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Legitimising bibliotherapy: from problematisation to irreversibility?

Purpose

To explore how a self-help bibliotherapy scheme became national policy, focusing on its legitimisation via policy agendas and institutional discourses.

Design/methodology/approach

A mixed methodological approach was used to gather data, incorporating semi-structured interviews, documents and descriptive statistics. Actor-Network Theory (ANT) was used as a critical lens to frame analysis.

Findings

The study concludes that while the scheme is presented as evidence based by the focal actors in the scheme, in practice, the bibliotherapy scheme is introduced in response to a number of pressing institutional requisite agendas.

Research limitations/implications

Limitations of the research include the absent voice of the patient, and future research should aim to present a more patient-centred account to compliment this policy-focused work.

Originality/value

Little in-depth work has been conducted on the strategy behind the introduction of bibliotherapy schemes in the UK or elsewhere, and this paper presents an in-depth theoretical analysis of the first nationalised bibliotherapy scheme in the world.

Keywords: bibliotherapy, Books on Prescription, Actor-Network Theory, mental health, policy analysis.

Research paper/ Conceptual paper

Introduction

Chamberlain *et al* (2008: 29) note the benefits of bibliotherapy and conclude that ‘there is a wealth of evidence that supports the delivery of bibliotherapy for a host of mental health disorders’. However, this evidence concentrates mainly on the effectiveness of self-help bibliotherapy, and does not examine appropriate methods of delivering bibliotherapy. This paper will investigate the introduction and delivery of bibliotherapy in a ‘prescription’ model, focusing on the adoption of self-help bibliotherapy as a national service inscribed in mental health policy.

Self-help bibliotherapy in the UK is typically delivered using the Books on Prescription model (Frude, 2004a). This model focuses on a list of books collated by a number of mental health professionals. It is designed to capture aspects of the expertise of secondary care and

deliver advice in a primary care setting. The list comprises a number of cognitive behavioural therapy (CBT) based self-help books on specific conditions, including depression and anxiety (*Booklist - Book Prescription Wales*, 2005). Over 100 self-help bibliotherapy schemes have been set up in UK public libraries (Frude, 2008a). These schemes aim to allow people with mild to moderate mental health problems to access high-quality self-help books via a list of recommended materials. The scheme is usually run in partnership between the public library and the health service, with the public library holding the collection of recommended books, and GPs prescribing a specific book to a patient they feel could benefit from the techniques and information in the book (Frude, 2004a). The patient takes the prescription to the public library, in the same way that a prescription for medication is taken to the pharmacy.

Books on Prescription was originally implemented as a pilot scheme in Cardiff in 2003. Basic evaluation of the scheme indicated that it was successful, and it was extended across the whole of Wales in 2005 (Frude, 2008a). Most Books on Prescription schemes currently operating across the UK are based on the original Cardiff model and use its book list (Smeaton and Leonard, 2009). For this reason, this paper will concentrate on the introduction of the initial Cardiff pilot, and the resulting Book Prescription Wales (BPW) scheme.

The study uses an Actor Network Theory (ANT) approach, discussed below, to examine how the use of self-help books was translated from an informal practice in secondary-care psychotherapy, into a national primary-care scheme. It focuses on several legitimising discourses utilised to guide healthcare policy; namely evidence-based medicine, patient choice, and the creation of 'expert patients'. The analysis focuses on partnership working and the application of a discourse of cost-effective care. The paper demonstrates that such legitimising discourses constitute and stabilise the network forming BPW; though these discourses have often been reinterpreted by actors in the network. The paper concludes that while the focal actor presents a discourse of evidence-based medicine to legitimise the network of BPW, this is supplemented by a number of needs-based agendas, which actually instigated network construction.

The scheme has achieved wide acceptance, though it cannot be seen as simply an outcome of evidence-based practice. As is noted elsewhere, the evidence-based ideology presented by healthcare services does not fully explain how certain treatments come to be accepted and others do not (Fitzgerald et al., 2003; Morgan, 2010). The analysis of bibliotherapy presented

here reveals some of the methods used to encourage acceptance of its use in healthcare, specifically examining the current need of healthcare service providers to offer an accessible, low-cost treatment for mild to moderate mental health problems. However, the use of evidence-based arguments legitimises the disregarding of other paradigms accepted in healthcare as valid justifications for treatment options; in particular, patient perspectives are excluded.

The paper is set out as follows; firstly, it reviews the research literature on self-help bibliotherapy, before outlining ANT, the theoretical perspective utilised throughout data collection and analysis, and discussing methods used to collect the data. An analysis of BPW, framed using ANT concepts of problematisation, interessement and enrolment will then be presented, followed by a discussion of the implications of allowing policy to drive self-help bibliotherapy schemes. The paper concludes that BPW is legitimised by drawing on key institutional agendas, which has potential repercussions for patients.

Bibliotherapy as a psychological therapy

There is a significant body of research on the effectiveness of self-help bibliotherapy for some mental health conditions (Marrs, 1995; Cuijpers, 1997; Gregory et al., 2004). However, most of this research was conducted in clinical trials and did not address the issue of the delivery of bibliotherapy to patients. Patients were typically allocated a free book as part of the trial design, negating the question of the access to therapy and motivation to begin treatment. Nevertheless, the National Institute for Health and Clinical Excellence (NICE) has assessed the evidence base on self-help bibliotherapy and concluded that there is an argument for recommending its use as part of a stepped care model for depression, anxiety and bulimia nervosa (NICE, 2004a; NICE, 2004b; NICE, 2009).

Anecdotal evidence from secondary care mental health professionals also suggest that the use of self-help bibliotherapy is regarded as beneficial for patients. Surveys of secondary care psychiatrists in America have revealed that psychiatrists often recommend books for their clients to read, though this is usually at their own discretion (Clifford et al., 1999). This informal practice has also been noted in the UK, with a large number of titles recommended by professionals, typically for depression (Keeley et al., 2002; MacLeod et al., 2009). This was usually with an aim to empower patients, as a supplement to therapy (Keeley et al., 2002).

However, self-help bibliotherapy is not recommended for all mental health conditions, and the evidence to support its use to some conditions is limited. For example, The NICE guideline for Post-traumatic Stress Disorder (PTSD) notes that a guided self-help approach *may* be useful for the condition, but states that there needs to be further investigation of the evidence (NICE, 2005). Previous trials utilising self-help books for PTSD have found that self help is not a useful approach (Ehlers et al., 2003) or were too small-scale to be conclusive (Basoglu et al., 2009). Thus, the recognised evidence for self-help bibliotherapy does not support its use in every case.

Despite the limitations of the evidence base for the use of self-help bibliotherapy for some mental health problems, Richardson et al (2010: 68) conclude that there are number of reasons that the Books on Prescription model – with its focus on a wide range of conditions – has found popularity in the UK:

- § the need to treat common psychological issues in primary care
- § a lack of access to psychological therapies, despite increased funding
- § a shift in government policy towards self-care, particularly for long-term conditions

Added to this list should also be an awareness that the Books on Prescription model is highly cost effective, and easy to administer. McKenna et al (2010) noted that the ‘structured, transparent and clear’ nature of CBT means it is highly suited to self-help bibliotherapy, and the recent focus on CBT-based treatments in the NHS helps also to explain the popularity of these schemes (Holmes, 2002; Layard, 2006).

Some concerns have been noted about the books forming the basis of current practice in self-help bibliotherapy in the UK. The high level of literacy required to read CBT-based self-help books was found to be of concern in several studies examining readability (Martinez et al., 2008; Richardson et al., 2010). Participants in McKenna et al’s (2010) work also noted that the use of other formats, such as audio-visual material, may make the scheme more accessible. Notwithstanding these potential limitations, self-help bibliotherapy is still utilised in a number of cases. In Richards’ (2004: 117) view, this is in part because of a conflict between the expectations of healthcare services, and the financial limitations faced by these organisations; ‘without an emphasis on self-treatment, northern hemisphere state health

services would never be able to deliver the health improvement goals they have set themselves.’

Theoretical concepts

Actor-Network Theory (ANT) provides a framework for analysis of situations, relationships and systems. It focuses on network formation, and it aims to facilitate a greater understanding that is not centred only on the agency of individual human subjects; it awards agency to organisations and objects, examining the active role that they can play in the construction of networks. These actors are also not defined by size; an organisation, such as the NHS, can be considered an actor and can interact with an individual person as another actor of equal importance to form a network (Sarker et al., 2006). ANT was seen as an appropriate framework for investigation in this instance as it provided the opportunity to explore the role of non-human actors, including self-help books and policy documents within a network. As the aim of the project was to trace the formation of a network, ANT was also seen as a particularly prescient method of analysis.

ANT was used to deconstruct the strategy behind the BPW scheme, examining how the network was created, maintained and how the main actors enlisted others in the project. In ANT, these concepts are referred to as ‘moments of translation’ in which the network is created – specifically problematisation, interessement and enrolment (Callon, 1986). These moments of translation are defined as:

- § Problematisation, or the definition of the object of concern for the proposed network by the focal actor.
- § Interessement, or ensuring that all actors in the proposed network agree to take the roles formulated by the focal actor as a solution to the problem.
- § Enrolment, which can be defined as strengthening the network via relating defined roles and connecting the agendas of different actors.

Cho *et al* (2008: 616) link these abstract concepts to a more process-orientated understanding that can be applied in practice, defining the aims of ANT as to understand ‘how people and objects are brought together in stable, heterogeneous networks of aligned interests... through processes of translation’. Shaw’s (2010) work on analysing healthcare policy from a ‘policy-as-discourse’ perspective was also used to provide theoretical background. Instead of viewing

policy as ‘a formal, rational process that can be planned in advance’, policy-making decisions are located as ‘an emergent stream of social action’ (Shaw, 2010: 196).

Methods

A number of methods of data collection were used to examine the formation of the network of BPW. The BPW scheme is evaluated by health and library staff using statistical methods focused on examining numbers of books on the prescription list issued annually. As these statistics are considered integral to demonstrating the success of the scheme, this study also collected and analysed book issue statistics to demonstrate the negotiated impact of the introduction of the scheme. The Public Lending Right (PLR) database was used to locate the issue figures for each title on the list (Public Lending Right, 2010). The PLR figures do not provide a complete picture of self-help book borrowing, but they are designed to provide a representative sample from a population of library services (Parker, 2009).

The main mental health strategy for Wales, *Raising the Standard: The Revised Adult Mental Health National Service Framework and an Action Plan for Wales* (Welsh Assembly Government, 2005a), and overall Welsh health strategy *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century* (Welsh Assembly Government, 2005b) were utilised to examine the role BPW plays in healthcare policy. The study patient information leaflets, entitled *Books Can Help* and *Book Prescription Wales Patient Leaflet* to gain further understanding of the perspective presented to patients about what they should expect from the scheme (Welsh Assembly Government, 2005c; Welsh Assembly Government, 2005d). Two semi-structured interviews were conducted with representatives identified as being key actors in the scheme. Interviews lasted around 45 minutes each, and were audio-recorded and transcribed before analysis. To protect anonymity of participants, it is not appropriate to provide further demographic data. These interviews were used to clarify key points and gain further insight into the translations forming the network in accordance with an ANT perspective.

Problematisation

To study the translation of an informal practice into a national healthcare policy requires an engagement with discourses of healthcare policy. All actors in the proposed network had to accept the focal actor’s formulation of the problem; the solution he proposed, and their role in the proposed network to enact the solution. In this case, the translation process was a two-

stage one; first, the need for a solution to access to psychological therapies had to be translated into a local Books on Prescription scheme; then this model had to be re-conceptualised as a national initiative – BPW. This is presented in figure one.

The first stage of network formation is considered to be problematisation, in which the focal actors define the object of concern and identify other actors who could be recruited to the network (Callon, 1986). For Books on Prescription, the stated aim was to enable more people to access expert psychological therapy in primary care. This needed to be achieved without increasing demand on secondary care services. The recommendation of a book fulfilled the need to access treatment options other than medication and satisfied the expectations of both patient and healthcare professional.

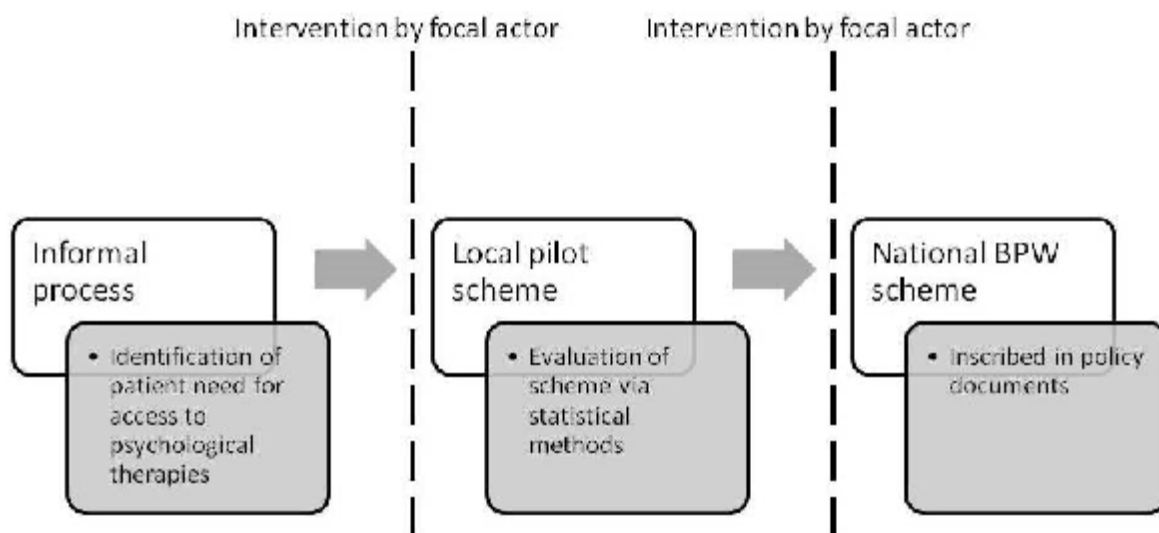


Figure one: BPW - from informal process to national scheme

The focal actor noticed a gap between the needs of patients, and the availability of psychotherapy services in his local area; *‘there was a waiting list of up to two years to see a psychologist and that was very frustrating. I thought there’s got to be something we can do to deliver these highly effective treatments to more people’* (Participant S1).

The focal actor identified the issues that formed the basis of the problematisation process as:

- § a lack of expertise in treating mental health conditions in primary care
- § a need for access to treatments other than medication for patients with mild to moderate mental health conditions

§ barriers, including waiting lists and limited resources, for patients wishing to access secondary care psychotherapy

Moreover, the focal actor identified ‘a problem about which something can and ought to be done’ (Baachi, quoted in Shaw, 2010: 200). As Shaw (2010: 201) states, “‘problems’ are never innocent, but are framed within policy proposals with power playing an integral role in the policy creation process.’ This led the focal actor to formulate a solution: that the psychological expertise contained in self-help texts might provide adequate treatment for mild-to-moderate mental health conditions. Patients did not need to be referred to secondary care to enable them to access these texts – but primary-care physicians would need to be aware of the high-quality resources recommended by secondary-care psychotherapists. It was perceived there needed to be a ‘cascading of expertise’ from secondary care to primary care (Welsh Assembly Government, 2005e: 4). However this implies that such expertise can be successfully transposed from secondary care professionals to those in primary care.

As a result, the solution of a list of books recommended for different mental health conditions was proposed. The need for access to these texts, which could be expensive to purchase for individuals, also needed to be addressed; while there were measures in place to enable people with low incomes to receive prescriptions for medication without cost, this needed to be translated into access to books. The purchase of books to give to patients in GPs’ surgeries would have required a significant increase in financial support for BPW; hence, a system of lending the books to patients was formulated. The ‘existing service infrastructure’ of the public library was used as a node in the network, which operated to provide access books to the local population for free (Welsh Assembly Government, 2005c: 5).

A number of actors needed to accept that the focal actor’s translation of the problem would result in a feasible solution that would benefit those within the proposed network. This process is represented in figure two. These actors were:

§ Psychiatrists, who needed to agree that self-help books would be useful to patients. Their acceptance of the problematisation rested on their recognition of the importance of quality resources which would ease the demand on secondary care services and enable them to meet targets concerned with waiting lists, without removing their role as experts in the field.

§ GPs, who were essential for administering the scheme by prescription and enrolling patients into the scheme. They needed to acknowledge the potential issues with

referral to secondary care, and that self-help books might be an appropriate alternative.

- § Patients needed to accept that self-help via books was a potential solution to their problems. They needed to view psychotherapy, rather than medication, as a possible treatment but to accept that it was not suitable for them because of long waiting times.
- § Librarians, who were responsible for administering the book stock, needed to accept the expertise of psychotherapists over their own expertise in selecting resources. They also needed to accept the benefits of joining a network predominantly concerned with health service aims. The benefits of the network were promoted to the library service as an increase in book issue and visitor figures, access to a socially-excluded audience and a prestige, funded partnership scheme with healthcare providers.
- § Books, which needed to be available to buy for the library. The books needed to be low cost, and accessible to patients, both physically in terms of availability, and in terms of literacy level. Of the focal actors listed above, books are excluded from figure two as they did not have an obstacle-problem to be overcome within the network; instead they were part of the solution, or the Obligatory Passage Point (OPP) within the diagram.

The focal actor's main argument was that if the treatment need was to be met in a cost-effective manner, bibliotherapy delivered by GPs and libraries must be used and would benefit all actors in the network (Frude, 2008b). The simplicity of the system of Books on Prescription was also one of the main selling points of the scheme.

Moreover, the essentials required for the scheme were already in existence; instead it was a question of 'joining the dots' together to create BPW; *'if somebody went to their GP and they got a prescription for a book which they would perhaps pick up from the library – but obviously the library would need to make sure it stocked the appropriate books, and the GPs would need to know about the list of books. So it needed really no new elements; there were the libraries, there were the GPs, there were the books. It just needed them to be threaded together into a system'* (S-1). Consequently, the acceptance of the problematisation that would be solved by the BPW model was achieved, and self-help bibliotherapy delivered via the public library was seen as the most feasible solution to the multiple problems defined in access to psychological treatment.

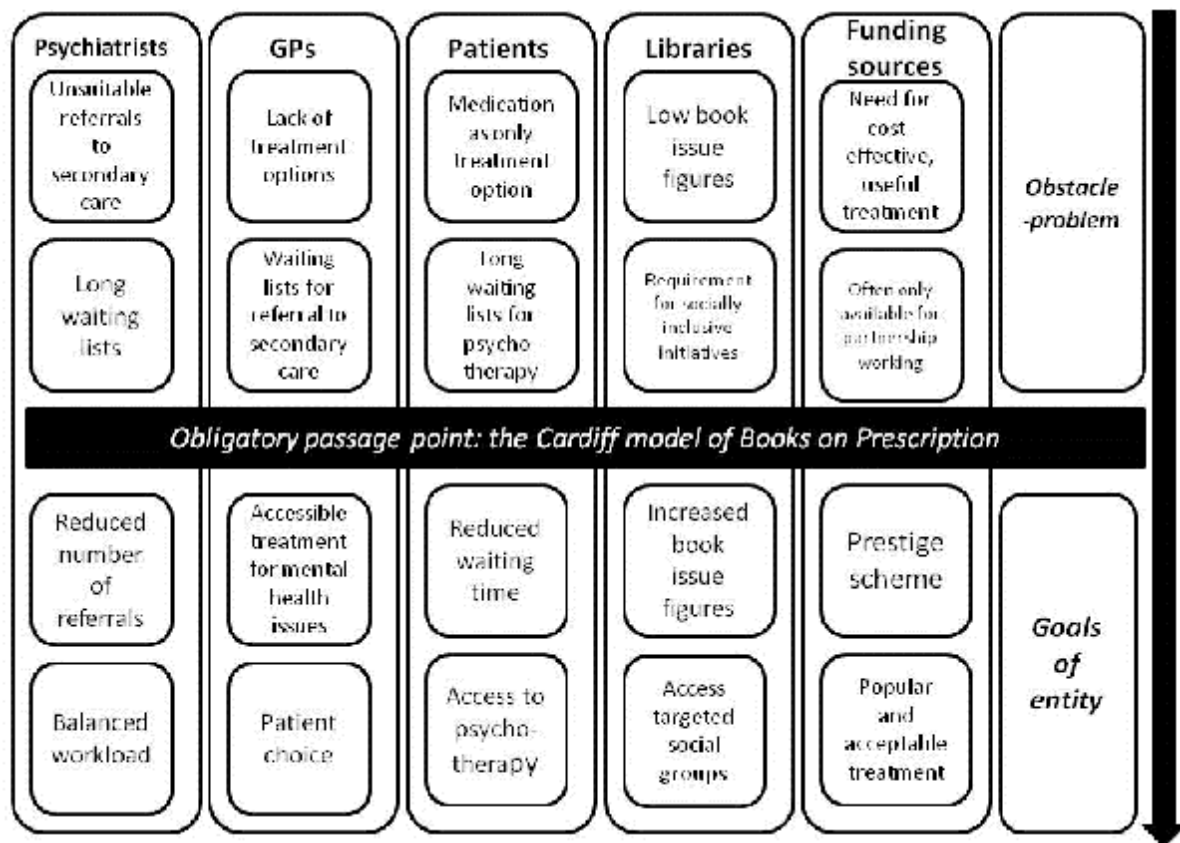


Figure two: from obstacle-problem to solution, via the obligatory passage point of the Cardiff model of Books on Prescription (based on Callon, 1986)

Interessement

This network creation needed to overcome several challenges before the next stage, interessement was complete. Interessement is defined here as an acceptance of network roles by all actors (Callon, 1986). The focal actor used agendas from healthcare to reinforce his argument that his treatment scheme was viable. Analysis of statements of these agendas provides an important contribution to understanding this stage of the process of translation. The agendas mobilised in this instance included the Expert Patient agenda (Department of Health, 2001), which argues that patients need to take responsibility for their own treatment, with the role of the health service as the provider of information. The Welsh Assembly Government, supporters of the scheme, subsequently observed that; ‘the scheme provides an excellent example of how patients can be encouraged and empowered to manage their own health care’ (Welsh Assembly Government, 2005e: 4). The Patient Choice agenda (Department of Health, 2007) was also appropriated to reinforce treatment choice in the

network; ‘this is an alternative treatment option that can be used to support existing psychotherapeutic services giving greater patient choice and empowerment’ (Welsh Assembly Government, 2005a).

Several translations also occurred during the interessement process, allowing the focal actor to conceptualise actors within the network in a way that stabilised their identity and legitimised their relations with other actors in the network. These translations included constructions of:

- § Self-help books as accessible to all
- § Libraries performing the role of pharmacies
- § Prescription models as familiar to patients
- § Geographical variation in care as unacceptable
- § Cost-effective care as ideal
- § Patients as responsible for their own self-management
- § Evidence-based medicine as a legitimisation for treatment

(Frude, 2004a; Frude, 2004b; Welsh Assembly Government, 2005b; Welsh Assembly Government, 2005c; Welsh Assembly Government, 2005e)

Nonetheless, at this stage in the translation process, the focal actor’s definition of the accessibility of self-help books links to a construction of the ideal patient, who would view the CBT-based self-help text as ‘*a gardening manual or a recipe book or whatever*’ (S-1) thus positioning themselves as ‘*somebody who is used to the notion of a manual to actually follow to do car repairs or something*’ (S-1).

Moreover, the scheme was constructed by the focal actor in such a way that the question of whether or not the books were an effective treatment was not addressed; ‘*we know that bibliotherapy works; we know that many of the books have been tested in randomised controlled trials type things. We know that that bibliotherapy is very, very powerful but I think it’s then a sort of act of faith to say if it works in America it’s going to work in Wales*’ (S-1).

Acceptance of the scheme therefore rested on the belief in a strong, defined evidence base of systematic reviews, meta-analyses and randomised controlled trials (RCTs) for bibliotherapy and this evidence base was noted in the patient and prescriber information leaflets and

healthcare policy documents. While it can be argued that an evidence base advocating bibliotherapy exists, it does not necessarily reflect the conditions defined as suitable for treatment by the scheme. As noted by Richardson *et al* (2010), the evidence base for bibliotherapy does not include evidence indicating that all the books specified on the BPW list are effective. Indeed, the majority of commercially available texts have not been subject to RCTs examining their effectiveness. The ‘act of faith’ argument posited above is vital for acceptance of the scheme, with an interpretation of the evidence base as ‘strong’ as more important than the evidence base itself. A 2008 review of self-help books concluded that it was inappropriate to apply an argument that any self-help book could be useful, because the texts were so diverse that ‘the results of trials generated by one book, therefore, cannot be generalised to others’ (Richardson et al., 2008: 551).

The majority of the books in the BPW list have not been tested in RCTs, challenging the assertion that a simple ‘leap of faith’ provides evidence of effectiveness. The evidence-base/ ‘act of faith’ argument is supplemented with an emphasis on self-help as the ‘sensible’ option, including statements professing that ‘empirical evidence, supplemented with plain common sense, points to a number of advantages of bibliotherapy compared with medication’ (Frude, 2005: 29).

Similarly, as Brown (2009: 23) states, running a bibliotherapy scheme ‘demands ambitious and creative partnerships between government, libraries, the health service.’ There needed to be agreement from all partners that the BPW scheme would be acceptable and fulfil their aims and needs. To achieve this, there needed to be recognition of key benefits of BPW over other possible solutions. Only then could the translation from a local pilot to a national mental health care solution occur.

This translation was predominantly achieved using two methods to ensure the advantages were recognised; a linking of the aims of the scheme to key national agendas, and the use of statistics.

Enrolment via inscription in documentation

Raising the Standard (Welsh Assembly Government, 2005a) lays out some of the key national agendas creating conditions in which BPW could flourish at a national level. It presents eight standards for improving mental health care in Wales. Those relevant to the

introduction of the BPW scheme include ‘social inclusion, health promotion and tackling stigma’ and ‘delivering effective, comprehensive and responsive services’. The implementation of BPW therefore fits in with a conceptualisation in which NHS Wales provides cost-effective, accessible, and evidenced-based treatment for mental health conditions.

Raising the Standard sets out targets and standards for Wales, and BPW is a vital component in services provided to meet these targets. For example, the target that ‘all patients... who are assessed to require access to evidence-based psychological therapies will commence therapy within three months of assessment’ (Robinson, 2008: 23) is supported by the availability of BPW in every library in Wales. This negates the potential for waiting lists for secondary care treatment to undermine set targets, as it will reduce the number of patients initially referred to secondary care because of a lack of treatment choice. Re-locating mental health treatment in primary care via BPW and branding it as evidence-based medicine enables the three month waiting time target to be achieved.

Designed for Life (Welsh Assembly Government, 2005b: 28) reinforces a focus on the changing nature of services, stating that ‘Mental Health Services will be remodelled over the three years to strengthen primary care.’ Situating BPW as a joint Primary Care/public library project supports this shift away from secondary care for mild-to-moderate conditions. However, in an ANT framework, ‘policy is seen as a process of incremental decision making, or ‘muddling through’... that involves negotiation across multiple perspectives’ (Shaw, 2010: 200). Thus, as *Raising the Standard* (Welsh Assembly Government, 2005a: 6) states: ‘services need to ensure timely delivery of evidence-based interventions that focus on outcomes and service user recovery. Such a cultural shift will require a change in both service user and staff expectations of where, when and how services are delivered’. Taken in the context of Shaw’s (2010) work, this statement can be seen as evidence of emergent strategy, and the association of BPW with outcomes not previously defined. Accordingly, it is clear that BPW enrolls actors in its network in several ways: it is an evidence-based intervention; it is instantly accessible; it focuses on changing behaviour that will be reflected in a treatment outcome (a key priority for healthcare providers hoping to reduce demand on secondary care); and it provides an innovative solution to service location and delivery. The inscription of changed location as a objective for services also supports the placement of schemes in public libraries.

Raising the Standard also notes the intention within Welsh mental health care to ‘improve the collaboration between existing services. These system developments require little or no additional financial investment’ (Welsh Assembly Government, 2005a: 6). Indeed, key action one in the document focuses on ‘strengthen[ing] inter-authority/ agency arrangements... [in order to] foster the development of life-skills’ (Welsh Assembly Government, 2005a: 10). BPW therefore fulfils several distinct aims in service provision that are not fulfilled by the prescription of medication.

BPW has also been positioned in such a way that, as previously defined by governmental representatives, it relates to a holistic construction of mental health. As *Raising the Standard* (Welsh Assembly Government, 2005a: 36) states: ‘our strategy and NSF [national service framework] have taken us from a purely illness, disease and treatment approach to one that makes the links between good mental health, poor mental health and the quality of life of individuals and communities. Improving the quality of people’s lives is at the heart of this strategy’. As CBT concentrates on changing patterns of thought and behaviour, it is directly focused on this ‘improved quality of life’ argument.

Returning to arguments surrounding clinical evidence, while healthcare in Wales is a devolved subject, there is still an obligation to subscribe to the NICE clinical guidance that forms the basis of NHS policy in England. NICE recommend the use of guided self-help treatments like BPW for depression, anxiety and bulimia nervosa (NICE, 2004c; NICE, 2004a; NICE, 2004b). Evidence from NICE was utilised by those championing book prescription to support the appropriateness of the scheme (Frude, 2005).

The importance of the clinical evidence was noted in interviews: ‘the National Institute for Clinical Excellence published guidelines on treatment for anxiety and depression and eating disorders, and in all of these they suggested that bibliotherapy was something to be considered... that GPs should consider books before considering medication’ (S-1). The prescriber information booklet (Welsh Assembly Government, 2005e) also highlights the importance of the NICE evidence base, mentioning it on no fewer than three occasions throughout the booklet, with comments like ‘NICE recommends bibliotherapy as an appropriate first active treatment strategy.’

One interview participant linked this back to the BPW model, and the appropriateness of using the book prescription collection in its current format; *'the problem was of course that while NICE said the high-quality books are really the ones to go for, they didn't actually point out any books. So the GP who wanted to follow NICE guidelines couldn't actually do it. With drugs they're told 'this drug's good, that drug's bad', but with books they weren't told'* (S-1). Consequently, GPs and health professionals were enrolled in the network via notions of evidence-based medicine and following nationally recommended guidance.

In addition to enrolling clinicians, there is a need to enrol patients in the network and this is demonstrated in the design of the patient information leaflets (Welsh Assembly Government, 2005c; 2005d). Firstly, the *Books Can Help* leaflet (Welsh Assembly Government, 2005d) emphasises that *'emotional problems are very common'*. This statement works to destigmatise mental health problems and tries to prevent misunderstandings about diagnosis. It draws on a discourse that locates mental health problems as an individual psychological responsibility, creating a context in which the patient possesses the resources to solve their own problems with limited medical intervention (Shaw and Taplin, 2007). Such clarification is important in light of surveys of the general public about depression, which emphasise that patients and medical professionals do not always see the same causes, or the same solutions to mental health issues (Jorm et al., 1997; Weich et al., 2007; Prior and Carman, 2008). The definition of illnesses like depression and obsessive compulsive disorder as based on emotion, rather than genetic or biomedical causes work to alters the perception of the patient, and thus their expectations of treatment; *'depression is sometimes called the common cold of psychopathology'* (S-1).

The second statement in the leaflet affirms that *'GPs can offer help for emotional problems.'* The pronouncement that GPs can provide guidance for these issues moves the focus of the network away from secondary care mental health treatment and posits mental health problems as a 'general' condition which primary care health providers can treat. While the leaflet refers to the possibility of being referred to secondary care, which may have been the expectation of the patient, it places a barrier to access to these services, stating that their availability is limited. The statement locates the self-help books as a stage between primary care and secondary care; one that needs to be explained to patients to ensure enrolment in the scheme.

The third statement made by the leaflet is that *'books can help.'* This unequivocal statement provides only minimal evidence to support its claims, and links back to the emotional nature of problems, the provision of care in primary care, and the introduction of BPW. The language used within the leaflet to impress on the patient the importance of the scheme to their lives is highly emotive. The leaflet stresses the 'award-winning' nature of the scheme, stating that only 'highly-recommended' self-help books are proposed. It differentiates between ordinary self help books and the 'best' ones, which are 'highly effective'. These books have been 'specially selected by health professionals' and the inference is that this selection makes them the 'best' books previously mentioned. The leaflet also concentrates on the equity of access and lack of cost to the patient. The emphasis on self-help – but not all self-help – contributes to the idea that the scheme is still the solution to the problem as defined by the focal actor; only high quality self-help will function in an effective manner.

To ensure that both secondary care providers and patients are enrolled in the scheme, the leaflet states that *'many of the most effective books present self-help versions of the kind of therapy that would be given by a professional.'* All actors in the network are thus made aware that while the contribution of secondary care professionals is valued and useful, it is not always accessible, and so these books often provide an adequate substitute in many cases.

Enrolment via statistics

Enrolment in the BPW network was also negotiated using statistics that represent book issues. Library services typically consider book issues to be an appropriate measure of the success of an initiative, and the number of books issued was also seen as a representation of a lower demand for secondary-care psychiatric services, leading to reduced waiting lists and demonstrating the perceived benefit for healthcare professionals. BPW statistics are thus taken to illustrate the legitimisation of BPW as demonstrably achieving its aims of reduced demands on secondary care and enabling access to expert psychological therapies.

It can be argued that these book issue figures do not represent the usefulness or effectiveness of the books as treatment – or even that the books were read by those who borrowed them – but these statistics do perform a function within the network of self-help book prescription. This quantification can be said to perform as a 'calculative lingua franca' (Callon and Law, 2005: 724) in a scheme in which there is partnership working between groups with different agendas, who need to agree defined outcomes.

The necessity of an awareness of the role of statistics in this research was reinforced in interviews with the representatives of the strategic discourse, and in written documentation concerning the scheme. One interview participant stated that ‘*our statistics are mainly based on what books are being borrowed*’ (S-2). The value placed on the scheme directly relates to figures showing how many people had used the scheme.

As previously noted, the PLR database was used within this study to examine the impact of the introduction of BPW on book issue figures in public libraries. Table one shows the number of books on the Book Prescription list issued in Cardiff libraries before and after the introduction of the scheme. It demonstrates the dramatic rise in issue figures that was used as evidence when considering the funding for the BPW scheme. While the increase in issue figures also reflects a rise in the number of copies of the books available, it is used to claim that usage has increased and meets a real need.

Table one: Books on Prescription list books issued in Cardiff 2000-2004

<i>Year</i>	<i>Total number of Prescription list book issues in Cardiff</i>
2000-1	84
2001-2	98
2002-3 [Books on Prescription introduced, 2003]	1113
2003-4	3704

Table two presents the data illustrating categories of books borrowed as part of the scheme in Wales as a whole in 2004-2008. As the figures show, BPW was introduced in 2005, dramatically increasing the number of books on each subject issued. Figures in bold represent the most borrowed categories in each year; books about anxiety, depression, panic and self-esteem make up the bulk of titles borrowed. These statistics reinforce this notion of the delivery of the scheme in response to a needs-based agenda.

Table two: categories of BPW list books issued in Wales 2004-8

Category of title, according to the BPW list	2004-5	2005-6	2006-7	2007-8
Anger	23	278	329	249
Anorexia	7	67	66	90
Anxiety	2	351	458	472
Assertiveness	11	150	131	103
Bereavement	0	107	132	131
Bulimia/ binge eating	3	184	129	120
Depression	37	1012	1204	890
Head injury	5	31	26	20
Health anxiety	0	9	32	10
Manic depression	7	130	115	88
Obsessions	3	361	304	309
Panic	37	350	435	380
PTSD	3	136	142	104
Self-esteem	27	500	574	544
Sexual abuse	15	164	132	100
Social anxiety	19	177	158	127
Stress	0	347	443	296
Worry	9	185	183	144
Total book issue figures for the year	208	4539	4993	4177

Note: BPW was introduced in 2005

While this usage reflects the epidemiology of mental health issues, the categorisation can also be said to reflect the needs of service providers, rather than the evidence base, with books for self-esteem, panic, obsessions, and stress – i.e. those which are not evidence based – forming a significant proportion of those issued. The evaluation of the BPW scheme by Porter *et al* (2006) revealed that BPW was being utilised to fill in gaps in treatment programmes where it may not have been appropriate to do so. In the case of anger management, it was felt that there were a large number of referrals to BPW for books about anger because of a lack of other treatment options (Porter et al., 2006: 40). However, it is important to note that some categories within the BPW list could be regarded as addressing specific symptoms of conditions like depression and anxiety. Low self-esteem, for example, can be a symptom of depression, and panic attacks are often a symptom of underlying problems with anxiety.

These book issue statistics are utilised to represent all patients with mild-to-moderate mental health difficulties. From Mol's (2008) perspective, this reduction of a person's presumed successful treatment to a number indicates an agreed translation from a point at which a person is deemed 'ill' to one where they are considered 'well'. In this case, once a book on the subject of depression has been borrowed from the library, the person with depression is regarded as 'well' or 'treated'. In this way, patients are provided with a role in the network that does not enable them to speak about their experiences. They are silenced by other actors in the network, as the capturing of the patients' perspective is replaced by the book issue statistics given here. The patients' perspective is translated into a set of numbers which can be used to mobilise and maintain the network. Through the use of these statistics; 'the enrolment is transformed into active support' (Callon, 1986: 218). The use of issue statistics enables the focal actor to speak for the librarians, patients and books – all have achieved their aims as defined by and within the network, and can be easily represented in the format of graphs and diagrams demonstrating impact.

Conclusion

BPW is legitimised by drawing on key institutional agendas including cost-effectiveness and reduced waiting times for treatment. These key agendas bypass the need for further evidence – for example, experiences of patients utilising the scheme. In this way, 'a constraining network of relationships has been built. But this consensus and the alliances which it implies can be contested at any moment' (Callon, 1986: 218-9).

Callon's (1986: 196) final stage in the translation process is that of 'irreversibility'. This can be defined as 'the degree to which is subsequently impossible to go back to a point where alternative possibilities exist' (Cho et al., 2008: 617). It is not thought that this point has been reached in the case of BPW. As Callon notes, 'translation is a process, never a completed accomplishment, and it may... fail' (Callon, 1986: 196). In the case of BPW, the network is under constant pressure from realigned governmental agendas such as those accompanying a change of elected parliament. There are a number of barriers that may impact on use of the scheme, which were discussed earlier in this article and may cause the network to disband. Readability of the texts may undermine the strength of the network, as the books are not as accessible as initial constructions suggested. Issues of patient motivation also need to be taken into account when considering the stability of the network. The symptoms of conditions like depression include: reduced energy; decreased activity; reduced concentration; and difficulty

carrying out ordinary activities (World Health Organisation, 2007). Thus, activities such as reading and concentrating on a text can be problematised for people with mental health conditions. Patients, therefore, may be able to destabilise the network by being unable to utilise the resources within it which have been designed to provide treatment for them.

BPW is portrayed by service providers as an evidence-based, cost-effective scheme, providing patient choice and reducing inappropriate demand on secondary care. However, as this paper has demonstrated, the construction of the network is actually more complex than this. Evidence-based agendas are utilised to justify the introduction of the scheme, yet in practice the scheme is driven by a pragmatic need for cost-effective, time-critical treatment. The focal actor has to represent the aims of the scheme in a language that will appeal to the other actors in the network. There is a need to use available discourses – for example, notions of a solid evidence base – to frame the construction of the network and ensure its stability. Documentation and statistical evidence are utilised to inscribe the network and ensure its continued stability. Discourses of partnership working, meeting targets, and providing quality care were also utilised to legitimise and strengthen the network.

Nevertheless, the aim of this paper is not to criticise evidence-based medicine as a rationale for decision-making; or to disregard the evidence base concerned with the effectiveness of self-help bibliotherapy under specific conditions. Instead, the intention has been to show that the reasons for using an evidence-based argument are manifold, and might in this instance conflict with the needs of the patient. The use of the argument that evidence-based medicine legitimises bibliotherapy enables the actors in the network to justify the exclusion of a more patient-focused narrative of the experiences of treatment. It notes that there are financial and political benefits to formulating an evidence-based approach, and critiques the use of evidence-based medicine to support the introduction of a national treatment programme. Evidence-based medicine is the most appropriate discourse to use to bond the disparate members of the network to accept the solution negotiated by the focal actor.

This article has explored the wider implications of analysing policy formation to reflect socio-political processes at policy level, and has implications for concepts of policy making as a rational and coherent endeavour. It has also explored some criticisms of the application of the notion of evidence-based practice in this case, demonstrating that the evidence can be translated to meet socio-economic agendas. While BPW is presented by policy makers as a

response to the needs of the general populace with mental health problems, this ANT analysis demonstrates that the needs of service users are interpreted to ensure that the requirements of policy makers are also fulfilled. In contrast with this analysis, there is a need for an in-depth study of users of bibliotherapy schemes to ensure that their needs are met. There has not been room within the constraints of this article to expand on this aspect of research, but a forthcoming study will conclude that imposing a top-down structure prescribing self-help texts to patients is just one model of bibliotherapy that can have an impact on mental health, and other models, including the use of novels, poetry and short stories to provide catharsis and a validation of emotions can have more of an impact in terms of improving mental wellbeing (Brewster, 2011 [forthcoming]). This has repercussions for wider health and LIS policy, in light of a move towards service user consultation and the need to create user-centred services.

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