

Exploring Psychological Wellbeing Practitioners' experiences of offering choice and
engaging in Shared Decision Making with people with depression.

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AI statement: Grammarly was used to proofread this thesis. This tool was used to check punctuation, spelling and correct word usage. Grammarly was not used to generate or rewrite whole sentences.

Abstract

Background: In 2022, the National Institute for Health and Care Excellence (NICE) made changes to their guideline regarding treatment of depression in adults. The NICE (2022) guideline changes included emphasis on the use of Shared Decision Making (SDM). SDM is an area of increasing research, but research in the UK is limited for Primary Care services.

Aims: This research aimed to explore if current levels of choice matched what was proposed in the NICE (2022) guideline. Additionally, this research aimed to explore experiences of Psychological Wellbeing Practitioners (PWPs) in offering choice and engaging in SDM. Finally, this research aimed to explore barriers and facilitators to SDM in services.

Method: This study utilised a mixed method approach, consisting of a survey and interviews. In total, 93 participants took part in the survey, and 12 participants took part in interviews. All participants were either qualified or trainee PWPs. Survey data was analysed with IBM SPSS statistics. Interview data was analysed using Braun and Clarke's (2022) Reflexive Thematic Analysis.

Findings: Analysis of the interviews produced 5 main themes "Mixed messages: The disparity between policy and training and in service practice", "Service pressures prevent wider use of SDM", "Upstairs downstairs: How established hierarchies and beliefs about the PWP role impact on opportunities to engage in SDM", "PWPs beliefs and experiences of using SDM in practice" and "Areas of hope: identified areas of good practice and ways to move towards increasing SDM". Analysis of the survey data provided descriptive statistics highlighting the current level of choice and knowledge of SDM.

Conclusions: Current levels of SDM for individuals presenting with depression do not appear to meet the levels recommended by NICE (2022). Key barriers to this include lack of time and resources, as well as external pressures regarding targets and funding.

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Commonly used acronyms and policies

Table 1

List of Abbreviations and Key Policies

Abbreviation	Definition
CBT	Cognitive Behavioural Therapy
HI CBT	High Intensity Cognitive Behavioural Therapy
LI CBT	Low Intensity Cognitive Behavioural Therapy
cCBT	computerised Cognitive Behavioural Therapy
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
BPS	British Psychological Society
PWP	Psychological Wellbeing Practitioner
SDM	Shared Decision Making
IAPT	Improving Access to Psychological Therapies
PHQ-9	Patient Health Questionnaire-9
RTA	Reflexive Thematic Analysis (Braun and Clarke, 2022)
NHS TT	NHS Talking Therapies
Key Policies	Reference in text
NICE (2022) ‘Depression in adults: treatment and management’ guideline	The NICE (2022) guideline
NICE (2021) ‘Shared decision making’ guideline	The NICE (2021) guideline

Note: both NICE guidelines will be referred to with full titles at their first use in text and then referred to as denoted in this table throughout the rest of the thesis.

Contents

Introduction	11
Chapter overview	11
Depression in the UK National Health Service (NHS) context	11
NHS Talking Therapies: a background	12
Current Guidance for the treatment of Depression	18
Introduction of a focus on client choice	18
Matched-care model	19
Shared decision making	21
<i>Shared decision making: What is it?</i>	21
Shared decision making: theoretical underpinning	23
<i>Shared decision making: Why use it?</i>	24
<i>Shared decision making: What does policy say?</i>	31
SDM: Critical considerations	36
Shared decision-making summary	37
Systematic review	38
Introduction	38
Method	38
Design	38
Search strategy	39
Inclusion and exclusion criteria	40
Data analysis	43

Critical appraisal of included studies	43
Results	51
The impact of culture	54
The impact of policy	57
Capabilities for engaging in SDM (Knowledge & Skills).....	59
Line of argument synthesis	60
Discussion	62
Strengths and limitations	62
Implications and directions for future research.....	63
Reflexivity	64
Rationale for current research	64
Aims and objectives of current research.....	65
Method.....	66
Chapter overview	66
Epistemological positioning and justification of methodology	66
Use of the mixed methods approach	66
History of mixed methods research	67
Paradigms	67
Pragmatism	68
Pragmatism applied to the current research	69
Design	70
Service context	71

Participant inclusion/exclusion criteria	72
Procedure	73
Recruitment.....	73
Survey procedure	75
Procedure post recruitment for interview	75
Measures.....	76
Quantitative measures.....	76
Qualitative materials.....	78
Analysis	79
Quantitative Analysis.....	79
Qualitative Analysis.....	80
Ethical considerations	82
Dissemination	83
Reflexivity.....	85
Results	86
Chapter overview	86
Quantitative results	86
Participant characteristics.....	86
Participant Awareness of NICE guideline changes	89
Choices available in service	91
Trainee specific questions	92
Confidence in understanding and using SDM.....	95

SDM training	97
Use of SDM in service	98
Importance of SDM	100
Factors that may predict use of SDM	101
Associations between factors that may impact use of SDM	104
Qualitative results	105
Participant characteristics.....	105
Themes and subthemes	106
Mixed messages: The disparity between policy and training and in service practice	108
Service pressures prevent wider use of SDM	116
“Upstairs downstairs”: How established hierarchies and beliefs about the PWP role impact on opportunities to engage in SDM	128
PWPs beliefs and experiences of using SDM in practice	134
Areas of hope: identified areas of good practice and ways to move towards increasing SDM	142
Bringing the data together	150
Discussion	151
Chapter overview	151
Relating the findings to the aims	151
Relating the findings to existing research	156
Clinical implications of the research	159
Service organisation	159

NICE (2022) guideline ‘Depression in adults: treatment and management’ ...	162
Commissioning level	163
University training courses	165
Strengths and limitations.....	167
Strengths.....	167
Limitations.....	168
Directions for future research	170
Researcher Reflexivity	172
Conclusion	173
References	175
Appendices	193
Appendix A. Analysis of studies included in the systematic review to determine common themes and provide second order interpretation.....	193
Appendix B. Recruitment poster used on social media	202
Appendix C. Initial contact recruitment message template	203
Appendix D. Follow up recruitment message	204
Appendix E. Survey information for participants	205
Appendix F. Consent page for survey participants.....	207
Appendix G. Qualtrics survey.....	208
Appendix H. Interview Topic Guide	209
Appendix I. Final thematic map	211
Appendix J. Participant information sheet for interview.....	212
Appendix K. Participant consent form for interview.....	214

Appendix L. Ethics application outcome	215
Appendix M. Text responses for survey participants discussing differences between value on SDM in services vs in training.....	216
Appendix N: QQ plots and scatterplots used to determine parametric assumptions for correlation between Use of SDM OPTION scale and Value of SDM OPTION scale	218

Introduction

Chapter overview

This chapter aims to introduce the context of this thesis, including the relevance of depression in UK health systems, current policy and service context. Policy changes which focused on the increased use of Shared Decision Making (SDM) will be discussed. SDM will additionally be discussed and critiqued. The second half of this chapter contains a systematic review of the currently available research on staff experiences in using SDM when working with individuals with depression. From this review, the rationale for the current research will be discussed, along with research aims.

Depression in the UK National Health Service (NHS) context

Recent statistics report that 1 in 5 (20.2%) adults in the UK have a Common Mental Health Condition (CMHC), 3.8% of which defined this as a depressive episode (NHS England, 2025). Data suggests that depression is rising in the UK, with prevalence increasing from 2.6% in 2007 to 3.8% in 2024 (NHS England, 2025). The total cost of mental ill health in England was reported to be £300bn, of which £60bn is for health and care services (Cardoso & McHayle, 2024). An exact breakdown of the cost of depression is hard to ascertain, as most recent statistics focus on overall mental ill health or CMHCs. However, depression was estimated to cost the UK 7.5bn in 2007 and was predicted to increase to £12.2bn by 2026 (Lamb, 2014).

The National Institute for Health and Care Excellence (NICE) provides guidelines for how health services should treat mental and physical health concerns. In England, mental healthcare is organised into Primary care (e.g., GPs, NHS Talking Therapies), Secondary care (e.g., Community Mental Health Teams [CMHTs], Crisis teams) and Tertiary care (e.g., specialist services such as eating disorders or forensic inpatient care) (ReThink Mental

Illness, 2025). Depression is most often first treated in primary care, in line with current NICE recommendations (NICE, 2022). NHS Talking Therapies (NHSTT) received 443,346 referrals for depression across England between 2024-2025 (NHS England, 2025). NHSTT provide most of the first line response to those who are experiencing depression.

NHS Talking Therapies: a background

Prior to 2007, if an individual required support with depression, they would need to visit their GP and the most likely outcome would have been antidepressants (Pickersgill, 2019). However, in 2004 NICE had issued guidance which summarised and presented evidence supporting the increased use of psychological therapies (Clark, 2018). Layard (2005) (a behavioural economist and member of the UK House of Lords) subsequently presented a report making an economic argument for the widespread use of Cognitive Behavioural Therapy (CBT) for treatment of depression and anxiety disorders.

It was suggested that increasing access to CBT would enable individuals to return to work, reducing the welfare bill and increasing tax revenue. Layard's (2006) Depression Report referred to the evidence base for other psychological therapies but focused heavily on increasing the provision of CBT. In 2006, two pilot sites in Doncaster and Newham opened which aimed to recruit a workforce of CBT therapists and deliver therapy. Both pilot sites worked within a stepped-care model and employed both High Intensity (HI) and Low Intensity (LI) workers (Clark, 2018). A stepped-care model contains stages which begin at the intervention deemed "least intensive" and then work up to interventions deemed "most intensive" in terms of resource use. In stepped-care, the level of "need" the client presents with is what would determine the stage of care they access. Increasing Access to Psychological Therapy (IAPT) services provided Step 2 (LI treatment) and Step 3 (HI treatment), for those with mild to moderate presentations of anxiety and depression (NHS England, 2024a).

The pilot sites were considered a success, and consequently, a national roll out of IAPT was announced in October 2007, with the first services opening in September 2008. Within three years, the whole of England had access to a local IAPT service. Successive governments have continued to expand these services and their workforces (Clark, 2018).

In 2023, IAPT services were renamed NHSTT for mental health and depression. It was felt that the name IAPT reflected a policy drive, rather than a reflection of what the service delivers, potentially causing confusion. The name was also changed to highlight who the service offers support to and to create a greater distinction between it and services that support more complex needs, such as CMHTs (Clark & Whittington, 2023).

NHSTT employ both LI and HI clinicians who work within a stepped-care model. LI workers are those who provide treatments as Step 2 of the stepped-care model, such as guided self-help based in CBT. HI workers are clinicians trained in a therapy modality such as CBT; they work within Step 3 of the stepped-care model and provide treatment to those who would be considered to have moderately severe symptoms. Individuals can self-refer or be referred by their GP or other professionals. Following referral, individuals are offered an assessment which is designed to investigate their current contextual circumstances, levels of risk, presenting problem and motivation for treatment. This information is then used to decide on what level of intensity of treatment would be the appropriate first step for the individual (NHS England, 2024a)

NHSTT services have a strong focus on outcome measure data collection, with the aim being that outcome measures are taken as part of every session and services are given targets for data collection to be 90% complete (Clark, 2018). These measures form the ‘minimum data set’ and consist of (NHS England 2024a):

1. Patient Health Questionnaire-9 (PHQ9) (Kroenke et al., 2001).
2. General Anxiety Disorder-7 (GAD7) (Spitzer et al., 2006)

3. IAPT Phobia Scale (IAPT Toolkit, 2008)
4. Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002)

The data collected are used in two ways. When collected within the initial assessment, they form part of the decision for where an individual should be within the stepped-care model. They are also used within and at the end of treatment to measure progress (NHS England, 2024a). NHSTT use the concept of ‘recovery’ to determine if a treatment has been successful. ‘Recovery’ from depression means that an individual who scored at ‘caseness’ (10 or above for the PHQ-9) at assessment has scored a 6 or below on the PHQ-9 following treatment (NHS England, 2024a).

The concept of ‘reliable recovery’ is additionally reported. NHSTT use ‘reliable and clinically significant change’ to determine ‘reliable recovery’. This concept was first introduced by Jacobson and Traux (1991). Reliable change means that the change in scores is unlikely to have arisen from measurement error (Jacobson & Traux, 1991). This is represented in the reliable change formula: $x^1 - x^2 / S_{diff}$ in which x represents pre and post intervention outcome measure scores and S_{diff} represents the standard error of the difference between the two outcome measure scores (Jacobson & Traux, 1991). A reliable change score of greater than 1.96 represents a change that is likely to be representative of real change having occurred. For a change to then be reliable *and* clinically significant, the change must represent a move away from a clinical population score (e.g., a score above 10 on the PHQ-9) and closer to the non-clinical population range. Jacobson and Traux (1991) proposed three ways in which clinically significant change could be met:

1. A post treatment score that is within two standard deviations from the non-clinical population mean.
2. A post treatment score that has moved two standard deviations away from the clinical population mean and towards the non-clinical population mean.

3. A post treatment score that is closer to the mean of the non-clinical population than the clinical population mean.

NHSTT translates this approach into the concept of ‘reliable recovery’. To meet ‘reliable recovery’, a score must first have ‘reliable improvement’, which is calculated the same way as “reliable change” described above (NHS England, 2024a). ‘Reliable recovery’ is met when both the conditions for recovery (akin to clinically significant change method 3) and reliable improvement have been met (NHS England, 2024a).

There are alternative definitions of recovery; Anthony (1993) defines recovery as an individual regaining control over their life and being able to live a life that is meaningful to them, and which fits with their values. The focus of Anthony’s (1993) definition of recovery is not simply reliant on symptom reduction as in the NHSTT concept of ‘reliable recovery’ but instead describes a more patient centred and holistic view. The lack of consideration for a more nuanced view of recovery may in itself reflect a barrier to SDM within healthcare services, as the types of changes discussed by Anthony (1993) which may result from other types of treatments may be missed in favour of treatments that produce high reductions on outcome measures.

Decisions around stepping up care may be made based on the statistical concept of ‘reliable recovery’. If an individual has not recovered or reliably improved after a course of LI CBT, the decision may then be made to ‘step up’ to HI CBT (NHS England, 2024a).

The NHSTT (NHS England, 2024a) manual lists the recommended depression treatment options that should be available at each step; these can be seen in table 2.

Table 2

Psychological Therapies Recommended within NHSTT for Depression.

Level of stepped-care model	Severity of depression	Recommended treatments
Step 2: Low Intensity interventions	Less severe depression	Individual Guided self-help based on CBT, group and/ or individual Behavioural Activation, structured group physical activity programme
	More severe depression	Individual problem solving, individual Guided self-help based on CBT, structured group physical activity programme
Step 3: High intensity interventions	Depression that has not responded to Step 2 treatment	CBT (individual or group), Group and/ or individual Behavioural Activation (BA), Couple's Therapy for Depression (CTfD) or Behavioural Couple Therapy; (BCT) Interpersonal Psychotherapy (IPT), Person-Centred Experiential Counselling for Depression (PCECfD), Brief psychodynamic therapy (Dynamic Interpersonal Therapy; DIT), Group Mindfulness Based Cognitive Therapy (MBCT)
	More severe depression	CBT (individual), individual Behavioural Activation, PCE-CfD, DIT or IPT, each with or without medication
	Chronic depression	CBT with or without medication
	Depression (prevention of relapse)	CBT or mindfulness-based cognitive therapy

Note. Recommended treatments are taken from the NHSTT manual (NHS England, 2024a)

Within the NHSTT manual (NHS England, 2024a), it is recommended that services have 70-90% of their HI workforce qualified as CBT therapists. This leaves 10-30% of the workforce that can then be therapists trained in other modalities. Whilst the manual states that all services must provide a 'meaningful choice' of therapies, other than CBT, there are

currently no minimum requirements for how many or which non-CBT therapies must be offered within each service.

The exception to this is that all services must have capacity to offer couples therapy for depression (NHS England, 2024a). The rationale for why couples therapy is the only other therapy that must be offered by services is somewhat unclear, but regarding this, in 2010, Tavistock Relationships was commissioned by NHS England to develop a training for Couples Therapy for Depression (CTfD) to train therapists within NHSTT services (Tavistock Relationships, 2021).

The NICE (2022) guideline ‘Depression in adults: treatment and management’ recommends the use of couples therapy for depression when an individual’s depression is affecting their relationship, or when the involvement of a partner may help in treatment. The stated rationale for this is that despite limited ‘poor quality’ evidence for the effectiveness of couples therapy for depression, the committee decided on its inclusion in the guideline due to its existing availability within NHSTT services (NICE, 2022). It therefore appears that clinical opinion or other unknown factors can over-ride quality of evidence in some circumstances and not others, even though NICE reports to be politically neutral and separate from the government, with decisions being made based on scientific evidence (Timmins et al., 2017).

The current NHSTT manual recommendations mean that some services may offer CBT, couples therapy for depression and either one or more other therapy options. Other services may offer more variety of therapy types but have a small proportion of workforce able to deliver each. Examples of this can be seen within the data set which NHSTT publish each year. This data set can be used to give an indication of which treatments are available in a locality as it shows how many of each type of treatment were carried out within a year (NHS Digital, 2024). As an example, NHS Birmingham and Solihull Integrated Care Board

(ICB) had a range of 13 treatments on offer for depression, of which eight were non-CBT based. However, CBT had the highest number of completed treatments at 1,510, followed by counselling with 1,250. At the lower end of the scale, Brief Psychodynamic Psychotherapy had 10 completed treatments, suggesting that whilst a wide range of treatments exist, there may be less access and resources for non-CBT therapies. As another example, NHS Cambridgeshire and Peterborough ICB had six treatments for depression that individuals had completed across the year, of which four were non-CBT based. However, LI guided self-help accounted for most treatments completed at 2,090, followed by CBT with 1,875, and counselling with 130 treatments completed (NHS Digital, 2024). This suggests a vast difference in the number of resources spread across ICBs. This disparity ultimately leads to unequal access across the country to the full range of treatment options for depression, limiting clients' ability to consider all options when making decisions.

Current Guidance for the treatment of Depression

In the UK, guidelines for the treatment and management of depression are published by NICE. NICE issue periodic updates to this guidance; for depression, the most recent of these updates was in 2022. This update introduced several changes; the focus here will be on the changes related to client choice and stepped-care.

Introduction of a focus on client choice

The NICE (2022) guideline included new recommendations on offering of choice of treatment to individuals. It recommends that all individuals should be given information on potential benefits and harms of available treatments, be offered a choice of recommended treatments (table 2), and be given choice of how and where the treatment will be delivered. Furthermore, it recommends that all individuals should be able to express a preference for a certain NICE recommended treatment; that those treatments should be available in a timely

manner; and that availability of treatment should have equality of access and experience (NICE, 2022).

The NICE (2022) guideline introduced recommendations for how decisions about care should be made, including that all decisions made should be shared decisions and should consider the views and previous experiences of the individual accessing care. The NICE (2021) ‘Shared Decision-Making’ (SDM) guideline is cross-referenced to frame what constitutes a shared decision. This states that a shared decision is one which is collaborative between the individual and their healthcare practitioner, considering the individual’s beliefs and preferences whilst giving the individual details on risks and benefits of certain treatments.

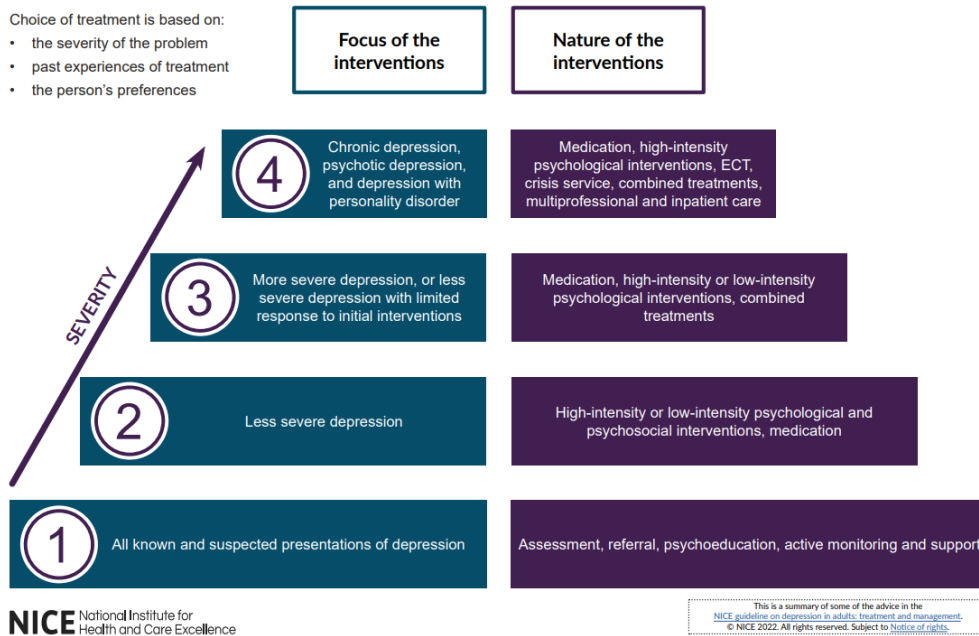
Matched-care model

The NICE (2022) guideline introduced the concept of the ‘matched-care model’. This follows the same principles as a stepped-care model but introduces the role of client choice and previous experience in decision making. See figure 1.

Figure 1*NICE (2022) Matched-care Model***Depression in adults: the matched care model**

Choice of treatment is based on:

- the severity of the problem
- past experiences of treatment
- the person's preferences



Note. © NICE [2022] Depression in adults: the matched-care model. Available from www.nice.org.uk/guidance/ng222 All rights reserved. Subject to [Notice of rights](#). NICE guidance is prepared for the National Health Service in England. All NICE guidance is subject to regular review and may be updated or withdrawn. NICE accepts no responsibility for the use of its content in this product/publication.

The matched-care model does not seem to differ significantly from the previous stepped-care model. Care is still organised into steps based on severity, with certain treatments being available at certain levels. The only marked change in the matched-care model is the suggestion that treatment choice should incorporate individuals' preferences and previous experiences. However, the model then assigns what treatments are available by severity, which suggests that choice is still primarily bound by the previous steps. The third level of the diagram states that treatments in this category are for those with more severe depression, or those who have not responded at the previous level of treatment. This contradicts the element of client preference that the model indicates, as it suggests that the

previous level of treatment must have been tried first, which reflects a stepped-care model. Whilst the explicit inclusion of client choice to guide decisions is a welcome change, the stepped elements of the model remain in place, and these changes are likely not significant enough to effect any real change in the practice of SDM. Instead, its inclusion appears tokenistic when paired with apparent contradictions to choice evident within the model.

Shared decision making

Shared decision making: What is it?

SDM in healthcare is an area of increasing research, with an increase from 95 publications with SDM as a keyword in the year 2000 to 581 in 2013 (Légaré & Thompson-Leduc, 2014). This study used PubMedReMiner to search abstracts but does not clearly define what keywords were used within the search. This search was updated in 2025, using EBSCO Host to search MEDLINE Ultimate, APA PsycArticles, APA PsycInfo, and CINAHL Ultimate, using the key words: “shared decision making OR SDM OR shared decision-making” AND “healthcare OR hospital OR health services OR health facilities”, resulting in 6,658 results between December 2013 to December 2024, suggesting the interest in shared decision-making has continued to grow.

SDM is not a new concept, and the idea of involving clients in choices about their care has been referred to as being essential to practice in the medical field for a long time. The term SDM was first used in 1997 (Charles et al., 1997). However, for a long time it was not clear what SDM would mean in clinical practice, creating difficulties in measuring its effect on care (Elwyn et al., 2000). Towle et al. (1999) proposed a set of eight competencies for physicians to use when engaging in SDM (see table 3).

Table 3

Eight Competencies Required for SDM

Competencies required for SDM

1. Develop a partnership with the patient.
 2. Establish or review the patient's preferences for information (such as amount or format)
 3. Establish or review the patient's preferences for role in decision making (such as risk taking and degree of involvement of self and others) and the existence and nature of any uncertainty about the course of action to take.
 4. Ascertain and respond to patient's ideas, concerns, and expectations (such as about disease management options)
 5. Identify choices (including ideas and information that the patient may have) and evaluate the research evidence in relation to the individual patient.
 6. Present (or direct patient to) evidence, taking into account competencies 2 and 3, framing effects (how presentation of the information may influence decision making), etc. Help patient to reflect on and assess the impact of alternative decisions with regard to his or her values and lifestyle.
 7. Make or negotiate a decision in partnership with the patient and resolve conflict.
 8. Agree an action plan and complete arrangements for follow up.
-

The competencies above appear similar to the current definition provided by NICE.

SDM is defined by NICE as being a process which involves collaboration between health care professionals and the individual receiving care, in which a joint decision about care is made (NICE, 2021). This requires evidence for and against the option to be provided.

Individual views of the client, including beliefs and values, are to be included within the decision-making process; and that receiving no treatment should be an option a client may choose. Additionally, the guidance recommends individuals be able to choose to be less involved with making decisions regarding their care if they wish. (NICE, 2021).

There are alternative shared decision making models to the one proposed by the NICE (2021) guideline. One such model was developed by Elwyn et al. (2012), which proposed that SDM requires three stages: introducing the choices, providing descriptions of the choice, typically with the use of a decision aid and finally assisting clients to explore their preferences and values in relation to the choices (Elwyn et al., 2012). This model centres the importance of clients' opinions and clinicians exploring these in sufficient enough depth whilst also providing enough information to enable the client to make an informed choice. Grim et al. (2016) built on this model and added two additional steps: preparation and follow up. Preparation regards the clinician setting an agenda for the session and providing information about the potential decisions to be made prior to the appointment. The follow up stage was proposed to allow clients a way to access further information after making the decision, and for the possibility of the decision being reviewed or amended later in the process. Whilst the NICE (2021) guideline definition of SDM appears to encapsulate most of the original three steps proposed by Elwyn et al. (2012), it misses the concepts of preparation and follow up proposed by Grim et al. (2016).

Shared decision making: theoretical underpinning

Self Determination Theory (SDT) was originally developed in the context of organisational psychology by Deci and Ryan (1985). However, it has been applied to explain processes relevant to SDM. SDT proposes that motivation for behaviour change exists along a continuum ranging from controlled, in which the motivation results from external pressure, to autonomous, in which motivation is fully in line with the individuals' own values and preferences (Resnicow et al., 2022). Behaviour change has been suggested to be more likely to occur when motivation is autonomous (Ng et al., 2012). Resnicow et al. (2022) discuss that the three fundamental human needs suggested by SDT, which are competence, relatedness and autonomy, highlight the importance of SDM. They suggest that SDM allows individuals

to make decisions that take into account these three needs, and therefore theoretically this should lead to greater behaviour change (Resnicow et al., 2022). However, they also discuss that decisions that are more “provider driven” may not violate these needs if they are in keeping with the client’s desires for how much responsibility for decisions they want to take (Resnicow et al., 2022).

There are many theories of behaviour change. The COM-B model is one such theory and is taught within PWP training and will therefore be considered here (NHS England, 2025). The COM-B model describes that for behaviour change to take place, the individual must have Capability, Opportunity and Motivation to engage in the processes necessary to change the targeted behaviour (Michie et al., 2011). In the context of depression, this might be engaging actively in treatment and changing an element of behaviour that maintains depression, such as engaging in more enjoyed activities. If the SDT explanation of autonomous motivation being linked to individuals having greater values alignment is correct, using an SDM model should theoretically provide an increase in the motivation element of the COM-B model. It could therefore be argued that SDM use, which is in line with the client’s preferred level of decision making, should lead to an increased likelihood of behaviour change.

Shared decision making: Why use it?

There is a moral and ethical argument to be made for SDM. Veatch (1972) discussed four models of decision making between client and clinician. Veatch argued that the ideal model would involve sharing decisions in a way that centres the clients’ rights and dignity and allows for both the clinician and client to “retain moral integrity” (Veatch, 1972).

As highlighted in the definition of SDM given above, the process can allow for an exchange between clinician and client in which the clinician can give information based on research and population norms, and the client can bring their own experiences and values to

make an informed decision that feels right for them (Deegan & Drake, 2006). A meta-analysis on the use of SDM found that research often portrayed SDM as a move towards creating more modern services and helped to move away from ‘paternalistic’ services in which decisions were made on an individual’s behalf (James & Quirk, 2017). SDM tools were often seen as tools which allowed for this process to take place (James & Quirk, 2017).

This use of knowledge that comes from the client’s own experiences has been suggested to be particularly important to consider when thinking about mental healthcare, in which research has suggested that decisions feel more complex and uncertain than in physical healthcare (Adams & Drake, 2006). This is due to the number of options available for treatment of mental health disorders, including multiple forms of psychological therapy. These therapies all have different evidence bases, and some may have comparable results for the same condition (James & Quirk, 2017). The importance of the individual being able to consider treatment options within their own context is essential, as they can analyse the risks and benefits of the treatment unique to their situation (Drake et al., 2010).

Evidence regarding the usefulness of SDM in increasing the reduction in symptoms of mental health conditions is mixed. A systematic review which aimed to consider the usefulness of SDM in relation to treatment outcomes suggested that it was not possible at the time of the review to determine with any certainty if SDM use increases clinical outcomes (Aoki et al., 2022). However, the review did suggest that the use of SDM did not significantly increase appointment length, and clients who experienced SDM felt more involved in their care when followed up immediately after the intervention (Aoki et al., 2022). An updated review in 2024 identified a neutral to positive effect of SDM on treatment outcomes but acknowledged the low quality of the evidence included within the review (Bruch et al., 2024). Montori et al (2022) suggest that instead of focusing on traditional outcome measures,

the use of SDM should instead be judged by how meaningful the care plan that is produced is, as well as how well the plan fits in with their current lifestyle.

SDM has been argued to improve adherence to treatment, including medication adherence in mental health (James & Quirk, 2017). Individuals receiving psychiatric care show a preference for care that is collaborative, and individuals who rate their care as highly collaborative are more likely to rate themselves as being more adherent to their treatment plan (De las Cuevas et al., 2014). However, a systematic review reported that SDM's effect on adherence could not be concluded with certainty due to the quality of currently available evidence (Aoki et al., 2022). There is some evidence that use of SDM can reduce costs to services due to better outcomes (Joosten et al., 2008) and reduce prescription of psychotropic medication that may be unnecessary or unwanted by the client (Adams & Drake, 2006).

However, the promotion of adherence and compliance has been critiqued as both imply clients must follow the plans set by healthcare professionals. Research has often focused on the use of two words to describe this behaviour, compliance and adherence (Chakrabarti, 2014). Compliance was typically thought to describe how much a client's behaviour matches what the health professional has recommended (Chakrabarti, 2014). The concept of compliance was criticised as being reflective of paternalistic ideas, and for its suggestion that clients are to blame when they do not act in ways which the health care professional recommends (Bissell, 2004).

Concerns around the use of compliance led to some using the concept of adherence instead. The World Health Organization (WHO) aimed to explore and refine the term adherence by reviewing previous definitions of the concept. From this, they suggested that the term should be used to suggest that the client agrees with what has been recommended for them (WHO, 2003). Horne et al. (2005) defined adherence as "the extent to which the

patient's behaviour matches agreed recommendations from the prescriber" and encouraged that non-adherence should not lead to the client being blamed.

Despite these efforts to distinguish the concept of adherence from the concept of compliance, a concept analysis of the term adherence found no distinct difference in definitions given between adherence and compliance (Bissonnette, 2008). Bissonnette's (2008) concept analysis found the most used definition of adherence was "the extent to which patients follow the instructions they are given for prescribed treatments". Whilst the term adherence is used more frequently in SDM research, perhaps due to the implied element of clients agreeing with the treatment, in practice the term is still used to describe clients being compliant with what is recommended (Bissonnette, 2008). Therefore, a focus on SDM being a tool to improve adherence could be seen as going against the moral imperative argument in which increasing choice is seen to improve freedoms and dignity for clients, as argued by Veatch (1972).

Some have argued that the way in which choice and SDM is being implemented within health services currently seeks to create a more individualistic culture in which clients are given the entire burden or responsibility for their health outcomes, with the responsibility of society and health policy being lessened (Hutchison & Holdsworth, 2021). This shift to individualism can lead to social issues, such as poverty and lack of adequate housing, being ignored in favour of promoting health policy that focuses on promoting healthy lifestyles (Hutchison & Holdsworth, 2021). It may be that this could then lead to a shift in which client choice is used to place blame solely with clients, as they may be seen to have been given the choice to follow healthcare advice and seemingly chose not to, with limited or no thought as to the systemic factors that may have led to the client being unable to engage in what is recommended. With these criticisms in mind, it is important that services move towards

encouraging client choice in a way that is meaningful and does not seek to shift the burden of responsibility but instead holds both the individual and wider societal issues in mind.

One way in which services could address this shift in burden of responsibility is by considering ideas around structural competency. Metzl and Hansen (2014) discuss the idea of structural competency, which proposes that healthcare staff should be educated in ways in which they can assess what structural issues may be at the centre of a client's presentation and work towards a way to address this with the client. Whilst the current NICE (2021) definition of shared decision-making states the client's values and beliefs should be included in the decision-making process, there is no explicit mention of the importance of exploring systemic factors that may be affecting the individual and therefore may affect what choices they are able to make.

The impact of these systemic issues could be viewed within the context of the Power Threat Meaning Framework, which is a framework that seeks to understand psychological distress in relation to individual's experiences of and reactions to power, the threat this can cause, and the meaning made of these threats. (Johnstone and Boyle, 2018). For example, if a client is experiencing poverty and lives rurally with no access to a car but strongly believes that face to face therapy would work better for them as they have struggled with online therapy in the past, they may have to accept either telephone or video call treatment as the service may not have anything in place to assist them to access their preferred choice. In this situation, the service and commissioners maintain the power over the options available to the client. This could trigger a threat response from the client based on previous experiences of feeling unheard or rejected; this may then lead to the client interpreting a meaning about services as being unhelpful and unable to meet their needs. This could lead to a complete withdrawal from services, or reduced engagement. A greater focus on equitable access to

choice and using SDM in a patient centred way may help to reduce some of these experiences.

To further increase a focus on the shared element of SDM and move away from a potential shifting of responsibility to the client only, it might be useful to implement ideas such as Zisman-Ilani et al. (2021) concept of shared risk taking within SDM. Shared risk taking encourages the clinician and client to jointly reflect on risks and include explicit discussions about how both the clinician's and client's beliefs may impact the decision making process (Zisman-Ilani et al., 2021). This concept also includes exploring why a risk may represent something meaningful to the client and using this as part of the discussion when weighing up treatment decisions (Zisman-Ilani et al., 2021). This would help to increase how patient centred the SDM process is for each individual.

The NHSTT manual (NHS England, 2024a) refers to services that offer home visits as being “better performing services” and references that commissioners should consider appropriate funding to allow home visits to take place. However, it is not clear how common home visits are in practice as NHSTT do not currently publish this data. In the most recently published NHSTT monthly statistics data, there are variables to report number of face-to-face appointments and a variable for “other” mediums of treatment delivery, which could be where home visits are captured (NHS Digital, 2026). However, other mediums of delivery are considered explicitly, such as videocall, telephone and internet enabled mediums (NHS Digital, 2026).

With these ideas in mind, if healthcare providers want to truly move away from paternalistic cultures that reinforce hierarchy, the language of SDM and adherence may need to change. The concept of concordance has been used by some to overcome the problems associated with the concept of adherence (Chakrabarti, 2014). Initially, concordance was used to describe behaviours related to medicine taking when both the client and clinician had

discussed their views, with the clinician being responsible for eliciting these views from the client and placing the client's views as the most important (Chakrabarti, 2014). Additional concepts were then added to concordance, including an emphasis on the importance of effective communication with clients, which is detailed enough to allow them to reach an informed decision (Chakrabarti, 2014). The concept of concordance appears to be much more aligned with the NICE (2021) SDM guideline definition of SDM, which highlights the importance of the exchange of information and consideration for the beliefs of the client.

This highlights another issue with the current provision of SDM within services. As discussed earlier, the types of therapy on offer through Talking Therapies differ by area. This means a client might strongly believe that Brief Psychodynamic Psychotherapy is the right intervention for them, have done the research and be informed on why they think this would work best for them, but if the client lives in an area where this is not offered, they may feel prevented from making this choice. Instead, they would likely be given a choice from the list of options available in the service. Irvine et al. (2021) suggest that being given a choice from the list of options is common in NHSTT services, as is being given a single option with a yes or no option. Irvine et al. (2021) found in a transcript analysis that if a single option was given and declined, a second option would then be offered, but that often clients were given a single binary choice unless they pushed.

Theoretically, individuals do have the option to choose what service they are referred to for mental health care. In 2014, the legal "Right to Choose" mental healthcare providers was introduced, after having been a part of physical healthcare already (NHS England, 2014). This legal right means individuals can choose who they are referred to for mental health support; however, the referral must come via the individual's GP and individuals cannot self-refer. This allows for individuals to be referred to services that are outside of their local area (NHS England, 2014). It is not clear how commonly this is used for NHSTT.

For an individual to use this legal right, they would need to be aware that it is an option. The Independent Healthcare Providers Network (2022) survey into public awareness of the legal Right to Choose found that 53% of those surveyed were aware of their legal Right to Choose a hospital or clinic for a first NHS outpatient appointment. Whilst this legal right does cover mental health services, the phrasing of “hospital or clinic” may be more suggestive of physical health care, and at the time of writing this thesis no data could be found on public awareness of the Right to Choose specifically for mental health care providers.

Shared decision making: What does policy say?

SDM is an area of focus within the NHS, and SDM is referred to as a principle within the NHS Constitution: stating that all clients should be involved with making decisions about their care (Department of Health and Social Care, 2023). The NHS constitution details the rights of those who use NHS services for how they can expect to be treated, and provides the values of NHS England. With this enshrinement in the NHS constitution, it could be assumed that all services would be making increasing efforts to engage in SDM.

As discussed throughout this chapter, the most recent NICE guideline update for depression took place in 2022 (NICE, 2022). Among other changes, the guideline was updated with multiple references to making a “shared decision” on treatment choice as well as medication and relapse prevention. Specific recommendations were added to highlight that mental health services should include SDM within their design. The NICE (2022) guideline links to the NICE (2021) guideline for SDM and encourages health care professionals to follow this.

As discussed, the NICE (2021) guideline lays out a definition of SDM. The NICE (2021) guideline additionally recommends that services have a leader in the organisation whose focus is on implementing SDM within the service, as well as having an organisational

plan for increasing SDM. The aim of this is to encourage putting SDM at the centre of service planning to ensure clients can be involved in making decisions. The NICE (2021) guideline lays out how training for SDM should be included within induction materials and training for existing staff. Additionally, the recommendations encourage services to actively promote SDM to the people who use their care by encouraging the asking of questions such as “what are my options?” or “how can we make a decision together that is right for me?”. To assist with this, services are recommended to provide information for clients prior to discussions around treatment to help the client to feel prepared for the discussion.

Following this, the NICE (2021) guidance gives recommendations for how the discussion about the decision should take place, recommending a clear agenda is laid out, and that individuals are given the full information about what a particular treatment may aim to achieve along with the risks of each option. The guideline recommends that individuals are given enough time to ask questions and that, if it is needed, the individual should be given time to consider their options and a second discussion arranged. After the discussion and decision have been made, the guideline recommends giving the individual information about the option they have chosen.

The NICE (2021) SDM guideline recommends the use of client decision aids to support discussions around treatment options. There is a NICE produced client decision aid for depression, made on behalf of NHS England (NHS England, 2024b). This decision aid provides some information on what depression is and does allow the individual to consider their values and what they want to get out of treatment. However, the decision aid gives the treatment options as “supported self-help options”, “talking therapies as part of a group”, “physical exercise in a group”, “mindfulness or meditation done in a group”, “Talking therapies with just you and a therapist” and “medicines: Antidepressants”. Within the information sections for the talking therapies options, it is discussed that the intervention may

be CBT, other psychotherapies or counselling. However, these are all treated as making one decision to have talking therapy rather than the client being given information on the distinct types. (NHS England, 2024b).

Whilst this decision aid moves towards providing more information, it does not represent the client being given a true informed choice on type of therapy; they are only being given the informed option of therapy or medication. This decision guide has been criticised for the apparent lack of client involvement and lived experience that went into its development, as well as the lack of lived experience involvement in the development of the NICE (2022) guideline for the treatment and management of depression that the decision aid stems from (McPherson et al., 2025). McPherson et al. (2025) argue that the decision aid and NICE (2022) guideline appear to lack consideration into the ideological background of the concept of client choice, which, along with the lack of lived experience involvement are likely to limit the usefulness of both the guideline and decision-making aid in facilitating client choice. Conversely, a Canadian team of researchers developed a website-based decision aid for depression which provides in-depth information and was developed from extensive research about what the target population would value from a decision aid (Beaulac et al., 2016). Developing a useful decision aid for depression is important as there is research to suggest that decisions support by a decision aid can have improved outcomes. For example, a feasibility study for the use of a decision aid for choice of antipsychotics within first episode psychosis suggested that use of decision aids can reduce decisional conflict and lead to clients experiencing a greater sense of satisfaction with their treatment choice (Zisman-Ilani et al., 2024).

Whilst not mentioned in the NICE (2022) guideline, there is increasing interest in the use of mobile app-based decision-making aids, and clients generally find the use of these acceptable (e.g., Korsbek & Tønder, 2016 & Edbrooke-Childs et al., 2019). More recently,

research has looked towards the use of Artificial Intelligence (AI) in guiding SDM, and there is some evidence of services beginning to use AI within SDM tools to provide recommendations and treatment predictions (Abbasgholizadeh Rahimi et al., 2022). Some research suggests higher client satisfaction when AI is used to guide SDM (Jayakumar et al., 2021). However, others have highlighted the potential for AI to show bias as being a risk of its use in guiding decision-making (Hassan et al., 2024).

The current NICE (2021) guideline definition for SDM discusses SDM as being a collaborative decision between the individual and their healthcare practitioner. There is increasing research into the importance of triadic decision making, in which the views of carers or family members are also included within the decision making process (Schuster et al., 2021). Research on triadic decision making within inpatient mental healthcare identified mixed results regarding the usefulness of triadic decision making, with reports of the usefulness of caregiver expertise alongside acknowledgement that caregiver involvement could also sometimes be unhelpful. (Schuster et al., 2021). More evidence of the use of triadic decision making within the context of primary care is needed to explore if this would be useful for clients experiencing depression.

Within the NHSTT manual, there are two mentions of SDM (NHS England, 2024a). One of these concerns the number of sessions that can be offered to an individual using the service; previously these were limited in a rigid way. The manual now states that this decision should be made with consideration of NICE guidelines and by using SDM to consider if more sessions would have an increased benefit. The manual encourages that there should be no arbitrary limit on session numbers. The second mention of SDM is related to care of individuals with a long-term condition (LTC). The manual encourages the use of disease specific outcome measures to aid in SDM with clients with an LTC.

The manual refers to using the stepped-care model for treatment, which is out of line with the current guidance for depression, which introduced the matched-care model. The section of the manual on clinical leadership encourages a focus on “balancing effective and efficient service delivery with compassion and keeping person-centred coordinated care at the centre by involving patients in the development and improvement of services.” However, no specifics are given of how to do this or if particular staff have this a defined responsibility, as suggested in the NICE (2021) guideline. Within the section on supervision, which includes the discussion of treatment options, no references are made to considering the client’s views or beliefs. However, cultural competency is referenced, suggesting some consideration of the client.

The manual includes a section on how a “good assessment” looks. Whilst in the introductory paragraph it is encouraged that clinicians “determine the appropriate NICE-recommended treatment and step in collaboration with the patient,” within the description of what an assessment should include there is no discussion of how to discuss options, what information should be given about options or any indication of the need to provide pre-assessment information. Additionally, the encouragement to use the stepped-care model negates real input from the client, as the stepped-care model suggests treatments based on severity and/or previous treatment without inclusion of the client’s views and beliefs (NHS England, 2024a).

Further into the manual, it is encouraged that treatment decisions are made in collaboration with the client and considering their views “where possible.” However, as services have different options available, this may be limited. Concerning delivery of treatment, the manual states that clients should be given meaningful choice that is not forced onto them due to staff availability for a certain delivery type, e.g., less staff offering face to face (NHS England, 2024a).

There is overall a minimal amount of discussion of SDM or collaborative decisions within the NHSTT manual (NHS England, 2024a). Where this is mentioned, it is often counteracted by discussions of using the stepped-care model and outcome measures to determine treatment. Ultimately, it appears that NHSTT cannot currently offer meaningful choice as the choices that exist do not exist equally across services. This may be why the manual falls short on offering more specific guidance around SDM and client choice and why the manual is not fully in sync with the NICE (2022) guideline.

SDM: Critical considerations

Throughout this chapter, SDM has been discussed and considered in relation to its status within policy and its moral considerations. However, it is equally important to explore the limitations and criticisms of SDM. The implications of concepts used within SDM, such as “adherence”, have already been discussed. Elwyn et al. (2023) describe multiple situations in where SDM may not be the most ideal tool. One such occasion is what they describe as “wider interests override individual preferences”, which they explain as when an individual’s choice would overrule the clinician’s responsibility to prevent harm to both the individual and/or the broader population. Within mental healthcare for depression, this could a situation in which an individual presents with significant risk to self but does not want to be referred to crisis services. In this situation, taking an SDM approach would risk the clinician being held responsible for the potential consequences that may stem from allowing this choice. Similarly, Elwyn et al. (2023) also discuss limited decision making capacity due to cognitive decline as a situation in which SDM may not be ideal. Within the context of depression, this could occur within the context of severe presentations of depression which result in difficulties with apathy and motivation.

Resnicow et al. (2022) suggest that experiences of significant overwhelm and limited psychological resources due to experiences of severe mental ill health may be a situation in

which clients prefer a “provider driven” approach. Resnicow et al. (2022) also argue that using a “provider driven” approach is not necessarily paternalistic in nature and can constitute person-centred care when it matches the level of input the client wants to have with making decisions. This is reflected in the NICE (2022) guideline, which does include the caveat that professionals should be ascertaining the level of SDM that clients want to have.

Shared decision-making summary

There have been increasing efforts to implement SDM into policy in recent years, and there is increasing evidence for its use. However, some argue that SDM does not as its current definition represent meaningful choice and may instead be used to further notions of clients needing to “adhere” to treatment plans given by healthcare professionals as the goal. Despite these critiques, policy and guidelines suggest that SDM use should increase within services. However, in the context of NHSTT, the implementation of SDM appears minimal, owing mainly to the limited choices that exist across the board and an apparent resistance to moving away from the stepped-care model. As it stands, guidance and policy on SDM fails to guarantee equitable access to choice for clients with depression across the country.

Systematic review

Introduction

As discussed, interest in SDM has increased in recent years. Previous systematic reviews have aimed to explore the potential benefits of SDM for those experiencing depression, which suggest that SDM can improve client satisfaction without increasing the time needed for consultations (Marshall et al., 2021). Cartwright et al. (2024) conducted a meta ethnography to explore experiences of SDM for both staff and clients involved in mental health services. Cartwright et al. (2024) produced 4 main themes, which were the “role of service user ownership”, “the influence of fluctuating capacity”, “the importance of therapeutic alliance” and “changing clinicians’ behaviours and attitudes”. Cartwright et al. (2024) reviewed experiences of SDM within mental health broadly; this review aims to explore specifically the experiences of staff using SDM when working with clients with depression. Whilst it can be assumed that some of the experiences may be similar, a meta-ethnography has not yet been conducted to explore if there are any specific barriers to SDM when working with people with depression. Exploring barriers and facilitators may clarify what needs to change to increase use of SDM in line with the NICE (2022) guideline.

Method

Design

A meta-ethnographic approach will be used to analyse the studies in this review. The meta-ethnographic approach was developed by Noblit and Hare (1988), and the approach aims to not simply just aggregate available data but instead to add new meaning. Historically, the ideal number of studies included in a meta ethnography has been suggested to be between six and eight (Noblitt and Hare, 1988).

There are seven steps which must be followed for the meta-ethnography approach. The first of these steps is getting started, followed by deciding what is relevant, reading the studies, determining how the studies are related, translating the studies onto each other, synthesising translations and finally expressing the synthesis (Noblit & Hare, 1988). All steps were followed within this review.

Search strategy

Systematic reviews require for the inclusion and exclusion criteria for the review to be pre-defined, and to do this it is useful to first consider the concepts that the review aims to explore (Hannes et al., 2011). The use of the PICO tool is endorsed by the Cochrane library as a tool to define these concepts. PICO stands for Population(s), Intervention(s), Comparator(s) and Outcomes (Hannes et al., 2011). If a review aims to explore a specific study design type, such as aiming to review only qualitative designs, the PICOS tool may be more useful as it adds Study design as a search criterion for consideration (Centre for Reviews and Dissemination, 2009). The PICOS tool can be edited to include only concepts relevant to the review question (Centre for Reviews and Dissemination, 2009). For this review, there is no 'Intervention' or 'Outcome' to consider. Therefore, for this review the PICOS tool will be shortened to Population, Intervention, and Study design (PIS), in which the intervention is defined as use of SDM. The search strategy was developed in collaboration with the lead thesis supervisor, who has expertise in researching using SDM for depression. See table 4 for the full search strategy.

Table 4

A Table to Show the Population Intervention Study Design (PIS) Search Terms Used Within the Search Strategy.

PIS tool	
Population	staff or nurse* OR healthcare professional* OR professionals OR psychologist* OR psychiatrist* OR therapist* OR PWP* OR Healthcare Assistant* OR HCA OR GP* OR "family doctor*" OR consultant AND "mental health services" OR "mental health care" OR "psychiatric services" OR "mental health support" OR "primary care" OR "secondary care" OR "stepped care" OR "psychological treatment service*" OR "talking therapies" OR psychological therapies" OR IAPT AND depression OR depressive OR "major depressive disorder" OR MDD
Intervention	"shared decision making" OR "shared decision-making" OR sdm or "patient involvement" OR "patient participation" OR "collaborative decision making" OR concordance OR "doctor patient collaboration" OR "patient-as-partner"
Study design	qualitative OR interview OR "grounded theory" OR "focus group" OR "thematic analysis" OR phenomenolog*

The search was conducted through EBSCOhost, and five databases were included in the search: MEDLINEUltimate, APA PsycArticles, APA PsycInfo, CINAHL Ultimate and OpenDissertations. These databases were chosen due to their relevancy to the topic area and the likelihood of yielding high numbers of results. The search for this review was completed in July 2025.

Inclusion and exclusion criteria

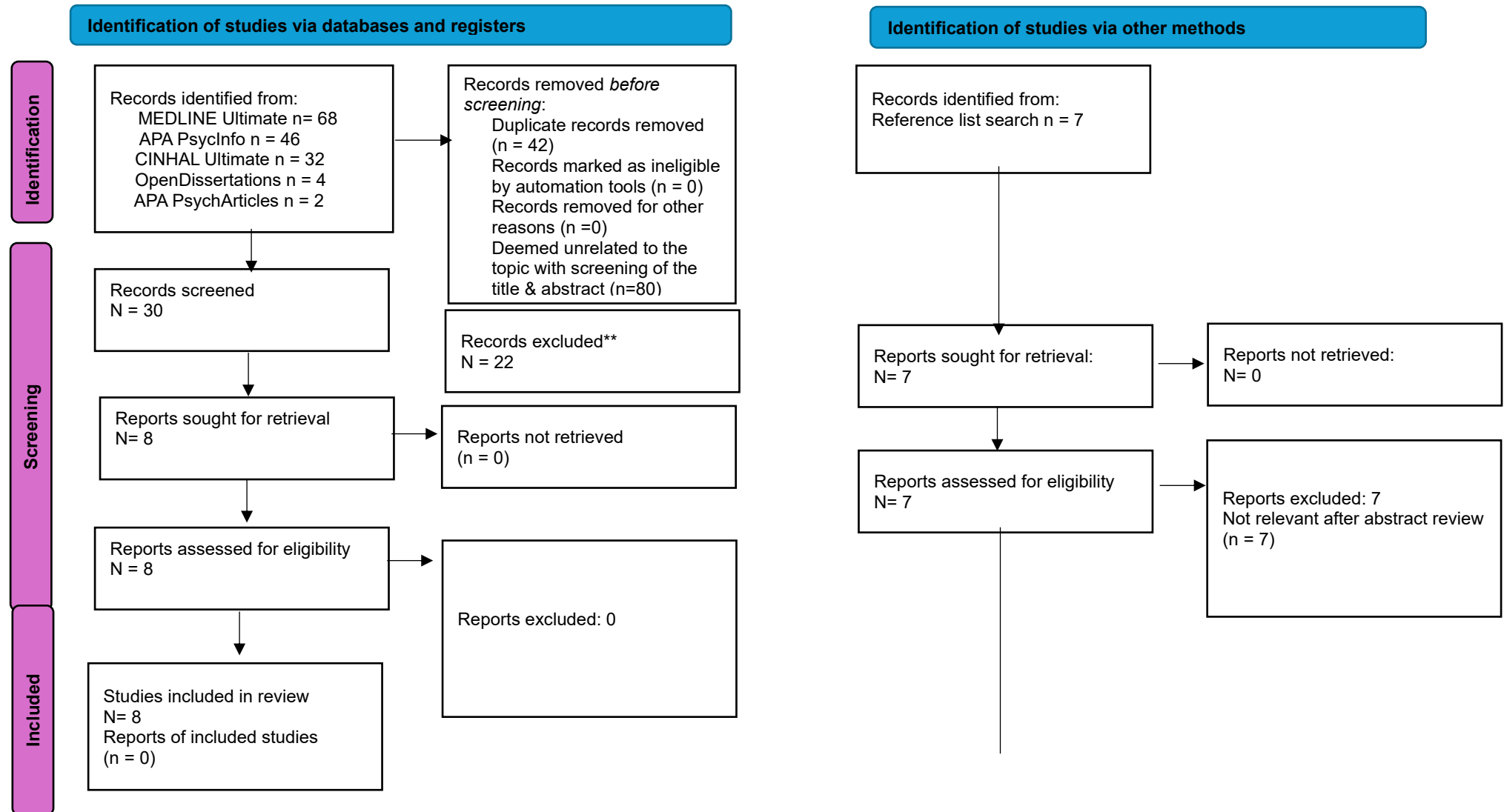
In order for studies to be included in this review they had to meet the following inclusion criteria: a) included sufficient discussion of staff experiences of involving clients in decisions, b) The decisions being made were in relation to working with people with depression, c) used a qualitative method, or mixed methods which contained sufficient qualitative results to allow for extraction, and d) papers from any country could be included, as long as they were written in English. Staff were defined as any healthcare professional who may be involved with making treatment decisions for those experiencing depression. Ideally, this review would have included only studies in which the focus was purely on treatment decisions for those with depression. However, due to the lack of very specific focused research on this, a decision was made to include studies that had a broader focus if evidence was sufficient within the research that the staff worked with people experiencing depression. Qualitative methods were defined as any method which would be likely to extract in depth discussions about experiences.

Studies were excluded if it was unclear which population the staff group were considering when discussing experiences of SDM, or if discussions were specific to a different presentation. There were several studies which centred around reviewing app-based shared decision-making tools. These were excluded as discussions were too specific to the experience and usefulness of the app.

A full break down of the process of inclusion and exclusion can be seen in figure 2. In order to assess the quality of the studies screened and deemed to be relevant for inclusion, the CASP tool for qualitative studies was included (Critical Appraisal Skills Programme, 2023). Table 5 summarises the results of the CASP tool.

Figure 2

PRISMA Diagram to Show Studies Included and Excluded (Page et al., 2021).



Data analysis

Initially, all studies were read through, and codes were added into a Microsoft Word document version of each study. These codes were then compiled into a Microsoft Excel document, and overlapping concepts were merged. Once compiled, this helped with determining how the studies overlapped and common themes among them. From here, themes were developed. This process took place over several days, and themes were reflected upon and altered throughout this process. Once this had taken place, each study was reflected on regarding each of these themes, and a second order interpretation was generated for each study, to assist in translating the studies onto each other. This is discussed further within the results section. This allowed for the themes to then be synthesised into concepts which represented knowledge from all studies included, which was then used to develop a line of argument synthesis. Themes and synthesised concepts were reviewed by research supervisors, and some edits were made to refine the results.

Critical appraisal of included studies

The critical appraisal of qualitative studies is an area for debate, with some suggesting that applying critical appraisal to qualitative studies stifles creativity (Dixon-Woods et al., 2004). Others recommend trying to balance methodological issues within a study with the importance of the richness of the data to decide quality (Edwards et al., 2000).

Within this review, a quality appraisal was conducted to guide thinking about inclusion and exclusion of studies; however, the richness of data was also considered when making decisions about inclusion. The CASP appraisal tool was chosen due to its recommendation by the Cochrane library (Hannes et al., 2011). In total, eight studies were included within this review. See table 5 for full criteria considered.

All studies showed appropriate levels of methodological based considerations, such as having a clear statement of aims and considering suitable methods of recruitment. Studies generally showed rigour in the ways that analyses were conducted and demonstrated the value of the research to the local population.

Areas of weakness for this sample were in considerations of impact of the researcher on the participant. This was only considered adequately in one of the eight studies. Gellatly (2011) was the only study that began to explore the potential impact of bias. This included having a section detailing characteristics of the researcher and described an acknowledgement that they may have some preconceived ideas and discussed how this bias would be limited, as well as discussion around how similarity to participants has benefits and costs. Some studies included mention of the use of multiple researchers in the analysis being how bias was limited. However, there were no details about the researchers or explorations of potential bias.

However, opinions vary on if researcher bias is something that researchers should aim to remove completely. Some argue that researcher bias can be a useful tool to highlight voices and experiences that may not be explored by researchers who do not have a bias towards a certain community or idea, and that these areas being brought into consciousness is useful in health research to have open and useful conversations (Buetow & Zawaly, 2022). Others argue that removal of the bias of the researcher is inherently impossible in qualitative research, and instead the importance lies in the researcher being reflexive and transparent about how bias may have affected the collection and analysis of the data (Galdas, 2017). This reflexivity and transparency are only present in one paper in this analysis.

Studies all reported having received ethical approval. However, outside of this declaration, only 2 of the 8 studies had further discussion of ethical considerations, such as informed consent. Whilst the reader can assume from ethical approval being granted that

ethics has been considered adequately, it is likely that procedures and considerations for what is deemed to be ethical will vary across different countries and organisations. This could lead to some discrepancies, and without clear details of ethical processes within the article, it is not possible to draw a clear conclusion on the ethics of a study.

The studies appraised included a good mix of professionals as well as a range of mental health settings. However, the appraised studies all took place in Western settings. One study (Patel et al., 2014) focused on experiences of African American and Latino participants specifically. No other included studies discussed the cultural backgrounds of participants or the people they worked with. This creates a difficulty in knowing who the results within the papers pertain to; there may be differences in experiences of SDM for staff from different backgrounds, and it is difficult to explore this without information on staff background. It may also be that different considerations need to be in place when thinking about SDM with clients from different backgrounds, and with no clear identification of the participant staff or the demographics of those they care for, it is hard to find this nuance within the data.

Research suggests that race can affect the way clients are perceived by staff (Medlock et al., 2017). There is also research that suggests race affects the way staff are perceived by clients (Crenshaw et al., 2025). Therefore, a deeper understanding of how this may affect SDM would be useful but is not possible with the currently available studies. Gelletly (2011) and Simmons et al (2013) both focused on staff who were working with children and young adults. This is useful as it may give insight into potential differences regarding age and the use of SDM.

The CASP (2023) tool used encourages studies to be critiqued for the value of the findings for the community being researched. The tool suggests considering if studies clearly summarise findings in relation to current policy or practice and if new areas for research are identified. They suggest considering if researchers have discussed the potential for how their

findings may be applicable to other populations or other ways their findings can be used. Patel et al. (2014) and Hamman et al. (2015) are the only two papers which did not provide areas for future research; however, both still considered the impact of their findings on policy and procedure. None of the included studies considered applications to other populations. The suggestion of considering applications to other populations appears to aim to test if a study is considering its generalisability, a concept that qualitative research often faces criticism on (Agius, 2013). However, some suggest that generalisability in qualitative research should instead be based on the idea that there is value in understanding situations and people that are similar, rather than needing to represent an entire population (Agius, 2013).

Whilst the CASP (2023) tool provides ideas for criteria that suggest if research has value, some have argued that a decision on value is much more likely to be influenced by the individual who is reviewing its “taste”, i.e., if they like the study or not (Sandelowski, 2015). Additionally, the value of adding voices less likely to be represented was considered when judging the value of a study. For example, Patel et al. (2014) focused on highlighting the voices of those who work with underrepresented populations and was the only study to do so.

With these critiques in mind, the CASP (2023) tool was used alongside a judgement on study richness and value in what it added to current research. With all these criteria considered, all reviewed studies were deemed suitable for inclusion.

Table 5

*Outcomes of the CASP Tool. Key: * indicates a score of yes on the question.*

[illegible]

Table 6*Key Features of the Studies Included in the Analysis.*

Study	Sample	Topic	Method of data collection	Method of analysis	Key findings
Menear et al. 2024	65 health professionals based in Canada working in primary care mental health care homes.	Use of person-centred care in primary care mental health care homes	Semi-structured interviews	Grounded theory	Importance of building a strong therapeutic relationship and several barriers to person centred care.
Kelly et al. 2021	10 GPs based in Ireland (3 female, 7 male).	GPs' decision process for stopping antidepressants	Semi-structured interviews	Thematic analysis	GPs less likely to de prescribe when severe depression symptoms evident. SDM reported as ideal for guiding decision making.
Bear, 2020	52 (8 males and 44 females). Mix of professional roles including both Psychologists and medical staff working in UK CAMHS settings	Clinicians' perceptions of how to manage clients with poor treatment outcomes	7 round table discussions	Framework method	4 themes influenced clinicians' management of poor outcomes: systemic pressures, treatment availability, complexity, and features of good practice
Kokanović et al. 2018	32 (18 female, 14 male). Ranging in age from 20-65. Mixed Allied Health	Exploring clinicians' use of SDM in mental health settings	Narrative interviews	Thematic analysis	Staff generally in favour of increasing use of SDM but noted their

Study	Sample	Topic	Method of data collection	Method of analysis	Key findings
	Professionals (AHPs) and medical staff working in a variety of community settings.				own disempowerment as a barrier.
<i>Hamann et al. 2015</i>	Psychiatrists working in acute mental health settings. Based in Germany.	Exploring clinicians' beliefs around what clients can do to facilitate SDM	Focus groups	Content analysis	Several themes identified, including openness; barriers also identified, such as capacity.
<i>Patel et al. 2014</i>	15 primary healthcare professionals based in the United States.	Treatment decision making from clinicians' perspective when working with African Americans and Latinos	Interviews using a topic guide	Grounded thematic analysis	Some participants reported preference for SDM, but cited barriers such as stigma and readiness to make decisions.
<i>Simmons et al. 2013</i>	22 professionals (13 female, 9 male) including AHPs and Psychiatrists based in Australia. Age range 25-54.	Clinicians' experiences of making decisions for young people with depression	Semi-structured interviews	Thematic analysis	Clinicians supported using collaborative models of care, except where issues of risk were deemed too high.
<i>Gellatly, 2011</i>	24 participants, a mix of HI and LI workers and GPs working in stepped-care.	Exploring clinicians' experiences of decision making within stepped-care.	Semi-structured interviews	Framework analysis	6 themes guided decision making, divided into service-related themes,

Study	Sample	Topic	Method of data collection	Method of analysis	Key findings
	care in England. 19 females and 5 males.				professional related themes, and client related themes.

Results

All studies were analysed to develop the key themes (see table 6). Initially, all studies were read through, and codes were added into a Microsoft Word document version of each study. These codes were then compiled into a Microsoft Excel document, and overlapping concepts were merged. From here, themes were developed that represented these concepts. This process took place over several days, and themes were reflected upon and altered throughout this process. Table 7 was created to show which themes were present in each study.

Table 7

Key Themes Occurring Within Included Studies

Study	Theme							
	Lack of choice and resource s availabl e	Time constraint s create barriers	Perception s and beliefs of healthcare staff regarding risk	Worries about discussio n of choice creating pessimis m	Greater educatio n needed for both staff and clients	SDM as ideal choic e	Paternalisti c culture as a barrier	Importanc e of honesty and therapeutic relationshi p
<i>Menear et al. 2024</i>	*				*			*
<i>Kelly et al. 2021</i>	*		*			*		*
<i>Bear, 2020</i>	*		*	*		*		*
<i>Kokanović et al. 2018</i>			*		*		*	*

Study	Theme							
	Lack of choice and resources available	Time constraints create barriers	Perceptions and beliefs of healthcare staff regarding risk	Worries about discussion of choice creating pessimism	Greater education needed for both staff and clients	SDM as ideal choice	Paternalistic culture as a barrier	Importance of honesty and therapeutic relationship
<i>Hamann et al. 2016</i>		*					*	*
<i>Patel et al. 2014</i>		*			*		*	
<i>Simmons et al. 2013</i>	*	*	*	*		*	*	*
<i>Gellatly, 2011</i>	*		*			*		

Note. * Is used to indicate that the theme is present within the study

The themes from all studies were then translated into a set of key concepts that considered themes from all studies. To complete the translation, studies were analysed individually and a second order interpretation was generated for each study based on the themes found within it. An example of this process can be seen in figure 3. The complete analysis can be found in appendix A.

Figure 3

An Example of Analysis of Individual Studies.

1. Study Gellatly, 2011

Lack of choice and resources available: Clinicians reported they frequently received referrals that were “unsuitable” and had minimal options to consider for onward referrals. Clinicians felt a bias towards focusing on offering treatments that had a shorter waiting list and may not mention treatments that may require waiting for longer. Clinicians recognised they were being asked to give choices to patients but highlighted a feeling that there were limited or no choices to really offer.

Time constraints create barriers: /

Perceptions and beliefs of healthcare staff regarding risk: Complex or riskier presentations, such as when drugs and alcohol were involved, resulted in more control of decisions being taken by the clinician.

Worries about discussion of choice creating pessimism: /

Greater education needed for both staff and patients: /

SDM as ideal choice: Most participants rated decisions that took into account patient preferences as being the most ideal and reported that this would likely increase engagement and outcomes.

Paternalistic culture as a barrier: /

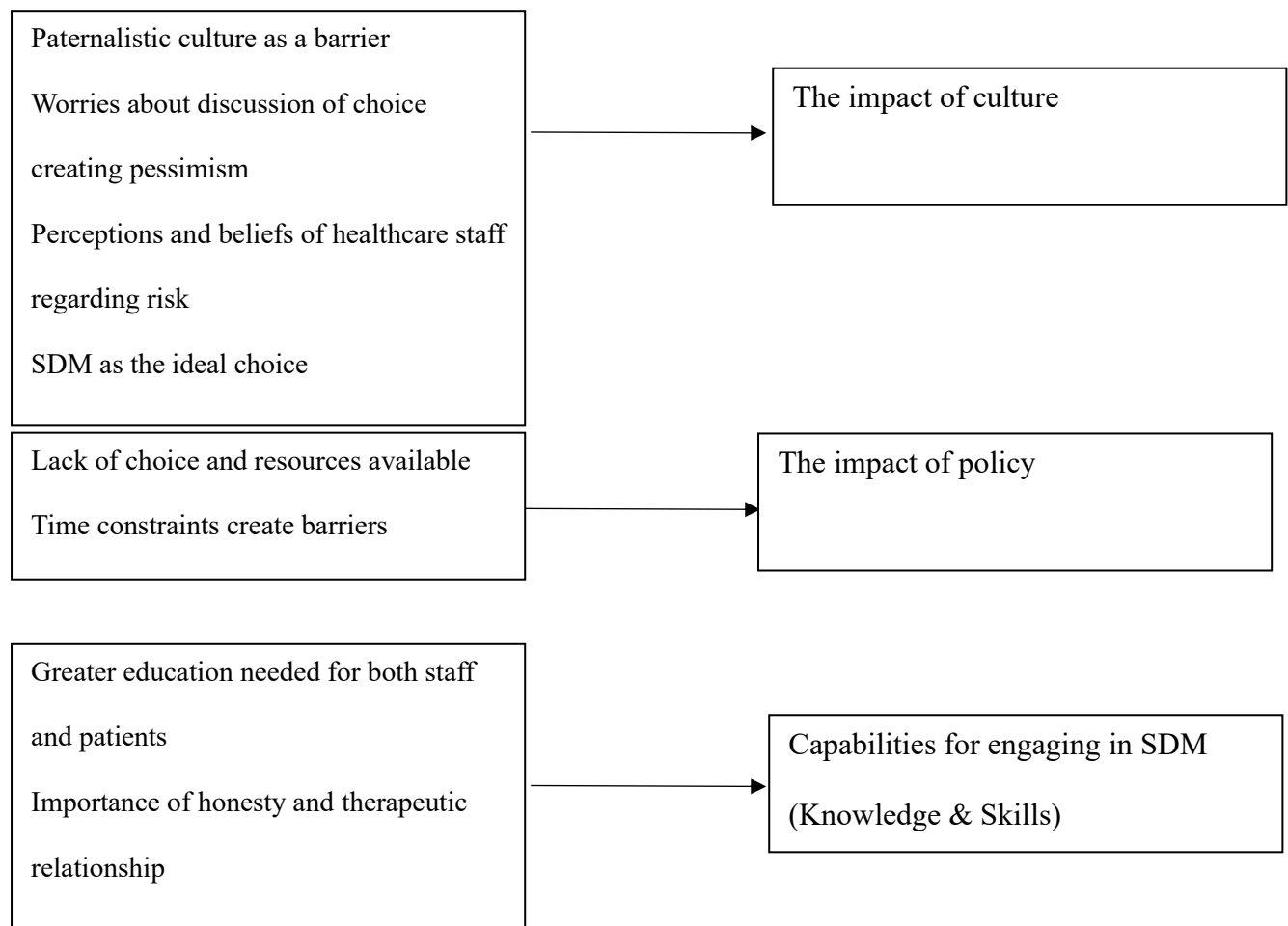
Importance of honesty and therapeutic relationship: /

Second order interpretation: Clinicians appear to be recognising a paradox in which SDM is felt to be the best option for decision making but working in a system which has minimal choices to offer. Systemic pressures such as waiting times compound this sense of a lack of choice and resources, preventing true SDM from taking place as patients are often not being offered all of the small amount of choice available.

From here, the emerging themes were then synthesised into three key concepts, and these can be seen below in figure 4. Each of these concepts and its related themes will be discussed in turn.

Figure 4

Synthesised Themes into Three Key Concepts.



The impact of culture

Paternalistic culture as a barrier. Four of the included studies made references to paternalistic cultures being a barrier to use of SDM in services. Kokanović et al. (2018) included experiences of a mix of Allied Health Professionals (AHPs), as well as medical staff. This study discussed that making a shift away from paternalistic culture would take a lot of effort on the behalf of all staff in a service, as well as highlighting that “junior staff, described attitudinal barriers to SDM that they found difficult to challenge” (Kokanović et al., 2018, page 7). Another study highlighted that “disagreements between clinicians” and “style and approach of individual clinicians” present as a barrier to SDM (Simmons et al.,

2013, page 8). This suggests that differences in attitudes towards SDM may differ within staff groups, with both AHPs and Psychiatrists being involved with this study. Services that had made a “general shift in healthcare culture towards collaborative approaches/informed clients” were identified to be more likely to engage in SDM (Simmons et al., 2013, page 8). Hamman et al. (2016) addressed this split in culture, with some Psychiatrists reporting that they did not attempt to engage in SDM as clients would likely not expect it, whilst others described clients as “partners”, suggesting a more collaborative view. This suggests that even within groups of staff from the same background, there are variances in beliefs about SDM.

Client expectations of services were also suggested to play a role in continuing a culture of paternalism, particularly when considering clients who come from a marginalised background (Patel et al., 2014). Clinicians from various backgrounds, including nurses, psychiatrists and social workers, discussed a “deference to their authority” which would be accepted by some, whilst others would attempt to involve the client in decision making (Patel et al., 2014, page 5). It is worth noting that SDM use in the US at this time was relatively low, with a 2014 review of SDM use in primary care for depression with a sample of 1168 clients indicating SDM was used around 50% of the time (Solberg et al., 2014). Therefore, this difference between clinicians would have likely been common at the time.

It was suggested that “The notion of patients as autonomous agents implied in the shared model of decision making may not align with some culturally diverse groups who identify with...paternalistic model of decision making” (Patel et al., 2014, page 6). However, efforts to educate clients on depression, stigma, possible treatment decisions and including the client’s social network in the decision-making process were identified as potential ways to address this (Patel et al., 2014). This suggests that for some groups, increasing SDM may require a greater family and community focus rather than focusing only on the client and clinician relationship. The context for Patel et al (2014) is the US healthcare system; research

conducted at a similar time to Patel et al. (2014) highlighted unequal access to services for black and Latino clients in the US (Cook et al., 2014). The service discussed by Patel et al. (2014) aimed specifically to increase access for these two groups. It could be that clinicians who accepted the “deference to authority” did so to increase the chance that clients continued to engage, rather than risking the potential rupture they may have perceived as being possible if they tried to implement SDM. This complexity may make interpretations regarding clinicians’ opinions on SDM within this study more difficult.

Worries about discussion of choice creating pessimism. Clinician worries about having discussions about choice and potential impact on clients emerged from Bear (2020) and Simmons et al. (2013). Both studies discussed a fear that being honest about available options may impact negatively on recovery and engagement. These included concerns about sharing side effects which might sound “alarming” to the client and may decrease the likelihood of medication use (Simmons et al., page 14). When talking about psychological therapy, psychologists and medical staff spoke of fears of “being too pessimistic about outcomes” for a fear that this may “put them off treatment at the beginning” and spoke of the need for “balancing hope with honesty and transparency” and how this can become “complex” (Bear, 2020, page 284).

However, there appeared to be variance between clinicians with feelings around this, as some reported a “strong desire for more informative resources” and authors noted that “Clinicians were asked about the type and amount of information they provided...variation in their Responses demonstrates a key gap in the decision making process” (Simmons et al., 2013, page 15). This suggests that, similarly to paternalistic culture, there are variances between staff groups on how much information is deemed appropriate to give.

Perceptions and beliefs of healthcare staff regarding risk. The presence of high-risk behaviours and thoughts were reported in 4 of the studies to be a reason to not engage in

SDM. A variety of different types of clinicians reported feeling uncomfortable with the possibility of harm occurring if they were not in control when risks were judged to be higher. In Gellatly (2011), HI CBT and LI CBT workers and GPs reported that if the use of drugs and alcohol were present, they would feel a need to be more in control of decisions. Psychologists and medical staff gave some insight into the potential causes for worries around risk, and authors highlighted that “Practitioners spoke about a cultural shift towards personal responsibility, liability, blame, and fear of reprimand if something bad were to occur” (Bear 2020, page 288). Kokanović et al. (2018) referenced that AHPs and medical staff who understood how to facilitate shared decisions less had greater worries around the potential risk implications of making a shared decision.

SDM as the ideal choice. Half of the studies reviewed included participants who identified that the most ideal choice of how to make decisions in services is through using SDM. All four studies suggested that the use of SDM would be “best practice” and suggested that this would be the preferred method of making decisions within their service. This was present across different clinical backgrounds, such as Kelly et al. (2021) study of GPs and Simmons et al. (2013) study, which, among others, included Allied Health Professionals (AHPs). Not all the studies discussed included direct reference to a preference for SDM; notably, some psychiatrists in Hamman et al. (2016) suggested that they do not use SDM as they believe clients would not expect it. However, others within the same study did express a desire to work more collaboratively (Hamman et al., 2016). As the studies which did include direct reference to a preference for SDM are representative of many staff groups, the development of this theme was felt to be sufficiently strong for inclusion, whilst bearing in mind that some staff groups may have more diversity in beliefs.

The impact of policy

Lack of choice and resources available. Lack of choice and resources was a strong theme generated by this data, with 5 of the 8 studies referencing that lack of choice or resources impacts offering choice and use of SDM. Bear (2020) suggested that the lack of choice available may be a result of budget cuts to services. Bear (2020, page 272) highlighted that this led to “compounding pressure on [Child and Adolescent Mental Health Services] CAMHS and caused practitioners to hold on to cases, even if they weren’t improving” to avoid individuals being “left without any support at all” due to the lack of other services available in the local area. This theme was built upon by discussions in which clinicians, including HI and LI CBT workers and GPs, identified that they often received referrals in which the “patients presenting for assessment had problems not suited to a low intensity way of working” and that this would lead to clients who “did not fit the stepped-care model...going back and forth between services as the majority of services did not see themselves as appropriate” (Gellatly, 2011, page 190 & 192). SDM was also affected by decisions having been made in other services prior to the client arriving at their current service, leaving clinicians with a prearranged treatment plan to follow which may not have been made with the inclusion of the views of the client (Simmons et al., 2013).

The impact of waiting lists was an often-reported theme within the data; clinicians discussed prioritising discussions for treatment options with shorter waitlists and withheld options with longer waitlists. HI and LI CBT workers and GPs highlighted that wait times led to “an inability to follow the principles of the stepped-care model” and led to them “making decisions they would not have necessarily made” if waiting lists were not an issue (Gellatly, 2011, page 194). Lack of adequate staffing and service options were common reasons for inequality in wait times. The overarching theme generated in relation to this sub theme is that clinicians often felt that there were no or minimal choices to offer.

Time constraints create barriers. As mentioned earlier in the “paternalistic culture as a barrier” theme, it was highlighted by Patel et al. (2014) that some clinicians, when faced with clients who expected to be given a prescribed treatment plan, did not take the time to educate the client around SDM and give the option of having choice. Some clinicians within this study, who were all primary healthcare clinicians from a variety of backgrounds, highlighted that whilst they would have preferred to do this, they did not feel they had enough time to do so with the length of appointments and caseload demands. Concerns around SDM taking too much time for the standardised length of appointments was also discussed in Simmons et al. (2013). AHPs and psychiatrists reported that there was “not enough time to discuss all of the potential risks and benefits of treatment options” in a standard-length appointment (Simmons et al., 2013, page 14). Psychiatrists expressed “regret that time constraints hinder them from making more extensive attempts to foster active patient behavior or more mutual decision making” (Hamman et al., 2016, page 8). This links with the theme of SDM being the ideal choice but suggests that time constraints make its use less likely.

Capabilities for engaging in SDM (Knowledge & Skills)

Greater education needed for both staff and clients. Three of the included studies reported a similar theme of the need for both staff and/or clients to receive education around choice. Staff needed to receive enough training about involving clients in decisions to feel confident in being able to offer education to clients about how this may benefit them (Kokanović et al., 2018). AHPs and medical staff reported that focused supervision on decision making as well as training would be helpful to increase collaboration (Kokanović et al., 2018). AHPs and medical staff suggested that clients also needed to have a better understanding of being involved in decision making for staff to feel more comfortable doing so (Kokanović et al., 2018). Psychiatrists discussed finding SDM easier if clients had become

an “expert” on their own presentation and if they engaged in “expressing treatment preferences” and if they asked for “explanations required to make an informed decision” (Hamman et al., 2016, page 4). This suggests that some clinicians expect clients to take the lead in initiating SDM and may be more unlikely to engage if they do not view the client as being an “expert”. In another study, primary care clinicians discussed the importance of “educating and orientating patients at the onset of decision making, during the information exchange stage” (Patel et al., 2014, page 5). This contrast suggests that some staff are perhaps making a shift towards placing more responsibility for education onto the clients themselves, whereas some staff are of the belief that it is their role to provide this education.

Importance of honesty and therapeutic relationship. Six of the eight studies referenced that a good therapeutic relationship laid the groundwork for conversations about choices that were more open and honest for both clinicians and clients. Primary care staff who worked in mental health care homes discussed that it was “important for them to be authentic and genuine” and that this “facilitated person centred care” (Mennear et al., 2024, page 11). AHPs and medical professionals reflected that “building trust” was key to make decisions more collaborative (Kokanović et al., 2018, page 8).

Whilst many of the studies focused on the importance of clinicians’ role in facilitating this openness and honesty, in one study psychiatrists highlighted that clients’ “lack of adequate or good manners often impedes shared decision-making” and authors noted that “physicians put more emphasis on patients being polite and respectful” (Hamman et al., 2016, page 3-4). This suggests that for some staff groups, responsibility for SDM taking place lies with the client.

Line of argument synthesis

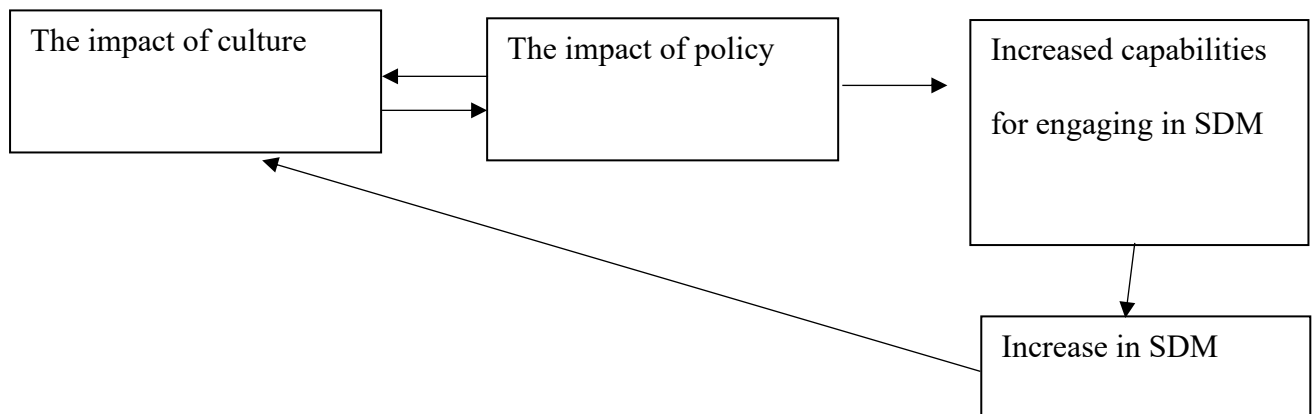
The themes generated from these studies are closely interlinked and can be synthesised to create a model for how SDM use could be increased within healthcare using

line of argument synthesis as described by Noblitt and Hare (1988). A need for culture to shift to enable greater use of SDM was identified; however, policy often limits the ways in which services can change as policies and procedures need to be in place to support clinicians to make shared decisions. Lack of resources and time were both strongly referenced as barriers to SDM, and whilst these barriers remain in place, culture is unlikely to shift as staff are more likely to default to what is quicker and readily available. For this to be addressed, changes in policy would need to take place on a much wider scale than the service level, with changes required in funding and service availability which would require governmental level intervention. Increased staffing and resource would address the barrier of clinicians feeling as if there are no choices to be offered.

As policy begins to shift in favour of SDM, it is likely that culture will shift, and as the culture shifts, further policy changes in alignment of SDM become more likely. The need for increased education for both staff and clients was highlighted; for staff to receive more training in SDM policy would have to be in place to require this. It may be necessary for public health policy to focus on greater education campaigns into the concept of SDM and the rights that clients have to be able to make choices. This would likely result in a shift in culture and reduce the time barrier cited by clinicians around having to spend time educating clients on the basics of SDM. Changes in all three of the themes would likely see an overall increase in use of SDM, with an increase of SDM use being likely to contribute to further cultural shifts. A diagram summary of the interaction between themes and increased use of SDM can be seen in figure 5.

Figure 5

Proposed Model of Improving Use of SDM Within Healthcare Services.



Discussion

This meta ethnography aimed to review and synthesise the research currently available for barriers and facilitators to making collaborative decisions that staff experience when working with individuals with depression. Using the three themes generated, a model of how to increase the use of SDM in services was proposed (see figure 5).

The theme of SDM as an ideal choice may be reflective of the impact of current policies which increasingly focus on the use of SDM in services, such as the NICE (2022) guideline and the NHS Constitution (Department of Health and Social Care, 2023). This may suggest that staff are aware of this emphasis from a policy level, and that perhaps the values of SDM align with their own moral values on client care.

However, it appears that on the ground staff are impacted by a lack of real choice to offer and being given adequate time to allow for thorough discussions of choice. So, whilst staff generally appear to be able to see the value of SDM, they are often unable to practice it due to service constraints that are beyond their control.

Strengths and limitations

The amount of research into this area is currently low. Studies were reflective of different staff populations, such as GPs, AHPs and psychiatrists. This was helpful in having a more holistic overview of the barriers experienced throughout the healthcare system, as well as highlighting that the cultural shift and perhaps the level of training required may vary by discipline.

Some of the studies included within this review were not only focused on treatment decisions for those with depression but did focus on staff groups who regularly treated clients with depression. Due to this, some of the data included within the analysis may include reflections on SDM more broadly than just a focus on depression. This lowers the overall accuracy of the review, and whilst it would have been preferred to focus on studies that clearly focused on only depression, there were not sufficient studies available to allow this. Kokanović et al. (2018) study focused on “supported decision-making”, which has some differences to Shared Decision Making. However, the study still met the criteria of discussing decision-making which takes into account the views of the client and explored the experiences of staff facilitating this and was therefore included.

Additional search terms included within the search strategy may have yielded more results for analysis. For example, including Psychological Wellbeing Practitioner in full rather than abbreviating to PWP may have found papers in which the abbreviation is not used. More types of qualitative methods could have also been included, such as content analysis.

Implications and directions for future research

Further qualitative research into staff experiences of use of SDM when working with clients with depression is needed across mental health settings. Whilst SDM as an ideal choice was generated as a theme, it often appeared that despite this, many were not practising SDM regularly. It would be useful for further research to generate more of an insight into

what level of the system is currently creating the biggest barrier to SDM, i.e., does this take place at a governmental policy level, a service level or individual clinician level. Whilst, as highlighted by the proposed model, all levels of the system would need to change, it may be useful to identify which level of the system is most resistant to that change.

Reflexivity

I am a white, working-class background woman who has direct experience of working in healthcare with individuals experiencing depression. Thus, creating a dual role of both clinician and researcher. I have been in the position to engage with decisions around treatment for depression and have experienced firsthand the difficulties that can present in trying to use an SDM approach when doing so. My own experiences of working in this field, and experiences of privilege, likely had an impact on how the themes were interpreted. For example, a focus on difficulties that were similar to my own was present during initial review of the studies. However, frequent reflection took place to ensure the credibility of the review and repeated re reading allowed for themes that were not present within my own experiences to be interpreted, such as themes around differences in opinion about SDM by those from backgrounds different to my own. Themes were also reviewed by research supervisors to assist with credibility.

Rationale for current research

The proposed research aims to work towards addressing the gap in research into NHSTT, specifically at the LI level. Whilst NHSTT publishes its own data yearly and there is an established evidence base for CBT, there is little research that focuses on NHSTT, and even less onto the practice of SDM within the service. Following the changes to the NICE (2022) guideline, and the introduction of matched-care, there should be differences in the availability of choice and an increase in SDM. Research is needed to understand if the level

of choice and SDM available in NHSTT for individuals with depression matches with NICE (2022) guideline recommendations.

As evidenced by this systematic review, there is relatively little research into staff experiences of using SDM when treating depression, and therefore the proposed research will be able to add to this in a meaningful way. The results of the proposed research may be useful in discussing how much meaningful change has occurred within NHSTT since the guidance change and may reveal new areas for future policy updates and changes.

Aims and objectives of current research

As discussed, guideline changes have encouraged wider availability of choice within NHSTT services. Therefore, one aim of this research was to get a sense of how much choice is currently on offer within these services and if this reflects what has been encouraged within the guideline. As PWP's are often the staff who assess clients that enter NHSTT services, their own views of the importance of choice and SDM appears essential to understand, and this formed a second aim of the current study. However, PWP's do not work alone within the system and are under influence of policies made by those higher in the system. This study did not aim to explore the opinions and experiences of higher management directly but did aim to understand how PWPs' perception of management views on choice and SDM impacts their work and the level of choice that can be offered. Finally, the current study aimed to examine to what degree PWP's feel able to offer choice and engage with SDM within their roles, with a focus on identifying barriers and understanding facilitators.

Method

Chapter overview

This chapter outlines the epistemological positioning of the research and how this justifies the methodology. Following this, the research methods are detailed with discussions of all aspects of data collection and analysis, including ethical considerations. Finally, potential routes of dissemination are considered.

Epistemological positioning and justification of methodology

Use of the mixed methods approach

A mixed methods approach was used to fully address the aims of the research. Quantitative methods are better suited to understand the level of choice currently offered and allowed for a wider sample to be analysed for opinions and use of SDM. Availability of specific options was not always addressed within the qualitative part of this research and was rarely considered in detail. Therefore, without the qualitative data, it would have been harder to get a clear picture of the availability of different options in different services.

Qualitative methods are useful to meet the aims of developing a better understanding of experiences and allowed for a more detailed exploration of barriers and facilitators to SDM. Exploring barriers and facilitators quantitatively would be difficult; as established in the systematic review, there are several themes that emerge as barriers. However, there is minimal research into specific barriers experienced by PWPs; therefore, studying this with a list of options for people to pick from quantitatively may have missed out the nuance and context of the services. For example, a focus on data collection impacting on SDM was not included within the quantitative survey, but this did become a strong theme throughout the interviews. Without the inclusion of both methods, this would have been missed. In summary, the use of a mixed method approach allowed for a more complicated research question to be

explored fully rather than narrowing down the research question to be purely quantitative or qualitative (Doyle et al., 2009).

History of mixed methods research

Creswell and Clark (2018) refer to the ‘formative years’ of mixed methods research as being from the 1950s to 1980s. They suggest this is when initial interest in using more than one method began, first with research using more than one quantitative method followed by researchers beginning to use both qualitative and quantitative methods within the same research in the 1970s (Creswell & Clark 2018).

This increasing interest led to conversations about if qualitative and quantitative research could be combined, due to the conflicting philosophical beliefs of both methods (Creswell & Clark, 2018). This led to a shift in mixed methods research beginning to develop its own set of philosophical foundations, and with suggestions to allow for the use of different paradigms if each was followed rigorously and explicitly discussed (Greene et al., 1989). From here, Creswell and Clark (2018) suggest that mixed methods research entered a phase of early procedural development in which researchers began to write more often about the purposes of mixed methods research and focused on consolidating a set framework. This procedural development continued into the early 2000’s, and mixed methods research began to become more formalised and accepted within the research community, with the American National Institute of Health (NIH) publishing guidelines for mixed methods research in 1999 (Creswell & Clark, 2018).

Paradigms

Historically, mixed methods research has come under scrutiny for the apparent mix of paradigms it requires (Creswell & Clark, 2018). A paradigm was defined by Kuhn (1970) as a set of beliefs and values held by individuals within the same speciality and community;

however, he suggested that a shared paradigm does not necessarily include an agreement on set rules.

Traditionally, quantitative research has been viewed as following a realist paradigm, in which the shared belief is that there is an objective reality that can be measured and observed and that the world follows defined rules (Harper, 2011). This paradigm can be further split into direct realism, in which the assumption is that data directly mirrors reality, and critical realism in which the assumption is that data can tell us about reality but that participants may not have a conscious awareness of the impact of every factor that may affect their experience of the concept being studied and therefore the data does not fully mirror reality (Harper, 2011).

Qualitative research has typically been associated with a constructivist paradigm (Creswell & Clark, 2018). This paradigm suggests that concepts can be understood through the study of individuals' views, assumptions, and experiences of the concept (Creswell & Clark, 2018). These views and assumptions are termed constructions (Harper, 2011). Social constructionists argue that constructions are formed through engagement in the social world and that some constructions have more power within society than others (Harper, 2011).

In short, quantitative paradigms typically follow a belief that there is an objective truth to be measured, whilst qualitative methodologies typically follow a belief that there is no objective truth to be measured and that individuals construct their own realities. As discussed, a period of conflict regarding the mixing of these paradigms occurred. This led to a desire to develop a paradigm that better reflects the philosophical views of mixed methods research (Creswell & Clark, 2018).

Pragmatism

Pragmatism is a common paradigm applied to mixed methods research (Creswell & Clark, 2018). Whilst the previously discussed paradigms aim to apply a single belief about

the existence of reality and how this can be measured, pragmatism instead focuses on the consequences of the research and the importance of the question that the research aims to explore (Creswell & Clark, 2018). Pragmatism works under the assumption that there can be both single realities, as proposed by realism, and multiple realities, as proposed by constructionism. The focus is on what methodology would work best in real world practice, rather than a focus on philosophical principles and paradigms (Creswell & Clark, 2018).

Concerning Axiology, the role of values within research, pragmatism allows for a researcher to take more than one stance. This means that the researcher can both acknowledge their potential biases and use these within interpretations and present unbiased perspectives in which checks take place to remove potential bias (Creswell & Clark, 2018). Pragmatism also allows for deductive methodologies in which a preexisting theory is being tested to be mixed with inductive methodologies in which the experiences of the participants are used to generate theories (Creswell & Clark, 2018).

Pragmatism applied to the current research

A pragmatic paradigm is suitable for this research due to a combination of both constructionist qualitative research, which focuses on inductive methodologies to generate knowledge about theories and quantitative deductive research in which there is a view of SDM as something that can be measured.

In initial descriptions of Reflexive Thematic Analysis (RTA), the method was proposed not to be bound to a specific ontological or epistemological theory (Braun & Clark, 2006). However, in more recent works the method has become more rooted in a constructionist approach (Braun & Clark, 2020). Taking a constructionist approach has implications for considering how the importance of information within the data is derived from the interviews (Byrne, 2022). For a theme to be thought of as important, it was deemed essential that the theme did not simply just have a high level of reoccurrence within the data,

but that the theme was explored in terms of its overall meaningfulness, taking into account things such as the amount of certainty a participant spoke with regarding the theme and the importance of the theme in answering the research question.

The constructionist view influenced the way in which coding of the transcripts took place. As discussed in Braun and Clarke (2022), the use of codebooks or coding frames, as well as a focus on inter-rater reliability, does not fit within the framework of RTA. This is because of the belief that meaning and knowledge are subject to the context they are found in, and the researcher themselves and any subjectivity they may hold are part of how the knowledge is produced. This differs to other approaches to Thematic Analysis (TA) in which the subjectivity of the researcher is avoided using strict, predetermined coding practices (Braun & Clarke, 2022).

This view of the researcher's potential subjectivity as forming part of the knowledge production was a key reason for choosing this methodology. There is undeniably a level of subjectivity with which the data will be analysed, as the researcher themselves has worked within the role being studied and felt the direct implications of the, at the time, perceived lack of SDM in NHSTT. The concept of analysing the data in a reflexive manner is to consider the researcher's subjectivity that will exist in the analysis, and to reflect on this as means to further expand on the meaning generated from the data (Gough & Madill, 2012).

The quantitative survey element of the research focuses on SDM use as something that can be measured. The survey focuses more on measuring understanding of what SDM is, awareness of policy changes, presence of discussion of SDM in training, and individuals' own use of SDM in clinical work. This presents a much more deductive methodology, which the qualitative research will then build upon with the generation of themes of what SDM looks like in practice, and the felt experience of using it.

Design

For this research, both the qualitative and quantitative research will run at the same time but separately to one another. The data from both will be analysed separately; however, once analysis is complete, the qualitative and quantitative data will be compared to allow for a combined interpretation of both data sets. This is referred to by Creswell and Clark (2018) as convergent parallel design. This allows for a greater understanding of the use of SDM and PWPs' experiences of it to emerge. This fits within the framework of pragmatism, which allows for qualitative and quantitative methods to be occurring concurrently within the same study and allows for this data to be integrated to answer the proposed research questions (Creswell and Clark, 2018).

The quantitative element of the study aimed to explore the current practices of PWPs regarding SDM; this was explored using an online survey. Upon completion of the survey, participants could opt to leave contact details to agree to be contacted with more information about the qualitative element of the study, an interview. Interviews were chosen for this research to allow participants a free space for individual reflections on personal experiences. It was felt that focus groups may lead to a biasing towards one opinion or experience becoming the predominant narrative and that this may have limited the richness of data.

Service context

The context for this research includes both NHSTT and PWP training courses at various universities. For trainee PWP participants, both contexts are relevant at once; for qualified participants, their NHSTT service is their context.

NHSTT began as Improving Access to Psychological Therapies (IAPT) in 2008, with the name changing to NHSTT in early 2023. NHSTT services have an aim of treating those with low to moderate depression and anxiety symptoms, and services are typically focused around delivering evidence-based interventions, the use of frequent outcome measures, and outcome focused supervision (Health Education England, N.D). Services are commissioned

by ICBs, and on a local and national level the services are controlled by NHS England (NHS England, N.D).

It is important to note that this research focuses only on PWPs within England. NHS Scotland introduced a similar service in 2019, called the Mental Health Hub, which includes PWPs within its workforce. However, the service is different to NHSTT in several ways; there is a larger Multi-Disciplinary Team (MDT) focus, and there are some client population differences. Training is also different, with training taking place inside services and lasting for 4 weeks. Currently, the service is only available in two locations in Scotland and has not been adopted as broadly as the NHS England NHSTT (NHS Education for Scotland, 2023). Within NHS Wales, the role of PWP exists; however, NHS Wales do not currently have an NHS Therapies offering, and there are no training courses at Welsh Universities (Health Education and Improvement Wales. (n.d.). These differences would make for different contexts for PWPs in England vs PWPs in Scotland and Wales, which may require further analysis to compare results within the different contexts, and therefore it was decided that this research would focus on PWPs within NHS England.

PWP training courses are offered at universities throughout England and are required to follow the British Psychological Societies (BPS) approved curriculum. Courses take place typically over 12 months and require students to attend a mixture of university teaching days and placement days to gain in service experience as well as theoretical knowledge.

Participant inclusion/exclusion criteria

The target population for this research was both trainee and qualified PWPs. Any trainee PWPs currently enrolled on a British Psychological Society (BPS) approved course were eligible.

Qualified PWPs were defined as PWPs who had completed an accredited training course. Qualified PWPs did not have to have stayed in the service they trained in to be

included, and there were no requirements for length of time qualified. However, to be included, they were required to be currently practising as a qualified PWP. No criteria for length of time worked was decided to be able to capture a range of experience levels more fully. As the changes to the NICE (2022) guideline, which prompted the study was very recent, it was thought that there may be an effect on those who had more recently qualified versus those who had been in post longer. This would allow exploration of if changes have happened within the university training courses more recently, and if services had provided training to staff who would have completed training prior to the changes in policy.

Both trainee and qualified PWPs were included in the study for similar reasons as discussed in the previous paragraph. Allowing for both trainees and qualified staff to respond allowed for greater exploration of potential barriers to SDM and choice within services, as it allowed for identification of where the barriers sit; either in training, within services, or both. It was also felt to be important to understand what changes had been made to the university courses since the guidance change, and if these changes were sufficient. As if the results highlighted that teaching on choice and SDM were not significant enough, this would highlight a key area for change and improvement. Similarly, having the inclusion of qualified staff was important to identify any service specific barriers and areas for improvement. If barriers in both training and service provision are identified, the potential solutions can target both areas and have a greater overall impact on service delivery and client care.

Procedure

Recruitment

Participants for the survey were recruited via social media in several ways. Pre-existing social media pages dedicated to PWPs were used to advertise the study. An advert was posted on these pages with a brief explanation of what the research would entail and the

aims of the research. Social media was used more generically with posts on the researchers' LinkedIn page, and advertisement via social media influencers in the relevant field on Instagram. A copy of the poster used to advertise the study on social media can be seen in Appendix B.

LinkedIn was used to contact those who had Trainee PWP or PWP as their job role to share information about the study. First, participants identified this way were sent a brief message outlining the study and seeking consent to share further information (See appendix C). If the individual replied and indicated consent to receive more details, they would be sent the study link, an introduction to the research and a copy of the study poster, which provided further details. The message scripts used for this can be seen in Appendix D. No personal information (e.g., contact information) was collected this way; individuals instead were encouraged to either email the researcher directly or leave their contact details at the end of the survey.

Social media was used to recruit to attempt to provide access to a wider geographical range of participants than advertising through local resources. This was felt to be important to ensure that the research reflected broad experiences, rather than experiences in one locality.

Professional networks were used to spread the study; the BABCP LI Special Interest group included the study poster in their newsletter sent out to those registered for the group.

Participants who completed the survey were asked at the end if they would like to receive information about the interview part of the study. If participants indicated interest, they were then given the option to leave contact details.

This research recruited 12 participants for the interviews. Research suggests that saturation is typically reached in interview studies after 11-17 participants, meaning that after this point it is unlikely that any new rich information would be added (Hennink & Kaiser, 2022). The current number of registered PWPs in the UK is 4100, including trainee staff

(Health Education England, 2022). With this population size and utilising a confidence level of 95% and margin of error of 5%, the appropriate sample size for the quantitative survey element of the research would have been 352 to conduct inferential statistics such as linear regressions to test, for example, if value placed on SDM could be used to predict use of SDM. However, as the quantitative survey element of this research was not designed to be standalone and acted as a method to gain descriptive statistics and wider perspective on the level of choice, such a high sample size was not needed.

Survey procedure

As discussed above, the survey was accessed by participants via a link. The initial page of the survey acted as a participant information and consent form (see Appendices E & F). All consent options had to be agreed to move on further within the survey. From this page, participants were then presented with demographic questions including their status as either a qualified or trainee PWP. Depending on this answer, participants were asked different questions, and some questions were omitted to ensure relevancy for the group they belonged to. The end of the survey provided the option to end the survey or continue to receive more information about the interview and provide contact information.

Procedure post recruitment for interview

Once participants had opted in to receive more information regarding the interview portion of the research, they were emailed the consent and participant information forms by the researcher. From here, participants were given the chance to review all information and ask any further questions. If happy to proceed, the consent form was signed and returned to the researcher. Once consent had been gained, the researcher set up an online interview at a time that was mutually agreed upon.

At the beginning of the interview, participants were reminded of confidentiality and their rights to withdraw from the research. Participants then engaged in a one-hour interview using the interview topic guide to provide structure to the interview, but with priority given to exploring the points raised by the participant that felt important to explore. At the end of the interview, participants were given a space to reflect on their experience of the interview and to ask any questions they may have following the interview. These check ins were brief, and participants did not report any distress that needed formal debriefing. Following this, participants were thanked for their involvement and reminded of contact points should they have any questions or concerns.

Measures

Quantitative measures

Within the survey, as an aim of the research was to analyse the number of participants aware of policy changes and examine level of choice in services, a mixture of Likert scale questions and multiple-choice questions were used. See Appendix G for full survey.

Demographics. To assess the reach of the survey, participants were asked to provide demographic information. Participants were asked which university provided their training, and if they were qualified or still in training.

Experience and knowledge questions. All participants were asked to indicate if they were aware of the NICE (2022) guideline updates. Participants were asked to identify what types of choice are on offer where they work, which included both treatment modality and mode of offer (e.g., face to face, telephone). A question was included to ask participants about how much space and time is given to SDM within their standard assessment protocol. Participants were asked to rate the value they place on SDM as a practitioner on a 0-100 scale, they were asked to do the same for how much they felt SDM was valued by their

service leads. Additionally, participants were asked about how often they would be asked about client preferences within supervision spaces.

Trainee specific questions. If participants identified that they were still in training, they were asked a distinct set of questions. This included questions about amount of SDM teaching, the importance that was placed on SDM by both the university and their placement and if there were any assignments or classwork that specifically addressed SDM. A mixture of multiple choice and scale questions were used for this.

Qualified specific questions. If participants identified they were qualified, they were directed to a question which asked how long they had been qualified for. They were not shown the trainee specific questions discussed above.

The OPTION Scale. To analyse the level of SDM currently used by the participants, the Observing Patient Involvement (OPTION) scale was used and adapted. The OPTION scale is typically used within observations of clinical practice (Elwyn & Edwards, 2003). The OPTION scale was developed following a systematic review which revealed that at the time there was no measure to use to indicate how much healthcare professionals were involving clients in making treatment decisions (Elwyn & Edwards, 2003).

The OPTION scale items were constructed through analysis of literature reviews and previous qualitative studies and through consultations with both practitioners and clients. The construct validity of the scale was tested through the examination of four hypothetical constructs. These were that the OPTION score level would be influenced negatively by client age, positively in favour of females for clinician gender, positively by qualification level of the clinician and positively for consultations in which ‘clinical equipoise’ was present for the topic being consulted on (Elwyn & Edwards, 2003). Clinical equipoise is defined as “a state of genuine uncertainty on the part of the clinical investigator regarding the clinical merits of each arm in a trial”, meaning that equipoise is present when clinicians have a genuine

uncertainty in which treatment option is more beneficial (Freedman, 1987). Two of these 4 hypotheses were found to be correlated with involving the client in decision making, presence of equipoise and age of the client; the lack of correlation for the other two hypotheses is suggested by the authors to be explainable due to the lower research quality in support of the two remaining hypotheses (Elwyn & Edwards, 2003). In a sample of 186 recorded GP consultations, the OPTION scale was found to be reliable in detecting differences in client involvement in decisions between groups of consultations. Inter-rater and intra rater reliability was tested, and both were found to be above acceptable levels (Elwyn & Edwards, 2003).

For use in this research, the scale was adapted to encourage participant self-reflection on their current use of SDM. The adapted scale contained the original twelve questions from the OPTION scale reframed to “I” statement questions to encourage this self-reflection, such as “I explain the pros and cons of options to the patient (taking ‘no action’ is an option)”.

Answers were scored on a 0-4 scale in which:

0= I never do this

1 = I make a minimal attempt to do this but I do not think I do this often enough

2 = I do this to a minimally acceptable level

3 = I think I do this fairly well

4 = I think I do this very well

The score is then totalled, with a higher score indicating more involvement with SDM practices than a lower score.

As well as rating use of each OPTION scale skill, participants were then also asked to rate how important they felt each OPTION scale skill is to get a sense of the value placed on each skill by clinicians. This score was totalled to give an overall OPTION scale value score.

Qualitative materials

To guide the interview, a topic guide was developed and can be seen in full in Appendix H. The topics included within the guide were chosen to break down the experiences of PWPs into three areas: experiences of training, experiences of clinical work and perceptions of management views. These areas were chosen to enable PWPs to reflect on different areas where both barriers and facilitators to SDM may be present within their roles. The content of the topic guide was also discussed and agreed with the research supervisor. The aim of the topic guide was to structure the interview but allow freedom to explore topics brought up by the participant which may have otherwise been missed with closed questions. The semi structured nature that the topic guide provides has been suggested to give a good balance between allowing the researcher to focus the conversation on the desired topics and themes whilst allowing the participant and researcher to explore additional topics and themes that become important during the process of the interview, which is likely to lead to richer data (Leavy, 2020).

Analysis

Quantitative Analysis

Survey data was analysed using IBM SPSS statistics version 31.0.0.0. Descriptive statistics were the focus of most of this analysis, to address one of the aims of the research, which was to determine the level of choice available and awareness of SDM policy changes. Survey data helped to contextualise the views and experiences of PWPs in using SDM and the perceived views of management.

For questions that contained yes or no answers, the frequencies of each answer were found. For the questions that involved rating scales of 0-100, the averages of these scores were calculated, and means and standard deviations (*SD*) were reported.

To help to explore if training facilitated higher engagement in SDM, an independent sample t-test was run to explore differences between use of SDM for qualified and trainee PWPs.

As this study aims to explore barriers to SDM, correlations were explored between variables that may be associated with SDM use. The length of time a participant was qualified for was correlated with total score on the SDM use version of the OPTION scale. To explore if valuing the items in the OPTION score more highly was correlated with higher scores on the use of OPTION scale items, a correlation was run between the means of these scores. It was considered that the mean rated importance participants believed senior leads placed on SDM may be associated with a higher score on the SDM use version of the OPTION scale; therefore, a correlation was completed to test this.

Qualitative Analysis

The interview data was analysed using RTA (Braun and Clark, 2022). The six steps of analysis for RTA as discussed in Braun & Clark (2022) were followed. This began with the process of transcription and then the repeated re-reading of the transcripts to become more immersed in the data, considering things such as how the words were said as well as the content. For the transcription process, the automatically generated transcript provided by the video calling software was used. However, this was then checked using the recorded interview to ensure accuracy of the transcript. This helped to begin the process of becoming emerged in the data. Transcripts were checked and corrected in this way as and when the interviews occurred and therefore began before all data had been collected. This allowed for reflection and increasing knowledge around common challenges and barriers that presented often in interviews to help to guide the interview questions.

When formal data analysis began, to further enhance the immersion in the data, each transcript was read through again. At the first re-reading, no formal notes or annotations were

made; the aim was instead to get a picture of the data as a whole and to become re-emerged within the transcripts that had been created much earlier in the recruitment process.

Following this, each transcript was then revisited one by one and coding began. Coding took place via the use of annotations directly onto the transcript on Microsoft Word. A database of initial codes was kept on Microsoft Excel, as well as timestamps for where the code was present and how many transcripts it was a part of. All transcripts were worked through in this way. Once all transcripts had been coded, the initial codes were revisited. It became clear at this point that some codes were very similar to one another, and that some codes could be merged. An example of this was that in initial coding, codes for inaccurate referrals making SDM harder and lack of GP understanding causing inaccurate referrals were both present. This could be better explained by a code covering both factors: lack of understanding from referrers leading to inaccurate referrals, which make the process of SDM harder.

Once codes had been revisited and tidied, the final codes were then used to begin to interpret the themes they represent. Once these themes were extracted, codes were assigned to a theme using a colour coding system. These were then checked over again after a short break in time. From here, themes were broken down into smaller sub-themes and the codes that corresponded to these sub themes were then arranged into them. Some themes were identified at a semantic level, meaning they were representative of what could be explicitly interpreted from the data (Campbell et al., 2021). However, some sub-themes involved a latent analysis of what may have been more of an underlying concept that could be interpreted upon reflection from the data but was not as explicitly stated by participants (Campbell et al., 2021). An example of this is the sub-theme of “Moral injury created from being unable to engage with SDM”. Whilst participants did comment on the difficult feelings that arose from not always being able to offer choice, they did not specifically identify this as a moral injury. However, reflecting on both the semantic data which supported the views of

PWPs being that SDM did align with their personal values, and the data which supported that these difficult feelings contribute to people leaving the role, a sub theme about moral injury could be reasonably interpreted.

Transcripts were again revisited and re-read, within the context of finding the quotes from each paper to represent each theme. Quotes were compiled together. Once this was complete, the quotes were read through for each theme, and the quotes that best represented the theme or subtheme were chosen to then be used within the write up.

Throughout this process, themes and subthemes were continually revisited, and as quotes were gathered, this led to some subthemes changing and merging as it became apparent that they were covering very similar ideas. Theme names changed throughout the process of write up as it became clearer exactly what that theme was interpreting. A final thematic map was created which shows all finalised themes and subthemes, and this can be seen in appendix I.

Ethical considerations

As this research used an NHS staff group, attention was paid to the way in which participants were recruited to minimise the risk of ethical issues arising. Participants were not recruited directly via any NHS trust platform. This was to decrease the chance of potential participants feeling obliged to take part due to the invite coming via their employer. Conversely to this, it was felt that recruiting directly via the trust may lead to ethical dilemmas for participants who wanted to engage with the research but may have had concerns about the research having direct links back to their employers and if this may have any impact on them within their role. This was additionally combatted by having all interviews take place away from any NHS setting.

Anonymity of data was always ensured during the research. Where survey respondents chose to give contact information to be contacted for interview, this contact

information was stored securely within the survey and not exported. All interview recordings were stored securely online in password protected accounts and deleted once transcription had taken place. Any potentially identifying information, such as names or locations of a service, were omitted from the transcripts.

Informed consent was obtained from all participants. Initially, participants were asked to provide consent for the online questionnaire. All consent boxes had to be ticked before participants could move to the next stage of the survey. Additional consent and participant information was then provided if the participant opted to receive further information about the interviews. The information sheet for interviews can be seen in appendix J along with the consent form in appendix K.

It was not the aim for questioning within the interview to be upsetting or distressing for participants, and the risk of this was viewed to be low given the themes of the research. However, attention was paid to the fact that individuals in the interview may have felt they were being questioned on how well they were doing within their job role and that this could cause unpleasant emotions for the participant either during or after the interview. This was addressed by clarifying with all participants that the aim of the study is to improve service provision, rather than to focus on an individual clinician level.

Ethical approval was granted by the University of Essex ethics committee under Annex B (see appendix L).

Dissemination

All participants who engaged in the interview part of the research were offered the option of receiving a summary of the research findings. This summary provided key details of the findings and the potential applications for future research, as well as potential implications for clinical work/policy. This method of dissemination was felt to be important as it has been argued that including participants in dissemination of results is more ethical

and helps to ensure participants are not just seen as something useful to meet a research goal but are respected in their rights (Fernandez et al., 2003). As the participants in this research are the clinicians within the field in which this research is trying to enact change, it was felt to be even more essential that the participants were made aware of the results of the research. Contact information for those who took part in only the survey was not gathered; however, it is hoped that dissemination via the use of the same social media sites which were used for recruitment will reach many of those who took part.

Another channel of dissemination for this research could be within relevant academic journals. There are currently no specific journals for research within the area of LI CBT, or NHSTT work in general. However, there are journals that are provided by the two options of registering bodies for all PWPs within the UK: the British Association for Behavioural and Cognitive Psychotherapies (BABCP) and the BPS. The BABCP provides access to the Behavioural and Cognitive Psychotherapy Journal and the Cognitive Behaviour Therapist journal for all members. The BPS provides access to multiple journals for its members, with the British Journal of Clinical Psychology appearing to be the most relevant for dissemination in this case. There is currently no available data to show which of the two registering bodies received the most registrations from PWPs; however, with the more explicit focus on CBT and practice within CBT based organisations that is held by the BABCP, it may be that opting for a journal they provide ensures that more staff working in the area being researched are able to read the research.

A final method of dissemination that could be considered is seeking to present research findings at a relevant conference. The BABCP run an annual national conference in the summer which has in the last few years included a one-day workshop specific to discussing LI CBT specific research. This conference would likely be the most relevant one

to discuss the research findings to target dissemination to the group to whom the research is relevant.

Reflexivity

Choices made regarding the design of this research were impacted by my positionality as the researcher. The design of both the qualitative and quantitative questions used within the research were influenced by my own experiences as a PWP, which gave me an insight into what areas would be useful to ask about to gain rich data. Acknowledging this aspect of positioning was also relevant when choosing RTA as the qualitative method, as attempts to remove the impact of these experiences on data collection would not be possible. My own previous experiences as a PWP also influenced the choice to include PWPs as the focus within this research. There were many types of clinicians that it would have been equally possible and relevant to study. However, reflecting on my own experiences as a PWP and feeling unheard in relation to clinical decisions despite being at the frontline of assessments resulted in the desire to focus on PWPs. Frequent reflection took place during analysis to ensure that all aspects of data were being considered.

Results

Chapter overview

This chapter provides the full results for this piece of research. Firstly, quantitative results are presented. Secondly, the themes and subthemes identified from the interviews are discussed. The data discussed within this section were collected between January 2025 and March 2026.

Quantitative results

Participant characteristics

In total, 93 participants took part in the survey part of this research. Participants were given free response boxes to provide demographic information. For the sake of brevity and anonymity of this report, some self-defined categories have been merged in table 8. Overall, 69.9% of participants were between the ages of 22-30, 84.9% identified as female, and 70.9% were white. A broad geographical area of respondents can be seen in table 9.

Table 8

Participant Demographics

Demographics	N (%)
Age	
22-25	30 (32.3%)
26-30	35 (37.6%)
31-35	11 (11.8%)
36-40	8 (8.6%)
41-44	4 (4.3%)
44-48	2 (2.2%)
48-52	2 (2.2%)

Demographics	N (%)
Gender	
Female	79 (84.9%)
Male	6 (6.6%)
Non-binary	6 (6.6%)
Ethnicity	
White British	48 (51.6%)
British (undefined ethnicity)	6 (6.5%)
White European	3 (3.2%)
White (undefined)	11 (11.8%)
White other	4 (4.3%)
Black African or Black	4 (4.3%)
Caribbean	
Mixed – white and black	4 (4.3%)
African or black Caribbean	4 (4.3%)
Mixed – white and Asian	2 (2.2%)
British Asian (Pakistani or	4 (4.3%)
Indian)	
Asian	3 (3.2%)
Indian	2 (2.2%)
Other	2 (2.2%)

Table 9*Participant Location (service where employed)*

Location of service	N	Percentage
London	19	20.4%
Southwest England	5	5.4%
Southeast England	17	18.3%
East of England	12	12.9%
West Midlands	7	7.5%
East Midlands	4	4.3%
Yorkshire and the Humber	9	9.7%
Northeast England	14	15.1%
Northwest England	2	2.3%
No response	4	4.3%

Qualified participants were the bulk of respondents at 75.3%. The full split of qualified vs trainee participants can be seen in table 10.

Table 10*Qualification Status of Participants*

Qualification status	Number	Percentage
Trainee	19	20.4%
Qualified	70	75.3%
No response	4	4.3%

Qualified participants were asked to indicate how long they had been qualified for. This was a free text response; these text responses were recoded to become numerical data. Responses of less than 1 year were coded as 0.5. All other responses were coded according to the total years qualified, e.g., 2.5 years would become 2. Where text values were unclear, e.g., “1” with no qualifier of months or years, this was recoded to be treated as missing (n=27). Most participants (53%) had been qualified for 1-2 years. Table 11 summarises the data for valid responses for length of time participants have been qualified.

Table 11

Years Qualified

Years qualified	Number	Percentage
Less than 1 year	21	31.8%
1-2 years	35	53%
3-4 years	5	7.6%
5+ years	5	7.6%

Participant Awareness of NICE guideline changes

When asked if they were aware of the NICE (2022) guidelines changes, 46.2% responded that they were aware of this change. However, a similar number of respondents were unaware of the NICE (2022) guideline changes (40.9%). Responses to this are seen below in table 12.

Table 12

Participant Awareness of NICE (2022) Guideline Change.

Aware of guideline change	Number	Percentage
Yes	43	46.2%

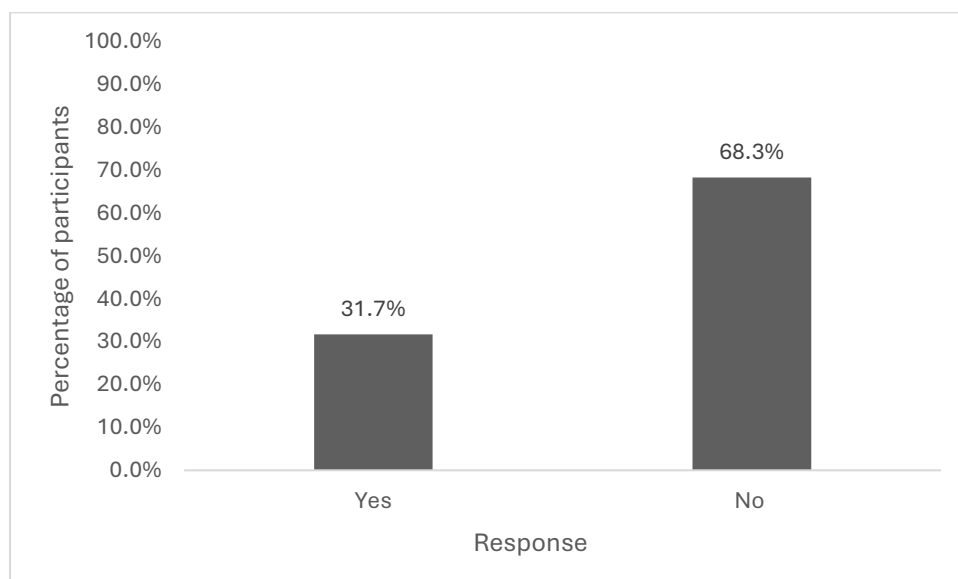
Aware of guideline change	Number	Percentage
No	38	40.9%
Further details given	7	7.5%

As part of this question, participants were given the option to provide free text response for further details if they wished. In summary, some participants used this response box to detail reasons they may be unaware. One respondent used this to report that they were not aware of the guideline change but detailed how they find their service does well at offering choice and SDM. One respondent used this box to state “this service does not offer choice at all”.

Participants were asked if they had noticed any changes in the amount of SDM in services since the guideline changes in 2022. This question was not relevant to all respondents. The responses for those who responded yes or no (n=63) can be seen represented in figure 6 below.

Figure 6

Participants' Awareness of Changes to Amount of SDM Taking Place in Services Post 2022.



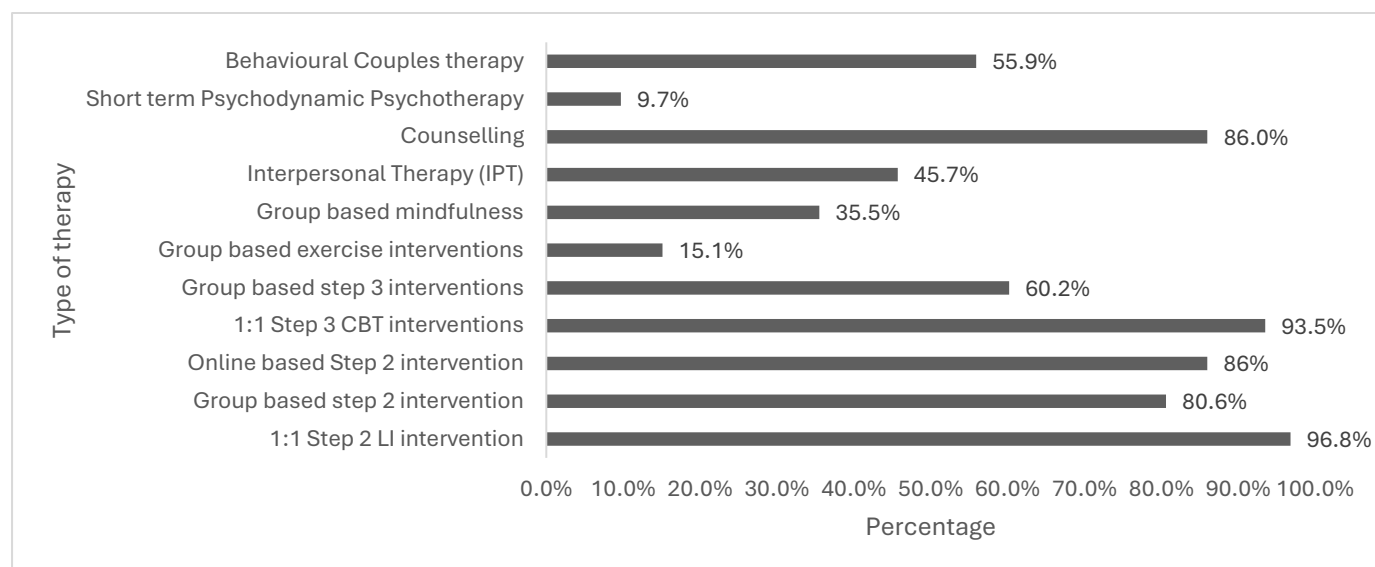
Participants were given the option to click to provide further options; this was mostly used by participants to indicate they had started after 2022 but was used by some to detail what they had noticed in terms of changes.

Choices available in service

The most commonly available option was 1:1 Step 2 LI interventions at 96.8%; the least commonly available was Short Term Psychodynamic Psychotherapy at 9.7%. A summary of these results can be seen in figure 7.

Figure 7

Availability of NICE (2022) Guideline Recommended Treatment Options in Participants' Services



There was a free text response option to provide details for other therapies that are offered. Dynamic Interpersonal Therapy (DIT) was often mentioned, as well as EMDR and relational therapies.

The most common method of delivery was Telephone at 96.7%, and the least common was home visits at 10.8%. See table 13.

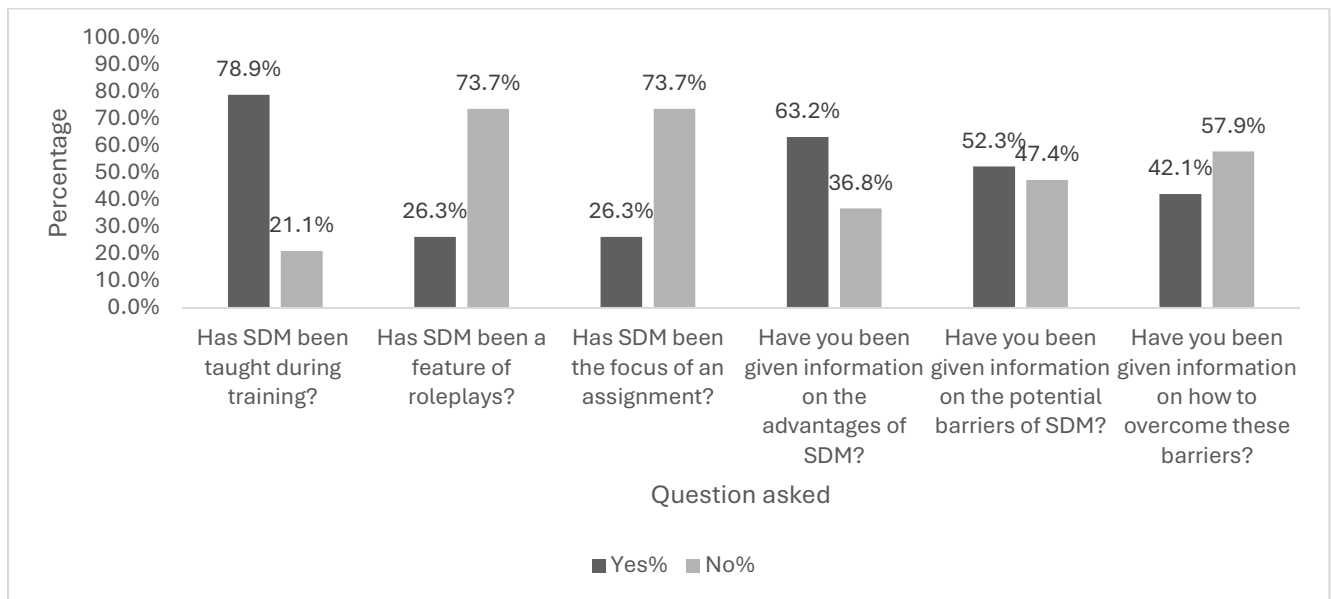
Table 13

Availability of Methods of Delivery Within Participants' Services

Method of delivery	Number of respondents	Percentage
Telephone	90	96.7%
Face to Face (at service)	85	91.4%
Face to Face (at community location e.g., GP)	51	54.8%
Video call	88	94.6%
Home visit	10	10.8%

Trainee specific questions

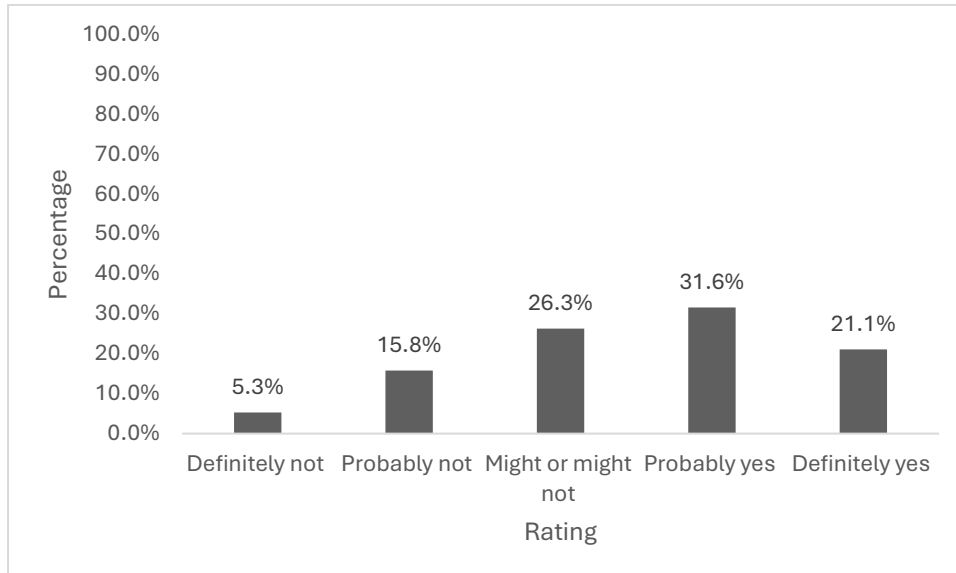
It is important to note that trainee respondents within this data could be at any stage within their training, and data on stage of training was not collected. SDM was reported as being taught by 78.9% of participants, and 63.2% of all participants reported they had been given information around advantages of SDM. However, SDM was rarely featured in roleplays (26.3%) or assignments (26.3%). Whilst advantages of SDM were discussed 63.2% of the time, barriers were only discussed 52.3% of the time. Only 42.1% of participants reported being given information on how to address barriers. These results are summarised in figure 8.

Figure 8*SDM Training Content Received by Participants During University Training*

Trainees generally reported feeling training had equipped them well to use SDM, with 31.6% reporting training had ‘probably’ equipped them, and 21.1% reporting they ‘definitely’ felt equipped. These results are summarised in figure 9.

Figure 9

Trainees Perceived Level of How Well Their Course Prepared Them to Engage in SDM Post Qualification

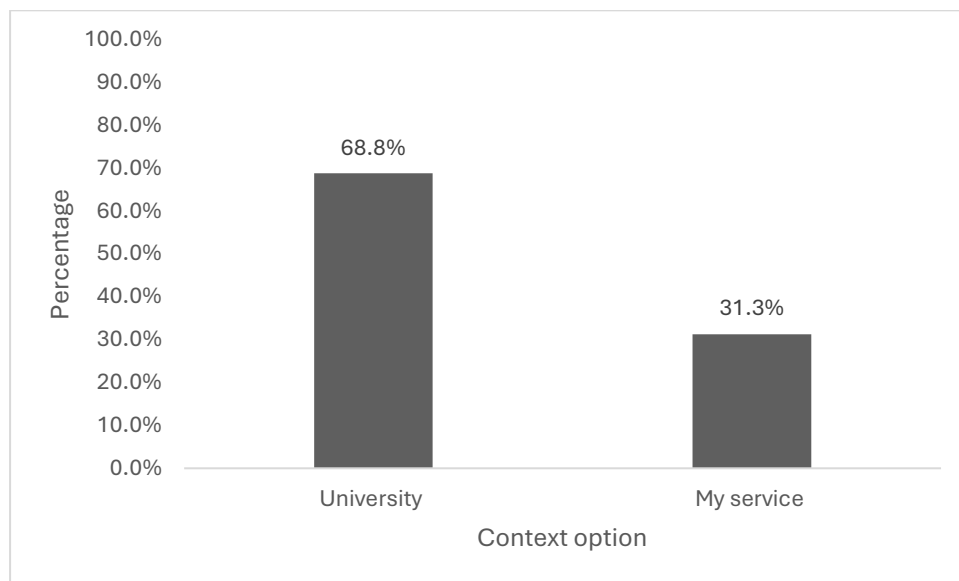


When asked to rate how much value their university placed on SDM out of 100, there was a reported value of $M = 63.33$ ($SD = 27.87$). Whilst this suggests that trainees felt their courses placed a fairly high level of importance on SDM, the SD suggested that there was a high level of variance within this data.

When asked if they had noticed a difference in value placed on SDM between their course and their service, 17.6% of the trainees reported they had not noticed any differences whilst 64.7% indicated that they had noticed definite differences. Out of those who reported differences, 68.8% reported their university valued SDM more than their service. These results can be seen in figure 10.

Figure 10

Trainee's Views on if Their Service or University Appeared to Value SDM More.



As part of this question, trainees were given the option to provide free text further information if they wished; 11 free text responses were received. The full text data for this can be seen in Appendix M. In summary, trainees spoke about how the university will teach the principles of SDM but that they find themselves unable to follow this in practice for a variety of reasons. These reasons included being told to only offer one choice ($n=1$), demands on waitlists changing what options are available ($n=4$), limited availability of choice to offer ($n=2$), being told to not mention certain options and being told to only offer computerised CBT (cCBT) or groups ($n=5$).

One trainee described that they felt their service valued SDM more as the service assessment has sections on describing different treatments, where this had not been required during their Objective Structured Clinical Examination (OSCE) at university. An OSCE is a verbal examination, in which the student roleplays an aspect of client care with an actor.

Confidence in understanding and using SDM

This section and the sections that follow include the data for both qualified and trainee PWPs. For level of confidence, which was rated out of 100, in understanding the concept of SDM, results indicated $M = 76.55$ ($SD = 17.04$). More detailed results can be seen in figure 11. For level of confidence in using SDM in clinical practice, results were slightly lower but still high overall, $M = 66.63$ ($SD = 19.71$). More detailed results can be seen in figure 12. Frequency of use of SDM either during or after an assessment, on average, was $M = 71.24$ ($SD = 21.58$). More detailed results can be seen in figure 13. The standard deviations for all these results are large, suggesting a large variability in the data.

Figure 11

Participants Identified Level of Confidence in Understanding the Concept of SDM.

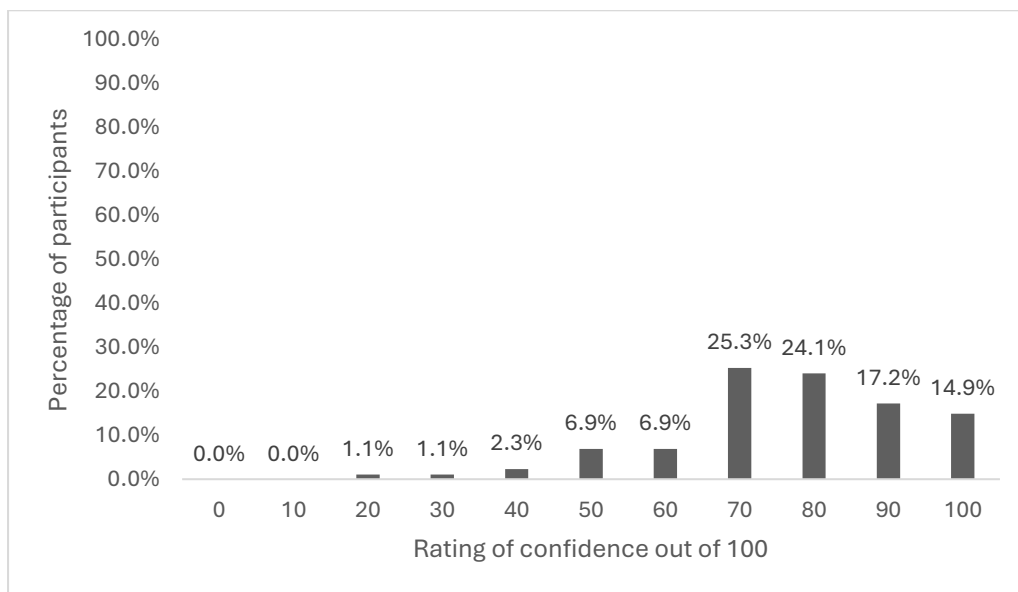
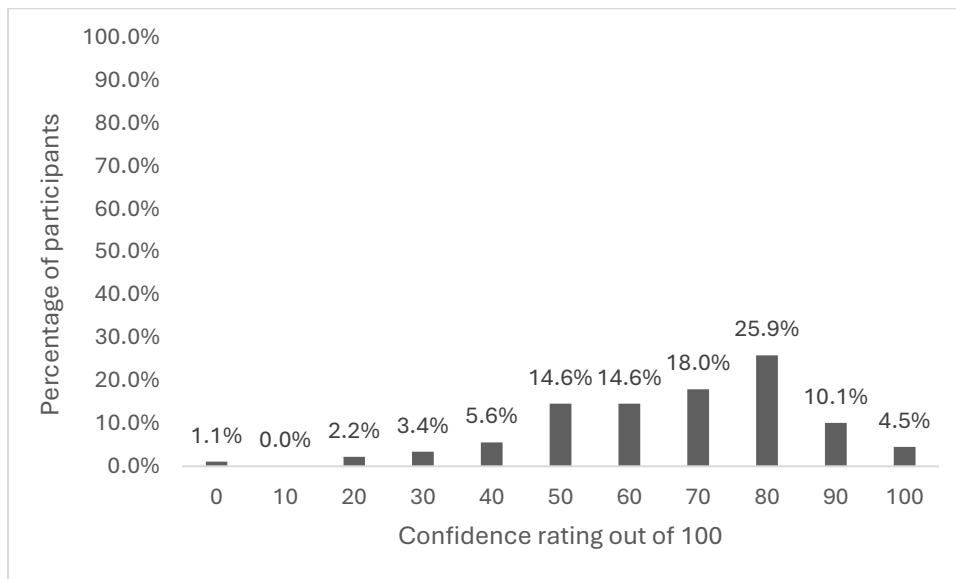
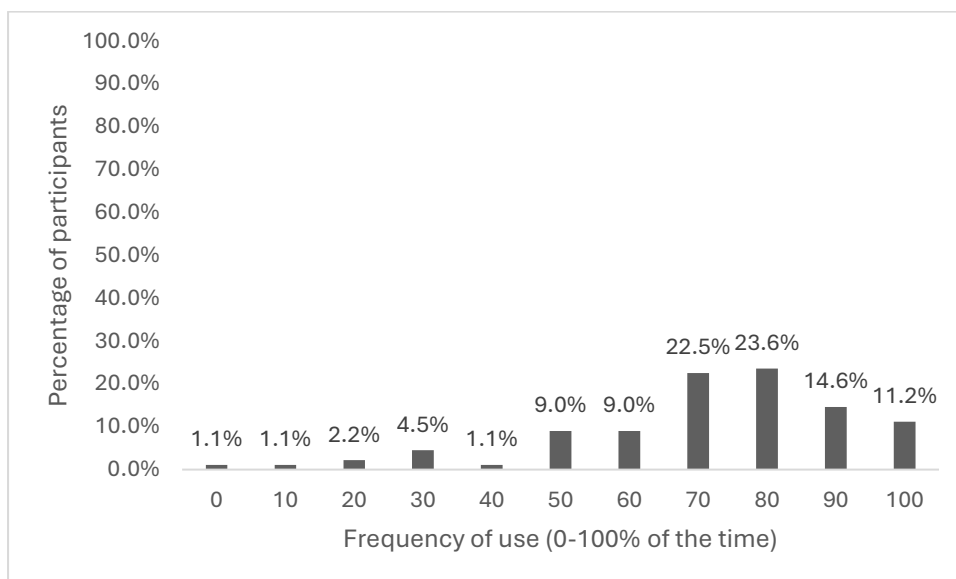


Figure 12*Participants Rated Confidence in Using SDM in Clinical Practice***Figure 13***Reported Frequency of SDM Use During or Following Assessment.***SDM training**

Reports of receiving specific SDM training were low, at 16.9% of participants. Of those that gave a clear yes or no indication ($n=24$), 12.5% reported training took place prior to 2022 and 87.5% indicated this had taken place after 2022.

Use of SDM in service

Most participants reported that they felt a small amount of SDM was contained within the assessment templates, at 69.7%. However, almost 20% of participants did not feel that their assessment templates had any indication of SDM. Full results are provided in table 14.

Table 14

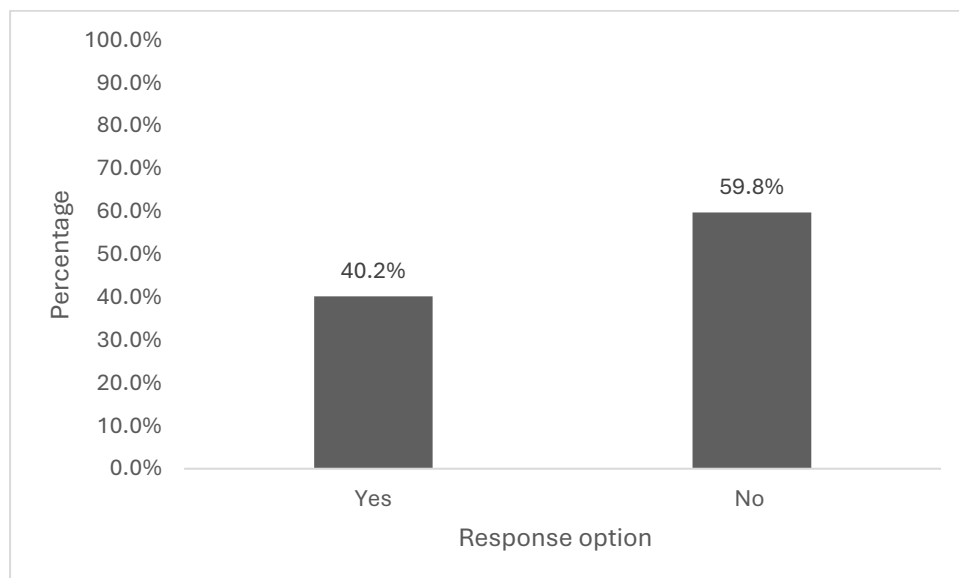
Reported Amounts of SDM Present Within Assessment Templates.

Response option	Frequency of response	Percentage
Yes – a small amount	62	69.7%
Yes – a large amount	10	11.2%
Not at all	17	19.1%

Most participants (59.8%) did not feel enough time was spent on SDM within assessment. See figure 14 for more details.

Figure 14

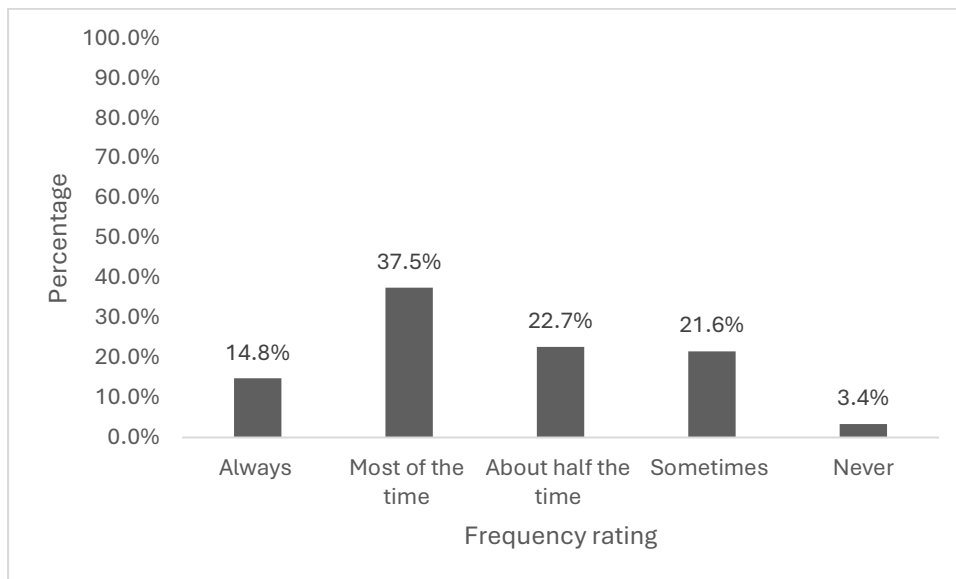
Participants' Views on if Sufficient Time is Spent on SDM During Assessment.



Regarding supervision, 37.5% of participants reported they were asked ‘most of the time’ about client preferences, and only 3.4% of participants reported that they were never asked. Full results for this question can be seen in figure 15.

Figure 15

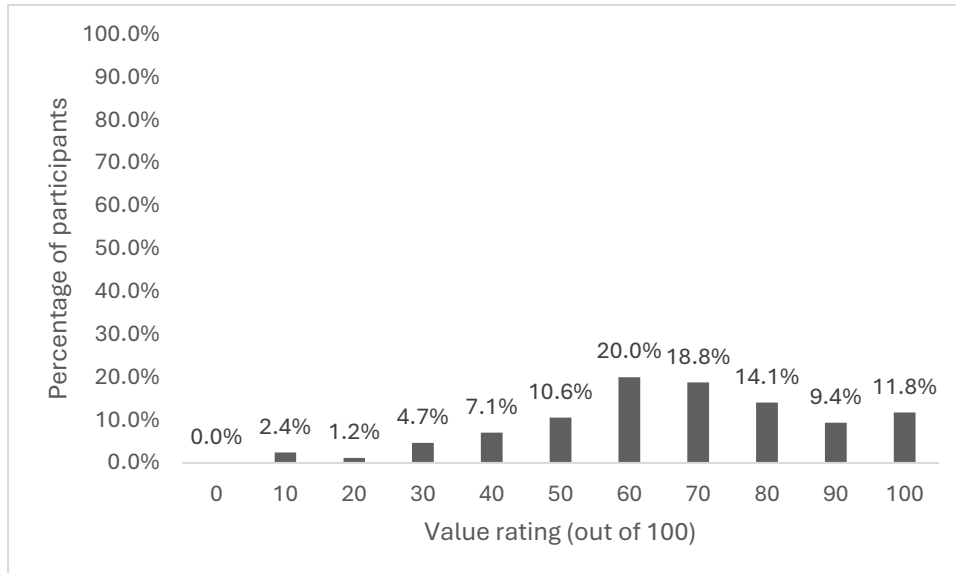
Participants’ Reports on How Frequently They are Asked About Client Preferences in Supervision.



The value placed on these preferences was rated out of 100 and overall was rated highly, $M = 66.71$ ($SD = 21.62$). Overall frequencies of response can be seen in figure 16.

Figure 16

Frequencies of Response for how Much Value Participants Feel is Placed on Client Preferences in Supervisory Discussions.

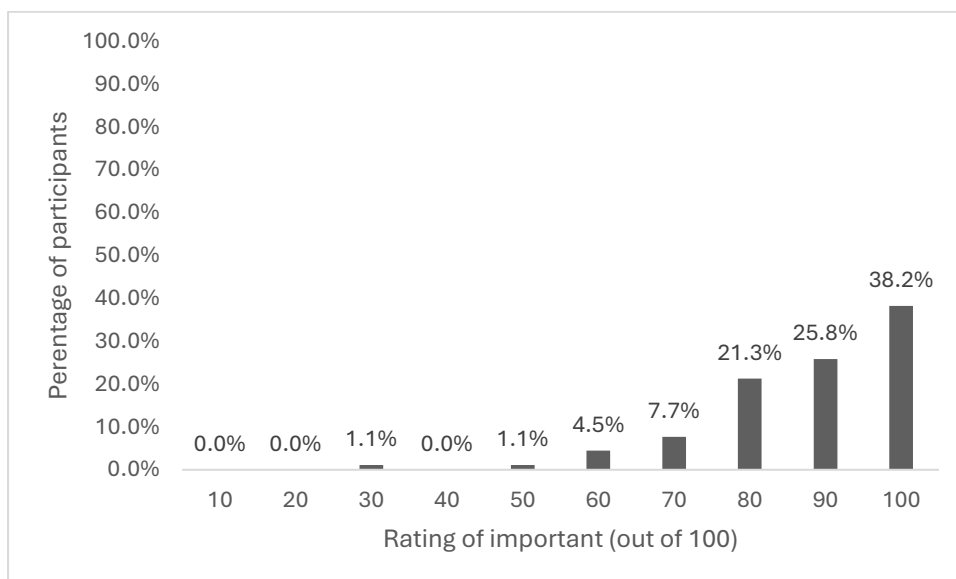


Importance of SDM

PWPs, on average, rated their level of importance of SDM highly, $M = 87.64$ ($SD = 13.65$). The frequency of scores can be seen in detail in figure 18.

Figure 18

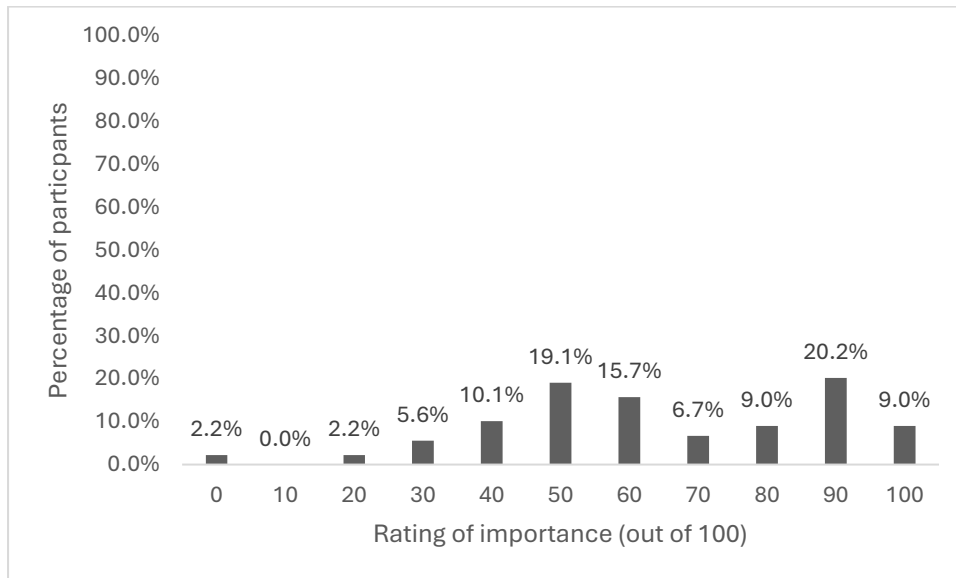
Ratings of Level of Importance of SDM for PWPs.



The level of importance that PWPs believed service leads place on SDM was lower, but still high, $M = 64.27$ ($SD = 24.16$). See figure 19.

Figure 19

Participant Ratings of how Important They Believe SDM is to Management



Factors that may predict use of SDM

As part of the survey respondents completed, they were asked to complete an adapted version of the OPTION scale. This scale is discussed in more detail in the methods chapter on page 63.

Overall, the average score on the use of SDM OPTION scale was $M = 33.86$ ($SD = 7.5$). An independent samples t-test was used to see if there were any differences in scores on the use of SDM OPTION scale between qualified and trainee participants. There was a significant difference; qualified participants, on average, scored higher $M = 34.98$ ($SD = 6.89$) than trainee participants $M = 29.41$ ($SD = 8.49$) $t(83) = 2.84$ $p = 0.006$. Confidence intervals for this test were large (95% CI [1.67, 9.45]); this may be due to the smaller sample size of the trainee group. This lowers the overall precision in estimating the difference between the two groups. Parametric assumptions for the use of an independent t-test were

met; variables included were continuous and independent. Levene's test for equality of variances confirmed $p>0.05$, meaning the assumption of homogeneity of variance was met. A Shapiro Wilke test of normality of variance confirmed $p>0.05$ for the trainee group, meaning the data within this group were normally distributed. For the qualified group, the Shapiro Wilke test of variance significance was $p=.049$, placing this data on the borderline for normal distribution. However, as the n for this group was sufficiently large, a t -test was still run due to the sample size being large enough to protect against mild non-normality (Ghasemi & Zahediasl, 2012). Full results can be seen in table 15.

Table 15

T-test Results for Comparison Between Total Scores on use of SDM Version of the OPTION Scale for Trainee and Qualified Participants, Including Levene's Test for Equality of Variances.

Independent Samples Test

		t-test for Equality of Means							
				Significance		Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
		t	df	One-Sided p	Two-Sided p			Lower	Upper
Total score for use of SDM OPTION scale	Equal variances assumed	2.843	83	.003	.006	5.55882	1.95494	1.67052	9.44713
	Equal variances not assumed	2.527	21.717	.010	.019	5.55882	2.19997	.99292	10.12473

Homogeneity of Variance Test

		Levene's Test for Equality of Variances	
		F	Sig.
Total score for use of SDM OPTION scale	Equal variances assumed	.414	.522

Overall, the average score on the value of SDM OPTION scale was $M = 38.01$ ($SD = 4.77$). When completing the values rating version of the OPTION Scale, qualified PWP's on average scored importance of SDM highly, $M = 38.47$ ($SD = 4.32$), as did Trainee PWP's, $M = 36.17$ ($SD = 6.01$). This difference was not statistically significant when tested using an independent t-test. For ease of reference, the highest total score for the OPTION scale is 48.

Associations between factors that may impact use of SDM

As an aim of this research was to explore barriers to SDM use in service, some factors were explored to consider if they may correlate with the amount of SDM clinicians use within their practice.

One such association that may be important is whether how much an individual values SDM has an impact on how likely they are to use it. Total score on the OPTION scale for how often SDM is used was positively correlated ($p < .001$) with total score for the OPTION scale that measured value placed on each SDM skill, suggesting that the more an individual values SDM, the more likely they are to use it. This can be seen below in table 16. Parametric assumptions for use of Pearson's correlation were met; normality of distribution was determined using QQ plots. Whilst the QQ plot for the total score for use of SDM Option QQ plot showed some slight deviation, the plot was determined to overall show normality. Linearity was assessed using a scatterplot, which confirmed a positive linear relationship between the two variables. See Appendix N for plots.

Table 16

Correlations Between use of SDM OPTION Scale Score and Value of SDM OPTION Scale Score.

<i>Correlations</i>			
		Total score for value of SDM on the OPTION scale	Total score for use of SDM OPTION scale
Total score for value of SDM on the OPTION scale	Pearson Correlation Sig. (2- tailed)	1	.541** <.001
	N	88	85

**. Correlation is significant at the 0.01 level (2-tailed).

Another potential association explored was length of time working in the role post qualification. There was a weak positive correlation between length of time qualified and score on the SDM use version of the OPTION scale; however, this was not significant $r(62) = 0.18, p = .145$.

A potential association between rated importance that participants felt their service leads placed on SDM and participants' total score on the use of SDM OPTION scale was explored. A weak positive correlation was found, but this was not significant $r(83) = 0.19, p = .077$.

Qualitative results

Participant characteristics

In total, 12 participants took part in the interview. For the purposes of anonymity, participants were assigned a letter generated using a random generator. Participants were mostly female, white and qualified for less than 1 year at the time of interview. Demographic information is summarised in table 17.

Table 17

Participant Demographics

<i>Participant ID</i>	<i>Gender</i>	<i>Ethnicity</i>	<i>Length of time qualified</i>
<i>Participant Z</i>	<i>Female</i>	<i>White</i>	<i>Less than 1 year</i>
<i>Participant J</i>	<i>Female</i>	<i>White</i>	<i>Less than 1 year</i>
<i>Participant K</i>	<i>Female</i>	<i>Black African</i>	<i>1-2 years</i>
<i>Participant N</i>	<i>Female</i>	<i>Asian</i>	<i>Less than 1 year</i>
<i>Participant V</i>	<i>Female</i>	<i>White</i>	<i>5+ years</i>
<i>Participant T</i>	<i>Female</i>	<i>Indian</i>	<i>Less than 1 year</i>
<i>Participant H</i>	<i>Male</i>	<i>White</i>	<i>5+ years</i>
<i>Participant X</i>	<i>Female</i>	<i>White</i>	<i>Less than 1 year</i>
<i>Participant L</i>	<i>Female</i>	<i>White</i>	<i>Less than 1 year</i>
<i>Participant R</i>	<i>Female</i>	<i>White</i>	<i>Less than 1 year</i>
<i>Participant F</i>	<i>Female</i>	<i>White</i>	<i>1-2 years</i>
<i>Participant B</i>	<i>Female</i>	<i>White</i>	<i>Less than 1 year</i>

Themes and subthemes

Using RTA, interview transcripts were analysed, and 5 main themes were generated, along with subthemes. The 5 main themes were: Mixed messages: The disparity between policy and training and in service practice, Service pressures prevent wider use of SDM,

“Upstairs downstairs”: How established hierarchies and beliefs about the PWP role impact on opportunities to engage in SDM, PWP’s beliefs and experiences of using SDM in practice, and Areas of hope: identified areas of good practice and ways to move towards increasing SDM. See table 18 for sub-themes.

Table 18

Themes and Sub-Themes Constructed Following Reflexive Thematic Analysis

Main themes	Sub themes
Mixed messages: The disparity between policy and training and in service practice	“Start again at ground zero”: service unwillingness to offer higher intensity treatments. Differences between training and clinical practice. Limited application of NICE (2022) guideline in practice.
Service pressures prevent wider use of SDM	Time pressure and its impact on SDM. Services do not have enough resources to allow for choice. The push towards quantitative data collection creates a pull away from lived client experience.
“Upstairs downstairs”: How established hierarchies and beliefs about the PWP role impact on opportunities to engage in SDM	The impact of hierarchical control on the decision-making power of PWP’s. High PWP turnover and its impacts on SDM.

Main themes	Sub themes
PWPs beliefs and experiences of using SDM in practice	SDM as the right thing to do. Clinicians' views on the impact of SDM on clients. PWPs' experiences of cultural and individual differences as barriers to SDM. Moral injury created from being unable to engage with SDM.
Areas of hope: identified areas of good practice and ways to move towards increasing SDM	Changes individual clinicians can make to facilitate SDM. Changes needed within the NHS Talking Therapies system to facilitate SDM. Changes needed in external services to allow for an increase in SDM in NHS Talking Therapies.

Mixed messages: The disparity between policy and training and in service practice

Participants were often unaware of changes to the NICE (2022) guidelines, including the introduction of the matched-care model. Participants were generally supportive of the concept of the matched-care model. However, participants still overwhelmingly referred to the stepped-care model when talking about how decisions for the treatment of depression are made. This suggests that this part of the policy has not yet made its way into services.

Regarding the stepped-care model, throughout the interviews it could often be interpreted that depression was seen as something that was by default to be treated at Step 2 using LI CBT. This means that often clients would not be offered any other choices than this

at assessment, whereas this did not seem to be the case when other presentations were discussed. Interviews highlighted that often the stepped-care model led to clients becoming stuck at Step 2, even after repeated episodes within the same service. This contrasts with the initial intention of the stepped-care model, in which repeated episodes should lead to higher intensity treatments. This desire to keep clients at the Step 2 level may be reflective of the impact of service pressures, which is a theme which will be discussed on its own.

The impact of the differences between PWP training courses and the reality of clinical practice is discussed here. Overall, participants often painted a picture of a university course that encouraged collaboration when deciding on goals and treatment. However, PWPs often described that clinical practice did not reflect this.

“Start again at ground zero”: service unwillingness to offer higher intensity treatments. Participants often spoke about a system which rigidly stuck to the stepped-care model in which clients would be offered the least intrusive option first and only offered other options if the first option was declined. This is discussed by Participant T “A hierarchy of which, you know, the least intrusive...so we talk through it...so first...talk through the groups, then online reviews, then [cCBT]...then guided self-help”.

Starting at Step 2 regardless of the previous experiences of treatment the client had was commonly discussed, such as by Participant N “But even if people have had, like, some history involving, like, successful therapy, even at Step 2 or Step 3. It's very much like, right, we'll start again on ground zero”. This suggests that clients who return to the service are offered similar or the same treatments and that perhaps different therapy options are not being considered, in favour of keeping people at Step 2. Offering choice in this way does appear to conflict with both stepped and matched-care. This could be caused by some of the service pressures discussed in the theme that follows this one.

When it comes to the role of outcome measures in decision making, participant N reported “it doesn’t matter what scores people are on” and suggested that “it’s [score on PHQ-9] like moderately severe, severe, they would still say go through Step 2 first”. It appears that the role these outcome measures play in decision making has shifted, in favour of offering the least intensive intervention for the service each time, seemingly regardless of a lot of other factors. Importantly, this suggests treatment decisions are being made away from the client.

This led to the development of the sense that clients who have more knowledge are the ones who can push for more options to be revealed, whereas clients who do not have the knowledge and who do not push will only be given the first option. Participant J reported the requirement of knowledge of how the stepped-care model works “they’d have to, I guess, know the step care model. Know what they want...and really really want it”. The terminology of “really really want it” suggests a level of determination that would have to come from the client to have this wish fulfilled.

Clients who presented to the service in a way which was outside of the normal boundaries of what is treated within talking therapies were often identified as being cases in which more interest would be given to their personal opinions and preferences for treatment. Participant F reflected on this when thinking about clients who have had multiple episodes with the service.

The person has say multiple episodes will come back to the service on multiple occasions...Then it might be a bit more like, okay, can you ask them what they liked about those sessions, what is important for them, where their focus is?

Whereas clients who were seen to fit more neatly into the Step 2 model were often more likely to be given less choice and would have less exploration of their values around treatment. Participant Z reported, “Those ones that aren't quite sure or might not completely

fit neatly into a box, then those ones can be a little bit more challenging”. The suggestion of a “box” to fit into suggests that services may be using this framework when making decisions around what to offer and therefore removing choice in instances where the “box” seems to fit.

There was also specific discussion of how depression is often seen as being a presentation that is treated at Step 2 as a default, even more so than other presentations treated within talking therapies; this was described by Participant F.

For my training, my experience of it anyway, it seemed more like, we will try a CBT approach first, regardless of what the client wants, especially with depression, and get them, like, activated, get them motivated, and then think about other treatments from that.

Participant B stated this link even more clearly “the majority is, well, if it's depression, it's CBT. Start at Step 2”.

Other presentations appeared to sometimes attract more flexibility, such as when Participant T was asked about SDM around extending session limits “Unfortunately not, I think there isn't too much flexibility. I think the only context we do have that flexibility is when it's OCD”. When talking with participants about SDM for depression and availability of other treatments than CBT, participants would often begin speaking about other presentations, such as PTSD, suggesting that there may be an internalised view in NHSTT of depression as a presentation that does not require other interventions and as a presentation that does fit neatly in the Step 2 “box”.

Differences between training and clinical practice. Almost all participants spoke about an emphasis on shared decision-making within clinical training. Such as Participant N when asked to reflect on the NICE (2021) guideline definition of SDM “It mostly fits with what's been taught, like, we are encouraged to make decisions with clients, not just saying, right, this is what you should be doing, this is what, like, we're gonna be doing”.

However, almost all participants highlighted that the level of SDM that was emphasised in training was not reflective of what was realistic during their clinical work, such as Participant V “like, it's... it's... a focus of the training.... I think it's... Easy for that to get a bit dismissed once you move into full-time clinical practice” The phrasing of collaboration being likely to “get a bit dismissed” once working clinically full time may be suggestive that the systemic factors discussed in later themes have a direct impact on creating this disparity between training and practice, as other factors become more urgent to services.

Whilst most participants reflected on the inclusion of SDM, although it was often referred to as collaboration, in training it was reported that there was limited specific guidance on how to do this part of the assessment outside of just being informed that it should take place. Participant Z reflected on the difficulties of beginning to use this skill in clinical work.

This is where it was a bit kind of. I think they could have expanded on a bit, because I think then a lot of us then, was like trying to think how to include the patient because they hadn't given us any like. This is a good idea. That's a good idea.

What Participant Z may be expressing here is that the teaching on SDM at the university level may have been slightly tokenistic; it was seemingly included as something that trainees were recommended to do but with limited emphasis on how to do so in practice.

Participant H explains how this emphasis on SDM that happens in training is sometimes not reflected during case management discussions during placement.

And early on in the case management process, you are kind of indoctrinated into, these are the things that you're allowed to think under these circumstances. So, of the things you're allowed to think. Which best matches what the patient will probably benefit from.

This quote calls attention to how quickly the differences between what is taught at university and what happens in services comes up for trainees. Participant H introduced the idea of choosing from the options “you’re allowed to think”, suggesting that trainees are taught very early about what options the service deems to be appropriate to offer. This again suggests that the choice is being made mainly away from the client, which contrasts with how training appears to be teaching PWPs to act in their role.

The use of goals to help clients to make decisions on treatment was discussed throughout many of the interviews and was highlighted as a focus during both training and from services. However, Participant F reflected that this process can sometimes become more of an exercise in getting goals that will lead to Step 2 being the right decision for a client.

And I guess also, with the way our assessments are structured...the goals and, like, what you're hoping for therapy is a really small part of that, and it's not framed as, like, what type of therapy do you want, or, like, what do you think would be helpful? It's more like. I don't... it feels more like... We're trying to get behavioural goals, so then we have a rationale for step two.

This quote again summons a sense of tokenism in the way that services are currently offering choice or collaboration, whilst a focus on goals may at the surface feel useful for facilitating client choice; if the goals are asked about in ways that are more likely to lead to the client giving an answer that fits only a CBT narrative, who are the goals useful for?

The structure of the assessment within their service was discussed further by participant F.

I think probably thinking about the structure of assessments a bit more, and thinking, you know, that goals section at the end. Are we just trying to get behavioural goals here, or are we asking? that question. What do you value? And... what does wellness look like for you?

This quote suggests that the participant is identifying that a change in the way goals or treatment aims are discussed might allow clients to gain more knowledge about themselves and be empowered to use this in the decision-making process. This suggestion appears to be more in line with what PWPs are taught in training.

Limited application of NICE (2022) guideline in practice. There was an acknowledgement that guidelines often take a long time to make an impact and change in services, and most participants interviewed had not been given any specific information on the NICE (2022) guideline changes. Participant R said.

Well, so I've not heard of the matched-care model, I have to say. I was gonna say, in terms of, like, the changes to the NICE guidelines, there's always a bit of a gap before it catches up with the services, isn't there?

There was acknowledgement that part of the delay for the implementation of these guidelines may be because services have other pressures that mean SDM is seen as less important for the service, with Participant J suggesting risk management may be one of these areas.

I guess everything else I, I don't want to say needed, because it is obviously needed for them. But it's not needed for us...it should be needed...but we can do our jobs without it. You know what we gather is the risk, because we need to make sure patients are safe. But again, that comes down to our liability.

The use of the word "liability" may be suggestive of a sense of fear within services that failure to manage risk will have implications, and there may be some truth to this consideration. This fear may be why risk management is prioritised for time within assessments and elements of SDM are left out to keep assessments the same length, with time being a huge factor that inhibits SDM and a subtheme which will be considered later.

SDM being seen as less important due to these pressures was thought by some to be a symptom of management's removal from clinical work, meaning that they become more

acutely aware of other service issues and less so of the impact of clients not being able to engage in SDM. Participant R reflected on some of these pressures.

They're [management] probably much more focused on just trying to get people in, get people into treatment, get people out...when you go further down the chain to the people that are actually speaking to patients, where you get the emotion from that person...you can see what they're wanting, you can hear the emotion in their voice and everything...you're much more willing to try and get that particular option for that person, because you now have that connection with them.

Additionally, this quote shows how this removal of management from clinical work impacts on the PWPs' experiences of hierarchy and moral injury, which are present in other themes, as what participant R suggests here is that decisions are being made away from clients and PWPs are then being asked to relay decisions they did not make.

With the context in mind that SDM is not always prioritised within services, and with the context discussed in later themes around availability of choice and time limitations, a sense of decision making that was much more guided began to be identified. This was named explicitly by Participant K.

I think shared decision making is important, because obviously, as I said, they're the expert in their own experience, but it is also very, kind of, important how you phrase it, because it's not, kind of, they can choose whatever they like. It has to be very guided decision-making.

The concept of “guided decision-making” may be a result of an acknowledgement of what is currently possible in services due to pressures discussed in subsequent themes. However, the use of “guided” suggests that the clinician is the one who holds the most power, as the implication is that only they would have the full knowledge of options.

There was a strong desire from participants for the guidance around how to use SDM within their service to become clearer, and for specific service-based training to be given.

Participant N reflected on this after being introduced to the idea of the matched-care model

I think a lot of training, actually. Training would be helpful, like, we've not, like, that kind of, like, the match care model type of thing hasn't been taught in our service, and people aren't aware of it as much.

It may be that for changes to NICE (2022) guideline to be implemented more effectively, services need to respond to significant changes in guidance with the roll out of training and/or information sessions.

Service pressures prevent wider use of SDM

This theme is perhaps the most present throughout the interviews and has a part to play in all the further themes discussed within this thesis. This theme also provides context for why there may be a difference between policies, training and in-service use of SDM. Service policy is often a reaction to the pressures within services, and the two cannot be viewed in isolation.

PWP's described a system that does not prioritise SDM, not necessarily because it does not want to or does not believe in it but because it faces pressures it views as more urgent. PWPs often spoke of how much more difficult it is for clients to be able to choose other therapy options than Step 2 LI CBT, as often there are significantly fewer clinicians and significantly longer waitlists. This often means that in practice these options are not offered, limiting the level of SDM that can take place.

The impact of the data focus of NHSTT services was highlighted as something that gets in the way of SDM. Services were described as focused on meeting access and recovery targets, and with longer waitlists for other options, LI CBT was often left as the only option that could help to achieve this. This data focus was reflected as being a result of the need to

prove service effectiveness to retain or gain funding. Overall, there was a sense of services which had become so overstretched that the focus had become offering something now, rather than engaging in conversations to help the client find the option that would be right for them long term.

Time pressure and its impact on SDM. Participant Z discussed that engaging with SDM with clients can sometimes take a lot of time, as clients often enter the service with very limited knowledge

Even when you give them choices, they can be a bit like I don't know. What do you think? So again, there is. We do have to spend a lot of time kind of expanding, explaining things so that they can make an informed decision.

A strong sense of there being not enough time to dedicate to SDM was developed from the data, with Participant K highlighting the high caseloads of PWPs as a factor in this “I think it is difficult to balance the time pressures with creating that collaborative space, within the kind of, you know, PWPs see, 30-plus patients a week”. Participant X spoke about the time that is allocated to assessments, and how this is often only enough to get a good sense of the presenting problem and doesn't leave time to think about SDM

We have 45 minutes for our assessments. And then 15 minutes for admin tasks...I feel like I try my best to get as much information as possible for their presenting problem, so that I can discuss it in supervision.

As mentioned, many of the PWPs interviewed had not heard about the NICE (2022) guideline changes, and Participant N suggested that lack of time comes into this “And they say, you know, you should always be looking at NICE guidance, but we don't have the time”. This links back to previous discussions around the usefulness of offering training on a service level to address significant guideline changes that were raised by other participants.

This lack of time may impact on the way that SDM looks in services when it is used. Participant J reflected on how the way decisions that are made in service do not reflect the NICE (2021) guideline definition of SDM “not sure how much we follow that...like the risks, the benefits, the consequences. I’m trying to think about times. I may have had the conversation with someone, and that’s quite, quite limited so”. Instead, where there were decisions to be made, options may instead be presented with only positives. This ultimately may help to save services time, as clients with limited knowledge may be less likely to push back on the positive picture which is presented and more likely to accept the first option they are offered.

This effect may be exacerbated by the descriptions of many participants of a system that often does not give clients much time to think over their options and make decisions. Participant Z discussed how decisions are most often made within the assessment process, which is typically around 45 minutes.

Yes, yeah, yes, rather than it just being on the spot, which obviously in [assessments] quite often, it is because we don't tend to come back and phone them...It's kind of then and there. What do you think your best choice is?

Participant R highlighted that this isn’t always the case but discussed how this wouldn’t be typical due to the time pressures.

There have been occasions where people might be like, can you give me some time? And you can say, yeah, okay, I'll call you next week. But again, we're under a lot of pressure as PWP's to get your admin done.

This quote highlights a disparity in service between clients who may be more likely to advocate and push for their needs versus those who may be more likely to accept the view of a professional.

As mentioned, when considering the impact of policy, the idea of using goals to guide decision making was generated from the data in relation to trying to get Step 2 goals.

However, using goals to guide treatment also developed as a theme in relation to trying to save time whilst still maintaining a level of collaboration with clients, such as this quote from Participant R “And kind of based on what they've said in their goals as well, you can determine, kind of, what would be the most appropriate options to present to them”.

Participant X described how when clients were clear on not wanting CBT, they would make sure the goals were reflective of this to make the process of getting a different treatment agreed quicker.

How can we make these goals a little bit more related to what you're looking for now, kind of thing? So, is it a case of, like, processing a certain event? Is it a case of, looking into, like, relationships?

Overall, it appears that clients who have more knowledge of what they do and don't want are likely to be able to access options that others might not.

A sense of information being withheld from clients developed throughout the interviews, and often when decision making was discussed, it was highlighted that only certain options would be presented to save time, but sometimes due to availability, which will be discussed in more depth in the next subtheme.

The problem comes with guidance from services, so shared decision making is not as it's presented in the NICE guidance, so there is some shared decision making. But the truth of the decision to be made is very often hidden from the patient (participant H). The suggestion that the “truth of the decision” is often “hidden” adds further weight to the idea that most decisions are being made elsewhere in the system, and clients instead may be given a tokenistic choice from options that are predetermined by factors such as time and availability, rather than appropriateness to their presentation.

Often, clients appear to be given pre-selected options which reflect the “box” they are most likely to fit into, and other options are not mentioned, raising questions as to how informed each decision is when not all relevant options can be considered.

The level of SDM in services appeared to vary across participants, and areas of good practice will be considered within a separate theme. However, Participant F suggested that within their service it was not typical to ask about the values and beliefs of clients, and that this would not be asked about by supervisors either

But I don't think I've ever been asked What does this client value? Like. That kind of individualised... formulation of it at all. I don't think that's ever been anything I've asked to, like, follow up on, or something that anyone has flagged as being missing from an assessment.

This may again highlight the differences in the availability of time to have these types of conversations in services.

Services do not have enough resources to allow for choice. This sub-theme links very closely to the sub-theme regarding time. However, this sub-theme focuses on the availability of tangible physical resources.

Almost all participants interviewed reflected on the impact that waitlists have on clients' ability to make choices. Participant K discussed how knowledge of waitlists determines how decision making looks in services.

But yeah, I think because of, obviously, like, waiting times, like, cost and service and things, I have to be quite... structured in terms, like, you know, guided decision-making, essentially, so not kind of giving them free rein to pick whatever they want.

Here, the concept of “guided decision making” is being explicitly linked to the service pressures that have caused this way of thinking about making decisions to develop. The concept of “guided decision making” has been discussed within other themes; however, its

link here to service pressures reveals why it is significantly different to true SDM. If these service pressures did not exist, it is unlikely that suitable options would be withheld and clients would be able to make fully informed choices about all available options. Whereas the use of “guided” indicates that clients are led towards an option that is easier for the service to provide, regardless of whether this is truly the best option for the client. However, whilst this does not match with a true SDM, it also must be acknowledged that it might provide some elements of choice within the currently stretched service model, which is better than no choice being provided at all.

Later, Participant K discussed how waitlists can change what options are available “when I first started, they told us, do not offer face-to-face at all, because the waiting lists were astronomical”. They discussed how even if the option is offered, a higher waiting list is likely to alter the choice a client will make “once they hear the waiting time for face-to-face, they're like, oh, you know what, I'll just stick with video or phone”. Whilst informing the client of the waiting list could be seen within the framework of SDM as giving the client the chance to make an informed decision, certain options being significantly more available than others creates an unbalanced choice. Participant X reflected on this impact in services “Lots of clients don't want to wait that long. Which is... which is fair, which is fine, but then it's that kind of a forced decision if... If that is the case”.

Participant J discussed their service does not allow discussion of wait times “we have a long, long wait in our service... I know how long the wait is, roughly...but at assessments, we're not allowed to say...so I don't feel like I'm fully giving them the choice”. Despite reflections around the impact of revealing longer waits, withholding the information is more obviously against the ideology of SDM and prevents clients from making an informed decision.

Participant N gave a direct link between wait times and the impulse for services to start all clients whenever possible at Step 2 “because of the waiting list pressures, it's always been step two first”. Further adding that there are fears that not doing this may create a knock-on effect on the waitlists for other options “in the past, like, the Step 3 waiting list was, like, too unmanageable...and I think a lot of that is that fear of, like, happening again”.

Face to face delivery of treatment was often discussed as having the longest wait. The reasons behind this seem to be related to the lack of clinical space for appointments, with Participant X saying, “face-to-face is really limited because of the rooms that are available in a day”.

Another resource that appears to impact waiting lists is the availability of the staff to provide the options. Participant V spoke of the counselling team in their service.

So, we do have counselling for depression. It's quite a small team, and they are quite protective of their waiting list. So, the patient... has to have very counselling-appropriate goals, no deactivation that would be appropriate for a Step 2 BA intervention.

This suggests that smaller teams for non-CBT options can sometimes create the need for these teams to become selective in who they add to the waitlist. However, for the client, this may lead to them not being offered or given information for any other options in the service if their goals are seen to not be in alignment.

The use of a group or cCBT as a first treatment for those coming into the service was a common discussion across interviews, with many reporting that their service requires completion of either of these before allowing clients to access any type of one-to-one therapy. With Participant H discussing how in some services refusal to engage with group therapy or cCBT can lead to discharge “services will often enforce that patients go through, say, a group

or [cCBT]. Some services will discharge at that point if a patient is not willing to take part in either and will not offer a one-to-one intervention”.

However, Participant F explained that in some services there may be “caveats” to this “actually depression is quite interesting for [cCBT]. So if the PHQ-9 score is over 19, that automatically, like, bypasses step one”. However, regardless of this, what is being described is not SDM, as even with these caveats the client themselves is being left out of the decision-making process.

When asked their opinion on if there is enough choice available in NHSTT services, Participant X discussed how waitlists are an impacting factor in the availability of choice.

I mean, there's 3 main modalities, right? Which, which isn't a lot, but, and also, we're not... giving them the full spectrum of those three modalities, just because of wait times and the capacity that we have as a service. So, no, is my answer.

Here, Participant X is suggesting that they don't believe that what is on offer is enough and reporting that waitlists mean that a lot of what is offered is not actually often available.

There was an acknowledgement among participants that funding has a large impact on choice and shared decision-making, and that management are impacted by this when making policies and service decisions. Participant H highlighted these pressures.

It is only through those pressures that these decisions are made, because I don't believe the people that are higher up in the hierarchy... that they are in any way malicious. I think it is a case of they have a job that they would like to keep. And staff that they're responsible for, and a budget where they can either provide a service to that budget, or no service at all. And what people get is the lesser of the two evils.

With the phrasing of “lesser of two evils”, participant H appears to be reflecting on how the current service provision may not be ideal, but that services lack the necessary funding to

make the changes that would allow for more SDM, and that instead services must provide as much as they can within what is possible with budgets.

Participant H highlighted how funding would need to be changed and viewed differently for real change in decision making to take place.

It is much cheaper to put somebody through step two, but in the long term, if you're then putting Step 2 and Step 3...what's the saving there, other than people that drop out or spontaneously recover only to come back in the next financial year? I do think that the way that services are commissioned, the expectations and targets that are set are a problem.

This quote suggests a shortsightedness in the apparent desire to save money by keeping most clients as Step 2. With the suggestion being that clinicians are noticing that people are having both Step 2 and Step 3, or repeated episodes at Step 2, which may ultimately cost more than one episode of a treatment that could be reached by making a shared decision.

These financial pressures are similarly reflected externally to NHSTT, with Participant R discussing how other options in the community are sometimes unavailable due to their own funding and waitlist pressures

There have been different occasions. Where those referrals have been closed for, like, they're not accepting professional referrals.... we know that this would be the most appropriate service, but we can't offer you that at the moment.

This provides evidence for the need to consider how NHSTT are impacted by the other services around them, as it appears that their ability to signpost when appropriate is reduced by funding issues in other areas.

This created a sense of any discussions of SDM within services as being tokenistic, with Participant H discussing why they believe services would be unlikely to give resources to provide training on SDM

My guess would be... that shared decision making in the service, that we wouldn't actually be able to provide such training, because what we are asked to do is not genuine shared decision making. What it would be is training on how to enforce the organisation's... Guideline on where patients need to go. For the service, and to meet other demands

It appears that service pressures have led to a system which cannot fully integrate SDM, as it lacks the resources and funding to do so.

The push towards quantitative data collection creates a pull away from lived client experience. An additional pressure that faces PWPs is data collection, and of course being able to provide data to show your service is working has a direct impact on levels of funding. It is understandable that data needs to be collected for these reasons, and it is beyond the scope of this thesis to postulate on the ethics of this. However, the focus on data collection was highlighted as a pressure which prevents SDM from truly taking place within services. Participant N said

Like, it's very much a data-driven service. So, it's like, right, well, we need to say that we've seen this many people, we've discharged this many people, we've got this much in recovery, this much in reliable improvement. And I think until there's less of... until there's more value, I suppose, put on. Patient experience, what they're saying, like, how many people are actually satisfied with their care. then I don't think there's gonna be much of that shift.

A focus on client experience being needed to begin to shift services towards working in a way that is more aligned with SDM is mentioned here, and this will be expanded on in a later theme. However, importantly for this theme, participant N is suggesting that the current numbers-based data focus appears to be incompatible with making a cultural shift.

Participant N discussed how the focus on outcome measures can sometimes mean that people are focused on more as numbers than in a holistic way.

It used to really frustrate me that so many decisions seemed to just be made based off of recovery rates and where they are in terms of questionnaire scores and things like that, because it felt like it was missing a lot of the client as a person.

The report of “so many decisions” being made due to recovery rates and outcome measures again suggests that decisions are being made in a pre-determined way, and that the client is likely to have very little input into this.

Data is used as a way for decisions about care to be made, as discussed by Participant X.

So, I explain, it's really important that you do the questionnaires, because they're a measure to see how you're getting on with the therapy, and then those actually do... steer the therapy in some sense. So, for example, if I'm noticing in session 4 that a client's scores are still really high. And they're saying it's reflective of their experience, then we would perhaps add a couple more sessions.

Whilst in this case, data was used for an outcome that the client may have wanted, Participant N discussed a case in which the use of this data had negative outcomes for a client.

Participant N spoke of a case in which the client had been in treatment presenting with depression and still had many symptoms remaining that would traditionally be treated at Step 3. However, due to them having a “good week” in which they saw lots of friends and family, their scores on the outcome measures improved

But because he was in recovery, the clinical lead said he wasn't able to go for, Step 3, and we should... and basically told me I needed to tell him that he should have, like, a period of, like, like, just allowing the time for the intervention to, sort of, do itself, and then re-refer in the future if he needed to instead.

There was no evidence of the possibility of SDM in this case, and it was not the PWP who had the power to make this decision. This experience is suggestive of how the use of outcome measure data can sometimes override other factors that may be useful to consider when making a clinical decision. Outcome measures may be a quicker way for services under pressure to make treatment decisions, but this quote suggests that the human element of client experience is being missed when decisions are made in a binary way. It may suggest that targets are being prioritised above experience; in the example above, the client discussed would count as a client who completed treatment and met recovery, which would help the service towards meeting its targets in both areas. This example would help to avoid adding someone to the Step 3 waitlist, as waitlist times are also a target that NHSTT services are required to report.

Participant R spoke about how the pressure and focus on data collection can take up a lot of management time

So, the higher up you go in terms of, like, team leads, service leads, they've got a lot of other, kind of, pans to be watching, don't they? They've got a lot of other things to have on their mind in terms of monitoring the service and looking at data and everything that's going on.

This may contribute to the experience of management as being more removed from client feelings as discussed within other themes, as this quote would suggest that the management of this data is what begins to become their priority instead.

Participant H reflected on how this may mean that implementing the changes needed to make SDM a reality becomes sidelined “I would suggest that shared decision making becomes a minor... Concern, and it's more about... the number of people coming through the door”.

There was an acknowledgement that PWPs are required to hit their own data targets,

we wouldn't be able to, kind of, complete the day as we're supposed to, because we have to hit this target for the amount of assessments we do in a day, in a week, in a year, to make sure that we are, kind of, seeing everybody (participant F).

This may help to explain why participants often felt a lack of time to engage in SDM, as these targets become a focus and a way their performance is measured.

“Upstairs downstairs”: How established hierarchies and beliefs about the PWP role impact on opportunities to engage in SDM

Even when not explicitly mentioned, the theme of PWPs being ultimately unable to make the final decision regarding care of the clients they were working with, or assessing, was strong within the interviews and has been mentioned within several of the previous themes. PWPs described a system which demands a lot of them but often leaves them without the power to function as independent clinicians. Where decisions need to be made for clients who do not fit neatly into the NHSTT “box” need to be made, these decisions are often referred to clinicians of a higher banding. This leaves very little scope for PWPs to directly engage in SDM with clients, as they fear having a conversation with a client which leads to a choice that they then cannot honour once the decision is taken to supervisors.

The impact of hierarchical control on the decision-making power of PWPs. The ability of PWPs to actively engage with SDM to their full potential has been touched upon in other themes and sub-themes. However, when considering hierarchy explicitly, this needs to be considered separately. Participant R described how hierarchy impacts on levels of SDM in services.

We're just kind of communicated down the line as to kind of what's going on, and kind of being told what we can and can't do, and what's kind of more realistic, what we should be encouraging, what we should be discouraging.

The use of “being told what we can and can’t do” suggests a teacher and student type relationship, in which rules are clearly set by the teacher and diligently followed by the student. This suggests that the options that are offered are not always reflective of what the PWP may want to offer, but that, more realistically, this is what has been determined by the service to be available.

This was highlighted by Participant L in which they discussed how they do not always agree with what they are told to offer “like, if I put through a request for a one-to-one, and it's declined, and they're like, put them into a group. I'm just a bit like, mmm... I don't know. If that... if it's helpful”. Participant T suggested that they are allowed to ask questions about why those higher up make decisions “I’ve been quite lucky that within my service...they’re more than happy to sort of clarify. Like, we’re allowed to question”. However, this suggests that ultimately the choice would still be made by a third-party clinician, rather than between the PWP and the client in some cases.

When talking about experiences of supervision to discuss treatments for a case participant N reported

My usual case manager is, like, just give them all the Step 2 options, that's fine...and she's just a regular PWP, but when I had, like, covered case management...That was a senior, and then she was like, just offer the group.

Interestingly, there is the suggestion of variance perhaps being related to different staff backgrounds, as it is noted that the usual case manager is “just a regular PWP” and the case manager that presented with less flexibility “was a senior”. This may link back to previous discussions about the awareness of pressures such as data and funding being more of a focus of senior staff, whilst the focus of staff with a predominately client facing role was discussed to be getting the treatment that felt right for the client. The use of “just” in “just a PWP” could be an acknowledgement of hierarchy.

Participant J acknowledged the variance in case management, and focused on experiences of this with senior clinicians

They've got a waitlist...they need to sort things out. It does really impact, I think, without them realising. They just say no, this is the only option, and sometimes we do have the conversations. I think it's not really right for them...Shouldn't I give them the option...but some of them are really good, and they will say you can suggest this or this to them.

It appears that there is variance even within the senior team as to how much choice is prioritised.

Participant T spoke of how PWPs' perceived position often means they are not given as much of the contextual information about service pressures, and how this can affect how SDM is carried out

The top-down hierarchy that does play in...sometimes we don't see the whole perspective. We are, you know, at a lower level; we are the PWPs, and then there's the seniors, then you know, higher management...we may not be able to see the things that they are seeing...acknowledging that while we set that expectation for that shared decision making, I think that becomes really important.

It appears that what is being highlighted here is that PWPs are asked to set expectations regarding how shared decisions can be, sometimes without the full context of the barriers services are facing that create the apparent need for limitations around SDM to exist.

PWPs' status within the hierarchy permeated as a theme regarding the availability of training regarding different choices available within service. Participant J discussed that in their service, concerns about PWPs becoming "confused" and trying to do other therapies means that they are currently not allowed to have much information on the other modalities available. Participant N discussed how this can make SDM difficult as PWPs do not always

have enough knowledge to speak to clients about the differences between modalities to allow an informed choice.

I don't think I know enough about the counselling to be able to actually have that very transparent conversation between, like, of, like, this is what it involved, this is the benefits, this is what could happen, like, this is, like, the costs and things.

There are potentially two factors at play here; it could be that PWPs are being viewed within the confines of the role and there is concern around learning about other therapies leading to confusion, as suggested by participant J. It could be that with the pressures facing services, the impact of imposed hierarchy becomes heightened as a response to fear around increased waitlists.

Whilst Participant F reported that they do feel they understand the options in service relatively well, but they have much more limited information on what might be available externally, such as within secondary care or local charities “I have a good understanding of what's offered within our service, not necessarily outside of it, in terms of, like, secondary care or, going beyond that”.

An impact of this imposed hierarchy in which PWPs are often not able to engage in true SDM led to discussion of choice offering which were often likened to being a lot like sales. With Participant Z naming this explicitly “almost a bit like being a bit of a salesman at times, and just like... Selling it to them”. Participant K compared the PWPs role in offering choice to marketing and sales “So, it's kind of like... like a little marketing job at the end of it, like a little sales advisor at the end of the telephone assessment”. Participant N provided further context for why discussion of options often focused on positive aspects, as discussed in previous sub themes.

For example, advertising-like stuff. Like, you don't advertise the bad things, really; when you're watching a TV adverts, it's usually the good things. It's kind of portrayed

as, like, that's what we should be doing, is, like, saying, these are all the good things about it, so that they'll buy into it.

This quote contains multiple aspects that were touched on by other participants around the idea of “sales”, “advertising” and “marketing”, and links it to why discussions about choices tend to focus on the positives rather than engaging in more open discussions around waitlists, or any potential difficulties that people may find with different treatment options. It appears that ultimately the rigid hierarchy at play has merged the PWP role into something more equated to a “sales” job in some respects, due to the imposition of what can and can’t be offered. This may link to further discussions around moral injury in later themes, as aspects of the job perhaps do not match up with the version that is presented when people apply.

Participant X summarised how the choices made elsewhere in the hierarchy result in limited realistic options for clients, and how PWPs often feel discouraged by seniors in offering other choices.

You know, you can say no, and I can take it back to my supervisor, and we can discuss alternatives. It's not, like... you have to do this therapy, or see you later, kind of thing, you know, but I think it is quite... hard, because we are trying to push groups, and trying to push [cCBT]...Just because the waitlists are much shorter for that. So, it does feel dis... discouraged to... To make that clear.

This quote again picks up on the idea of needing to “push” certain treatments over others and contains references to returning to the supervisor if someone is unhappy with these pushed options, suggesting that PWPs do not have the flexibility to allow for other choices to be made. This may be an interaction of both hierarchy and service pressures.

Participant F described how this way of offering choice may mean that the changes to the NICE (2022) guideline are not being reflected in practice

More of, like, a... almost felt like persuasion, as opposed to, like, that shared decision making as it is outlined in the NICE guidance. I will say, I think that has changed now, but just speaking on my experience when I was training, that's what it felt like. There is suggestion here that they are noticing changes within their service, and aspects of why and how this change came about and can be further facilitated will be explored in the final theme presented.

High PWP turnover and its impacts on SDM. Whilst, as discussed, SDM, or at least principles of collaboration, are discussed within training courses, there was an acknowledgement that becoming proficient at engaging with SDM was a skill that can take time to learn. Participant F reflected on how this ability has developed over time.

because I have been qualified for a year...I feel like experience, I've just learned a lot, and I can kind of... recognise those steps now, and I can recognise, like, what to look out for in assessments, but it's not necessarily something that was taught; it's more through my experience.

Participant V discussed how this should be a skill that services focus on when supporting PWPs to develop “we've been focusing on trying to, enhance their ability to take the information and then, like, put it through that clinical training that they've had. into that decision-making process”. As discussed in the next theme, participants reported an alignment with SDM that felt likened to a moral value; there is an acknowledgement that this can be built upon further with training and experience of clinical work, if this is supported and encouraged by supervisors and seniors in the service.

The time that it takes to develop the skills necessary to engage in SDM effectively is important to consider, as it emerged that the PWP was often associated with high turnover. Participant F spoke of this as a widely held belief “I think... It's probably... widely... understood that PWP is maybe more of a stepping stone role as opposed to

something that people aim for”. With Participant V stating, “the average life of a qualified PWP is 2 years”.

There may be multiple factors in why the PWP role experiences high levels of turnover; however, Participant V discussed the impact that PWP's perceived placement in the hierarchy has on this

I mean, one of the things that I feel...is a greater respect for the PWP role within the broader mental health workforce is really important, even within talking therapies...there is a kind of upstairs, downstairs feel to PWP's versus...CBT therapists

This impact of hierarchy was highlighted by Participant V as something that also happens externally to NHSTT

But then I've sat in MDTs with people in other mental health teams, and they've gone, oh, well, have they had any mental health input? And I'll say, oh yeah, they had a full, like, course of treatment with us. No, mental health. And I'm like, and what is it you think we do over here?

This brings to light the question that if it takes time to learn the necessary skills to implement SDM, and feelings of hierarchy differences impact on turnover, does the existence of a hierarchy therefore prevent SDM from being as big a part of the PWP role as it could be? The reflections of PWP's within these interviews would seem to suggest that this is part of the barriers to SDM that exist within services.

PWP's beliefs and experiences of using SDM in practice

PWP's commonly referred explicitly to SDM as being something that feels right to do within their work, often comparing it to something that aligns with their values. This implies that SDM is seen in a good moral light within clinicians and something that they strongly believe impacts client care. Clinicians expressed concerns about the impact a lack of SDM

can have on client experience, and how areas of difference both for the clinician and the client can sometimes make SDM more of a complex picture than is presented.

Whilst reflecting on the ways in which SDM reflects their values and beliefs as clinicians, this often led to the identification of a moral injury which occurs when clinicians are unable to act towards their values. This exposed the reality faced by many clinicians, of having to find ways to soften the blow of going against their values or leaving the role entirely. This sense of moral injury is additionally compounded by the previously discussed theme of the impact of hierarchy, in which PWP's are often the staff who must feedback decisions to clients that they did not make, and may not agree with.

SDM as the right thing to do. SDM was often spoken about by participants as something that they believe is the right thing to do, and something that is or should be important in the role. An example of this comes from participant L.

I think decision-making, shared decision making is very important to me, and in my service, it's really important. And I think even just as personality-wise, even if it wasn't so, like, heavy, I think I would still just do it, because it's what I would want as well.

Participant L appears to be suggesting a moral imperative to engage in SDM and acknowledges that if they were the one receiving care, then they would prefer to be treated this way. There is the likening of working in a way that allows for SDM to be part of their personality, suggesting again that this may form part of a moral value.

Participant T described the way that they view SDM, and the role of both the client and the therapist as “You are the expert of your experience, you know what has happened for you...but I’m an expert on the CBT side of things. So together that’s what each of us brings to the table”.

Participant N reflected on how they would like SDM to be a bigger part of their role, but that previously discussed barriers get in the way of this “I definitely want it to be a bigger part of my clinical work. It's just that there's so much in the way of actually being able to do that, that it's not a bigger part”.

Overall, participants appear to be suggesting that they believe that SDM is an important part of the role, and something that they would like to be able to do more within services.

Clinicians’ views on the impact of SDM on clients. PWPs often discussed SDM regarding its role in boosting engagement in therapy, and this often appeared to be the reason that practitioners wanted to be able to use it.

I think it is really important for clients to have their opinion on their treatment and their perspective coming into it...and if they're... Kind of given this thing that they really don't feel motivation for...They're not gonna get benefit out of it, or it's not gonna be as successful (Participant F).

At first glance, this quote may appear to touch on themes of compliance, which has been a feature of a lot of SDM research regarding its usefulness. However, instead, what participant F appears to be suggesting is that if the client has an initial high belief in the treatment, because they have been involved in the decision, enthusiasm to engage will be higher and this may lead to a more “successful” intervention. Increasing initial motivation may be particularly important when thinking about depression, which is a disorder often characterised by a lack of motivation.

SDMs role in reducing the power imbalance between clinician and client was considered as important by Participant T “Gradually, the 50-50 reduces...the client has more locus of control over their treatment journey...hopefully by the end of treatment we'd like it

to be 100%...shifting that shared decision making, the ratio of that power can be really helpful”.

SDM was seen to be useful in helping clients to gain more of a sense of responsibility for their treatment and recovery. Participant T used this to discuss how the amount of SDM may change throughout treatment “It sort of restates that, okay, you are responsible for your treatment journey...maybe it’s [SDM] supposed to be...60-40 or even 70-30...giving that locus of...higher locus of control to the client I think...”.

However, participant T acknowledged that sometimes this shifting of responsibility may also be to help the clinician to feel less responsible for outcomes “otherwise eventually the practitioner also sits with a little bit of guilt...could I have done something differently?”. What is being highlighted here appears to be a consideration of a precarious tipping point, in which increasing responsibility for outcomes can be seen as useful and helpful for clients, but that also how this can tip over in to perhaps unconscious attempts to remove responsibility from clinicians.

Participant R likened the increase in ability of clients to engage in SDM to being a part of treatment itself.

a lot of our treatments, which are very, kind of, behaviour-focused... I think it's always good for... to try and make everything therapeutic. So, in terms of, like, okay...making the decision might be really scary...you just kind of don't feel up to it. Trying to help build their confidence in making those decisions.

Participant J framed this feeling of increasing the client’s confidence to engage in decision making as being empowering.

They've kind of got to take that control. So, there's no point in us just saying you've got to do this. You got to do that it's it's empowering them, really, so that they make choices themselves to keep moving forward.

These discussions around empowerment and engagement in SDM being “therapeutic” link to the subtheme of how NHSTT can increase use of SDM, as they highlight how client experience in these areas could perhaps be measured and used to help guide treatment and inform ideas of “recovery” in more holistic ways.

Clients not having access to SDM in services and the potential impact of this was considered by Participant F when reflecting on policies such as requiring clients to start with a group or cCBT.

Maybe it feels quite, like, rejecting. Like, why can't you have a person for me?... Are my problems not severe enough? Am I not suffering enough? And that might feel a bit, like, dismissive...I have had that feedback in the past of, like, I'm really struggling; why would you give this to me? And I think, especially for depressed clients, a lot of [cCBT] is self-driven. You have to log on every day. You have to make that time for it. It's not a scheduled appointment.

They additionally reflected on what impression this may give to clients and how this may impact their view of therapy and stop them from engaging again in the future.

it can feel quite damaging. There's, like. the idea is, like, this is the first line, so if you've never had treatment before, this is what you're starting with... if this is their first experience of therapy, and they're really not on board, and they don't like it, are they gonna come back? Like, are they ever going to reach out for support again, or is... are they going to think this is... The option, this is what... what happens (participant F).

This concern around lack of choice and SDM was shared by participant B, who wondered about dropouts from a depression group and if they may feel a sense of “I can’t be bothered” and that they may not “face having to ring up and ask for something else” and discussed that this “can have a detrimental impact”. These quotes taken together suggest that participants

were concerned that clients who experience limited choice, and perhaps feel forced into options, may develop an idea of service provision as being just those options and that this may prevent them from trying to reach out again.

PWP experiences of cultural and individual differences as barriers to SDM.

Cultural differences regarding SDM were identified by PWPs as being an area that is not always considered well. Participant T explained how in some cultures the style of SDM may be interpreted as “lack of expertise” due to beliefs around the role of clinician as expert being predominant. They expressed that their service was starting to offer training to address areas of cultural differences in relation to other aspects of care but suggested that this training did not explicitly consider SDM.

Participant T, who is from a non-British background, discussed concerns about how this difference may play out for them when engaging in decision making with clients.

Are you looking at me as someone who lack expertise?... Personally, for me that it does come up...I’m already a woman at a younger age bracket, from a different cultural context...that is not your stereotype of a therapist...does that put me in a position where I have to restate the balance in that therapeutic relationship.

Services not understanding the cultural needs of clients around SDM may present as a barrier to this being done effectively. Additionally, this suggests that services may not be supporting the needs of clinicians from non-white British backgrounds and not offering support around the complexity of power in the therapeutic relationship for these staff.

Age was also highlighted by Participant K as a difference that may impact on expectations around SDM.

And I think there's probably, like, an age... thing in that, like, I think older patients tend to want you to tell them what they need to do, whereas younger patients might have a bit more of an awareness of what options there are.

Participant L suggested that pre-held client beliefs about therapy can differ between age groups “because I think a lot of people do come to the service maybe with an idea in their head, because they’ve seen people online, especially younger people”. The differences in knowledge of services and expectations around being involved in decisions may highlight that services need to do more to educate older people on what SDM is and provide more information prior to assessment. Whereas the suggestion for younger people appears to be that they may be more used to engaging with decision making but there might need to be more work done to make it clear what services can and can’t offer.

Moral injury caused by SDM limitations. This sub-theme has significant links with the considerations within earlier themes which explore the role of hierarchy and staff turnover. However, it is considered under this theme due to the high rate in which PWPs identified SDM as being the right thing to do and the comparisons to it being representative of their personality.

Participant J described how it feels to have to withhold information regarding waitlist times

You can hear the desperation of the help that they need...and they say, well how long is it? [the waitlist], Oh I’m going on holiday in 2 weeks is that going to impact it? And your heart drops, you think oh, and you can’t tell them [how long the waiting list is] ...it is a horrible feeling...

This quote touches on exploration of withholding information, and highlights that this removes the ability of the client to make an informed choice. When considering this in tandem to participants' discussions around SDM being the right thing, and the alignment with personality and values, it becomes clear how clinicians can begin to feel a sense of moral injury described here as being like “your heart drops”.

Participant N described how feeling forced into discharging a client whose scores had temporarily improved felt.

I didn't like how it [discharging a client whose scores decreased just because of having one “good” week] felt...I can understand why scores are there for a reason...but... it... Working with that client, it didn't feel good to have to then turn around and say, well, we've said that we're going to offer you this, but actually, we're going to take it away now. And it did feel really uncomfortable, particularly because it wasn't my decision.

Two important aspects leading to a sense of moral injury are highlighted in this quote: firstly, the participant is recognising that the client was unable to make a choice about treatment due to an arbitrary decrease in outcome measures. Secondly, the participant appears to suggest that part of the injury is caused by having to relay decisions they disagree with.

Participant F reflected on how having conversations that did not reflect SDM impacted how they felt about their role as a PWP.

The part of me as a clinician who wants to take the time with every single client to do a really nice, thorough assessment.... But then there is also the part of me who is quite overworked, quite overwhelmed, under a lot of pressure, under a lot of stress, don't have that autonomy over the decisions I'm making... And know, I can't do both, I can't work and align with my values, I can't work and align with... who I want to be.

It appears from this quote that clinicians are recognising that holding the desire to involve clients in decisions feels incompatible with the current system they are working within.

Participant H provides an account on what may happen when clinicians make the realisation that the role may be incompatible with how they want to work “I know that from the people that I work with...They're planning to leave. About... two-thirds of the way into the course. Because the job that they applied for is not the job that they got”. It appears that

these feelings of moral injury may be contributing to the high turnover rates experienced within the role. This suggests that, overall, PWP's want to align with the values of SDM and equate these to being the morally right thing to do. However, due to current service pressures, the impact of policies and hierarchy, they often find they cannot do so. The result of this is often that they leave the role to find work that does allow them to work within their values. This impacts the number of clinicians that become highly skilled in their roles and perhaps prevents SDM from becoming a bigger focus in services.

Areas of hope: identified areas of good practice and ways to move towards increasing SDM

Throughout interviews, participants spoke of the barriers that affect SDM. However, there were also multiple instances of clinicians highlighting positive changes that are beginning in services or are being proposed that can help to shift the culture of services. Some changes were on a more personal clinician led level, whilst others were wider changes in systems. Whilst this continues to highlight disparities between services, it similarly highlights that in some services things are beginning to shift.

Changes individual clinicians can make to facilitate SDM. Honesty was something that clinicians felt was necessary when engaging with SDM. For Participant R, this honesty remained important even when acknowledging service pressures around availability of certain choices.

If you do have a really strong preference for counselling, I can definitely ask my team if that is going to be available, but...if they tell me, kind of, maybe start with CBT, is that something you'd be okay with? So, kind of, like, I think being really clear and transparent in terms of what we are able to offer.

Whilst this quote still contains references to choices being made elsewhere in the system, participant R suggests that being honest about what can currently be offered is important as it gives the client indication of the likely outcome. In an ideal system, the client would be able

to make the choice in collaboration with their clinician in a much freer way; however, acknowledging the current limitations allows the client to be informed and removes the requirement to withhold information.

Participant L identified that rapport was important in helping clients to engage effectively with SDM.

Especially maybe more medical-based ones...you're just kind of told what to do...I don't want clients to speak to me to have that experience, you know? So, I think setting out the expectations, like, at the beginning, and building rapport with them.

Within this quote, participant L is building on the previous quote from participant R. There is an acknowledgement that the current system may not offer as free a choice as would be desired, with the reference to “setting expectations” perhaps implying that the client should know from the beginning what the realistic outcomes are. Participant L suggests that this honesty may help to build rapport and allow for some informed SDM to take place despite service limitations. The comparison to “medical-based” appointments is interesting and suggests a desire for this clinician to be able to provide a service which is different to the one received in more medical settings, perhaps suggesting an acknowledgement that services currently may be leaning more towards a traditional medical model. This quote may attempt to address how small changes in being more honest and a focus on rapport may help to move away from this.

Participant R described how SDM was spoken about in training, and how they would like to be able to do this in service.

And then at the end of the assessment, there would probably be, kind of, a general question as well...is there anything else about, kind of, your, like, identity or background you feel like is helpful for us to know, or kind of, include within

treatment? Anything, kind of, do you have any strong preferences in terms of, like, therapist type or, like, location, like, medium for treatment

They also described how it can be useful to consider how much of a choice the client would like to have, and how this could be best given to them “talking to that person, you can see, okay, like, how much would this person like in terms of making that decision? Would they like to only choose between two options?” These quotes highlight that the knowledge of how to engage in SDM and what questions to ask are knowledge that PWPs already have, and as discussed are often linked to values that they hold. It would be ignorant to suggest that PWPs can make the change towards asking all of these questions in assessments without support from the system around them to allow for necessary changes, however, Participant B highlighted that they continued to offer all options despite sometimes being given advice not to “I... give myself that flexibility, to be honest, because I don't morally agree with withholding stuff”. This suggests that individual clinicians can begin to make changes, and perhaps if this began on a wider scale, this may begin to force a cultural change.

Changes needed within the NHS Talking Therapies system to facilitate SDM.

Participant X spoke about how clients often come into the service with limited knowledge about what the service is and how the assessment will look “At the assessment stage, the clients aren't... aren't very sure about what treatment it is that they want, because a lot of them are unfamiliar with it”. This lack of information given prior to assessment was discussed in other interviews. However, Participant V discussed how they had tried to address this in their service “one of the things I'm trying to launch in my service is that all the patients will receive, like, a leaflet...like, how to prepare for your assessment”.

Similarly, Participant F identified that clients had found the guide they made regarding treatment options to be useful “I made, like, a... a handout with CBT versus counselling, so clients could, like, see the difference between the two and have some time to

digest it on their own". Both participants F and V highlighted the need to increase access to resources that can boost the knowledge that clients have prior to attending their assessment or prior to deciding. Whilst participant F took initiative to develop their own resource, a system wide approach to increasing access to resources, as highlighted by participant V, may be more effective in creating system-based change. As discussed previously, participants highlighted that clients who had more knowledge could push for other options and therefore resources to boost the knowledge of all of those who attend assessments may create motivation for services to increase access to choice.

In the discussion of other themes, it was highlighted that PWPs were not always given information about what other options exist in service, and it was discussed how this impacts on SDM. However, Participant K described how this had not been the case in their service as they had been given information sheets during training and that "in my team meetings for the last few months, we have someone from each of the modalities basically come and explain, you know, what it is".

This again highlights the amount of variation within services and between different clinicians as to the importance placed on providing sufficient information to allow for SDM. The development of a service wide resource like the one identified by participant K would be useful to allow for all PWPs to have access to the same information in an easy to reach format, which would in turn improve the ability of all PWPs to be able to offer information to clients.

The impact of hierarchies in preventing PWPs from being given this information has been discussed within other themes; however, Participant V in the quote above suggests a move away from this as training from other modalities has begun to take place. It appears in some services, hierarchies may be starting to flatten. However, for this to change across all

services, NHSTT may at first need to begin to make this cross modality exchange of information a more formal requirement.

Participant T reflected on how community outreach could be used to build pre-assessment knowledge for clients.

I used to work at a different service...and a lot of what I used to do was community outreach... I think that's really, really helpful because it sets that pretext and that expectation, even before people enter therapy.

This quote suggests that a shift for services towards engaging in more community outreach may be essential to help some individuals to feel more confident and knowledgeable enough to engage with therapy. Some populations may be less likely to reach out to services and may have less understanding of how mental health services in England work. As discussed, individuals with less knowledge about options and services typically do not know they can push for other options, and those from groups who are less likely to be represented in services may therefore be more likely to experience less choice. Addressing this with community outreach may help to empower more people from underrepresented populations to access services and start conversations around how they may want to be spoken with regarding making choices.

Some participants spoke of clients' abilities to engage in SDM as being a marker for recovery progress.

A lot of what we try and foster is in terms of, like, if you're avoiding decision making, if, kind of, you feel too anxious or too stressed to do it. You're never actually going to learn that you can make those decisions (participant R).

Here, participant R is highlighting that the client's ability to make decisions easily may be impaired by the symptoms they are experiencing, and that perhaps being able to monitor how well they can engage with decision making could be a good way to measure progress within

treatment. Whilst this does not directly help with thinking about SDM in the context of assessment, it might be a useful tool to consider when engaging in decisions that take place in treatment, such as thinking about next steps or engaging in discussions around session length or homework tasks.

Participant N felt similarly and suggested that a focus on client experience, with SDM as one of the measures of this, may be a better way to gather data in services and that this in turn would be likely to increase the amount of SDM present in services.

Whereas if, like, there was some sort of data around how many clients have met their goals for therapy. I feel that that would kind of cause a lot of a shift in the...the shared decision making, because we're needing...the client to be involved in that, because they've set the goal.

NHSTT do collect some data on client experience already; however, the type of experience data suggested by participant N may be more useful in allowing clients to express how much therapy has helped them in a way that may be more meaningful for some than traditional outcome measures. If this type of experience data could be utilised in the same way as traditional outcome measures, this may help clients to have more control over decision making as they would be able to clearly define if there was work they felt was still needed towards their goals. This may be important in decreasing the tendency to make decisions on recovery based on scores on the MDS alone.

The NICE (2021) guideline for SDM includes discussing not having treatment as an option when discussing options with clients. Participant K highlighted why this may not be happening in services.

I feel like sometimes I really, really want to [suggest no treatment] but I can't, because a lot of the time, people have gone to their GP, and then as soon as they say the word, like, depressed, or stressed, or anxious, the GP's like, oh, let me send you

the link to this service, they'll help you. So, it feels like we've got an obligation to give people something.

With this quote, participant K was referring to clients who are referred by their GP for what may be a normal response to difficult ongoing life events that may resolve spontaneously if the stressor is removed.

Participant R touched on the offering of no treatment and highlighted that there may be reasons why no mental health treatment may be the most effective option for a client.

And then, like, as you said earlier about, kind of, having no treatment as an option, if there's someone that has a lot going on, maybe they're trying to, kind of, sort out different areas of their life in terms of physical health, in terms of maybe they've got, kind of, court cases going on, or they've recently been bereaved. Kind of being like, is this the right time to be engaging in treatment?

Within both quotes, participants appear to be highlighting that NHSTT currently may be trying to fill gaps to attempt to “treat” difficulties that are more systemic in nature. This may be due to a lack of resources available in certain areas, or due to a lack of knowledge and links with other services in the area. Community outreach, as highlighted earlier, may be useful in helping services to become more aware of what is available locally, and a focus on developing these links may be useful in increasing options and choices available to clients who may fall into this bracket.

Participant F spoke of a recent shift towards SDM “It seems like recently there has been more of a shift towards shared decision making, so it is something that's being spoken about more within my service”. They were unsure of what may have caused this shift “I kind of assumed it was an external change...like... the high, high, high ups that had recognised that we weren't, kind of, quite doing correctly, or...weren't taking into consideration as much as we should have been”. This quote highlights the role that management have in beginning

to shift the culture of services and suggests that for at least some services this is beginning to take place.

Changes needed in external services to allow for an increase in SDM in NHS

Talking Therapies. Participants often spoke of how clients' expectations of the service can sometimes be impacted by the lack of SDM that happens in services that refer into NHSTT. Participant X spoke about how referrals that come from GPs often enter the service with very limited knowledge.

One of them will be referred by their GP, and they'll know nothing, because the GP won't tell them. They'll just kind of... oh, you're... you're depressed, here...and I get they're busy, I'm not bashing on GPs, but... sometimes the easy option is just to refer them to us.

Many participants spoke about GPs as referrers, and there was often a suggestion that they may not always understand what NHSTT can offer. Within this quote, participant X appears to be suggesting that sometimes GPs may see NHSTT as “the easy option” and may be making referrals to ease their own workload. There is acknowledgement of “I get that they’re busy”, suggesting that there is an understanding that other parts of the system are experiencing similar pressures. However, lack of understanding between systems appears to be preventing clients from being able to make informed choices.

Participant K discussed how sometimes referrers will tell clients what treatment they should ask for, and that this sets an unrealistic expectation and makes the process of SDM harder.

I do find as well, sometimes people get referred, and they get told about, for example, EMDR...but they might be presenting with depression and no symptoms of trauma, but I don't know, the GP or the mental health practitioner...has said you would benefit

from EMDR, and then they come in and they say, no, well, I've been told that EMDR is what I need.

It appears that if external referrers had more knowledge of what NHSTT offers, and NHSTT provided more information to clients prior to assessment, clients would enter services with the knowledge they need to better navigate the system. This may mean that more clients are able to push for different choices, which may eventually create a system that can no longer expect most clients to go with the first option they are offered. This may push for a culture that is more receptive to SDM.

Bringing the data together

When viewed together, there initially appears to be some disagreement between the quantitative and qualitative data discussed within this chapter. The quantitative data suggests that PWPs are actively using SDM frequently within practice, whilst the qualitative data reports mainly barriers preventing its use. However, this may be due to differences in how offering SDM is perceived. Many interview participants initially reported that they were offering choice and using SDM often; however, when reflecting further on the definition of SDM provided by NICE (2022), they began to identify that choice was being limited by service decisions and that clients were not always given the full range of applicable options, which limits the ability to truly perform SDM. If only quantitative data had been collected, this important nuance would have been missed. However, the quantitative data also allowed for a broader range of responses than could have been collected qualitatively and added rich data around availability of choice and PWP beliefs about SDM. The quantitative data suggested that PWPs highly value SDM, and this was supported by the qualitative data. When taken together, this allows for stronger conclusions to be drawn about the value PWPs place on SDM.

Discussion

Chapter overview

This chapter explores the findings in relation to the study aims, situating findings in relation to existing research. Potential impact will be considered in relation to policy and guidelines, services, university training and commissioning. This chapter also includes a reflective account of conducting the research.

Relating the findings to the aims

The research centred around four main aims: exploring how much choice is currently on offer and if this is in line with the NICE (2022) guideline, exploring PWP's own experiences and views on SDM, exploring PWP's perception on management's views on SDM, and finally exploring how much PWP's feel able to use SDM in practice and what barriers and facilitators exist regarding this.

Firstly, the aim of exploring how much choice is currently available in NHSTT services, and if this reflects recommendations made in the NICE (2022) guideline, will be discussed. Looking at the survey data alone may seem to suggest that services do have a mix of the options available that have been recommended by NICE (2022), and that these options are offered in diverse ways. However, exploring the experiences of PWP's in being able to offer these choices during interviews is where implementation challenges become apparent.

Many of those interviewed reflected that their service has at least two or three psychological therapy options other than CBT for depression. However, they discussed that “gatekeeping” around these options means that most people who present to the service with depression would not be made aware of those other choices. Participants spoke of feeling a “push” towards only offering a certain option and only revealing further options if there is “pushback” from the client. For lots of the participants, options other than CBT were likely

only to be considered if the client had been to the service for multiple episodes of CBT in the past or presented as “complex”. Choices of how therapy is delivered were identified by some as limited, as they reflected that they were told only to offer face-to-face if there was an identified need or if the client explicitly asked. Whilst on the face of it, choices are available in NHSTT, clients are often not given the information required to be able to access these choices, leaving choice limited for most.

The NICE (2022) guideline includes recommendations for specific training about SDM. Whilst some survey respondents did report having received training about SDM, many reported they had not, indicating that this recommendation has not been implemented by all services. The NICE (2022) guideline recommends that services should be actively encouraging clients to engage in SDM and proposes types of questions and client information needed to facilitate this. Some participants did mention having developed their own resources, and one participant discussed that their service was developing a pre-assessment resource. There is some progress towards this recommendation, but there appears to be a large amount of variance between services.

Importantly, knowledge of the matched-care model introduced within the NICE (2022) guideline was low among participants. Even for participants who had trained more recently, they had been taught about the stepped-care model. Participants still referred to the stepped-care model and reported using this term in discussions with managers. One participant highlighted that as the matched-care model only related to the guideline for depression, this may be why services have not adopted it, as stepped-care covers all services and may be easier to refer to. As discussed earlier, the matched-care model is not significantly different to the stepped-care model and does not go as far as it could to encourage SDM. However, it may help to encourage a reduction in rigid boundaries of stepped-care. Participants highlighted that often the stepped-care model is not being followed as it was

written, as the model requires consideration of previous therapy, but clients are generally offered Step 2 even if they had multiple previous episodes of Step 2 treatment. Systemic issues surrounding NHSTT may have caused stepped-care to morph into something more rigid than originally intended.

The second aim of this study was to explore how important PWPs think SDM is. Survey participants rated the importance of SDM highly and rated use of SDM and value of the OPTION skills highly. During interviews, many PWPs described SDM as feeling like the right thing to do and likened this to being a part of their personality and integral to their values. There were no PWPs during interviews who did not think that SDM should be part of practice, and all discussed areas in which they think SDM use could be improved. Many participants discussed the discomfort they have felt within their role due to not being able to offer choice and the limitations impacting SDM. Some linked this to high turnover seen among PWPs. These discussions highlight that PWPs consider SDM to be a particularly important part of their work, and something that many would like to see improve.

Thirdly, this study aimed to explore PWPs' experiences of the importance that senior management appear to place on SDM, and the impact of university training. Most participants reported their university valued SDM more than their service did. When this was explored further, most participants felt that their university had placed value on SDM but rarely used the term explicitly. Rather, choice was generally described at university as “patient centred” care. Within the survey, trainee participants generally responded that they had been given information about SDM at university; had been taught about why SDM should be used; and potential barriers. An area of weakness appeared to be teaching on how to overcome barriers to SDM. When this was explored further, participants reported that sometimes teaching had fallen short of teaching them “how” to do SDM within the NHSTT context; only teaching that it should be done.

Both qualified and trainee PWPs who took part in the survey were asked to rate how much they felt managers in their service valued SDM. The average score of $M = 64.27$ ($SD = 24.16$) out of 100 suggests that overall PWPs do believe that managers value SDM highly but not as highly as PWPs themselves. However, the high SD indicates that there is quite a lot of variance between participants. Interview participants generally felt that most managers value SDM on a personal level but that barriers prevent them from being able to prioritise it over data, funding and waitlists. Some participants reflected that the more removed clinicians become from clinical work, the easier it is to lose sight of SDM as they are less directly affected by the impact that lack of choice can have on clients. Overall, it appears there is a mismatch between university taught content, real-life practice and management priorities.

The final aim of this research was to consider how much PWPs feel they can engage with SDM, what helps to facilitate this and what acts as a barrier. This has been partly addressed when considering the previous three aims but will be expanded upon further. The results from the OPTION scale suggest that SDM and the skills needed to demonstrate it are used frequently by PWPs. Initially, interview participants would often begin by indicating their service does well implementing SDM. However, as PWPs began to reflect throughout the interview, the narrative would often shift, and participants began to reflect on the limitations of SDM in services. Participants often spoke of the fact that clients are given a choice, e.g., group or online, and for some this was felt to be enough. Others reflected on how this choice does not reflect true SDM, as often information about what else is available is withheld, even if the clinician believes the other options may be more suitable.

Some felt this was a result of the stepped-care model, whilst others felt this indicated overly rigid application of the model. The stepped-care model encourages offering the least intrusive option first and then moving to higher steps if this treatment is unsuccessful or the client presents again. As discussed, participants highlighted this was not always the case.

Interview participants were largely unaware of the matched-care model introduced in the NICE (2022) guideline, which added considering clients' views, values, and previous treatment experiences in treatment decisions. It appears that in services, the idea of least intrusive suitable option has drifted into Step 2 LI CBT as a default. This presents as a significant barrier to SDM, as it omits exploration of the clients' views, previous experiences, and values.

One cause of this drift may be waitlist management. Interview participants spoke of historically high waitlists for other therapies, and a fear among managers of waitlists growing. Participants reported managers instructing staff to offer only certain options to avoid long waitlists, usually cCBT or group-based therapies, and to offer other options only if the client is insistent in not wanting these. Participants felt this may be because it is cheaper to put people through Step 2. However, participants highlighted that having repeated episodes at Step 2, or having Step 2 and then Step 3, is more expensive than it may have been to give the client another option initially that may have been better suited to them.

Participants spoke about how limited time was for assessments, and with high caseloads they sometimes felt unable to dedicate enough time to explore clients' views and differences. Instead, participants spoke about spending time identifying goals and using these goals to decide what treatments would be offered. This makes sense in theory; however, one participant highlighted that this approach was inherently CBT-focused. Another reflected that when the service increased treatment types, the assessment did not change to reflect exploration that might lead to goals more suited to other modalities. This suggests that the framing of the assessment may lead to clients being more likely to give CBT suitable goals, and therefore to them being given CBT options. Time was additionally a barrier for clients, who participants reported were not usually given an opportunity to think over decisions and

were often asked to make decisions on the spot. Time is therefore another factor which contributes to the drift towards Step 2 LI CBT being the default offering.

Many interview participants commented that many clients come into the service with limited knowledge about what to expect and limited general knowledge about therapy. Some participants spoke of having developed guides to the different options that they send to clients, and that this had been useful in helping them to reach a more informed decision. Information giving was often highlighted as being essential to SDM, but many highlighted that opportunities to do this were more limited than they would like.

Relating the findings to existing research

There is little previous research on choice and SDM in NHSTT services. However, the results of this analysis suggest that the way choice is offered by PWP in NHSTT settings has remained similar to the way it was described in Irvine et al. (2021) transcript analysis of PWP assessments. Irvine et al. (2021) described that clients were usually given one option and then asked to either accept or decline this option; and that clients were often only given subsequent options if they pushed for them, which was almost identical to findings in this research. This would suggest that despite the NICE (2022) depression guideline changes which recommended more focus on SDM, the way that choice in NHSTT is offered has stayed the same.

A key part of the barrier to SDM within NHSTT identified within this thesis is the lack of information provided to clients regarding their choices, especially in the form of decision-making aids. This matches with findings from Verwijmeren and Grootens (2024) meta-analysis of barriers to SDM within mental healthcare services, which identified this as a commonly reported barrier.

This research also generated themes mirroring themes from the meta-ethnography in this thesis. For example, Gellatly's (2011) study explored how decisions are made within

primary care and included LI and HI workers, as well as GPs. Gellatly (2011) suggested that often the choices offered to clients are determined by waitlist lengths, and that clients would often not be offered options with longer waits; again, almost identical to the current findings. Gellatly (2011) reported that clinicians often felt they received “unsuitable” referrals from other services, which is similar to this study finding that PWPs felt referrers often had limited knowledge of what the service offers and sometimes gave unrealistic expectations. Gellatly (2011) took place 3 years after the initial creation of IAPT, and it appears that 18 years later, barriers to offering choice remain similar and have not changed despite the changes to the NICE (2022) guideline centring SDM and client choice.

One area of change is that Gellatly (2011) suggested clinicians reported a lack of alternatives to CBT to offer, while in the current study clinicians had multiple options to offer. However, these were often not accessible to most who attend the service and so could not be offered in practice, generating for some clinicians a sense of moral injury.

As suggested in the meta-ethnography, Patel et al. (2014) highlighted that clinicians often struggled to provide education about SDM to clients who arrived at the service with the expectation of decisions being made for them. PWPs reported that this is still the case for some clients, with this being more likely for some groups. However, it is worth noting that the Patel et al. (2014) study was conducted within the US healthcare system, and therefore direct comparisons with the UK may be more difficult. Kokanović (2018) suggested that staff struggle to have these conversations with clients as they often have not received enough training to feel confident in being able to discuss why it may be beneficial. Participants in this study expressed a desire for training about SDM, feeling that greater education for clients prior to assessment would be useful in facilitating SDM. Lack of staff training was felt to limit capacity to provide enough information for an informed choice.

Simmons et al. (2013) suggested that SDM is limited owing to strict time constraints such as standardised appointment lengths, and that clinicians want to offer clients the time to think about their decision. However, they felt they could not give this time due to service pressures. Participants in this study also spoke about time constraints related to standardised appointment lengths and how this can impact conversations about choice. They similarly highlighted a desire to give clients time to think about the decision, but that they felt that the service would not encourage this due to service pressures such as caseload and waitlists.

Several studies have suggested that clinicians working with people with depression see SDM as the most ideal way to make decisions (e.g., Bear, 2020). Participants within this study felt that making decisions in a shared way aligns with how they would like to be able to practice, with some likening it to being a part of their personality and identifying that it is the way they would like to receive care. The idea of SDM being an ideal way to work with clients was also further supported by a call to include greater use of SDM and placing clients at the centre of services as being a key part of overhauling mental health services to be more effective globally (Patel et al., 2023).

A key area of difference in the themes found in this study and many of the studies included within the meta-ethnography is the idea of paternalistic culture being a barrier to SDM. Participants described that they were often told to deliver “patient-centred care” and to be “collaborative” with clients by both services and training courses. Participants believed that managers do value SDM, but that this gets lost due to the systemic pressures services are currently facing. This suggests a culture that does not want to be paternalistic but is forced to be due to pressures of time, waiting lists, data collection, and funding; ultimately further consolidating the drift towards offering Step 2 LI CBT as a default out of necessity rather than choice. This may suggest that there is a willingness on a service level to move towards SDM, but that external factors prevent this.

Clinical implications of the research

The results from this research suggest that SDM and client choice, as suggested by the NICE (2022) guideline, are not being adhered to within NHSTT. Findings suggest that to improve SDM, action needs to be taken at a systemic level, including service organisation and commissioning. The research provides insights into how the NICE (2022) guideline could be revised in future to be more impactful and meaningful. The potential for recommendations for university courses is less clear due to the low number of current trainee PWPs that took part in the research. All interview participants were asked to reflect on their experiences of training, but as these experiences were not current, it is harder to draw conclusions on the current level of SDM focus of PWP training. However, the quantitative data does suggest gaps in current teaching relating to the specifics of use of SDM and highlights the disparity between university teaching and clinical practice. Therefore, it is possible to make some recommendations for university courses.

Service organisation

One barrier to SDM within NHSTT was the lack of information given to clients prior to assessment and when faced with treatment decisions. Participants suggested that it was not usual to allow time for clients to think about their decision, and that often no resources were available to support decision making. Some services have begun to change this and are sending more information before assessments, and some participants having created their own guides to the different treatments. However, it appears that decision-making aids are not routinely used within services.

There are decision guides published by NICE in conjunction with NHS England that cover making decisions for the treatment of depression (NHS England, 2024b). However, as discussed earlier, currently this guide does not provide clear guidance on the different types

of therapy but simply lists talking therapy as an option to consider (McPherson et al., 2025). Critique was made of both the mismatch ideologically for how the guide was developed, and for its practical use due to the limited information contained within it (McPherson et al., 2025). The current research supports these arguments and, in addition, finds that the official decision aid is not widely used and was not mentioned by participants. When specifically asked about use of decision aids, participants often responded that they were not aware of them or discussed having created their own.

A more appropriate decision guide for depression should be developed which contains information on all of the treatments for depression available within the service, as well as information on when each type might be suitable and any specific considerations relevant to each type of therapy. Clients should also be given more pre-assessment information with a general introduction to the service, and brief introductions to different types of therapies. A more detailed decision aid could follow a triage discussion or the full assessment. Clients should then be given time to think over their choices with take home information and be given a period to consider; a follow up call should then be made to finalise the decision. Data from this research suggest that often clients are asked to make choices on the spot, with incomplete information about the range of evidence-based options.

Similarly, NHSTT services should link with GPs and have a decision guide suitable for both contexts as well as client home use, to enable joined-up SDM across settings. This would help to improve the knowledge of referrers and help to increase appropriateness of referrals. Insufficient knowledge of GPs and lack of consistent communication between GPs and NHSTT was a theme present in Marshall et al (2016) study, which sought to understand why clients may cease to attend their appointments within NHSTT. The data in this study suggests that this remains a problem within services ten years on.

Study findings highlighted a lack of training on non-CBT options in both services and universities. It sometimes seemed that this was felt to relate to a fear that teaching PWP about other modalities would cause confusion or cause them to try and implement those therapies. However, in cases where participants had been given information about other therapies, they reported to find this useful in helping them to identify when clients may be suitable for those therapies. It also helped them to formulate suitable goals for treatment which would enable the client to access the support they need, ultimately improving client care. PWPs are often the staff who complete most assessments in service, and without all the information about what is on offer, they cannot complete their job to the best of their abilities. Services should arrange training for all staff in the different options available in the service, led by clinicians who specialise in these options.

Participants in the survey reported low levels of training explicitly about SDM in services, and interview participants found guidance around SDM to be unclear and not featured in service training. Whilst the survey data suggest that PWPs feel confident in what SDM is and feel able to use different skills that SDM requires, interview findings suggest that theoretical knowledge of SDM and the desire to use it can be disrupted by systemic barriers identified in this thesis. Therefore, it is important to introduce training and workshops for service managers on NICE guidance and how to make organisational changes that support staff to implement SDM with Equality Diversity and Inclusion (EDI) considerations.

Regarding SDM for clients from backgrounds in which SDM might be less common, as discussed in the systematic review, Patel et al. (2014) suggested that increasing community focus can reduce the impact of stigma and increase the likelihood of clients engaging in decision making with services. A participant in this study also suggested that improving community outreach may help to increase engagement with SDM for clients from backgrounds in which SDM is not common. However, it is important that this community

outreach focuses on understanding the needs of the communities and what SDM would look like. Services should be conscious of the risk of applying SDM as a blanket offering; the NICE (2022) guideline references that clients should be given an option about how much choice they want to have. This aspect of the definition was not often discussed within interviews; services should therefore include guidance around this within any SDM training.

NICE (2022) guideline ‘Depression in adults: treatment and management’

As discussed within this thesis, there is a NICE recommended decision-making guide for depression, which was produced in collaboration with NHS England (NHS England, 2024b). However, this guide does not discuss the information and pros and cons of all the therapy options that NICE (2022) now recommends for depression. An updated and more interactive version of the existing guide with all options for psychological therapy would be useful, co-designed by researchers with service users and usable in different settings, including at home. As participants discussed within this research that clients often did not have access to enough information to make an informed choice, an interactive decision making guide would increase the amount of knowledge clients could access to help them to be able to make an informed decision.

As mentioned in the Introduction, there is increasing research on the use of decision-making smartphone apps, and more recently the role of AI. An updated decision making guide could ultimately be integrated into the NHS app. This would help to address the difficulties in clients being able to access enough information that were raised by interview participants. The NHS Long Term Plan (2019) provides the strategy NHS services are aiming for in the next 10 years and contains a focus on increasing digitisation. Commissioning a co-produced digital guide to be integrated within the NHS app would help towards this aim. This may reduce time constraints, as clients would be able to view the information they needed and perhaps be able to make the decision through the app if they did not feel they needed any

additional information directly from a clinician. This would both help to address the need for clients to be able to access more information and help clinicians with the issues they raised around not having enough time to engage in SDM.

The NICE (2022) guideline additionally falls short on recommending how much of each choice should be available for each of the therapies it lists as recommended. This creates little incentive for services or commissioners to feel a push to increase the number of clinicians available for each modality. As discussed, this maintains the problem of waitlists altering what choices are given, making true SDM difficult within services. Clear guidance from NICE on suitable levels of distinct types of therapies may help to reduce the amount of variance in availability of therapies evidenced in the survey data.

As discussed in the Introduction, the legal Right to Choose would cover individuals to be able to request treatment in a different NHSTT service (NHS England, 2014). The NICE (2022) guideline already includes recommendations for how healthcare professionals can include clients in discussions about care; further recommendations around including information on the Right to Choose may be useful in increasing awareness about this option. It is important that if this change is made, it is recommended clearly at all levels of primary care, including GPs, to increase consistency.

Commissioning level

Study findings indicate that systemic pressures from “above” restrict SDM and encourage PWPs to direct clients towards certain options, usually group or online options, to keep waitlists down. This would include the recommendation to only reveal one option and then reveal other options if the client “pushes back”. It cannot be described as SDM if only the service has knowledge of all the options, and the client has knowledge of only one. Foucault (1980) suggested that power and knowledge cannot be separated, and that power produces knowledge and equally this knowledge then reinforces power. Applying Foucault’s

(1980) power/knowledge concept to this example, the knowledge of the clinician, and of the accepted “truth” of what is the best treatment, is being presented, whilst the knowledge of the client is disregarded. Foucault (1980) suggested that whilst power is everywhere, so is resistance to that power, and this may be what is being demonstrated by those individuals who “push back”. However, it may be that individuals experiencing depression are less likely to feel empowered to display this resistance. Lowered self-esteem is often a feature of depression (e.g., Deb & Bhattacharjee, 2009), making it less likely that depressed individuals in particular will “push” for more options.

The reduced access to non-CBT options relates directly to insufficient staffing of these modalities, which can only be addressed at a commissioning level. The most recently available NHSTT workforce census reports that in 2024 there were 3,853 HI CBT therapists employed across England (NHS England, 2024). Comparatively, in 2024 there were 1,505 staff employed to deliver other types of HI therapy (NHS England, 2024), meaning therapists trained in other modalities are thinly spread. To increase access to other modalities, commissioners need to fund more training and posts in other modalities or increase funding opportunities for existing staff to gain additional qualifications.

It likewise needs to be considered that there may be some therapy options that are not chosen as frequently. It may be less applicable for every NHSTT service to have a high level of offering for every type of therapy. However, this is unknowable until clients are genuinely offered information and choice. A client preference survey could be undertaken to establish potential choice behaviour among a sample of people with depression to inform commissioning. Access can also be increased in the short-term by providing online access to certain therapies, and/or the establishment of these options within one service within a broader set locality which then offers these treatments across the area. This could be

organised by ICB areas, with consideration for how much provision would be applicable for ICBs that cover higher populations and more sparsely populated areas.

As mentioned above, the “push” participants experienced was often towards offering online or group options. From a commissioning standpoint, these options save money in the short-term, as they use less clinician time and can be run by clinicians on lower salary bands. Many individuals may benefit from these interventions, but the over prescription of these options needs to be reviewed and considered from the lens of SDM and longer-term clinical and cost effectiveness.

Within the Introduction, the use of home visits to improve access to choice was considered. The NHSTT manual (NHS England, 2024a) suggests that commissioners should consider making funding available to allow this. Within this research, only 10% of respondents identified that their service offered home visits. Increasing or ring-fencing funding to allow for an increase in home visits may help to address some of the inequality in accessing choice, especially within rural and/or higher social deprivation areas.

As discussed, when considering the service organisation recommendations, an increase in the community focus of services may be helpful in moving towards improving levels of SDM making in services, especially for groups that have often been left out of services. This was evident in Patel et al. (2014). Commissioners also have a part to play in changing this, as for services to engage in community-based work they would need access to the funding and staffing levels to do so. As mentioned frequently by participants, time is already a constrained resource, and it would be unlikely that many services could add this element whilst also continuing to meet the targets required of them to continue to receive funding. An increase in community focus would therefore require a change in the way services are designed and commissioned.

University training courses

Study findings indicated university teaching may be ‘idealistic’ and disconnected from service realities of offering choice in a system that does not always allow this. Findings also highlighted a disparity between the valuing of SDM at universities versus services.

Universities are working within national guidelines emphasising the importance of SDM and collaboration. However, the current mismatch between theory and practice is problematic. It would be helpful for training to be more transparent about the realities of practising SDM in the NHS currently. Universities should also focus on training trainees to advocate for change within services.

The BPS standards for the accreditation of Doctoral programmes in Clinical Psychology (2019) document makes frequent references to the importance of university courses training Trainee Clinical Psychologists to be critical in their approach to practice and reviewing evidence. A similar set of criteria for trainee PWP courses may help to train a cohort of PWPs who are more empowered to practice critically and challenge systemic issues. A research study involving healthcare staff in Sweden suggested that when “leaders” seek to make change via top-down processes, staff within the system can be resistant to this change (Erlingsdottir et al., 2018). However, when “leaders” instead identify the problem but encourage staff to reflect as a group and take ownership, this leads to a change outcome which is experienced more positively by staff within the system and leads to successful organisational change (Erlingsdottir et al., 2018). Universities could play the role of the “leader” who introduces the problem, such as a certain barrier to SDM, and encourage trainee PWPs to formulate solutions to these problems.

Study findings also highlighted a lack of teaching at universities on therapy options for depression other than LI CBT or HI CBT. Whilst the PWP role is specific to CBT, a large part of the PWP role is assessment. If PWPs are only taught about assessment within the framework of considering HI and LI CBT, it may be more likely that these treatments remain

the most likely to be offered. Increasing teaching on other options for the treatment of depression appears essential in starting to change this.

Participants often spoke of being taught about “patient centred care” at university, rather than being taught about the concept of SDM specifically. Participants themselves also often used terms such as “patient centred care”, being “patient centred” interchangeably with the concept of SDM. It is hard to draw a conclusion on the exact language used by universities and if the term SDM is being used specifically. However, the available data would suggest that teaching should be clearer on the specifics of what each of these terms mean. Implementation of SDM should be considered explicitly throughout training modules.

Strengths and limitations

Strengths

A key strength of this research is its novelty. As highlighted by the systematic review earlier in this report, qualitative explorations of staff experiences of using SDM with people with depression is limited, especially in the UK. To the researcher’s knowledge, the experiences of PWPs in using SDM when working with people with depression has not been researched before. As discussed, PWPs are responsible for a lot of the assessments in NHSTT services and are therefore a key part in understanding how SDM operates. This research contributes rich knowledge to this area and begins to form a picture of the barriers within NHSTT services that stop SDM from taking place as recommended within the NICE (2022) guideline. Whilst some of these findings, such as PWPs feeling like they do not have enough time, may seem ‘obvious’, it remains true that these findings are typically anecdotal and not previously documented in research. The study adds important evidence for the impact that not being able to use SDM has on staff and how this may contribute to high turnover in the role.

The use of RTA allowed for an in-depth exploration of experiences of PWPs. RTA encourages interview processes to remain flexible, and this was the case in this research. The topic guide allowed for the interview to remain focused on three broad areas of enquiry, whilst allowing for flexibility to ask questions that felt directly relevant to what the participant brought. This allowed for all narratives about the topic to be followed and hopefully reduced the likelihood of questions biasing the responses that could be given. The link between data collection and SDM use was not something that the researcher had considered before the start of these interviews, and it may be that if a less explorative approach was used, this important information may not have come to light, as questions designed pre-interview may not have allowed for this reflection to come from the first participant who mentioned it. As the interviews went on, reflections like this were used to guide later interviews.

The use of mixed methods research is a strength. Using a purely quantitative approach may have risked missing the nuances of experiences that were revealed through the interviews and led to a much more binary understanding of the current use of SDM and barriers to SDM. It is likely that the impactful data around moral injury and wanting to leave the role would have been missed. The combining of both data sets creates a richer overall picture of the current landscape than could be captured by either analysis on its own.

Limitations

It was difficult to keep interview participants focused on the topic of choice for people presenting with depression. Participants often drifted into talking about choices available for other presentations. As interviews continued, the researcher began to build more skill with redirecting these conversations. However, the tendency of participants to do this may be reflective of how depression is viewed within services and how this unconsciously changes the level of choice that is deemed necessary. This may be indicative of imposing a condition-

specific stepped/matched model of care in services which provide interventions across a broad spectrum of conditions and presentations.

A larger sample size for the qualitative interviews may have allowed for these limitations to be explored further. The amount of data needed for a qualitative analysis to be considered as having high quality is debated, and typically centres around the concept of saturation, the point at which it can be assumed that further data collection would yield no new concepts (Braun & Clarke, 2021).

However, Braun and Clarke (2021) argue that the concept of saturation relies on the belief that codes exist within the data waiting to be extracted by the researcher, which goes against the key principles of RTA in which codes and themes are interpreted from an interaction between the researcher and the data. Braun and Clarke (2021) suggest that when using RTA, there is always the potential to generate new ideas from the data set. Instead of focusing on saturation as an end point, they suggest that researchers need to make a judgement on if the data collected have sufficiently met the aims of the research, as well as making pragmatic judgments around time and resources that can be dedicated to the research. This research aimed to explore opinions and experiences of SDM use among PWP. It could be argued that the amount of data collected was sufficient to be considered exploratory and to bring insight into an unresearched area but may fall short of what would be required to begin to create a theoretical argument.

Braun and Clarke (2021) also suggest that researchers use information on the diversity of a sample required to match the diversity in the population as a guiding tool for assessing if sample sizes can be judged as adequately robust for RTA. Exact gender split data for PWPs specifically is not currently published; however, in the most recently available Health Education England report into the NHSTT workforce, 80% of staff were female, 18% were male, and 2% were 'unknown' (Health Education England, 2024). Only one male participant

(5.8%) took part in the interviews. For the survey, 6.5% of respondents were male, and 6.5% of respondents identified as non-binary. Towards the end of data collection, there was a conscious effort made to try to recruit more male PWPs for interviews; however, this did not come to fruition, and impending deadlines ultimately meant it was necessary to continue to collect data from female PWPs when the opportunity presented.

The quantitative element of this study is limited by its low sample size. At 93 participants, this does not give enough power to be able to run more sophisticated analyses and limits what can be interpreted from the data. This may have been impacted by the methods used for recruitment.

During the process of recruitment, universities were contacted and asked to help with survey distribution. The University of Essex did distribute the survey to trainees. However, often requests were not responded to, and in the cases that they were, it was highlighted that due to the timings of courses, cohorts had just started and may struggle to answer questions. If a similar study were attempted again, this would be a crucial factor to plan for from the beginning, as well as considering how far along in training participants would need to be to contribute to the questions meaningfully. Additionally, participants were recruited mainly via social media and word of mouth. It may be that having had more direct access to PWPs via NHS trusts may have yielded more responses. However, this may have introduced concerns for participants around how open they felt they could be in their responses if there was a belief that the researcher was in some way linked directly to their workplace.

Directions for future research

This study began to answer the question of how SDM currently operates in NHSTT services for people presenting with depression. However, as highlighted by the research, it is often not PWPs that have the power to implement how decisions are made. Whilst many of the PWPs interviewed were able to reflect on potential barriers that those in the position to

make these decisions may face, a natural next step for research is to begin to ask those in leadership positions directly about their experiences and views on SDM. Those involved in commissioning of services and service design should be of particular interest for future research.

Due to low completion rates by trainee PWPs, future research into training courses may be useful in further understanding what teaching currently looks like on SDM. It may be useful to consider a content analysis of current materials used by training courses that relate to choice, and a comparison to how this matches the NICE (2021) guideline's definition of SDM.

The research highlighted that changing the way NHSTT services are evaluated locally and nationally may be useful in encouraging SDM use. Future research into possible outcome measures that would allow clients to give feedback on how decisions were made would be useful. This would open possibilities for further research into the potential benefits of SDM, with the measure being used to compare with measures of recovery and general client satisfaction with care. This could also be used to explore potential impacts on long-term recovery. If those who have received choices that were more in line with SDM experience fewer repeat episodes of care, this may be suggestive of potential cost savings.

An issue that came up repeatedly in this research was PWPs feeling pushed into offering online and cCBT options as the first, and sometimes only, choice. Research into the experiences of participants of these groups and cCBT programmes for depression may be useful, with attention paid to how much it felt like they were given a choice before receiving this type of intervention. Participants in this study highlighted that for depression there were often high dropouts, and it is sometimes difficult to get feedback from these individuals around the reasons they dropped out. Outcomes from such research may help to further reinforce the evidence for commissioners when reviewing funding for services.

Researcher Reflexivity

Prior to clinical psychology training, I worked as a PWP, and this formed a large part of my interest in starting this research. I had experiences of assessing clients and knowing that the option was needed for them did not exist in the service and did not exist in the local area unless they could afford private care. I had experience of being told to “start at Step 2” and had my own level of discomfort with that. I also had many good experiences as a PWP, including working with staff who wanted to do their best to offer choice within the boundaries of what could take place due to service pressures. There are ways in which having this knowledge of the role made this research easier; I already understood the common terminology and had a sense of what it is like to work in NHSTT. However, this may also create an inherent bias that may impact the research. Reflecting on this and how it may impact the questions I asked and how I asked them was important, as I wanted to make sure that participants were able to explore all parts of their narrative and that they were not led down a particular path.

The recommendations I have made for how various parts of the system could make changes to the existing model of decision-making operating in NHSTT fall short of the main reflection that I had in mind whilst reviewing the data. My main reflection throughout data analysis has been that the system needs to be started again from the very beginning. The foundation of NHSTT was the idea of a service to increase access, with the goal to get people back into work (Layard, 2005). Data collection and CBT were built into this at the core, and this data focus has only increased throughout the evolution of the service model. There appear to be ideological differences between the service design and implementation of SDM in a meaningful way. However, an entire service redesign is unlikely, and this research does not go far enough on its own to suggest this. This research also makes recommendations to increase use of technology; however, it feels ethically important to point out that I do not

endorse the use of AI in clinical decision making due to concerns around inherent bias that AI can display, which may impact underrepresented communities (e.g., Hassan et al., 2024).

There are signs of progress; participants spoke of the ways that either they or their service have begun to implement practices that increase SDM. I was struck by how reflective and knowledgeable PWPs were about all aspects of their role pertaining to SDM and the passion they showed in considering barriers. It is my hope with this research that services will begin to explore the knowledge that already exists within their workforce to find ways to tackle barriers to SDM in service.

This has helped me to reflect on how I would like to act as a supervisor once qualified. The process of this research helped to remind me of the importance of not losing sight of exploring the knowledge that may exist in clinicians who are pre-qualified and giving the time and space to be able to explore issues that might exist. It has additionally helped me to continue to question the reasons why unethical or un-evidence-based decisions are made in a service, and the need to push back against these changes. This research highlighted to me that it is easy to get ‘lost in the numbers’ the further up the system you find yourself, and that it is important to frequently reflect on how changes and policies may impact client experience.

I was saddened to hear from a few participants post-interview that it was the first time they had been able to have a conversation about this topic, and I often got the sense that they did not experience much prompting for reflection in their roles despite their obvious ability and willingness to do so. I hope that this research will inspire further research into the PWP role, and that, taken together, this can enact changes to the way the role is viewed and the scope it is given.

Conclusion

At the time of writing, and to the best of the researcher's knowledge, this study is the first time that SDM for depression has been explored explicitly and in depth with PWP's. Findings indicate that the NICE (2022) guideline has had very limited impact on SDM practices in NHSTT services and that systemic barriers at service and commissioning level are preventing the full implementation of national guideline recommendations.

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Appendices

Appendix A. Analysis of studies included in the systematic review to determine common themes and provide second order interpretation.

1. Study Bear, 2020

Key Themes

Lack of choice and resources available: Staff discussed impact of budget cuts on the availability of alternative treatments to offer individuals. Creating a pattern of ‘holding’ clients who may previously have benefitted from support elsewhere.

Time constraints create barriers: /

Perceptions and beliefs of healthcare staff regarding risk: Staff discussed concerns around personal liability and blame if a patient was to come to harm as a result of a decision to discharge.

Worries about discussion of choice creating pessimism: Staff discussed worries about presenting open and honest discussions of treatment options for fears that patients may get put off and disengage from services.

Greater education needed for both staff and patients: /

SDM as ideal choice: SDM put forward by staff as a key part of best practice.

Paternalistic culture as a barrier: /

Importance of honesty and therapeutic relationship: Staff reported that openness and honesty is important but additionally discussed how this can be complex in practice and must be balanced with a full understanding of the individual.

Second order interpretation

Staff prefer SDM and believe it to be good practice; however, there is a recognition that systemic barriers, including availability of choice, create limitations for how effectively staff are able to put this into practice. Cultural barriers within the organisation also prevent the full use of SDM despite clear preference for working practice with openness and honesty in a collaborative model.

2. Study Kelly et al. 2021.

Key themes

Lack of choice and resources available: GPs discussed that a lack of choice in options to refer for psychological therapies prevented them from offering this as a choice to individuals.

Time constraints create barriers: /

Perceptions and beliefs of healthcare staff regarding risk: /

Worries about discussion of choice creating pessimism: /

Greater education needed for both staff and patients: /

SDM as ideal choice: GPs expressed that making a decision using SDM was their preferred method of making decisions to discontinue anti-depressant use.

Paternalistic culture as a barrier: /

Importance of honesty and therapeutic relationship: GPs discussed the importance of discovering psychosocial factors affecting the patient to help inform a collaborative discussion of options.

Second order interpretation

GPs prefer to use an SDM approach when considering stopping a patient's antidepressants but cite difficulties with availability of non-pharmacological options when discussing alternatives or complimentary treatment options.

3. Study Kokanović et al. 2018.

Lack of choice and resources available: /

Time constraints create barriers: /

Perceptions and beliefs of healthcare staff regarding risk: Staff highlighted that sometimes nursing staff feel uncomfortable with using SDM with patients displaying high risk, citing concerns about harm occurring.

Worries about discussion of choice creating pessimism: /

Greater education needed for both staff and patients: Clinicians highlighted that some staff are unsure about what SDM is and have not received training, creating a barrier to its implementation. Patient education around SDM was highlighted as necessary to increase staff feeling able to use it.

SDM as ideal choice: /

Paternalistic culture as a barrier: Clinicians recognised that the shift away from a paternalistic culture required a lot of effort from all staff involved in a service, and that some staff found this shift harder than others.

Importance of honesty and therapeutic relationship: Clinicians discussed SDM as something that can build a sense of empowerment for patients and highlighted that building trust was a first step towards this.

Second order interpretation: Staff believe increased use of SDM can lead to patients feeling more empowered but recognised the need for a cultural shift away from more paternalistic values. In order to achieve this, staff require training as well as increased education for SDM for patients. Concerns were raised around liability for decisions made in this way when risk is present.

4. Study Simmons et al. 2013.

Lack of choice and resources available: Clinicians reported that sometimes patients would arrive to the service with treatment decisions having been made for them by other services, and then this was then what they were given. Clinicians reported a preference for having decisional aids to help in engaging in SDM with clients but reported these were not always accessible.

Time constraints create barriers: Clinicians feared that having comprehensive conversations about treatment options would take too much time as appointment lengths were standardised. Clinicians discussed the importance of patients having adequate time to consider options but reported this was often not the case due to service pressures.

Perceptions and beliefs of healthcare staff regarding risk: Presence of risk created a reaction from staff in which they perceive that more control needs to be placed with the professional.

Worries about discussion of choice creating pessimism: Clinicians expressed concerns that discussion of side effects may be “alarming” and cited this as a reason they would not include this information.

Greater education needed for both staff and patients: /

SDM as ideal choice: Clinicians reported that they believe that SDM increases adherence to treatment programmes and rated the use of collaboration in making decisions as the most ideal option.

Paternalistic culture as a barrier: Clinicians identified that the style of assessment clinicians use may differ, and that this can impact SDM. Clinicians recognised the need for an overall cultural shift in this area for SDM to be more likely to take place.

Importance of honesty and therapeutic relationship: Good engagement with a patient was seen as necessary; once this was established and a good rapport gained, clinicians felt more comfortable in having open conversations about decisions.

Second order interpretation: Clinicians believe SDM is the correct model to use in most cases, with cases involving high risk being the exception to this. A need for a cultural shift away from paternalistic ways of working is recognised and observed more frequently in MDT environments that have a supportive and flexible culture. There is also a recognition of external systemic factors such as preset appointment lengths and decisions made externally as something that can prevent SDM from taking place.

5. Study Gellatly, 2011

Lack of choice and resources available: Clinicians reported they frequently received referrals that were “unsuitable” and had minimal options to consider for onward referrals. Clinicians felt a bias towards focusing on offering treatments that had a shorter waiting list and may not mention treatments that may require waiting for longer. Clinicians recognised they were being asked to give choices to patients but highlighted a feeling that there were limited or no choices to really offer.

Time constraints create barriers: /

Perceptions and beliefs of healthcare staff regarding risk: Complex or riskier presentations, such as when drugs and alcohol were involved, resulted in more control of decisions being taken by the clinician.

Worries about discussion of choice creating pessimism: /

Greater education needed for both staff and patients: /

SDM as ideal choice: Most participants rated decisions that took into account patient preferences as being the most ideal and reported that this would likely increase engagement and outcomes.

Paternalistic culture as a barrier: /

Importance of honesty and therapeutic relationship: /

Second order interpretation: Clinicians appear to be recognising a paradox in which SDM is felt to be the best option for decision making but working in a system which has minimal choices to offer. Systemic pressures such as waiting times compound this sense of a lack of choice and resources, presenting true SDM from taking place as patients are often not being offered all of the small amount of choice available.

6. Study Menear et al. 2024.

Lack of choice and resources available: Clinicians recognised that lack of staff resources sometimes limited the options they could offer patients.

Time constraints create barriers: /

Perceptions and beliefs of healthcare staff regarding risk: /

Worries about discussion of choice creating pessimism: /

Greater education needed for both staff and patients: Staff sometimes struggled to discuss choices without providing extensive education to patients first around mental health and what available options mean.

SDM as ideal choice: /

Paternalistic culture as a barrier: /

Importance of honesty and therapeutic relationship: A need to understand the whole person was recognised as important to build therapeutic relationship and guide decision making. Clinicians also recognised that an open conversation needs to take place in order for a decision to be made in a truly informed way.

Second order interpretation: Clinicians are keen to gain a full understanding of the patient they are working with and recognise the need for honest conversations that take into account each individual's personal circumstances. The amount of prior education needed before decisions could be discussed was recognised, it may be that in some services time could not be given to this and this may create a leaning towards more paternalistic decision-making strategies being used.

7. Study Patel et al. 2014.

Lack of choice and resources available: /

Time constraints create barriers: Some staff reported a belief that asking for patient preferences would take too much time and so preferred to describe a treatment plan without asking for preferences.

Perceptions and beliefs of healthcare staff regarding risk: /

Worries about discussion of choice creating pessimism: /

Greater education needed for both staff and patients: Clinicians reported that patients often default to expecting professionals to make decisions for them, and they were required to spend time giving education around SDM to patients. Some staff reported struggling to do this effectively.

SDM as ideal choice: /

Paternalistic culture as a barrier: Some clinicians were accepting when patients expected them to make decisions and did not attempt to guide them to engage in the decision-making process. Others attempted to increase patients' involvement in decisions, suggesting a difference in culture within the organisation.

Importance of honesty and therapeutic relationship: /

Second order interpretation Whilst many staff attempted to elicit patient preferences even when patients presented with the assumption that it was the professionals' job to make the decision, some staff allowed this culture to continue, and it appears that a lack of time to be able to educate patients about their rights in decision making impacted this decision.

8. Study Hamman et al. 2016.

Lack of choice and resources available: /

Time constraints create barriers: Some clinicians identified that being directive with decisions saved time within appointments. However, many expressed regrets that this is the case.

Perceptions and beliefs of healthcare staff regarding risk: /

Worries about discussion of choice creating pessimism: /

Greater education needed for both staff and patients: /

SDM as ideal choice: /

Paternalistic culture as a barrier: Some clinicians reported a paternalistic attitude to decision-making, reporting that patients would expect them to make decisions for them. Others reported beliefs much more aligned with SDM, describing patients as partners.

Importance of honesty and therapeutic relationship: Clinicians identified a need for patients to have trust in them as being necessary for joint decisions to be made. With this, the need for respect to work both ways were also highlighted.

Second order interpretation: Impact of time constraints appears to influence clinicians to stick to a more paternalistic model of working, despite conflicting feelings of wanting to work in a more collaborative way.

Appendix B. Recruitment poster used on social media



University of Essex

PARTICIPANTS NEEDED

**EXPLORING PERSPECTIVES OF
PSYCHOLOGICAL WELLBEING
PRACTITIONERS AROUND PATIENT CHOICE
AND SHARED DECISION MAKING WITH
DEPRESSED PATIENTS**



1 What would I need to do?

Part 1: An online survey which can be accessed via clicking this [link](#) or scanning the QR code (10-15 minutes)

Part 2: A 1-hour interview to explore your experiences in more depth

You can choose to complete only part 1





2 Who can take part?



Qualified PWP's

AND

Trainee PWP's



For more information:

Please email the researcher:
slwood@essex.ac.uk

Ethics reference number: ETH2324-1344

Appendix C. Initial contact recruitment message template

Hi [name]

I hope you're doing well! Thank you for accepting my connection request.

I'm a DclinPsy student at the University of Essex and I'm currently conducting my thesis research on the experiences and opinions of PWPs on the use of Shared Decision Making when working with clients presenting with symptoms of depression.

Your perspective on the topic would be very valuable, and of course confidential. Could I share a few details with you to see if you would be interested?

Appendix D. Follow up recruitment message

Thanks for getting back to me! Your time is very much appreciated. There are two parts to the study, and if you wish to participate you can choose to engage in either part of the study or both parts if you wish.

One part is an online survey which takes about 10-15 minutes and would ask about your experiences of using shared decision making when working with clients with symptoms of depression and what your knowledge already is about the topic. The survey can be found here: https://essex.eu.qualtrics.com/jfe/form/SV_5mRENLMrxTeD5s2

The 2nd part of the study is an interview which would take place online at a time that is suitable to you and would last up to 60 minutes. The focus of the interview would be exploring your experiences of shared decision making in more depth. If you do wish to take part in the interview, please let me know and I can provide more details about the interview specifically!

I've also attached a copy of the study poster which has a little bit more information on.

Appendix E. Survey information for participants



Exploring perspectives of Psychological Wellbeing Practitioners around patient choice and shared decision making with depressed patients

Information for participants

We are a team of researchers at the University of Essex. We are interested in the experiences of both qualified and trainee PWPs in regards to the availability of choice in their services, as well as their experiences with Shared Decision Making (SDM).

Who can take part?

Anyone who is currently employed as Psychological Wellbeing Practitioner (PWP).

OR

Anyone who is currently undertaking a BPS accredited Psychological Wellbeing Practitioner training course.

What is the aim of the project?

This study aims to explore the level of choice currently being offered within NHS Talking Therapies across England. This study is also aiming to explore perspectives of both Qualified and Trainee PWPs in regards to shared decision making, as well as their perspectives on the importance placed upon this by management within these services. Ultimately, the aim is to improve services and understand the barriers to shared decision making within services.

What is involved in taking part?

There are two parts of the study. You may take part in Part 1 only (the online survey); or you may take part in both (online survey plus an individual interview). If you just

Part 1

The first part of the project involves completing this online survey. If you tick the consent box on the next page, you will be guided through an online survey which includes a range of questions starting with demographic information and then moving on to explore level of knowledge about shared decision making and current practices.

Part 2

At the end of the survey there will be an opportunity to let us know if you would be interested in taking part in a further interview about your experiences. If you want to take part in an interview, you can enter your contact details and one of the researchers will get in touch to arrange a convenient time and place for the interview. The interview would be audio-recorded and transcribed.

The interview would take place by Zoom or telephone.

What if I'm not sure whether to take part?

If you have questions about the project or if you would like to talk more about it before you take the survey or before you decide whether you want to be interviewed, you can contact a member of the research team by email (details below).

Do I have to take part?

No. It is your choice to participate or not. No one will mind if you choose not to take part. You can also change your mind at any time during the survey or interview. You can let us know at any time that you no longer wish to take part.

Will people recognize me from the information I give?

No. All of your answers to the survey will be kept confidential. Your name or details will not be mentioned. All information will be stored securely in password protected files to which only the researchers will have access to.

What happens to the data?

All the information from all the people who take part will be compiled and then analysed. The findings will then be written up and (if you choose to provide contact details) will be shared with you and other people who took part. The project will be written up in an academic journal article.

Are there any risks to me?

Participating in the research is not anticipated to cause any harm or distress. However, discussion of any personal or emotive topics may bring up feelings for some. Please let us know if taking part in the project causes you any distress.

What if I'm not happy and want to make a complaint?

If for any reasons you feel unhappy with the process or treatment you receive when participating in the project you can contact one of the lead members of the research team: Sophie Woodward and Prof Susan McPherson. If you are still not satisfied, please contact the University of Essex Research Integrity Manager, Mantalena Sotiriadou (email: ms21994@essex.ac.uk).

Who has reviewed the study?

The study has been reviewed and approved by the University of Essex Ethics committee and signed off under Annex B.

Researcher contact details

Sophie Woodward: slwood@essex.ac.uk

Professor Susan McPherson: smcpher@essex.ac.uk

Appendix F. Consent page for survey participants



Before completing the survey, please read the statements below and indicate your consent by checking ALL of the boxes.

If you would like to contact the researcher in this study to discuss this research before you complete this survey, please contact:

Sophie Woodward
slwood@essex.ac.uk

☐ I confirm that I have read and understood the participant information on the previous screen

☐ I understand that my participation is voluntary and I am free to withdraw at any time, without giving a reason

☐ I agree to take part in this study

Take the survey

Appendix G. Qualtrics survey



Qualtrics Survey
Software.pdf

Appendix H. Interview Topic Guide

Introductions

Provide participant with an introduction to the study and the purpose of the study.

Explain confidentiality, note taking and audio recording procedures. Remind participants they can stop or pause the interview at any time. Allow time for any questions on the previously mentioned items and finally gain consent to proceed with interview.

Definition of shared decision making

Give definitions of shared decision making before proceeding with interview

“...a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. It could be care the person needs straightaway or care in the future, for example through advance care planning. It involves choosing tests and treatments based both on evidence and on the person’s individual preferences, beliefs and values. It means making sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing. This joint process empowers people to make decisions about the care that is right for them at that time (with the option of choosing to have no treatment always included) ... Some people prefer not to take an active role in making decisions with their healthcare professionals, but they should always be given the opportunity to choose to what degree they want to engage in decision making and the extent to which decisions that are made on their behalf are discussed and communicated with them, including the reasons for selecting a particular treatment” (NICE, 2022).

Questions about training received

- Content of training

- Importance of SDM
- Emphasis given to SDM

Questions about in service work

- Experiences of discussing patient views within case management discussions
- Training given regarding SDM
- Training/information given regarding guideline changes
- Emphasis given to SDM
- Views on patient involvement in decisions
- Availability of choice
- Experiences of offering choice

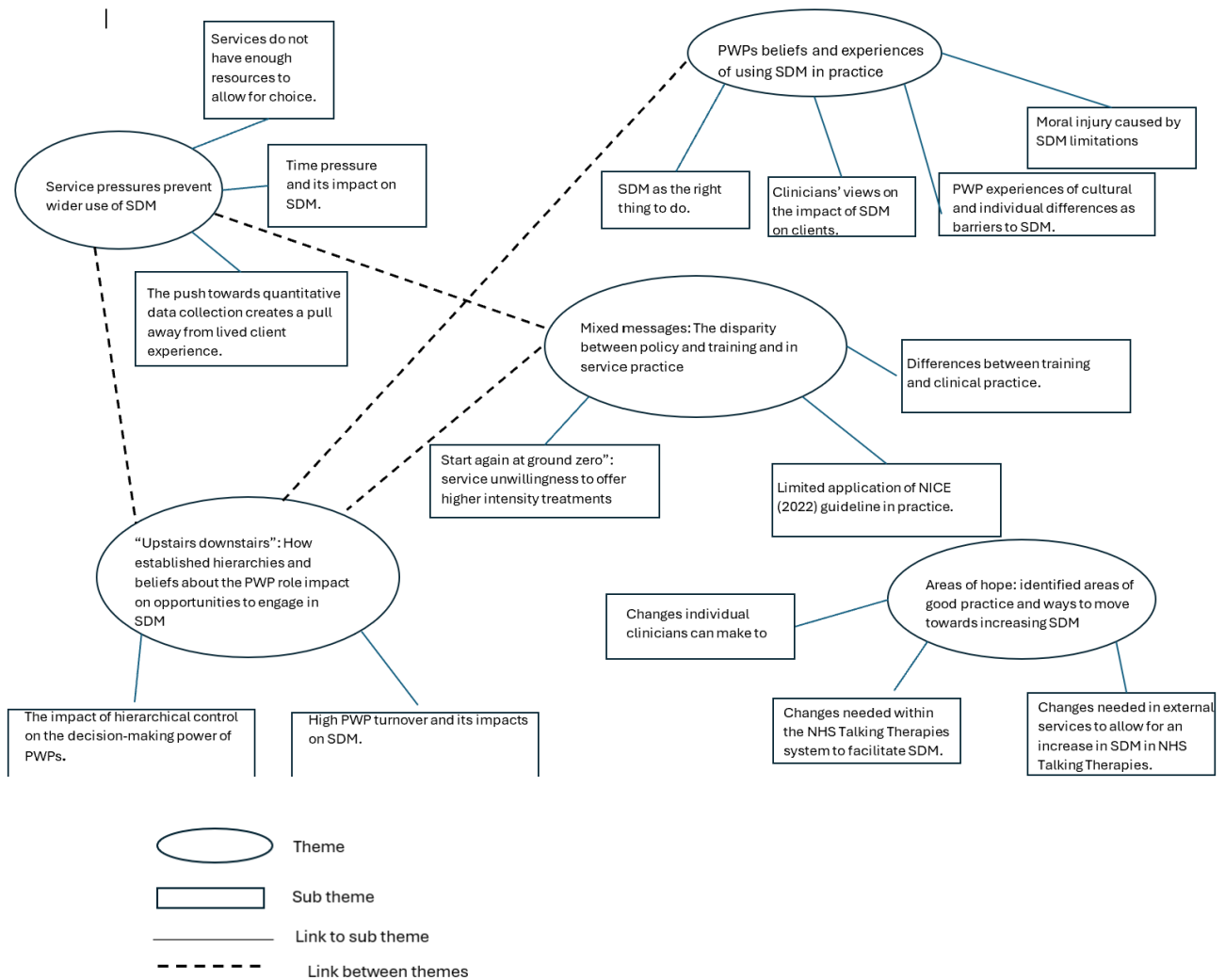
Management reflections

- Experiences of discussion regarding SDM with management
- Views on emphasis placed by management regarding SDM

Personal opinions about shared decision making

- Views on importance of SDM
- Views on barriers to SDM
- Views on availability of choice

Appendix I. Final thematic map



Appendix J. Participant information sheet for interview



School: Department of health and Social Care

Participant information sheet for interview

Research title: Exploring the perspectives of Psychological Wellbeing Practitioners in regard to patient choice and shared decision-making.

Thank you for considering to take part in this interview. This sheet has been provided to you to give further information in to the interview and why this research is being conducted. If you have any further questions follow this please feel free to contact a member of the research team:

Sophie Woodward (Lead Researcher): slwood@essex.ac.uk

Professor Susan McPherson (Supervisor): smcpher@essex.ac.uk

Summary

This interview aims to explore your experiences as a qualified PWP or during your training in regards to availability of choice and Shared Decision Making (SDM) when working with depressed patients.

What is the aim of the project?

This interview aims to explore perspectives of both Qualified and Trainee PWPs in regards to shared decision making, as well as their perspectives on the importance placed upon this by management within these services. Prior to this, you will have completed an online survey and the aim of this interview is provide more in depth information on similar areas to what was asked within that survey. However, much more attention will be placed in to your own personal experiences and views. Ultimately, the aim is to improve services and understand the barriers to shared decision making within services.

Who can take part?

Anyone who is currently employed as Psychological Wellbeing Practitioner (PWP) within an NHS Trust.

OR

Anyone who is currently undertaking a BPS accredited Psychological Wellbeing Practitioner training course.

What is involved in the study?

You will be asked to complete an interview with the lead research will which last for around one hour. This interview will take place either over the telephone or on zoom according to your preference.

During the interview, questions will focus around your experiences of SDM within training, within your service, management views regarding SDM and your own personal views and practices as well as any barriers to SDM you may face.

ERAMS reference: ETH2324-1344
Date: 07/04/2025



School: Department of health and Social Care

Do I have to take part?

No. It is your choice to participate or not. No one will mind if you choose not to take part. You can also change your mind at any time during the interview. You can let us know at any time that you no longer wish to take part.

Will people recognize me from the information I give?

No. All of your answers to the survey will be kept confidential. Your name or details will not be mentioned. All information will be stored securely in password protected files to which only the researchers will have access to.

The interview will be recorded. The recording will be kept securely and any personal details will be changed. Everything you say will be kept confidential and if something you say is quoted in a report, you will not be identifiable to others.

What happens to the data?

All the information from all the people who take part will be compiled and then analysed. The findings will then be written up and (if you choose to provide contact details) will be shared with you and other people who took part. The project will be written up in an academic journal article.

Once the project is complete, all data will be destroyed. You can also withdraw your data at any point before this and the data will then be destroyed and removed from the study.

Are there any risks to me?

Participating in the research is not anticipated to cause any harm or distress. However, discussion of any personal or emotive topics may bring up feelings for some. Please let us know if taking part in the project causes you any distress.

What if I'm not happy and want to make a complaint?

If for any reasons you feel unhappy with the process or treatment you receive when participating in the project you can contact one of the lead members of the research team:

Sophie Woodward (Lead Researcher): slwood@essex.ac.uk

Professor Susan McPherson (Supervisor): smcpher@essex.ac.uk

If you are still not satisfied, please contact the University of Essex Research Integrity Manager, Mantalena Sotiriadou (email: ms21994@essex.ac.uk).

Or the Health and Social Care Director of Research and Impact: Dr. Kostis Roussos
k.roussos@essex.ac.uk

ERAMS reference: ETH2324-1344

Date: 07/04/2025

Appendix K. Participant consent form for interview



University of Essex

Consent Form

Title of the Project:

Exploring the perspectives of Psychological Wellbeing Practitioners in regard to patient choice and shared decision-making

Research Team:

Sophie Woodward (Lead Researcher) and Professor Susan McPherson (Supervisor)

Please initial box

1. I confirm that I have read and understand the Information Sheet dated 07/04/2025 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal will be destroyed;

3. I understand that it is not anticipated that this research will cause any harm or distress to myself and I confirm that I am aware that I can contact the researcher for support should it be needed.

4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained.

5. I understand that my fully anonymised data will be used for analysing perspectives on Shared Decision Making (SDM) and availability of choice and will be published within relevant journals to distribute this knowledge.

6. I understand that the data collected about me will be used to support other research in the future and may be shared anonymously with other researchers.

7. I agree to take part in the above study.

Participant Name

Date

Participant Signature

Researcher Name

Date

Researcher Signature

Consent form (version 1)
ERAMS reference: ETH2324-1344

Date 07/04/2025

Page 1 of 2

Consent form (version 1)
ERAMS reference: ETH 2324-1344

Date

Page 2 of 2

Appendix L. Ethics application outcome

27/06/2024

Miss Sophie Woodward

Health and Social Care

University of Essex

Dear Sophie,

Ethics Committee Decision

Application: ETH2324-1344

I am pleased to inform you that the research proposal entitled "Exploring the perspectives of qualified Psychological Wellbeing Practitioners in regard to patient choice and shared decision-making." has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in **ERAMS** for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Alexandra Kaley

Ethics ETH2324-1344: Miss Sophie Woodward

Appendix M. Text responses for survey participants discussing differences between value on SDM in services vs in training

Table M1

Responses
Especially in terms of post-assessment choice, training prioritises patient choice whereas service asks us to offer one treatment and only mention other options if declined
I feel the university really push for shared decision making and reiterate the importance.
I think obviously putting theory into practice is hard. If a client wants a non-evidence based treatment (e.g. counselling for OCD) then what are you supposed to do? And we're not always able to offer all those choices so it feels unhelpful and confusing to the client to then give them a bunch of information about treatment we cannot even offer them. I'd find that frustrating as a client
It seems that the service is unable to fully prescribe to shared decision making due to demands on the waitlists
Less flexibility in offering choice due to limited availability of different ranges of therapies
My service doesn't value shared decision-making whatsoever when the waiting list for one-to-one treatment is too high. We've been told to not even mention that we have one-to-one treatment and to just offer the online computer CBT or webinars. I haven't felt comfortable doing this so I continue to offer one for one because it is a lot of the time what people are expecting and what people want from the service.
On our service scripts, it has a part about explaining different forms of treatment and talk about them and whether they will be open to the idea of receiving these forms of treatment, whereas this was not required as part of our OSCEs for University assessment.

Responses

Service is more likely to offer groups to ensure we can accommodate the community and keep waiting lists as low as possible. Preferences will be taken into account for each client however we are advised to guide clients to courses as a frontline option prior to being offered 1:1

Service offers limited choice depending on condition, i.e. counselling is only for depression, we are asked to only offer Step 2 interventions a lot. Step 3 often decline support.

Service restricts the amount of choice, with a bigger push to get clients to choose a group or online option due to waiting lists

Service still follow [redacted, possibly service specific] (stepped care)

Appendix N: QQ plots and scatterplots used to determine parametric assumptions for correlation between Use of SDM OPTION scale and Value of SDM OPTION scale

Figure N1: QQ plot for Use of SDM OPTION scale

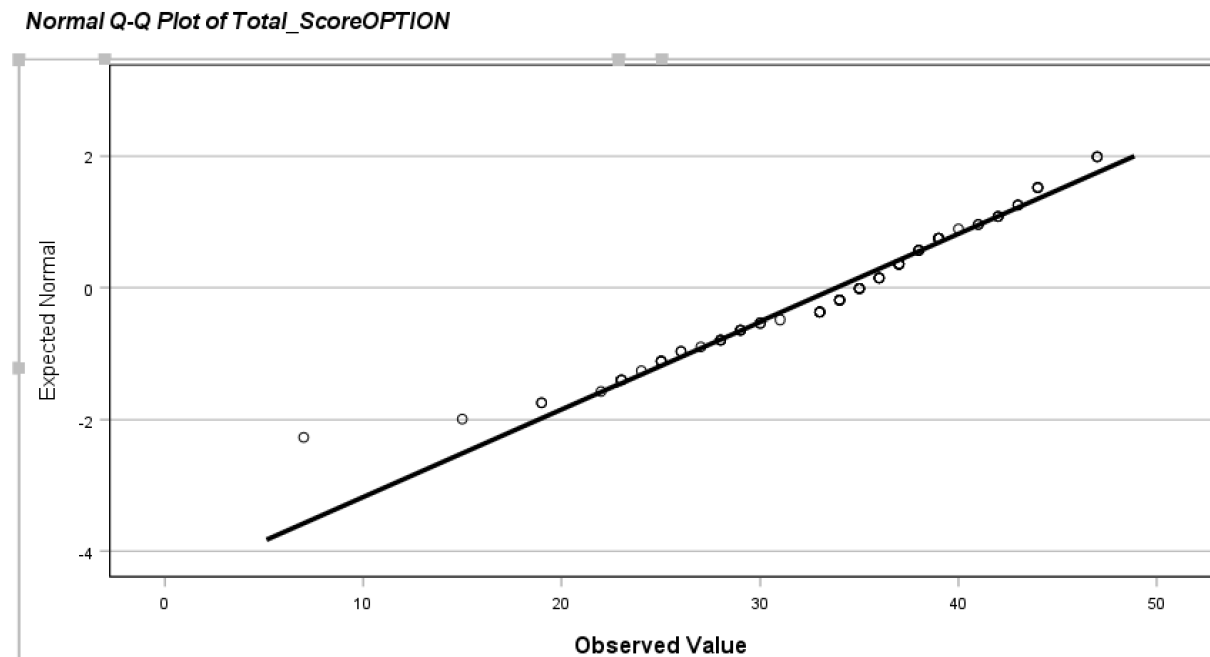
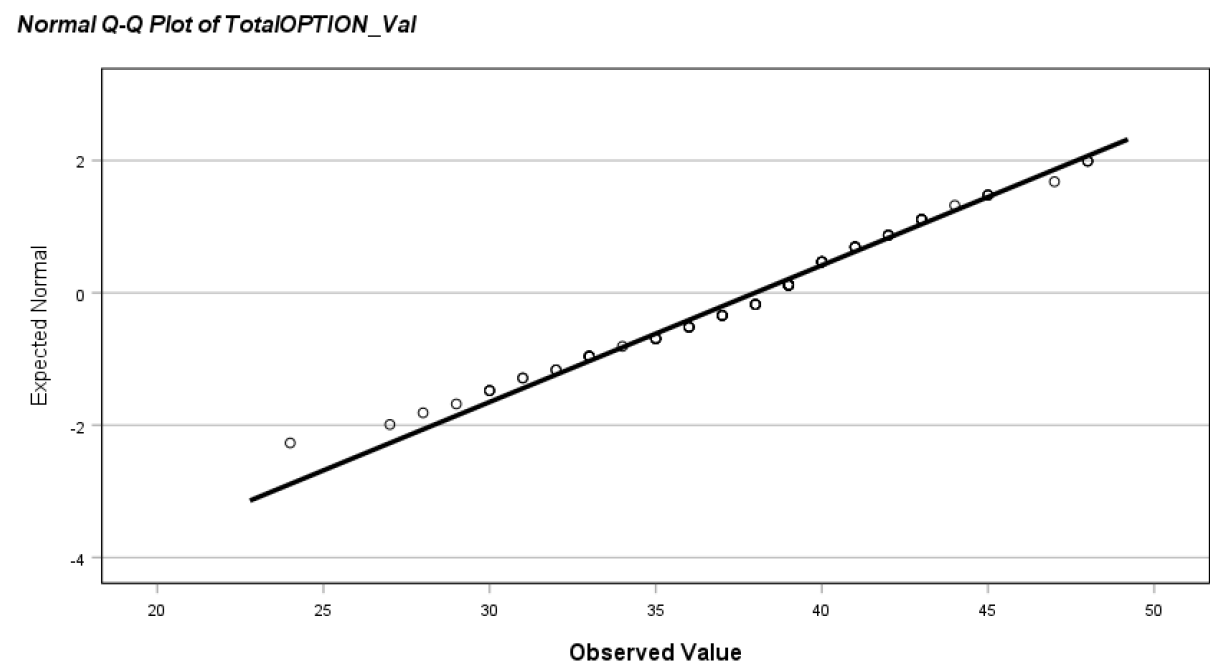


Figure N2: QQ plot for SDM value OPTION scale



**Figure N3: Scatterplot used to determine linearity of relationship between Use of SDM
OPTION score and Value of SDM OPTION score**

