

## Article

# The needs of primary care mental health service users: a Q-sort study

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## ABSTRACT

**Background** Within scientific and policy literature, the broader needs and preferences of the service user are usually described as being relatively homogenous for any particular condition. Additionally, despite common adult mental health problems being a huge burden to primary care services, there has been little research into the client's perspective of their needs regarding such difficulties. The aim of this research was thus to uncover the issues and preferences for this sample.

**Method** The attitudes of 28 service users were explored through use of a Q-methodology approach. This procedure involves statistical analysis of the order that participants rank pertinent statements associated with the area of study.

**Results** Five independent factors (clusters of preferences) were identified. These differed over issues

associated with: relationships with service providers, access/barriers associated with services, information provision, stigma, choices associated with therapy and the care pathway, medication and complementary approaches, as well as social support.

**Discussion** The study suggests that differing individual needs exist *within* diagnostic categories which, unless considered, may impede service engagement. Issues associated with the implications for service delivery for these differing clusters of perceived needs and viewpoints are outlined.

**Keywords:** adults, mental health, mental illness, needs, user involvement

## Introduction

Since the 1980s, there has been increasing rhetoric associated with the involvement of service users' perspectives in healthcare service commissioning and delivery.<sup>1,2</sup> Service user choice regarding treatment is enshrined in best practice guidance, and services are now guided to involve users 'at every level'.<sup>3,4</sup> Given the scope and duration of this policy, few studies have attempted to operationalise or evaluate the involvement of users in healthcare planning and development. Indeed, some authors have suggested that the policy is tokenistic in nature.<sup>5</sup> Where user views have been reported in the research literature, this has tended to be through the use of satisfaction survey.<sup>6</sup> However, several issues have been highlighted that question the validity of this

method. As these surveys tend to produce uniformly high ratings, there are doubts regarding both the sensitivity of the measures, and their ability to discriminate between satisfied and dissatisfied patients.<sup>7</sup> Research has found little relationship between levels of satisfaction and the *views* held by patients.<sup>8</sup> Further, the concept of patient satisfaction lacks a theoretical underpinning, its constructs being based more upon providers' assumptions than patients' values and experiences.<sup>9</sup>

Such issues have led some authorities to recommend the adoption of qualitative approaches. These tend to reveal a more negative experience within the user population.<sup>10</sup> However, qualitative investigations have tended to focus upon the views of users of

secondary care or inpatient services. Such samples include: users of adult inpatient psychiatric services; mothers' perceptions of their experience of inpatient treatment on a mother and baby unit for severe postnatal mental illness; women's experiences of admission to a crisis house and acute hospital wards; and those suffering with severe or enduring mental illnesses.<sup>5,11-13</sup> Indeed, few if any of the qualitative articles included in a recent review of user views appear to be associated with primary care, adult samples.<sup>14</sup>

The aim of this research was to uncover the sets of needs and issues for a sample of individuals who experienced 'common' adult mental health (AMH) difficulties, referred to a primary care psychological therapies service. In doing so, we attempt to identify subsamples of users with common needs, with a view to facilitating service delivery. These difficulties have been identified as a huge burden for health services, with up to six million individuals in the UK suffering from depression or anxiety.<sup>15</sup> This research question is particularly topical in the UK as the government has committed to a £300 million investment over a three-year period to increase access to evidence-based psychological therapy for common AMH problems.<sup>16</sup>

A Q-methodology approach was adopted, which elicits relationships between themes within a group of participants.<sup>17-19</sup> The procedure involves the statistical analysis of the order that participants rank pertinent statements or items (the Q-sample) according to instruction (e.g. the extent of agreement or disagreement). The items are collected from the wider 'concourse' (or flow) of communications surrounding the topic in question (usually determined via analysis of participant interviews). Similarities between participants are identified, and the 'factors' (clusters of preferences) revealed. This approach has specific advantages over an exclusive interview or questionnaire design. For instance, participants are required to respond to each item in relation to all of the others. This requires high levels of task engagement and item discrimination. Additionally, because it is difficult for participants to guess socially desirable Q-sort responses, the 'grateful testimonial' effects normally associated with user feedback are eliminated.

## Method

The concourse was sampled through participant interviews (Part 1). From these, a Q-set of statements was developed to be investigated via the ranking process (Part 2).

## Part 1: interviews

### *Participants*

Ten service users of primary care psychology (PCP) services were interviewed individually. They were recruited from the north east of England and had a mean age of 47.3 years (standard deviation (SD) = 11.0 years). Participants were recruited after they responded to an information pack distributed by therapists to their patients over a three-month period. Participants were given an information sheet inviting them to attend for interview and all of those who responded were contacted for interview. Seven were female and all were of white British ethnicity. This is in keeping with the very small proportion of ethnic minority populations within North Tyneside (<2%).<sup>20</sup>

A further ten participants from the Wallsend Self-Help Group (WSHG; a peer support resource for those suffering with AMH problems) were included and were interviewed together as a focus group.

### *Procedure*

A semi-structured interview schedule was used, which was initially shaped by a pilot interview and a literature search. This was then informed in an interactive manner by the subsequent interviews. A preliminary topic guide covered the various stages of the 'patient journey'. Interviews were recorded and transcribed verbatim. Interview length ranged from 14:21 to 103:45 minutes (mean = 44:28; SD = 24:42), the focus group interview was 72:15 minutes in length. Interviews were subjected to interpretative phenomenological analysis.<sup>21</sup> All transcripts were coded by both authors. Themes were compared between authors and differences resolved through discussion.

## Part 2: Q-method

### *Participants*

Twenty-eight PCP service users completed the Q-method on an individual basis. Table 1 summarises the clinical/demographic details for the sample and factor subgroups. They were recruited from the north east of England (as per Part 1) and those individuals who loaded onto a 'factor' had a mean age of 43.8 years (SD = 15.1 years); 64.7% of this sample were female and all were of white British ethnicity.

### *Materials*

A 'naturalistic' Q-sample was constructed in that the sample consisted of statements identified from the

**Table 1** Demographic data: percentages, means (standard deviations) as appropriate

	All factors	Factor A	Factor B	Factor C	Factor D	Factor E
Total number/female number	17/11	5/3	5/3	2/1	2/2	3/2
Age (years)	43.8 (15.1)	59.2 (11.9)	33.6 (11.6)	42.5 (7.8)	39.5 (14.8)	38.7 (14.5)
Number of children	1.1 (1.0)	1.0 (.63)	0.4 (0.8)	1.0 (1.0)	1.0 (1.0)	1.0 (0.82)
% Car owners	76.5	100.0	60.0	100.0	50.0	66.6
% Home owners	41.2	100.0	20.0	50.0	0	0
% In work or education/ % retired	41.2/23.5	40.0/60	60.0/0	0/0	50.0/0	33.3/33.3
% Married or cohabiting	52.9	100.0	10.0	50.0	0	66.6
% With previous mental health contact	64.7	80	80	50	50	33.3
Diagnoses (not mutually exclusive), %:						
Depression	76.5	80.0	80.0	100.0	100.0	33.3
Anxiety/PTSD	47.1	60.0	20.0	50.0	50.0	33.3
Eating disorder	11.7	0	20.0	0	0	33.3
Chronic fatigue syndrome	5.9	0	0	50.0	0	0

PTSD: post-traumatic stress disorder

analysis of the interviews (Part 1). This was a structured sample which was designed to be representative of the interview themes. A larger sample was scrutinised by an NHS service user panel, and adjustments were made according to both this panel's advice and initial piloting (i.e. in terms of choice of statements from a larger pool and in the clarity of these statements). A final sample was then transposed to cards which were used for the Q-sort procedure. Q-samples usually range between 40 and 80 items.<sup>19</sup> Our final Q-sample consisted of 64 statements.

### Q-sort procedure

Participants followed standard instructions that described the sorting procedure.<sup>17</sup> Participants ranked cards using an 11-point (-5 to +5) Q-distribution chart as a ranking template.

### Q-sort analysis

Data gathered from the 28 (Part 2) participants were analysed using the PQMethod computer program.<sup>22</sup> Within Q-methodology, overall configurations produced by participants are inter-correlated and factor analysed. This results in a set of factors that participants

load onto according to their individual Q-sorts. A five-factor solution was produced.

## Results

### Q-sort data presentation and analysis

Table 2 lists Q-statements that are consensual (rated as shared across the factors) and distinguishing items (rated as different for at least one of the factors). Within the Q-factor analysis process, information is provided regarding individual participants' sorting patterns that have a high degree of similarity. From these, a best estimate sorting pattern is calculated, which is known as the 'exemplary sort' for each factor that is representative of the subsample's preferences (see Table 2 for the position of statistically pertinent statements within these exemplary sorts – a version containing all statements is available from the first author). These five exemplary sorts, and the comments made by the individuals in the sample, as well as their demographic characteristics, were used in the process of interpretation. Statistically significant differences between exemplar sorts are noted

**Table 2** Statistically significant consensual and distinguishing statements from the Q-sample for each factor (or subsample), with their position on the distribution chart using the 11-point scale: -5 = most disagree to +5 = most agree

Statement	Factor A	Factor B	Factor C	Factor D	Factor E
3 I had all the information I needed about my problems from my GP.	1 ■	-5	-4	-1 ■	-5
5 I know how my problem differs from other psychological problems.	0	0	-3 ■	3 ■	-1
6 I would like to see a psychologist at my local GP practice, rather than at a different local health centre.	0	-1	-2	3 ■*	0
7 I was happy for my GP to make the decision about who I should see for help with my psychological problem.	3 ▲*	2	3	3	2
8 When you suffer with a mental health problem, it is easy to know how to get different kinds of help.	0 ■	-2	-5	2 ■*	-4
9 I would have liked to have had a choice whether to see a male or female psychologist.	-3	2 ■*	-1	-4	-1
11 My GP has always taken my feelings seriously.	5 ■*	-3 ■	0	0	0
13 Psychologists sometimes ask me to stop doing things that I find helpful.	-2	-3	2 ■*	-2	-1
14 It is important for me to be able to arrange psychology appointments around my other commitments.	1	1	-2 ■	4 ■*	1
15 I found it initially easy to talk to my GP about my psychological problem.	5 ■*	-4	-4	1 ■	-2
19 I was worried about discussing my psychological problems because I thought it might affect my job.	-2	2 ■*	-1	-3	-3
21 I feel stigmatised having suffered with a psychological problem.	-2	1	5 ■*	-4	1
22 The public should be better educated about psychological problems.	2	3	1	-3 ■*	5 ■
23 I wouldn't have attended a group because I don't like to talk in front of groups of people.	0	-2	3 ■	-1	-2
24 I had problems on and off for many years before telling my GP about them.	-3 ■	3	2	3	-1 ■
25 I could not initially get to see my GP when I needed to.	-3	-1	-2	-1	4 ■*
28 I need to be able to talk to the psychologist and know that what I say is confidential.	4 ▲	4	2	3	2
29 I do not need guidance from a psychologist within therapy.	-3 ▲*	-4	-3	-2	-3

**Table 2** Continued

31 I would hold back my emotions within my psychology appointments if I needed to pass by other people on the way out.	-1	0	-1	-5■	-2
32 As therapy draws to an end, it is helpful for appointments to become more spaced apart.	1▲	1	0	2	0
33 Attending a group for people with similar problems to my own would help me to 'get things off my chest'.	0	1	-5■	0	3■
35 It doesn't matter if a therapist is a psychologist or nurse, so long as they are trained to help me with my problems.	3	2	-4■	2	0
39 Medication is a solution for psychological problems.	1	-4■*	0	-2	-1
40 I would prefer to see a therapist who was allowed to assess me and provide the number of sessions I need rather than a fixed number.	3	4	3	-1■	1■
41 Having suffered with a psychological problem means that I will have more difficulties in terms of finding or keeping work in the future.	-2	4■*	0■*	-4	-3
42 The advice I have had from my GP or other services does not complement the advice I have received from my psychologist.	-4▲	-2	-1	-2	-2
44 Those people with more severe mental health problems seem to get access to services that would be helpful to myself but which are unavailable to me.	-1▲	-1	0	-3	0
46 There don't seem to be useful voluntary organisations for those suffering with my psychological problems.	0	-1	0	0	4■*
47 It is not important for me to always see the same therapist while receiving help for a psychological problem.	-5▲*	-5	-4	-5	-4
48 My GP always treats me with dignity and respect.	4■*	1	1	-1	1
50 I can't tell my GP about my psychological problems as they don't have time to talk with me about them.	-4■*	3	2	0	-1
52 A leaflet about the full range of mental health services should be available from my GP practice and/or from pharmacies.	2▲	0	0	1	2
53 A booklet about my condition with tips about coping would be helpful.	3▲*	1	2	1	1
54 There should be more information on the internet about how to cope with mental health problems.	0▲*	0	-1	0	0

Table 2 Continued

Statement	Factor A	Factor B	Factor C	Factor D	Factor E
56 I don't want others to be involved in my therapy because this would inhibit or embarrass me.	-1	0	3■*	-1	-2
59 A support group should be made available for those who have finished their individual therapy with their psychologist.	0	3	-3■	0	3
61 At some point, I would like to help others who have suffered with similar psychological problems to myself.	1	0	0	2	4■
62 My partner should be involved at some level or some of the time in my therapy.	2■*	-1	-2	-3	5■*
63 Once you have suffered with a psychological problem, it becomes difficult to know what is 'normal'.	1	3	3	-2■*	3
64 I should have asked for help for my psychological problem sooner.	-3■*	2	4	4	1

▲ = consensual statement (shared preference over the factors) non-significant at  $P > 0.01$ , with \* = non-significant at  $P > 0.05$ ; ■ = distinguishing statement (distinct preference) significant at  $P < 0.05$ , with \* = significant at  $P < 0.01$  (symbol placement signifies the distinguishing factor(s))

below ( $P < 0.05$ ) and other highly ranked items (items in piles -5, -4, 4, or 5) are also used for descriptive/elaborative purposes.<sup>23</sup>

#### Factor A: 'older and engaged'

Factor A accounted for 20% of the total variance (a table of varimax factor loadings for all participants and factor arrays for the five factors is also available from the first author). This factor is characterised by a good and functional relationship with services. It contained the oldest participants. Additionally, these individuals had a spouse and appeared to be relatively affluent. Individuals in this factor expressed the strongest positive views associated with the relationship with the general practitioner (GP; 11, 15, 48, 50) (numbers in parentheses refer to relevant statements, see Table 2). This viewpoint differs from that expressed by other factors which demonstrated more neutral or negative views regarding this relationship. According to the highly ranked items, these individuals appeared most satisfied with services and appeared to engage with therapy (10, 15, 18, 36).

Only Factor A individuals felt strongly that they would not have sought help sooner for their difficulties (64), apparently requesting this sooner than those in the other factors (24). Factor A individuals expressed more moderate views associated with a

desire for their partner to be involved in their therapy (62) – although this statement may be confounded by the reduced ratio of cohabitation within the other factors. Whereas those in the Factors B, C and E, expressed strong negative perceptions associated with information that they had received associated with their condition, Factor A individuals held more neutral views (3). Factor A also held neutral views associated with their knowledge of possible sources of help (8).

#### Factor B: 'stigmatised and reluctant to engage'

Factor B accounted for 14% of the total variance. This factor is characterised by negative views associated with services and feelings of stigmatisation. It contained the youngest individuals in the sample with the lowest number of children. These individuals' rankings indicated that they held the strongest negative feelings associated with both the relationship with their GP (11) and medication (39). The interview data suggested that such individuals see medication as an unhelpful or temporary solution. Interviews also indicated that barriers associated with the relationship with the GP are associated with: the brevity of appointments, the power differential which resulted in a communication barrier, and difficulty

in being able to see the practice GP that participants felt most comfortable with.

This factor also contained the strongest views associated with the importance of having a choice of therapist (9). Further, having the highest proportion of individuals in education/employment, individuals in this factor also had the greatest concerns about stigma associated with their problems affecting their job or future work prospects (19, 41). The interview data suggested that there were self-perceived discrimination/stigma issues which led some to keep their experiences secret. Consequentially, distress appeared to need to be relatively severe before they sought professional help from their GP. This level of difficulty appeared to be necessary for them to breach the barriers into services. Highly ranked items suggested that once these individuals attended for therapy, they engaged well in the process (36, 47).

#### *Factor C: 'stigmatised and psychologically isolated'*

Factor C accounted for 11% of the total variance. This factor also appeared to be characterised by beliefs associated with stigmatisation. However, for these individuals, it was indicated that personal feelings negated them from fully accessing social support systems. Once again, this was a relatively affluent subsample, although these individuals' sole source of income was state benefits. Like Factor B, these individuals appeared to feel stigmatised by their condition (21, 41), this being associated with views regarding the illness itself as well as potential work implications. As such, these participants expressed the strongest views against others being involved in their care. They did not want family/friends to be involved in their therapy (56) and expressed strong preferences against involvement in any form of group treatment/support (23, 33, 59). According to the highly ranked items, they appeared to struggle to access/engage with services generally (8, 15, 64).

Individuals in this factor stated that psychologists sometimes ask them to stop doing activities that they find helpful (13) and appeared to feel the least informed about their difficulties (5). Interview data suggested that some individuals resented being instructed by professionals to alter dysfunctional coping strategies. Factor C individuals placed the lowest priority on flexibility in appointment times (14), perhaps as they did not have ongoing work commitments.

#### *Factor D: 'informed and choice focused'*

Factor D accounted for 7% of the total variance and is characterised by high value being placed on choice in health care. These individuals are single, female and not house owners. These participants appeared to feel informed about their condition and how to access help (5, 8, 63), and felt that this information was accessible by the public (22). They rated more highly the importance of choice associated with aspects of their treatment (14, 6). Highly ranked items also highlight the lesser impact of stigma with this subsample (21, 41). They appeared to respond positively to therapy (36), felt able to express their feelings within their therapy (31) and had neutral views about their relationship with their GP (15).

#### *Factor E: 'socially oriented'*

Factor E accounted for 8% of the total variance. This factor is characterised by use of, and contribution to, social support and social capital ('networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit').<sup>24</sup> This appeared to be a demographically and diagnostically mixed group of individuals who expressed a viewpoint that the public should be better educated regarding mental health problems (22), and wanted others to be involved in their care (e.g. a partner or other clients; 33, 62). Additionally, members of this subsample expressed strong beliefs which indicated that they wished to help others who experience similar difficulties to their own (61).

These people indicated that there did not seem to be relevant voluntary organisations available (46) and felt unable to access their GP when needed (25). Like Factor A, members of this subsample indicated they did not tend to have difficulties for a long period of time before reporting these to their GP (24). Highly ranked statements indicated that information was also important to members of this factor and they had not received this from their GP (3, 8). Interview data suggested that the *amount* and *timing* of information provision appears to be important. This varied between individuals. Some did not want to be overloaded at the point of diagnosis, whereas others appeared to feel that they existed within an information vacuum. This factor also ranked highly statements associated with the importance of early access into therapy (34) and guidance regarding complementary approaches (38).

#### *Consensus statements (all factors)*

The five factors displayed a number of consensual views. The provision of information appeared to be

moderately important to all, and this was desired from a variety of sources (52, 53). The interview data indicated that individuals received little information about their condition from their GP. However, participants were happy for their GP to make decisions about their care (7). Members of all factors also expressed strong views about therapy 'containment', expressing preferences associated with confidentiality and continuity of therapist (28, 47). Individuals felt that they needed guidance within therapy (29), with a modest preference regarding sessions being spaced out further apart as therapy draws to an end (32). They perceived that the advice they received within therapy was concordant with their GP's guidance (42), and had some milder contrary or neutral views associated with certain beneficial treatment options only being available to those with more severe difficulties (44).

## Discussion

The study explores the differing needs and perspectives held by subsamples of service users of primary care mental health services. In doing so, it challenges policy approaches that categorise users in a homogenous fashion. Nevertheless, some consensual views were observed. Participants felt that there should be greater levels of information available from both their GP practice and community sources. Others have found that the sharing of information with patients remains the exception rather than the rule, with up to 50% being dissatisfied with the quantity of information received.<sup>11,25</sup>

Additionally, participants appeared content for their GP to make decisions about their care. There is a growing trend in health care towards patient empowerment.<sup>26</sup> However, the extent to which patients want involvement in their broader healthcare planning is uncertain.<sup>27</sup> In our sample, a lack of shared care planning appeared unproblematic. This appears to run counter to current policy. However, it has been suggested that this meets the needs of a more middle-class consumerist agenda and has less to offer those who fall within lower class demographics.<sup>28</sup> Finally, the factors shared common priorities regarding the content of their psychological therapy – demanding guidance, as well as confidentiality and containment. The former preference might be counter-indicative for some non-directive therapeutic approaches.

Five separate sets of service-user viewpoints were elicited from the analysis. Factor A, the oldest and most affluent cohort, appeared most satisfied with services. This relationship between age and satisfaction with health care has been commonly observed.<sup>29</sup>

Our evidence suggests that the positive relationship this cohort had with service providers may have facilitated earlier access or, alternatively, members of this sample were more passive as patients, placing less of a personal priority on the importance of their condition or access to services.

In contrast, individuals in Factor C held a viewpoint that prioritised patient choice in health care. These individuals appeared to struggle to engage, feeling stigmatised and wishing to exclude 'important others' from their treatment. Arguably, this group might be considered to be particularly vulnerable, social support being acknowledged to be a protective factor against difficulties emerging.<sup>30</sup> Similarly, Factor B appeared to be characterised by stigmatisation, albeit more in terms of concerns associated with employment prospects. We were surprised by the prominence of the issue of stigmatisation within the study, research in the area being previously associated with more 'severe' difficulties. Factor B consisted of the youngest cohort who also held negative views associated with GP services. These have implications for service delivery (e.g. length of appointment and choice of doctor). However, once they attended psychology services these were highly valued.

These latter two factors' characteristics suggest that GP training in shared decision making and in the provision of relevant information would be of relevance for these individuals – ideally normalising difficulties in a manner which would empower them to attend for therapy. With the high cost of unemployment and sickness benefit in the UK, arguments have been made for a seven-year investment in a spend-to-save therapy-delivery model.<sup>15</sup> A feature of this model is provision within community settings, including places of work. These results suggest that issues of stigmatisation will need to be addressed to allow patients to fully engage with this model. Methods of reducing stigma include improvement of employers' attitudes, improving mental health literacy within the community, and attempting to minimise the reinforcement of stigma via the media.<sup>31</sup> Additionally, stigma reduction will need to occur before full use can be made of more efficient group approaches.<sup>32</sup>

Factor D appeared to represent a more empowered and non-stigmatised subsample of single females who expect to exercise choice in their health care. Their responses indicate they responded well to therapy. Like Factor A, these individuals appeared to integrate well within healthcare systems and processes. Factor E represented a viewpoint associated with the contribution to, and the drawing upon, social support or capital. Social capital research suggests that it is a critical factor in determining health.<sup>33</sup> Service users can feel more 'normal'



within the company of other users at a point in time when their difficulties can cause distance within other relationships.<sup>34</sup>

Although our sample of participants was demographically diverse (see Table 1), North Tyneside houses a low proportion of black and ethnic minority groups and, as such, these were not represented in the study. There is now a substantial body of research indicating that these groups experience different patterns of service utilisation, as well as different diagnoses and treatment packages.<sup>35</sup> This is an area that warrants further investigation with primary care samples.

This analysis challenges the notion of the single care pathway within services for those suffering with AMH difficulties. National Institute for Health and Clinical Excellence guidance now highlights differential patient need by diagnosis, for access to alternative patterns of treatment interventions and services. However, the current study suggests that differing individual needs exist *within* diagnostic categories which, unless considered, may impede service engagement. According to our data, while some demographic factors (age and employment) appear to have limited predictive value in this regard, much further research is required in this area. Above and beyond this issue of heterogeneity, our results have highlighted a concern that, despite this primary care population being an enormous burden upon healthcare systems, there has been little research investigating their needs and preferences. As a step forward in this regard, we have outlined general service delivery issues that have implications within the broad domains: the training of staff; the nature, supply and location of information and support; the nature of shared decision making with health professionals; access to and promotion of non-statutory services; the structure and content of contact with professionals; and public/employer awareness of mental health difficulties.

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CONFLICTS OF INTEREST

None.

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