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‘So just to go through the options. . .’: patient choice in the telephone delivery of the NHS *Improving Access to Psychological Therapies* services

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Abstract This article considers patient choice in mental healthcare services, specifically the ways that choice is enabled or constrained in patient–practitioner spoken interaction. Using the method of conversation analysis (CA), we examine the language used by practitioners when presenting treatment delivery options to patients entering the NHS *Improving Access to Psychological Therapies* (IAPT) service. Analysis of 66 recordings of telephone-delivered IAPT assessment sessions revealed three patterns through which choice of treatment delivery mode was presented to patients: presenting a single delivery mode; incrementally presenting alternative delivery modes, in response to patient resistance; and parallel presentation of multiple delivery mode options. We show that a distinction should be made between (i) a choice to *accept or reject* the offer of a single option and (ii) a choice that is a *selection from a range* of options. We show that the three patterns identified are ordered in terms of patient-centredness and shared decision-making. Our findings contribute to sociological work on healthcare interactions that has identified variability in, and variable consequences for, the ways that

patients and practitioners negotiate choice and shared decision-making. Findings are discussed in relation to tensions between the political ideology of patient choice and practical service delivery constraints.

Keywords: Doctor–patient communication/interaction, Telemedicine, Psychotherapy, Mental health services, Patient-centredness, Shared decision-making

Introduction

Over the past two decades, the concept of patient choice has become enshrined in UK health policy. Greener (2009) provides an historical analysis of the use of the term ‘choice’ in UK Government publications, charting its conceptual transformation within an overarching framework of ‘health consumerism’. Today, the principle of patient choice in healthcare provision involves both a concept of *market level* choice between providers of a service, and choice at the level of what *specific treatments* (medications, therapies, etc.) will be taken up. The rationale for creating a market in healthcare provision includes driving up quality through competition, increasing equity and positioning the patient as empowered consumer or customer (Department of Health 2004, Dixon *et al.* 2010, Fotaki 2010), whilst choice of treatments sits within an ideology of patient involvement, empowerment and autonomy in their care. Here, we find concepts including shared decision-making (Bomhof-Roordink *et al.* 2019, James and Quirk 2017) and personalised care (NHS England 2019), which are believed to contribute to greater patient engagement, satisfaction and clinical benefit.

The extent to which patient choice is both realised and effective in terms of benefit to patients has been questioned. The work of Fotaki and colleagues (e.g. Fotaki 2010, 2014a, 2014b, Fotaki *et al.* 2008) alerts us to the complex and multifaceted nature of choice. Aspects of choice that are prioritised by a market/consumer rationale may not be those that are important to patients, and there is evidence that choice is exercised differently by patients with different socio-demographic characteristics, which can unwittingly contribute to inequality of access and outcomes (Fotaki 2010, Zolkefli 2017). Furthermore, the evidence of clinical benefits arising from shared decision-making is variable (e.g. Lovell *et al.* 2018, Shay and Lafata 2015, da Silva 2012). Nevertheless, within the UK health system, patient choice remains a strongly held policy commitment, both in terms of the specific rationales outlined above and the more general principle that ‘the exercise of choice is an important good in itself for patients’ (Fotaki 2014b: 16).

Patients gained the legal right to choose some aspects of their mental health care only in 2014 (Department of Health 2014). The NHS-commissioned *Five Year Forward View for Mental Health* (Mental Health Taskforce 2016) aspires to enabling people with mental health problems to ‘play a more active role in making choices about all aspects of their care, based on a more equal and collaborative relationship between the person and professional(s)’ (Mental Health Taskforce 2016: 43). Legislation on the provision of patient choice does not currently extend to mental health services in Primary Care (DHSC 2020). However, choice is a key principle within Primary Care mental health services, the majority of which in the UK are delivered through the Improving Access to Psychological Therapies (IAPT) programme.

Improving Access to Psychological Therapies is a publicly funded programme delivering psychological treatment for mild-to-moderate depression and anxiety-related mental health problems, within the National Health Service (NHS) Primary Care services in England (for

further information about IAPT, and the mental health problem in the UK lying behind IAPT, see Layard *et al.* 2006, Layard and Clark 2014, and Stansfeld *et al.* 2016). Patients access IAPT by GP referral or self-referral. Following referral to IAPT, the first in-depth contact that a patient has with a practitioner will generally be an ‘assessment’ session. The purpose of an assessment is to gather background information about the patient and their difficulties, to identify the main presenting problem and to make a decision about what type and intensity of psychological treatment is indicated. As clinically appropriate, and to the extent specified by UK national clinical guidelines, there should be a range of evidence-based *types* of therapy available to patients. These may include individual guided self-help based on cognitive behavioural therapy (CBT) principles, individual or group CBT, computerised CBT, psychoeducational groups, behavioural activation and several other forms of therapy (NCCMH 2019: 14–15). Beyond therapy type, there should also be ‘meaningful choices’ about the timing, *location* and *delivery mode* of treatment; the reason for offering such choices between delivery modes is explicitly linked to patient engagement and outcomes:

Patients should also be offered meaningful choices about where, when and by whom therapy should be delivered. Providing such choice is likely to enhance engagement and, consequently, improve outcomes. (NCCMH 2019: 50).

The present study focuses specifically on the choice of treatment *delivery mode*, rather than the type of therapeutic treatment. For patients experiencing milder forms of depression or anxiety, IAPT services are able to offer low intensity guided self-help intervention via a range of delivery modes, including (i) group, (ii) one-to-one, (iii) telephone and (iv) digital variants of treatment (NCCMH 2019).

From this, we see that patient choice exists at multiple levels within the healthcare system, with a funnelling of choice from the macrolevel of provider markets to the microlevel of patient-centred treatment decisions, involving what, when, where and via which medium these treatments will be delivered. At the microlevel, sociological attention has been paid not only to *what* treatment or healthcare options patients are offered, but also *how* they are offered in direct patient–practitioner interactions, that is the linguistic and interactional forms that these offers take (Chappell *et al.* 2017, Stivers *et al.* 2018). This matter of *how* options are presented is the core focus of the current paper.

The analysis presented below draws on direct recordings of IAPT assessment sessions conducted by telephone, by Psychological Wellbeing Practitioners (PWPs) – professionals trained to assess and deliver interventions for mild-to-moderate mental health difficulties. We focus specifically on how various *treatment delivery mode* options were presented to patients who had been assessed as suitable for treatment within IAPT services. We examine particularly how choices were offered (by practitioners) and taken up (by patients) in these two-party interactions. Our analysis is focused on the fine-grained detail of how patient choice plays out in practice, using the method of conversation analysis (CA) to examine closely the language used by practitioners when presenting treatment delivery options to patients. Building on the growing body of conversation analytic scholarship on patient choice in various medical settings (e.g. Alby *et al.* 2017, Reuber *et al.* 2015, Shaw *et al.* 2020, Stivers *et al.* 2018, Toerien *et al.* 2018), we provide further evidence of variability in – and in turn variable consequences for – the ways that patients and practitioners negotiate choice and shared decision-making. In sum, we focus on whether, and how, practitioners offered patients choice between available treatment delivery modes, at the point of entering the service.

Data and method

Five IAPT providers participated in the study, located across the North and East of England. Patients were recruited by PWPs, with written consent gained in advance of appointments and reconfirmed verbally at the beginning of their appointment. PWPs managed the recording of telephone appointments independently of the researchers. Ethical approval was granted by North West Greater Manchester West Research Ethics Committee (Ref: 18/NW/0372).

In total, recordings were made of 123 telephone-delivered IAPT sessions, of which 66 were assessments, 37 were first treatments sessions, and 20 were second treatment sessions. It is during the assessment session that the opportunity occurs for PWPs to introduce the possible modes of treatment delivery available to patients. Hence, the subset of data considered here comprises 66 assessment recordings, conducted over a four-month period (November 2018–February 2019), by nine different PWPs (age 24–72 years, six female, one male) with between one and nine years' experience in role (average 4½ years). Patients in the assessment subsample were aged between 17 and 71 years; 45 female and 21 male. Primary problem descriptors for the 66 patients were mixed anxiety and depression (32), anxiety (15), depression (14), anxiety plus depression (2), not stated (3).

The recordings were transcribed to include detail such as the timing of speech delivery (pauses, overlapping talk) and salient aspects of how things are said (e.g. prosody) (Jefferson 2004). The recordings were analysed according to the perspective and method of CA, a method used widely in research into medical interactions (e.g. Barnes 2019, Toerien *et al.* 2013), including therapeutic and counselling interactions (e.g. Buchholz 2019, Peräkylä *et al.* 2008) as well as other social and welfare interactions (author reference removed). It is a largely qualitative, micro-analytic and inductive method¹. CA focuses on observable conduct, rather than participant recall; in other words, on *what actually takes place* during real-life (authentic) interactions in those settings. Briefly, the key advantages of CA over other (e.g. interview) methods are that CA (i) does not rely on participants' (PWPs' or patients') recall, which is often incomplete or inaccurate (Waitzkin 1985); (ii) is less susceptible to filtering or 'socially desirable' reframing according to what people think they should say; and (iii) investigates directly how people actually behave and talk, at a level of detail that the speakers are unlikely to be consciously aware of and could not possibly recall (author reference removed). The data were analysed in order to identify recurrent patterns of option presentation observed in those sequences in which PWPs explained to patients the options available regarding the delivery mode of their psychological treatment.

Findings

The initial assessment session provided an *opportunity* for the mode of treatment delivery in subsequent sessions to be determined. However, we found that this did not always occur. The outcomes of assessment sessions in our sample were sometimes inconclusive with respect to what type of treatment would be appropriate for subsequent treatment sessions. At the end of such (inconclusive) assessments, PWPs announced that they had first to consult their supervisor and that until they had done so the mode of delivery could not be settled and agreed. In some other cases following assessment, patients were for a variety of reasons discharged from the service and therefore did not proceed to treatment. Including both deferred treatment decisions and patients not proceeding to treatment, treatment delivery mode was not discussed in a quarter of our recordings.

In those assessment sessions in which the type of treatment was settled and the specific *mode* of delivery was discussed with patients, we identified three main patterns:

- Presenting a single delivery mode
- Incrementally presenting alternative delivery modes, in response to patient resistance
- Parallel presentation of multiple delivery mode options

The various treatment delivery modes presented by PWPs to patients included: group courses in a face-to-face setting; individual sessions delivered face-to-face; individual sessions by telephone; online treatment via instant messenger; and web-based packages with telephone support (reflecting national clinical guidelines at the time of study). We did not have information about whether each participating IAPT service had all of these five treatment modes available. However, it is clear from the recordings that in each service a choice was available (in principle) between at least two, and usually three, of these modes of delivery. In the following sections, we show and discuss the significance of the three patterns of presenting options to patients observed in our data.

Presenting a single delivery mode

One way that delivery modes were proffered is that the PWP presented only a single option. This is illustrated in extracts 1 through 4, below.

Extract 1 [081:19:4]²

1	PWP:	Erm so just to go through the:: options, erm I think you may benefit from attending our wellbeing course, .hhh erm (.) so it runs over four weeks , so
2		you'll have four sessions to attend, they last up to an hour and a half each
3		week,.hhh erm and it's aimed to help people to understand a bit more about er
4		why they're feeling like this. So sort of common things we cover over the
5		course are stress-related symptoms um anxiety and depression symptoms um
6		understanding maybe what your triggers are for some of those feelings um and
7		also learning ways to um help yourselves as well. So um we'll go through
8		various different self-help techniques and tools to hopefully support you with
9		making those changes.
10		
11	Pat:	Okay.

Extract 2 [097:18:4]

1	PWP:	So I mean, we can offer you: erm we do a really, really good online CBT programme that looks at.H giving you strategies to manage worry.hh erm
2		[Oka- okay.]
3	Pat:	
4	PWP:	[so-] as long as you've got access to erm iPhone or a tablet or some sort
5		of a- erm a phone that you can get apps on, yeah?
6	Pat:	Yeah, I c- I've got that yeah.
7	PWP:	You've got that? And I- c- you- presume you can work your way around and
8		navigate your way around the you know, a- like an app and a system. Yeah.
9		[Are you quite good-
10	Pat:	[Yeah I can, yeah yeah.
11	PWP:	Yeah? Uh that- I think that would be really: <u>good</u> for you?

(Continued)

Extract 3 [092:17:4]

1	PWP:	So I'll just take you through um our- the <u>way</u> we bring people <u>into</u> therapy.hhh
2		erm what we look at initially is getting people back on track with their wellbeing
3		[.hhh
4	Pat:	[Mhm.
5	PWP:	So <u>that's</u> the general eating healthily um.hh looking at exercise er looking at
6		perhaps the reduced activity: the avoidance.H <u>all</u> of those things and s:leep.
7	Pat:	Yeah.
8	PWP:	So we offer <u>everybody</u> erm (0.5) a wellbeing course.

Extract 4 [096:18:4]

1	PWP:	One of the- the things we offer is a course? We run a- a worry management
2		course? I don't know if you'd be able to attend that? It runs on a <u>Tuesday</u> ? Erm
3		up at the [VENUE] and I think it's:::hh I think it's [()
4	Pat:	[Yea:h what time would it be.
5		Cos obviously if I'm- I'm hoping- I work Monday, Tuesday, Wednesday.

Where only one delivery mode was presented, PWPs sometimes promoted this option by emphasising its potential benefit to the patient, for example, 'I think you may benefit from... ' (ex.1) and 'I think that would be really: good for you' (ex.2). These formats were closer to a recommendation or suggestion, than an option neutrally presented (Stivers *et al.* 2018, Thompson and McCabe 2018). Another way that PWPs packaged the presentation of a single mode was to frame it as standard practice, that is what was routinely done in that service: 'we offer everybody a wellbeing course' (ex.3).

Incrementally presenting alternative delivery modes, in response to patient resistance

In the cases shown above, the patient took up (accepted) the first delivery mode that was presented, and for the remainder of the assessment session no alternative delivery modes were introduced for consideration. However, by contrast, in the second pattern, PWPs again *began* by suggesting a particular (single) mode offer, which patients resisted. Their resistance was variously manifested as hesitancy, delayed response, or explicitly problematising or rejecting the mode that was presented³. In response to this lack of take-up from the patient, PWPs revealed that there were alternative mode options available, as happened in extracts 5 and 6, below.

Extract 5 [098:18:4]

1	PWP:	A:nd we ↑do do an on:line CBT package.
2		(0.5)
3	Pat:	.mhhh yea:h?
4	PWP:	Oh actually, do we. Erm: (1.0) yes we do..H W- w- we've just had <u>one</u>
5		erm taken away from us but we do have another one so.hh yeah..hh It's

(continued)

(Continued)

- 6 called [. . .]⁴ and it's accessed online..hh erm you still have a therapist erm
7 that contacts you, but it's all done via email. So you talk to each other via
8 email and you access a program and complete some work.
- 9 Pat: .HH It's very, very: (.) clinical and what have you. I do find doing everything
10 online- when I was at work
- 11 PWP: Yeah.
- 12 Pat: .hhh you'd never really speak to anyone and I don't know- I really don't know
13 if that's:
- 14 PWP: No [↑okay.
- 15 Pat: [for me.
- 16 PWP: No okay that's fine? Alright? Er we- we run a course? We do a low mood
17 course? You could come to a low mood course, that.hh erm runs down at
18 [VENUE] on a Tuesday morning? A low mood course that looks at.h erm:
19 depression, it looks at giving you some ways to manage.hh your thoughts
20 better, gives you some erm strategies to look at.hh erm chall[enging
21 Pat: [No I d- go out on
22 a Tuesday with a friend so that ain't going to be any good is it.
23 (0.5)
- 24 Pat: [.HHH
- 25 PWP: [↑Okay?
- 26 Pat: [HHHHH.]
- 27 PWP: [So] we can offer you some telephone guided self-help then. So one-to-
28 one work with a PWP like myself but it would be over the phone. Half an hour
29 sessions weekly?.hh erm does that sound [okay?
- 30 Pat: [Yea:h it could be. That could be
31 alright.
- 32 PWP: Yeah?
33 (1.0)
- 34 Pat: Yeah.

In extract 5, the PWP began by offering ('we do do' line 1) an online CBT package, and after some hesitancy about whether this is still available (lines 4–6), the PWP went on to describe the CBT package structure to the patient. The patient resisted this suggestion, on the grounds that it sounded 'very, very clinical', lacking in personal contact, and that they therefore did not know if it was 'for me' (lines 9–15). In response, the PWP suggested an alternative delivery mode, a group course ('we do a low mood course' lines 16–20). The patient put up a logistical barrier to this option, that it clashed with a regular prior engagement (lines 21–22). The PWP then went on to present the possibility of one-to-one telephone treatment (lines 27–29), which the patient accepted (lines 30–34).

In extract 6, the PWP likewise revealed that there were further delivery mode options only after the patient resisted the option initially offered by the PWP ('we can start off with low intensity CBT. . . delivered in a group setting' lines 1–2, 8).

Extract 6 [068:19:4]

- 1 PWP: Erm because you've not had any therapy with us before..hh er we can start off
2 with erm low intensity CBT?.hh So (.) it will help you to: get a better

(continued)

(Continued)

- 3 understanding of maybe why you're feeling like this, and learn.hh techniques
 4 and strategies to manage the low mood? So: (.).tch the: CBT sessions.hh er
 5 run over four weeks? So you've got four sessions to attend here. Each of the
 6 [sessions last up to an hour and a half?
 7 Pat: [(Right/Yeah)
 8 PWP: .hhh erm they are delivered in a group setting, but there's no erm sort of
 9 pressure.hh for you to come here and talk about how you're feeling et cetera.
 10 It's mo:re.hh coming and learning about why you might feel like this and
 11 what sort of things you can do to try and.hh erm improve your mood..hh
 12 [erm is that-]
 13 Pat: [See already] now cos of my anxiety, y- I'm starting to back away
 14 cos [()]
 15 PWP: [A(hh)h with the] group option?
 16 (.)
 17 Pat: Yeah.
 18 PWP: Yea:h..mhh The: other option would be: erm ((clears throat)) maybe offering
 19 you some one-to-one sessions, erm.mhh so we can start off with the one-to-
 20 one sessions.=They will be half an hour,.hh again between sort of four to six
 21 weeks,erm [we can
 22 Pat: [Yeah.
 23 PWP: do those over the phone o:r face-to-face, whatever's easier for you?
 24 .hhh [a:nd
 25 Pat: [Yeah.
 26 PWP: again they will be on CBT techniques? S:o we provide a lot of self-help
 27 techniques, erm.hh so it's not a talking therapy, it's more practical approach,
 28 so looking at how you're feeling, why you're feeling like this and then looking
 29 at how we can make changes there..mhh[h
 30 Pat: [Yeah.
 31 PWP: Is that something you'd be interested in?
 32 Pat: Yeah, yeah, yeah, if it- if it's a way forward, yeah.

The patient resisted the first treatment mode offered (lines 13–14), which resulted in the PWP offering the further option of one-to-one treatment either over the telephone or face-to-face, mentioned in parallel in this instance. The patient accepted the offer of one-to-one treatment explicitly at line 32, though their preceding positively valenced receipts of the PWP's explanation (lines 22, 25 and 30) already projected take-up. Whether this one-to-one treatment would be face-to-face or over the phone was not discussed during the recorded session; the patient was told only that they would now be placed on a waiting list for the next available appointment.

Parallel presentation of multiple delivery mode options

In the first two patterns described above, PWPs either presented only a single option, or, in response to patient resistance, went on to present alternative treatment modes. By contrast, in the third pattern we observed PWPs provided patients with information about multiple delivery modes, in parallel. Patients were given a full 'menu of options' (Toerien *et al.* 2011) to consider, before making their choice about delivery mode, as illustrated here in extract 7.

Extract 7 [100:20:4]

1	PWP:	So just with regards to the therapy we <u>can</u> offer that in three different ways
2		now? (0.5) Again you might already <u>know</u> this from previous but if it was a
3		different service it'll probably differ?.hhh So it's the- all the same techniques
4		that are all cognitive behavioural therapy based and it's called guided self-help
5		(.) okay?.hh So we can offer an anxiety course which we run at the
6		[location].tch and that runs on a:: Tuesday afternoon for about an hour,
7		an hour and a half?.hhh The [second option
8	Pat:	[(yeah)
9	PWP:	is online CBT? So you would download an app to your smart phone, complete
10		the modules erm yourself in your own ↑time.H or online depending on what
11		option you take?.tch and then you'd have somebody like myself contacting
12		you once a week to guide you through that process? And then the third option
13		is one-to-one guided self-help which is half an hour a week for six to eight
14		↑weeks and that wou:ld erm be offered initially on the telephone.
15		(1.0)
16	Pat:	.HH Yea:h I would rather have one-to-one.
17	PWP:	Ok[ay?
18	Pat:	[I am not comfortable with the whole group thing [o:r.hhh
19	PWP:	[No that's fine?
20	Pat:	the- over th(h)e i(hh)nternet?
21	PWP:	No: that's absolutely fine.

In extract 7, the PWP previewed three delivery mode options ('we can offer that in three different ways' line 1), and then briefly outlined all three (group, online and telephone sessions, lines 5–14) before the patient made their choice (line 16), which in this case was individual telephone sessions. Note that the PWP stated that one-to-one sessions would be 'initially' on the telephone (line 14); at this stage, the option of face-to-face treatment was not made available and was apparently being withheld – for reasons that were not given by the PWP.

In this next example, extract 8, two options were presented in parallel.

Extract 8 [035:19:4]

1	PWP:	.hhh erm we've got a couple of different options, [patient's name]. It's up to
2		you what you prefer..mhhh So with the high-intensity CBT we've got two
3		options for you. One of them i:s.mhhh er one-to-one CBT sessions with us,
4		so they'll be face-to-face, and the sessions a:re an hour long, and we offer up
5		to 12 sessions.tch The other option i:s slightly different but it's the <u>exact</u>
6		same technique and approach. So it's CBT again..hhh again one-hour sessions
7		and <u>again</u> up to 12 sessions, but it's delivered slightly <u>differently</u> and it's done
8		through.mhhh instant messaging? So it's done <u>online</u> . So you won't have
9		face-to-face contact with your therapist.

Here, the PWP presented the patient with the two delivery mode options available⁵ ('We've got a couple of different options') in parallel, prefacing those options (face-to-face, or online via an instant messenger platform) by making it clear that 'it's up to you what you prefer'.

Language practices steering patients towards an option

Across these patterns through which delivery mode options were presented, we observed that PWP's language and explanations sometimes suggested or implied that one option might be preferable to another, in such a way as to steer a patient towards one of the available options. In some cases, PWP's discounted an option; in view of the information elicited from the patient up to the point of considering delivery mode options, the PWP suggested that a given option might be unsuitable for the patient due to their circumstances, as in extract 9.

Extract 9 [102:20:4]

1	PWP:	So it's exactly the same techniques for anxiety, just delivered in three different ways?. hhhh [so the first option is a group ((clears throat)) excuse me,
2	Pat:	[Okay.
3	PWP:	on a Tuesday afternoon?
4		(0.5)
5	PWP:	That runs for [about an hour
6	Pat:	[Okay.
7	PWP:	an hour and a half, up at the [...], but I appreciate that's the time that you'd
8		be at work?.mHHH
9	Pat:	Yeah?
10	PWP:	The second option. . .

In extract 9, the PWP mentioned the first option (group treatment), exactly as in the order in which the PWP gave the full menu of options in extract 7. However, having already learned that the patient was in full-time employment, the PWP immediately discounted that option as unsuited to the patient's schedule (bolded); this discounting is done with upward (question) intonation, thereby seeking – and receiving – the patient's confirmation/assent, before proceeding to other options.

In other cases, PWP's language conveyed the benefit to patients of one particular option, whether of the only option presented and considered, or one of alternative options. These practices included:

- 1 *Recommending a particular option:* In contrast to mentioning an available option ('we do do an online CBT package' ex.5), PWP's may use a form of words implying that a particular option is what is offered, and therefore recommended, 'so what I- **what we can offer you initially i::s** maybe our wellbeing course'.
- 2 *Highlighting an option as standard practice or popular:* An option is presented as one that everyone is offered or that many people choose or benefit from, 'I think more than anything a lot of people who do attend the course they find it helpful'; '**we offer everybody** (0.5) a wellbeing course'.
- 3 *Strongly endorsing an option:* Assessments of the value, effectiveness, accessibility etc. of an option indicate endorsing a given option, 'So I mean, we can offer you: erm **we do a really, really good** online CBT programme that looks at giving you strategies to manage worry'. It is notable that in the second example here the wording changes from the more 'open' form of mentioning an option to a form of words conveying that this is what is on offer (see (i) above), whilst simultaneously strongly endorsing this option.
- 4 *Emphasising an option's fit with the patient's circumstances:* An option is presented for its suitability to the patient, given their circumstances (medical, employment, availability etc.), either in general terms, 'I think that would be **really good for you?**', or more particularly,

'It might be a good opportunity to come and I guess meet other **people who might be in .hh sort of a similar situation** and might be experiencing similar sort of symptoms'.

- 5 *Presenting extensive supporting information:* The data are too extensive to show, but, for instance, having advised the patient in extract 8 of the two options available, one-to-one face-to-face meetings or online instant messaging, in parallel, the PWP then gave substantial positive information about the online CBT option, over 21 lines of transcript, rounded off with a caution about the 'extensive waiting list' for appointments for one-to-one sessions. Providing such extensive information 'promoting' the online CBT option weighted the choice in that direction as was understood by the patient who, when asked by the PWP for their 'thoughts about those two options' responded, 'Well I'm quite happy with the online one. I mean I pr- I would have preferred the other one but I'm not that sort of bothered. I just think it's easier to talk to somebody face-to-face. But I'm quite happy to try the online one if you think that would do the same'. The patient's self-correction from 'I pre(fer)' to 'would have preferred' plainly indicates that in choosing the online option they are making a concession to the direction in which they see the PWP guiding them. On occasions when a single option has been presented/offered, about which patients are hesitant and doubtful, PWPs may, instead of presenting further alternatives, give further positive information supporting the option in question.

The significance of these choice presentation patterns

There is a certain ordering of the three patterns of option presentation described above, in terms of patient-centredness. Presenting only a single option, as a form of recommendation, can be considered 'service led'. It is apparent in this setting, as in other medical settings, that when patients are offered 'single option choices', the decision-making process is being driven by the professional (this is congruent with the findings of Shaw *et al.* 2019 when neonatal doctors offer 'single option choices' to parents of critically ill babies). Though PWPs may announce 'just to go through the options' (plural), as in extract 1, or imply a plurality of options, 'one of the things we offer is' (example 4), they did so without informing patients what other options were available, unless and until the patient demurred. Whilst implying that options exist, in this pattern/format, therefore, the professional played a significant role in directing patient choice. The second pattern, in which the single/first option presented was resisted by the patient, resulted in a discussion that resembled shared decision-making, in which professional expertise and judgement were counterpoised by patient preference. The third pattern we observed, in which multiple (usually three) delivery mode options were presented in parallel, offered patients the most 'open' choice; this was perhaps closest to a patient-led model (again, Shaw *et al.* 2019). However, two caveats are in order regarding the first (single option) pattern. First, patients did on occasion resist or decline options that had been offered, and as a result were presented with further options, as was apparent in the second pattern of incrementally presenting further alternatives after patients had resisted the first one offered. As we have seen above, patients made concessions or indicated that an option would not have been their first choice. Nevertheless, patients did resist or decline certain options, until one was offered that was satisfactory. Second, patient concessions conveyed in such wording as 'if you (i.e. PWP) think' or, as in one case in the data, 'I'll bow to your judgement', cannot necessarily be considered evidence of persuasion or option limiting by PWPs. This is because shared decision-making involves four components – evidence, clinical expertise, resources (see below) and patient preference; so that clinical guidance plays an important part, along with patient preference, in selecting an appropriate choice of option. In those instances when patients resist or decline an offered option, shared decision-making emerges through the participants mutual deliberation and information exchange.

The third pattern in which options are offered in parallel coincides with Reuber *et al.*'s (2015) three-component option listing model used by practitioners in a different healthcare setting (neurology), suggesting the transferability or wider generalisability of this practice⁶. Presenting options in parallel – option listing (Shaw *et al.* 2019) – might be considered more authentically to offer choice, in that the patient begins with knowledge of all the available options, and so can then weigh and discuss those with the PWP. This could be viewed as better embodying shared decision-making and, to some degree, countering the ‘medical authority’ of the practitioner in the relationship (Toerien *et al.* 2013). However, presentation of a list can be done in ways that nevertheless favour one option over another (Tate and Rimel 2020, Toerien *et al.* 2011, 2013), as we saw here in PWPs’ use of practices that might steer patients in particular choice directions.

Discussion

The concepts of patient choice, patient-centred care and shared decision-making cannot be considered independently of one another; they are directly interconnected. Care, in this case delivery mode of treatment, cannot be patient-centred unless patients are involved in and share making decisions; and they cannot play a role in making decisions unless they are given some choice – options – as to the form of care they are offered. Hence patient choice, through being offered options, is the lynchpin of patient-centred care. Without being given choices, patients cannot share a role in making decisions; in which case the interactions out of which decisions are made are led by the professional, relegating the patient to confirming whatever is recommended by the professional.

The facilitation and negotiation of patient choice at the point of frontline delivery are arguably fundamental to realising any ambitions at higher political or ideological levels. Using the fine-grained observational method of CA, we have been able to show empirically that variations in practice and deviations from espoused policy exist and that the variable ways in which IAPT patients are invited to make a choice can limit, practically, the patient’s options. We have explored the way in which an overarching policy of patient choice plays out in *direct interactions* between patients and practitioners, in the particular context of the English IAPT service. We find that, where more than one treatment delivery mode is (in principle) available from a service, patients are not necessarily told about all of them before being invited to make a choice about taking up a proposed option. In some cases, PWPs’ forms of words may give the *appearance* of choice, but if the patient accepts the first proposal, no further modes are mentioned. These differences result in patients being given variable information about the options available, which can have the consequence of limiting the scope with which they are able to choose their preferred treatment delivery mode.

Echoing research in other clinical settings (Shaw *et al.* forthcoming; Kunneman and Montori 2017, Toerien *et al.* 2011), we have highlighted a distinction between (i) a choice to *accept or reject* the offer of a single option and (ii) an choice that is a *selection from a range* of options. As is well expressed by Kunneman and Montori (2017: 522), there is a difference between involvement that is ‘limited to accepting or rejecting a proposed path’ and ‘a more evolved response [that] presents and stimulates to consider more than one option and helps patients and clinicians to deliberate on what is best’. Rather fittingly, Kunneman and Montori conceptualise this process as a ‘conversational dance’.

Our findings have relevance to policy-oriented concerns regarding the availability of choice in the way patients receive and experience health care. Whilst we have not sought to quantify the patterns identified in this analysis, it is observable that where a single delivery mode was

offered, this tended to be a group course – arguably the least resource-intensive mode. Correspondingly, in incremental presentations, group courses again tended to be offered first, with the more resource-intensive option of individual, face-to-face treatment tending to be revealed in second or final position. These observations support qualitative evidence that PWPs' choice-offering practices may be driven by institutional concerns of resource management and efficiency, themselves a response to government-level monitoring of service performance (author reference removed). The IAPT Manual itself acknowledges the practical efficiencies of group interventions: 'group treatment can be a way of reducing the average clinician time per course of treatment which can have a positive impact on waiting times' (NCCMH 2019: 42). Generating the most benefit from a limited resource must be seen as a real and justifiable consideration for public services. But practitioners may find themselves negotiating a tension between the competing (perhaps incompatible) objectives of patient choice and resource efficiencies; it should be noted that PWPs work within the policy restrictions on available options associated with resource limitations, limitations that lie outside the remit of this study (cf. MacEachen *et al.* 2013). This may lead to treatment allocation being 'determined by these external pressures, more than by actual need', with consequences for clinical outcomes (Steen 2019: 165). Patients themselves may act on knowledge of these resource constraints, opting for the most quickly available treatment mode, rather than waiting longer for their mode of choice (Bee *et al.* 2010).

The tentative and indirect evidence here that more resource-intensive delivery modes may be withheld unless there is active patient rejection of the initial offer points to issues of equity, where more assertive patients may be more likely to arrive at their true treatment of choice. In a policy critique strikingly resonant of our empirical data, McPherson and Beresford (2019) advocate for a system within which 'the choice of treatment is offered upfront to patients, rather than left for clinicians to offer incrementally to those assertive patients who feel able to refuse enough times to move down the list of options they did not know existed at the outset'. (2019: 495). In line with McPherson and Beresford's proposal, the variety of option presentation patterns we have identified suggests that guidance on how to present options might be standardised around the third pattern (available options delivered concurrently or in parallel). PWPs' clinical expertise is expressed and plays a role in choosing between options through providing information about the available options (including the practices outlined in (i) – (v) above). The result would be shared decision-making through clinical expertise as well as patient preference; the pattern itself is led by the patient's response to the multiple options proffered in parallel.

We stand aside, in this study, from more fundamental critiques of the IAPT model, including its 'industrialisation' of the therapeutic process (e.g. Binnie 2015, Cotton 2019, Jackson and Rizq 2019) and problems of equity in access and outcomes for different demographic groups (Baker 2018, Moller *et al.* 2019). Whilst recognising these higher-level tensions, the present data do not provide empirical basis for contributing to this aspect of debate. Furthermore, whilst it has been shown that the availability of choice between different types of psychological therapy in IAPT is limited in practice (BACP 2014, Mind 2013, Perfect *et al.* 2016), the present data do not permit comment on that issue. Here, our focus has been at the micro-interactional level of how patients' ability to enact a choice process may be enabled or constrained by the ways in which their options are presented to them (or not) in direct interactions with practitioners.

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Notes

- ¹ More recently, CA research has coded and quantified certain results, especially in relation to medical interactions (Stivers 2015). However, for the purposes of this study, a qualitative approach was appropriate because we were examining only the interactional forms and consequences (i.e. *how*) treatment options are presented to patients, rather than the frequency or prevalence of choice options.
- ² Anonymous identifiers denote [recording number; PWP ID; Service ID].
- ³ The present analysis did not consider directly patients' reasons for resisting or rejecting options but we can see in some of the present extracts, and in the wider dataset, that both practical and attitudinal factors played a role. Patients cited work clashes, transport barriers, prior commitments and low IT literacy, but also their feeling that certain delivery modes were not 'for me' or they were 'not comfortable with'.
- ⁴ Trademark package name removed for anonymity

- ⁵ Note that in this instance, the patient has been assessed as requiring a high-intensity form of CBT, rather than guided self-help, so the group course that is also available within this service is not applicable.
- ⁶ In Reuber et al.'s (2015) model, developed from patient–practitioner interactions in neurology clinics, Component 1 is an indication by the practitioner that there is a decision to be made; Component 2 is the formulation of a list of options; and Component 3 is inviting the patient to identify a preference/selection. In the present data, extract 7 is a partial fit to this model (components 1 and 2) and extract 8 features all three components (data not shown in full).

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