a car and hasn't done so since the accident and avoids conversations, feelings or going places that may remind her of the crash. She misses her husband terribly and although the accident was not her fault, as she was driving she blames herself and feels guilty all of the time. She doesn't want her children to know she isn't coping. She recently attempted to commit suicide but was found by a neighbour. She has current thoughts and plans to try again.

Following assessment using an outcome measure it is indicated that she is suffering from severe symptoms.

AIS SCENARIO 6

A 72 year old female who been suffering from post traumatic stress disorder since being involved in a car crash three months ago in which her husband of 53 years died has come to see you. She constantly experiences intrusive memories, bad dreams and flashbacks of the event and additionally experiences physiological stress reminders of the event.

THINK-ALOUD VIGNETTE 7

A 21 year old male who has been suffering from feelings of anxiety and nervousness since he was eight comes to see you. These episodes have become more severe over the past four weeks and he feels that he is unable to get on with his everyday life. When in social situations these feelings are exacerbated and during these times he gets feelings that his heart is racing, he blushes, feels shaky and sweats a considerable amount. He also feels frightened and on edge most of the time. He has been experiencing some loss of hair and says that this makes him feel even worse and self-conscious. He completed a university degree last year but said that during his final year he often experienced heightened levels of anxiety when he was required to do a presentation in front of the class. He has recently lost his job as an IT teaching assistant, and this has further exacerbated his lack of confidence. Only at times when he is with his immediate family, his girlfriend or very close friends does he feel a little more at ease. He wants to get help to enable himself to overcome these problems and to be able to start working again. He has never thought about or attempted to commit suicide.

Following assessment using an outcome measure it is indicated that he is suffering from mild anxiety.

AIS SCENARIO 7

A 21 year old male who has been suffering from feelings of anxiety and nervousness since his time at infant school comes to see you. These episodes have become more severe over the past four weeks and he feels that he is unable to get on with his everyday life.

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THINK-ALOUD VIGNETTE 8

A 42 year old mother of two children presents with a twenty year history of obsessions and compulsions. She describes how she engages in extensive checking behaviour which occupies a large amount of each day. More recently this has started to significantly interfere with her life. In her twenties she was treated successfully by a psychologist but she says that things are much worse now. Whenever she leaves her house, and before she goes to bed at night, she is plagued with doubts that she has switched off electrical appliances and locked the doors and windows. This checking is performed in a ritualised manner because over the years the doubt that she has turned things off properly has gradually strengthened, and now just looking at things is not enough she must check them six times before leaving the house. She is terrified that if something was left on accidentally, there could be a fire and something terrible might happen to her two children who still live with her. Getting out of the house can take up to an hour, and the rituals leave her feeling anxious and exhausted. She is constantly running late and was recently asked to resign from her job in a post office as a result of her frequent lateness. She has indicated signs of being suicidal in the past and tried to cut herself recently. She would like some help as she hates how these problems are affecting her daily and working life. She thinks that she needs to do more than just talk about her problems.

Following assessment using an outcome measure it is indicated that he is suffering from moderate symptoms.

AIS SCENARIO 8

A 42 year old mother of two children presents with a twenty year history of obsessions and compulsions. More recently this has started to significantly interfere with her life.

THINK-ALOUD VIGNETTE 9

A 28 year old Chinese female attends an appointment. She has suffered from panic attacks, poor impulse control and occasional self-harm, although she has never attempted suicide. There are indications that she may also be abusing drugs and alcohol. She has a history of sexual abuse and violence from male family members which started when she was nine years old. She has always found it difficult to get close to people but has recently started a relationship. She is, however, finding it hard to cope with the demands of the relationship and wonders whether there may be something physically wrong with her. Although she feels in control most of the time her panic attacks are getting much worse, are often triggered by 'nothing in particular' and she finds it extremely difficult to control them. She wants to 'feel normal' again.

Following assessment using an outcome measure it is indicated that he is suffering from severe symptoms.

AIS SCENARIO 9

A 28 year old Chinese female attends an appointment. She has suffered from panic attacks, poor impulse control and occasional self-harm. There are indications that she may also be abusing drugs and alcohol.

APPENDIX ELEVEN: RESPONSES FOR QUESTIONS ASKED IN AIS THINK-ALOUD TASK

AIS1

A 65 year old male who you have been seeing once a month for eight weeks attends an appointment. He has made no significant improvements over the two months and still describes feelings of lack of motivation, low mood and poor sleeping and eating patterns.

Responses to potential questions:
As above:
Age: 65
Gender: Male
Problem type: Depression
Symptoms
Behavioural **-** lack of motivation, low mood and poor sleeping and eating patterns
Treatment length: 8 weeks
Outcome – no significant improvements

Additional Questions:
Possible cause/trigger: He retired from a demanding job in the fire service
Additional symptoms:
Cognitive - he feels like he has lost his self identity
Length of problem: 6 months
Severity: using an outcome measure – mild depression
Risk: He has never had thoughts of ending his life but often feels that life is not worth living.
Previous episodes/ Past history: was prescribed ADs from his GP 4 months ago when he first presented in primary care. he is still taking them
Outcome – he says that they help him get up in the morning but doesn't feel that the benefits are substantial
Patient needs/expectations: doesn't know what he can do to make himself better
Patient preferences: he would like to see someone who can help him to get motivated again
Social circumstances: His wife and all his friends are still working and therefore he spends most days on his own.
Social support: Due to the way that he is feeling he has noticed that his relationship with his wife is suffering. She is extremely supportive but he says that it is very difficult to talk to her about the way he is feeling as he doesn't want to burden her with his problems.
Personality: Appears agreeable and cooperative
Substance abuse: he has noticed that he is drinking alcohol much more than he used to.
Medicine: Antidepressants
Length of time – 4 months

> *AIS2*
> A 36 year old female attends an appointment with you following a referral from her GP. She says she is suffering from stress, particularly being in social situations. She describes how these feelings started six months ago following an incident when she was attacked and raped.

Responses to potential questions:
As above:
Age: 36
Gender: Female
Likely diagnosis: Anxiety
Symptoms:
Physical **-** stress in social situations
Possible cause/trigger: incident when she was attacked and raped
Length of problem: 6 months

Additional Questions:
Additional symptoms:
Physical - knots in her stomach, sweating and feeling panicked all of the time
Behavioural – frightened to leave her home
Cognitive – permanently anxious, fears that she will be attacked
Symptoms worst in social situations
Severity: using an outcome measure – severe anxiety
Risk: On one occasion she made plans to kill herself by overdosing on paracetamol but in the end she couldn't go through with it. She still thinks about ending her life and how she would do it but doesn't think that she would 'have the guts to do it'
Previous episodes/ Past history: none
Patient needs/expectations: wants someone to help her 'feel like she used to'
Patient preferences: Would like to be involved in possible treatment decisions and wants to be told what the options are for her
Social circumstances: spends very little time with her friends
Social support: has a supportive mother and a few close friends that know of her problems
Personality: Although clearly distressed shows signs of conscientiousness and self-discipline
Substance abuse: She has noticed that on rare occasions where she meets up with some friends that she drinks much more than she used to, particularly before going out. She denies taking any drugs
Medication: she was prescribed antidepressants 3 months ago but couldn't stand the side effects they gave her so she stopped taking them

Responses to potential questions:
As above:
Age: 44
Gender: Male
Ethnicity: Asian
Likely diagnosis: Depression
Symptoms:
Physical - tearful
Cognitive – worthlessness
Social Circumstances: lives with his wife and two young children in council house

Additional Questions:
Possible cause/trigger: recent dispute at work which has resulted in him becoming the subject of a complaint from a colleague, because of her attitude towards her. He has been suspended pending an inquiry.
Additional symptoms:
Behavioural – tendency to wake up in the middle of the night (5weeks), poorer appetite than usual (no loss of weight), finds it difficult staying at home
Cognitive – persistent mood of sadness, feels resentful, irritable and guilty for being like this around his family
DENIES morning waking or mood fluctuations; disturbance of concentration or feeling of lethargy
Length of problem: 8 weeks
Severity: using an outcome measure – moderate depression
Risk: He denies any suicidal thoughts. There is no past history of self harm
Previous episodes/Past history: none
Patient needs/expectations: doesn't think that there is anything that will help him
Patient preferences: wants you to choose the treatment that is 'best for him'
Social circumstances: lives with wife and three children
Social support: although his wife is supportive she doesn't really understand his problems and as she works full-time and looks after the children she doesn't have much time for him
Personality: Appears emotionally unstable and shows signs of antagonism
Substance abuse: he does not drink alcohol or take drugs
Medication: last week his GP suggested that he may benefit from some antidepressants but he doesn't think that medication is for him

> *AIS4*
> A 42 year old mother of two children with a twenty year history of obsessions and compulsions who you have been seeing for 6 weeks attends an appointment. She originally showed signs of improvement, however more recently her problems have gone back to the way they were when you first started seeing her. They are significantly interfering with her life.

Responses to potential questions:
As above:
Age: 42
Gender: Female
Likely diagnosis: OCD
Symptoms:
Cognitive – obsessions and compulsions
Behavioural – significantly interfering with her life
Treatment length: 6 weeks
Outcome – was improving but now back to the way she was

Additional Questions:
Possible cause/trigger: unknown but recently she has constantly been running late and was recently asked to resign from her job in a post office as a result of her frequent lateness (since the start of tx)
Additional symptoms:
Behavioural – engages in extensive checking behaviour which occupies a large amount of each day. Things are much worse now, just looking at things is not enough she must check them six times before leaving the house. Getting out of the house can take up to an hour
Cognitive – Whenever she leaves her house, and before she goes to bed at night, she is plagued with doubts that she has switched off electrical appliances and locked the doors and windows. Over the years the doubts have strengthened. Terrified that if something was left on accidentally, there could be a fire and something terrible might happen to her two children who still live with her. The rituals leave her feeling anxious and exhausted
Signs of improvement: reduction in amount of times checking things. Better overall feeling of life, stopped self-harming
Length of problem: 20 years
Severity: using an outcome measure - moderate symptoms
Risk: She has indicated signs of being suicidal in the past and self-harmed on a regular basis. She tried to cut herself recently.
Previous episodes/Past history: ongoing since her early 20s
Previous treatment: numerous over past 20 years
1. Course of SSRIs for about 3 years
Outcome – helped a bit (but still had OCD) 2. Some counselling via GP practice
Outcome - some help to sort out issues in her life but did not change OCD 3. Referral to a psychiatrist – diagnosed with OCD – prescribed SSRIs again
Outcome - took some help for a few months but then symptoms worsened
Patient needs/expectations: She would like some help as she hates how these problems are affecting her daily and working life.
Patient preferences: She thinks that she needs to do more than just talk
Social circumstances: mother of two children (10 and 12), both live with her. Has been divorced for 5 years

Social support: Feels isolated as much of her time as most of her time is spent with her children. Very rarely talks to or does anything with friends or family.
Personality: appears vulnerable and pre-occupied
Substance abuse: she denies abusing drugs or alcohol
Medication: she has taken Prozac on and off for the past 15 years. She has been taking it consistently for the past 3 weeks.

> *AIS5*
> A 28 year old Chinese female attends an appointment. She has suffered from panic attacks, poor impulse control and occasional self-harm. There are indications that she may also be abusing drugs and alcohol.

Responses to potential questions:
As above:
Age: 28
Gender: Female
Ethnicity: Chinese
Likely diagnosis: Panic attacks
Symptoms:
Cognitive – panic attacks
Behavioural – poor impulse control, self harm, abusing drugs and alcohol

Additional Questions:
Possible cause/trigger: She has a history of sexual abuse and violence from male family members. Her panic attacks are getting much worse, are often triggered by 'nothing in particular'
Additional symptoms:
Behavioural – She has always found it difficult to get close to people but has recently started a relationship. Often fails to attend her college course because of the way she is feeling. When she does attend she speaks to her boyfriend and only a couple of other well-known friends.
Cognitive – wonders whether there may be something physically wrong with her. Difficult to control the attacks
Length of problem: on and off since 9 years old (when abuse started)
Severity: using an outcome measure - severe symptoms
Risk: occasionally self-harms, although she has never attempted suicide
Previous episodes/Past history: Although she has suffered from the attacks for some time it wasn't until last year she suffered from a panic attack of similar severity
Previous treatment: last year she was provided with some reading material
Outcome: she didn't engage with it at the time and says she didn't relate to the stories
Patient needs/expectations: She is finding it hard to cope with the demands of the relationship and wants help to 'feel normal' again.
Patient preferences: Doesn't care what kind of treatment she gets as long as it helps
Social circumstances: She lives alone in a shared house with six other people that she does not know very well and very rarely sees them. She attends a college course where she met her boyfriend.
Social support: Her boyfriend is very supportive but is not aware of all of her past history. She has no family members close by and only one good friend who knows.
Personality: Appears agreeable and cooperative
Substance abuse: she has tried some marijuana a couple of times as she thought it would make her relax but denies drinking excessively
Medication: she takes some traditional Chinese medicines for her anxiety

APPENDIX TWELVE: AIS THINK-ALOUD INTERVIEW TRANSCRIPT EXCERPTS: IMPACT OF SEVERITY ON THE DECISION-MAKING PROCESS AND OUTCOME

DEPRESSION (ONGOING TREATMENT) SCENARIO:

HP24, site3, low intensity worker

[previous questions - symptoms and medication]…

LI worker: *You said that he's not really going out much so I'd probably want to, uhm, start doing behavioural things with him like the – cos that's possibly the least kind of intrusive intervention that I'd start off with him, so I'd probably do like small behavioural goals with him and see if he wanted to kind of get out a bit more see people. Uhm it says he's 65 so I don't know whether he's got like any health complications or -*

Interviewer: *Uhm, no he doesn't, no.*

LI worker: *I suppose that I'd uhm, would chat to him and see if he was, kind of how he felt about the fact that he'd not improved, cos I would probably kind of reassure him that it's, it's early days, and maybe negotiate with him that we'd carry on kind of with the behavioural things if he was happy with that, maybe for kind of three or four more sessions and then look at it, look at it again and if he's still at the same point where he is now I'd probably ask him kind of how he felt about uhm uhm doing some other, other things. I'm just thinking at that point maybe I'd bring him, bring him to supervision. Uhm, it doesn't say what his scores are, so I don't know how severely depressed he is.*

Interviewer: *He showed that he had mild depression.*

LI worker: *OK, uhm, so I probably wouldn't be thinking of, of stepping him up, certainly not at this point, uhm. I'd have a review with him like after the four sessions and see how he, how he got on and just basically reassure him it's, after two sessions it's kind of early days.*

For this health professional, asking about severity appeared to play a role in confirming the decision that they were considering – to carry on working at step 2 with the patient. Their initial decision was not altered by determining that the patient has mild levels of

depression. In terms of the stepped care model this decision, based on the level of severity, is as would be expected, but the sequence of questioning, however, does not reflect NICE guidance.

STRESS/RAPE SCENARIO:

HP12, site2, high intensity worker

HI worker: *So this is a woman stress, social situations six months ago following an incident when she was attacked and raped. I suppose uhm, there are, there are things I'd want to know, I suppose I'd want to either rule in or out a PTSD sort of a, uhm, uh, presentation. And there are, there are uh, uh, measures that can help to do that we already use. There's the impact of events scale I think is one for example, that I might be, I might have in the back of my mind as, as needing to know. I suppose with the P - if something is more clearly PTSD then here at least in [site name]there is a, uhm, an expectation that the person is referred for a high intensity CBT intervention. Which isn't without problems, because they could, that could involve quite a long wait. But I think, I think if the stress, if her symptoms and the stress and potentially all the avoidance and the rest of it that comes with that is marked and seen to be very linked with, or, and, and sort of specific to the assault, the attack and the rape, then I think that's an area to investigate or assess. Uhm, I mean it may or may not be of course. I think you'd have to, you'd have to be open to how the person presented. Uhm, it could, it could be that what she wants, and it might be, I always ask people sort of what they're here to do, and I suppose she may well say, actually it's the, it's the rape that I want to, you know, talk about or come to terms with in some way. Or that's the, that, that might be her focus I which case I might be thinking about, uhm, uhm, another sort of a treatment choice, a counselling treatment choice of some kind, which may or may not involve continuing in this service. Could involve, you know, other sort of uhm adjacent services, counselling agencies.*

Interviewer: *So if I said she, at the present moment in time, she wanted to focus on the anxieties that she's having.*

HI worker: *Well I think if they, I think if they were, uhm, if I understood, if, if I got to understand that a little more about what they were and the level, the severity of, uhm, and we'd ruled out PTSD, then I think the likely treatment suggestion would be a CBT base anxiety management. Now depending on the circumstances. You see, rather, rather cruelly of course I might think about, we run a stress class, stress management stress. Of course it's in a, it's in a social situation. And without wanting to be, you know, too, you know, cruel to the person that could actually be a really very, very useful place, if unlikely place from her point of view. But that might be, that would be a thought. Again, I'd be thinking about low, something of lower intensity to begin with. Psycho education or potentially, depending on the level of anxiety. Someone told me recently as well really that*

> *when you're dealing with anxiety, if you're doing it from a CBT point of view you, you really ought to be getting them to uhm - it's behaviour change that's the thing. So uhm, you need to be getting them to do things. So one way or another I suppose it's about that. But I think, I think I'd hedge my - well not knowing how severe it is and stuff, I suppose that would be the point of the screening.*

Interviewer: *if I said yes, that using an outcome measure she was found to have severe anxiety, would you still sort of treat her, as you said?*

HI worker: *Uhm, I think I may well start off with a, with a, with a, with something uhm - here we have uhm, CBT wise there's two, which would be the sort of main recommended treatment for this sort of thing. Uhm, there would be two uhm, you know, a low intensity choice and a high intensity choice. I think I would uhm, I would, I would be thinking, why can't we start off with something at lower intensity to begin with. Uhm, so doing a sort of, you know, explaining a little bit about CBT and how it works, what's involved, doing a simple formulation, making a link between thinking and feelings and behaviours and seeing what she made of that. And I think the purpose of doing that might be that well, a) that it might help her to understand more about her experience, but, but secondly it would help me to, and us both to judge whether or not that kind of level of help was going to be effective. But I could start to address all those parameters that I was talking about earlier on, can I get going with, with her at all? You know, can we home in and despite the kind of dra - not the drama, the, the uhm, you know, awfulness of the, of the rape, you know, can we find something to work on and get going with some work based on CBT principles. And then how, how much use can she make of it? So I think I would start there, I wouldn't just jump straight up.*

The discussion here clearly indicates that the presentation of severe anxiety did not result in an immediate 'step-up' to higher intensity services. It triggered thoughts that a higher intensity of service could be equally applicable but the decision made was to keep the patient in low intensity initially and revisit their decision at a later stage. This health professional very much seems to be following the principles of the stepped care model which suggests that the least intensive intervention should be adopted first.

WORTHLESSNESS SCENARIO:

HP24, site3, low intensity

LI worker: *pause Uhm, so it says he's uhm tearful and he feels worthlessness, I'd probably like ask him a bit more information. It does to me sound like, again leaning maybe a bit towards, towards depression.*

Interviewer: *Uhm, do you want me to tell you a bit more about this one?*

LI worker: *Yeh.*

Interviewer: *He had, in terms of the worthlessness he feels like uhm, just because uhm he's having all these problems he feels like he's not fulfilling his role within his family.*

LI worker: *Uhm, pause Uhm, again I'd want to know if he was on medication.*

Interviewer: *His GP suggested that he might benefit from taking some, but he said that medication wasn't for him.*

LI worker: *Right OK. Uhm, in that situation then I probably uhm wouldn't really push it. I mean I'd probably want to know like his scores were, like or how severe he was.*

Interviewer: *Yeh it showed that he had moderate depression.*

LI worker: *OK, uhm, I'd probably kind of talk to him about why he wasn't, wasn't keen on it. If he was adamant then I'd just kind of leave it at that, but maybe kind of point out the potential benefits given that he is moderate and say that, uhm, people do worry about taking them and kind of maybe reassure him if he's got some fears that he might be, he might become addicted to them or stuff like that. But, but if he was adamant that he didn't want them I'd say that there are, there are other things that, that we could try other than medication. Uhm, I'd probably want to know a bit more about like his, his home life, maybe if he's got uhm a wife and kids to support and he feels like he's lost his role.*

Interviewer: *Yes he does, he lives with his wife and three children.*

LI worker: *Uhm, pause It's probably difficult to kind of guess without like kind of thinking about what goals he might come up with, but uhm, I'd probably work on the same principle with the first one kind of talking him through the ABC model and kind of leaning towards maybe starting with some behavioural, behavioural things and see how, see how that went. If he was adamant against medication kind of just letting that, him make that choice, and kind of say to him that we'll have a couple of sessions and review how we're going and, and see how he feels about, about that.*

Severity in this case seemed to play a part in considering the role of managing this Pts depression. Initially the health professional stated that they would not impose medication as the patient stated they would prefer not to take it. However, on discovering the patient is suffering from moderate levels of depression, they identify more of a role for

antidepressants and stress that they would discuss the benefits of taking them with the patient.

This low intensity worker also stated that a higher level of severity may warrant a different decision to be made:

> LI worker: *I suppose uhm, he's already, he's already working, maybe he'd feel quite busy and he feels that maybe he's doing a lot of things kind of already, so he feels that that kind of side of things is kind of taken care of, that he doesn't need like his social interaction increasing, so maybe kind of look at, look at his cognitions, maybe he could benefit from some cognitive work if he's saying that he's, you know, feeling worthless, maybe there's, there's perhaps something that we could try instead. Uhm maybe if he deteriorates, like his scores like go up I would in that instance I'd bring him back to, to supervision and look at what's, what's gone on to make it, to make it worse and maybe consider him stepping up, but pause I don't know.*

RISK/DRUG

HP21, site3, low intensity worker

[previous questions – risk, length of problem]…

> LI worker: *OK, a long time, has she had any help from services in the past?*

> Interviewer: *Uhm, last year she was provided with some reading material, she says.*

> LI worker: *OK, uhm, pause Is she on any medication?*

> Interviewer: *She doesn't take any sort of normal medication, she takes some traditional medi – Chinese medicines for her anxiety.*

> LI worker: *OK, is that 'cos she's not been offered any antidepressant medication or -*

> Interviewer: *Uhm, she just uhm doesn't really think that medication's for her.*

> LI worker: *OK, so she's not really enquired about it herself cos she doesn't think it will help.*

> Interviewer: *Yeh, no, she just sort of doesn't ask about it.*

> LI worker: *Right, OK, <u>what's her measures like</u>?*

> Interviewer: *Showing that she's got severe symptoms.*

LI worker: *Anxiety and depression?*

Interviewer: *Moderate to severe depression.*

LI worker: *OK. I would explore with her some her beliefs about sort of antidepressants and whether her doctor, she's obviously seen her doctor about it and already been offered anything and say that, you know, it's her choice obviously what, what she kind of takes, but some people are quite worried about going on to something, right I could do some kind of education about antidepressants. Uhm, it sounds like uhm, quite a chronic problem as well if she's had this since she was nine, uhm, so I'd be looking to uhm, refer on to a specialist service and I don't, in terms of risk I think I'd need to think about CMHT depending – how much alcohol or drugs is she taking?*

Interviewer: *Uhm, she has tried some marijuana a couple of times as she thought it would make her relax, but she now denies drinking excessively.*

LI worker: *Right, OK, she denies it, but what, what makes the, what makes me think that she is drinking alcohol?*

Interviewer: *Uhm, she says that she probably drinks a bit more than she used to, but she doesn't think that it's sort of an excessive or addiction to the alcohol.*

LI worker: *OK, so actually the drug and alcohol thing might not be as bad as, you know, she's, she's denying that there's a problem there really, uhm, but it's the panic attacks and self harm, uhm, which we could do some work on, uhm, so maybe I would try and have a few sessions with her and see if we got anywhere with it. But also obviously talk to my supervisor and see if they had any thoughts on how, like a treatment plan or something, uhm, and just keep checking up on risk and things and then refer to CMHT or psychology if I needed to, or the drugs and alcohol team if it came out that she was actually abusing that.*

In this example, severity again appears to play a role in whether the health professional would consider medication for the management of the Pts problems. However, it appears that drug and alcohol issues are the driving force for the decision that is made as does the length of time the patient has been experiencing the problem for.

APPENDIX THIRTEEN: AIS THINK-ALOUD INTERVIEW TRANSCRIPT EXCERPTS: IMPACT OF PATIENT PREFERENCE ON THE DECISION-MAKING PROCESS AND OUTCOME

STRESS/RAPE SCENARIO

HP14, site2, low intensity worker

LI worker: *OK, so what factors. A 36 year old did not attend an appointment with you following a referral. She said she is suffering from stress, particularly being in social situations. She describes how these feelings started six months ago following an incident when she was attacked and raped. Oh dear! Laughs it sounded nice until it got to that. I'd probably be thinking as I was sitting there reading a referral, oh yes, this sounds, you know, straightforward. Kind of looking at stress, looking at what triggers this stress, looking at sort of any possible negative thoughts around social situations. Till I would get to the bit where it says, attacked and raped, and I'd kind of have that weird feeling in my gut. Uhm, so her feelings started six months ago following an incident when she was attacked and raped. I would have to – well obviously I don't have enough information, but I would have to find out what she wants to do at this stage, because it's certainly possible to work with, you know, social kind of, if it's social anxiety side of it, or fear of strangers or things like that, you know, it's possible to work with that, and that could be facilitated self help. But if she's having any images, any sort of flash backs, you know, then it might be kind of more complex, and kind of almost too fresh. It's a pity you don't know any more information about this person.*

Interviewer: *You can ask me some questions if you like.*

LI worker: *Well I would need her to tell me what she wants to do with it, you know, sort of, so I suppose it would be, you know, if you, you know, what is it that you want to gain from seeing somebody, that kind of question.*

Interviewer: *OK, yeh, if she said that she just really wants someone to help her feel like she used to.*

LI worker: *And then I would say uhm whispers So she wants to feel the way she used to. Well I'd give her the choice, I suppose, I would say well we have the option of looking at the here and the now and kind of*

looking at the connection between your thoughts and your feelings and help to, you know, help to kind of, you know, change those connections and see where it's all coming from. Or, you know, if this experience is something that your mind is coming back to all the time, you could sort of, well I suppose counselling would be an option, sort of explore what happened and, you know, sort of deal with any feelings of guilt or anger that you might have there, so I guess I would say there's the counselling, which is talking through what you experienced, and what it means to you, or looking at the here and now and how you want to progress from this point. I might be tempted to offer her both laughs which we tend to just kind of do a basis that I will give you three facilitated self help sessions, just on the, specifically looking at that. And then, and then you'll be sort referred onto counselling, which is four months wait at the moment anyway. And it may be that that's the best strategy for this person anyway, because you know she, she gets to sort of manage her present better and then kind of get a bit of closure on her past. There you go.

Within this scenario, at the outset, this low intensity worker gives an indication of the potential difficulties that they perceive with this case. Patient preference plays an immediate role in their decision-making about the suitability of seeing this patient. When asked if there were any situations in which their decision may be different the low intensity worker responded as follows:

LI worker: *If, uhm, well given I gave her lots of options there, I'm not sure how to answer that. I mean if she for example said to me, you know, I only want to deal with what happened, then I wouldn't suggest facilitated self help. But if she said to me, no that's not what I want to do, I wouldn't suggest that, or if she said, no, I just want to move on, I don't want to look back at the past, I would perhaps ask her to have a think about counselling, do the facilitated self help stuff, but review later whether she still wants to explore her past. Obviously had there been any risks beyond just thoughts I would refer her to medium intensity. If she was, and maybe if it was a little bit longer kind of, and she was presenting some obviously, you know, you know trauma, and, you know, almost like post tr – PTSD, consider her for CBT, but I am very unclear about that because we haven't been communicating very well with the high intensity because I'm never in the office and they've only just started. So I don't, I wouldn't know whether six months is not long enough, if you know what I mean, I just wouldn't know at this stage....(other influences over a different decision)*

They revealed that if the patient's focus was on dealing with what happened rather than managing the anxiety then it would not be appropriate to continue to see them at a low

intensity level. It is clear however, that this may be as much a clinical issue in addition to a preference one. Irrespective of patient preference, there appear to be specific factors such as a presentation of PTSD that would result in the health professional referring to higher steps. These decisions are in-line with the stepped care model and NICE guidance about how different problems should be managed.

RISK/DRUG SCENARIO

HP19, site3, low intensity worker

[previous questions – symptoms, and numerous on risk (self-harm, drug and alcohol use]…

LI worker:	*Does she notice any change when she's maybe used drugs or drank alcohol in terms of her panicking and self-harm?*
Interviewer:	*No, she says generally they just don't have any effect.*
LI worker:	*So not drinking to excess but is the, the marijuana used regularly or, just a couple …*
Interviewer:	*Just a couple of times probably, sort of once a week at the very most she says.*
LI worker:	*OK Um, there's, um, just thinking really about, talking a bit about sort of education just around sort of substance misuse, alcohol and drugs, just on mood generally, and, and sort of panic, anxiety, um, just so, although she doesn't sort of identify it as being a specific issue, just to highlight that these things can have an effect and just be kind of mindful of that really. Um, are there, is there anything that stops her self-harming?*
Interviewer:	*She said that when, when she's with her boyfriend, although she finds the relationship a bit stressful sometimes, that he sort of makes her feel comfortable and sort of often makes her forget about some of the problems that she's having.*
LI worker:	*Are they, because it sounds like there's been kind of ups and downs over the years, is there anything specific that, that she notices when the panic attacks return?*
Interviewer:	*No, she feels that they're sort of not really triggered by anything in particular.*
LI worker:	*Just kind of come back. Um, has she ever spoken to anyone about the abuse as a child?*

Interviewer: *She was only, she spoke to her doctor before, briefly, but not really about the abuse itself just about sort of the problems that she's having, and to be, provided her with some reading material but she said that she didn't really engage with that.*

LI worker: <u>*So is it not something she wants to, she's not in the place to … think about.*</u>

Interviewer: *She just felt that she sort of didn't relate to the stories and things that were there, they didn't feel like that, that was her.*

LI worker: *OK.*

[further questioning about risk (self-harm)]

LI worker: *OK. Just , just, sort of thinking through really, trying, trying to remember [laughter], um, just sort of thinking about, um, maybe working sort of identifying some specifics, so getting some kind of gauge of, of when the panic attacks happen so maybe, sort of thinking about doing some kind of log of, of the panic attacks and the severity and what's kind of happening and to try and get a picture of when it's happening and, you know, are there times when it does happen but its not as bad and what's different about those times, so that we can then maybe start focusing on, um, you know, how to, to help during those times, um some self-help material on panic attacks and sort of working through panic attacks and then sort of leading on from that, um, maybe talking about relaxation and sort of if it, if it comes across that kind of the panic attacks in certain situations, maybe looking at talking through those situations, you know, a bit like a, a role play, if that'd help like in preparation for certain things to help reduce the anxiety, so I think I'd, initially, I'd be looking at getting some sort of picture of when it's actually happening, um and talking in terms of around the self-harm I'd be looking at giving sort of education around alternatives, is it cutting, um and sort of finding out if other things, you know, like some, maybe using ice or, you know, you know, just alternatives for safer methods, um, bearing in mind that, you know, you want to reduce panic 'cos that seems to, sort of escalate the self-harm and sort of make sure she's sort of safe, staying safe while we're working on sort of the panic side of things, um just from what you've said it doesn't sound like she's in a place to or wants to go into the sexual abuse at this point, so, um, it'd just be something that I'd, I'd sort of come back to really in terms of when she does feel ready to re-visit that.*

Questioning by this low intensity worker focused heavily on risk issues, self harm in particular. As a consequence their decision to see the patient at low intensity focused on the management of the self-harm in addition to managing the panic attacks. The decision to

see the patient was driven by the health professional's interpretation that the patient would like to focus on this initially. They did indicate that should the patient express a preference to look at the abuse then this would drive a change in their decision. The incorporation of patient preferences here therefore relate to the clinical focus of the treatment rather than a particular preference for a specific treatment. When questioned about this, the low intensity worker gave the following explanation:

> LI worker: *I mean I think there's still stuff we could do around the panic but if it, if it was that and she was very fixed on the fact that it was, you know, re-visiting the abuse and what happened and working through those emotions, then it'd be a more direct referral to psychology from the start but work, maybe with work around the panic on a sort of, um, interim, um, but I think at this point it may, just from some of the things that you said, it doesn't sound like, you know. I'd probably be a bit more explicit with her and just sort of clarify that she definitely didn't want to, um, but she, it just depends where she's up to and whether she's ready for it I suppose, um and I think just initially working on the panic and maybe helping work through that, in itself might just be, um, enough at this point.*

The health professional also stressed that patient preference would not be the only factor that would trigger a change to their decision. In line with NICE guidance they indicated that risk would have a role for referring to higher steps. It appeared that patient preference would not necessarily have a role to play if this were the case.

> LI worker: *Um, I thinking my decision would be different if it was sort of suicide em as well as self harm, then obviously be keeping a check on that and if it was getting to the point, um, and sort of planned and intent to actually you know actually act on certain thoughts and I'd be looking to sort of step to, to sort of more secondary and crisis teams.*