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Priorities of Staff and Service Users in Mental Health Assessment: A Q Methodological Study

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Abstract: Service users' first contact with UK National Health Service (NHS) mental health services has been shown to impact on treatment and outcomes. However, there is no consensus as to what constitutes Initial Assessment (IA) and there appear to be disparities between professionals' and service users' views. Using a Q methodology approach, the research aims to explore clinicians' and service users' views of IA within community mental health services. Four service user consultants and six clinicians completed a questionnaire to elicit views on the topic. In conjunction with a search of the literature on IA, this produced a set of fifty five statements derived by content analysis, which provided the basis of the Q sort. A sample of mental health professionals and services users (N = 21) completed the Q sort. Factor analysis identified four factors which represented the different points of view about IA. These were interpreted and named as "standardised and person-centred", "efficiency of process", "positive and self-contained relationship", and; "supply vs. demand". The findings highlighted differences in how participants viewed the clinician's role, decision making, and topics discussed within IA. However, in contrast to previous research there were similarities across different professional groups and service users. The clinical impact of these findings is also explored.

Introduction

Assessment often determines who receives UK NHS mental health provision (Hird, 2007). On entering services, assessment provides an opportunity to identify core difficulties and establish collaboration and therapeutic alliance between clinicians and service users (MIND, 2011). Further, assessment of needs can inform service development (Fleury & Grenier, 2007) and confer therapeutic benefits (Hilsensroth & Cromer, 2007).

Various NHS policies suggest that assessment needs to be holistic, include cultural understandings (NICE, 2009) and family perspectives (DoH, 2011), with service users fully involved in care decisions (DoH, 2010). However, until recently, there has been little guidance regarding the content or process of mental health services assessment and, more generally, research is lacking (Hird, 2007). Service User Experience Guidance

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(National Institute of Clinical Effectiveness (NICE), 2011) emphasises the importance of timely and accurate assessment and outlines barriers to assessment including a lack of time and delay between diagnosis and treatment (NICE, 2011). Within the current NHS financial climate there is a strong emphasis on efficiency and timely and appropriate IA, and decisions are important in reducing mental health service costs (DoH, 2011). However, there is little research or consensus on definitions regarding what constitutes good quality initial assessment. One reason for the paucity of research may be the breadth of the term assessment within healthcare, from triage assessment through to clinical assessment. This potentially represents the need for an agreed definition. To do this, however, will involve a consensus of view and what is demonstrated in the literature is that different perspectives predominate.

Differences between clinicians' and service users' perspectives

Research suggests differences between clinicians' and service users' perceptions of what defines an unmet need (Slade, Leese, Cahill, Thornicroft, & Kuipersl, 2005), indicating different priorities. This is of particular relevance as service users' perceptions of unmet needs are linked to lower quality of life (Slade et al., 2005) and reduced therapeutic alliance (Junghan, Leese, Priebe, & Slade, 2007). Similar findings have been extended to mental health outcomes and recovery where research has shown that staff and service users differ in their understandings of these concepts and what they consider to be treatment goals (Lasalvia et al., 2011; Schrank & Slade, 2007). Often it appears that the health professionals' priorities dominate (Goss et al., 2008) suggesting that service user-determined needs do not remain the focus of these interactions. Further, there is evidence that a large proportion of service users within community mental health care report that their views are not accounted for in decision -making processes, or they had insufficient time to express their concerns (NICE, 2011).

Professional differences

Within UK healthcare there is a preference for multidisciplinary working – an approach linked to improved outcomes (Mitchell, Parker, Giles, & White, 2010). However, evidence suggests professional groups take different approaches, make different clinical judgements and have different cultures (Cestari, Munroe, Evans, Smith, & Huxley, 2006; Connolly, et al., 2009). This suggests that disparities in communication and definition of need may extend to professional groups. These findings are salient to IA as it is a process undertaken by a variety of professionals (NICE, 2011). Research as part of the developing knowledge base of IA within the UK showed inter-professional variability in defining difficulties, therapeutic outcomes, and follow up treatment (McEvoy, Colgan, & Richards, 2002; Ecob, et al., 2004), a finding which was apparent even when triage prior to IA was controlled (Russell & Owens, 2010).

A critique of this literature is that correlational approaches do not explore causality and the rigour of methods utilised is difficult to ascertain. Further, the research often focussed on a limited range of professionals and showed only superficial integration of service user perspectives.

Summary

In summary, existing research demonstrates that differences between service users and clinicians occur at many points of involvement with mental health services and these differences impact on therapeutic outcomes. Potential differences in understanding and priorities have not been explored sufficiently in IA. Although the research base is expanding there are some key gaps: issues, for example, such as the homogeneity of professionals contributing to research and a lack of integration of stakeholder views. The current study will attempt to address some of these gaps.

Aims of the Current Study

Using Q methodology, the current study aims to explore which factors clinicians and service users prioritise in their understanding of IA within secondary care mental health services. A secondary aim is to compare the priorities of initial assessment between service users and clinicians. Q methodology was deemed most appropriate to the aims of the study as it can be seen as a systematic method of qualitative analysis that enables exploration of multiple points of view within a social constructionist perspective (Watts and Stenner, 2012).

Method

Design: Outline of Q Methodology

There are four stages within Q methodology: initially producing the Q set (researching the concourse), recruiting participants, completion of the Q sorts, and finally, data analysis and interpretation (for a review see Watts & Stenner, 2005). The key processes for this study are outlined in Figure 1.

Producing the Q Set

The Q set is a range of statements focusing on initial assessment within mental health. In developing the Q set, a wide range of sources relevant to the subject were drawn on, including sampling a range of national NHS policies and academic and relevant literature. Additionally, ten individuals, including service user consultants from a local Clinical Psychology Doctoral training programme and staff members from a local Community Mental Health Team (CMHT) with experience of assessment completed a questionnaire asking about their views on IA. The first two authors developed the questionnaire which was opened-ended, and invited participants to give their responses to questions based on their understanding and expectations of initial assessment as well as perceived positive and negative features.

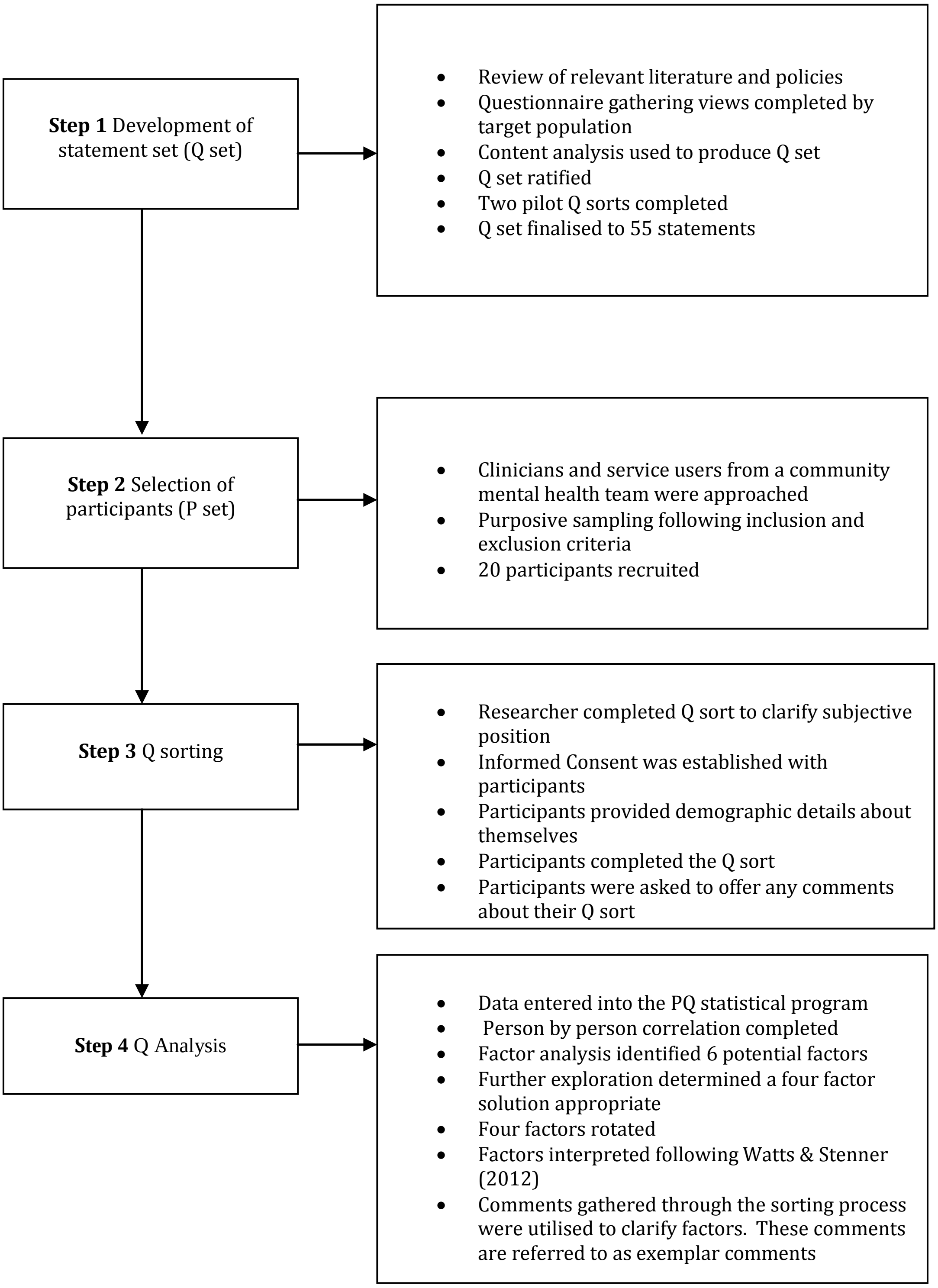
Summative content analysis (Hsieh and Shannon, 2005) was applied to the source materials and questionnaires. Meaning units were identified and grouped in terms of topic area. From this, a statement was developed which captured each of the grouped meaning units. Quality enhancement involved peer validation to check that the statements adequately reflected the content of each of the groups.

Following content analysis, the initial Q set was developed, consisting of 75 statements. These statements were refined and reduced to 54 statements. This process consisted of the first two authors removing duplicate or over-similar statements, or those not felt particularly relevant to the topic area. Two pilot Q sorts were then completed with Trainee Clinical Psychologists to establish whether the statements were ''clearly expressed'' and provided a ''balanced view'' (Watts and Stenner, 2005). One statement was added and this led to a final Q set totalling 55 statements (see Table 1) which is within the recommended range of 40-80 statements (Stainton-Rogers, 1995).

Participants

Q methodology utilises a strategic sampling approach (Stenner & Marshall, 1995) to meet its aim of gathering a wide range of views (Watts & Stenner 2005). Following ethical approval, participants were recruited from a Community Mental Health Team which served both urban and rural areas. Service users who had been seen by the team were identified by clinicians as meeting the inclusion criteria for the study and were offered an information sheet about the project. From this process, five service user participants agreed to participate and were recruited. Fifteen clinician participants were also recruited. The job roles of the clinicians included clinical psychologists (n=5), psychiatrists (n=3), psychotherapists (n=2), team managers (n=2), one nurse, one occupational therapist and one social worker.

Figure 1: Key Processes in the Study



Step 1 Development of statement set (Q set)

- Review of relevant literature and policies
- Questionnaire gathering views completed by target population
- Content analysis used to produce Q set
- Q set ratified
- Two pilot Q sorts completed
- Q set finalised to 55 statements

Step 2 Selection of participants (P set)

- Clinicians and service users from a community mental health team were approached
- Purposive sampling following inclusion and exclusion criteria
- 20 participants recruited

Step 3 Q sorting

- Researcher completed Q sort to clarify subjective position
- Informed Consent was established with participants
- Participants provided demographic details about themselves
- Participants completed the Q sort
- Participants were asked to offer any comments about their Q sort

Step 4 Q Analysis

- Data entered into the PQ statistical program
- Person by person correlation completed
- Factor analysis identified 6 potential factors
- Further exploration determined a four factor solution appropriate
- Four factors rotated
- Factors interpreted following Watts & Stenner (2012)
- Comments gathered through the sorting process were utilised to clarify factors. These comments are referred to as exemplar comments

The first author also completed the Q sort and included her data in the final analysis. The final recruited total was twenty one participants: eight males and thirteen females with an age range of 19 to 54, and a mean of 39.7.

Procedure

Participants completed a consent form and provided demographic information. Participants were then asked to complete the Q sorts into the Q grid with the first author present using the following procedure:

- A question was presented to participants to guide their Q sort: What are your (service user or clinician) priorities in an initial assessment within secondary care mental health services?

- Participants were asked to read through the statements and to initially sort them into three piles of disagree, neutral/not sure and agree.

- Participants were required to place the statements into a quasi–normal distribution grid (Watts and Stenner, 2005), ranking them according to their opinion

- Participants were asked to choose the statements they felt most strongly about and place them into either the + / - 5 column, and then continue to do this until they had utilised all the statements in this pile.

- Participants repeated the task with the other of pile of statements. When this was done participants were asked to sort through the neutral pile, splitting it again into agree, disagree, and neutral. The participants were then asked to repeat the above process until the Q grid was full.

- Participants were able to move statements around the Q grid throughout the process. On completion participants were given the opportunity to change their configuration of statements.

- Any comments offered by the participants throughout the Q sort were written down. Participants were then asked if they had any opinions about how they completed the Q sort or offer comments on the Q sort. These were also written down and used to inform the interpretative process.

The mean completion time to undertake the Q sort process was 49 minutes, with a range of 25 to 70 minutes. The first author used her clinical judgement to establish that each participant understood the task and was not distressed by taking part.

Results

Twenty-one completed Q sorts were analysed within the PQMethod database (Schmolck, 2002). A person by person correlation showing relationships amongst the factors was produced. To explore these relationships further a Principal Components Analysis (PCA) of the Q sorts was undertaken, six factors of which had an eigenvalue of ≥ 1. On closer inspection of the data, a four-factor solution revealed sufficient "dispersion" (Donner, 2001). Four factors were subject to a Varimax rotation. These four factors accounted for 66% of the variance. The significance level was set at ≥ 0.49 to allow for maximum significant loadings while minimising confounders (Watts & Stenner 2005). Two individuals (1 clinician, 1 service user) loaded onto two sorts (not significantly) and were therefore excluded from further analysis. A third individual (clinician) did not load significantly onto any factor. Eighteen people loaded significantly onto the four factor solution.

A structured approach was taken to interpret the factors, as outlined by Watts & Stenner (2012). The interpretation is based on the factor arrays (Appendix 1; Appendix 2, for factor loadings) which are calculated through weighted averages. Factor arrays are ''best estimate'' Q sorts (Lister & Gardner, 2006). Interpretation involves examination of the factor scores for each statement.

The four factors presented reflect perspectives on priorities within IA. The accounts are supported and clarified by participants' comments gathered throughout the Q sorting process. The names of the factors were informed by the exemplar comments and are aimed to reflect the central idea of each account (Watts & Stenner, 2012). The number and the factor array score for each statement are given in parentheses at relevant points in the interpretation.

Interpretation

Factor One: "Standardised and Person Centred". Factor 1 accounts for 46% of the total variance and has an eigenvalue of 9.7. Six participants significantly loaded onto this factor including five clinicians and one service user. The clinicians included a mental health nurse, a social worker, an occupational therapist, a psychologist and a team manager. One further service user participant was associated with factor one; however, the loading was not significant.

An interpretation of this factor appears to reveal a view that IA is an introduction to services in a standard but individualised, containing and boundaried way. A distinguishing statement of the current factor was the strong belief that professionals should explain and discuss what the service is (14: + 5), although it did not necessarily extend to talking specifically about what treatment involves (32: 0). Participants seemed to ascribe to the view of the assessor taking a professional approach to IA; discussing confidentiality was believed to be important (21: +4), introductions (39: +3) and knowing the details of the referral (11: +5). It is possible that these approaches were seen as important in helping people feel at ease (3: +2), which was clearly seen as the professionals' role (24: +4), a view supported by exemplar comments:

> *Most important as that is your first start…offers a chance to reassure someone why you are there and who you are. Basis of everything else you do.*

Despite the focus on the role of the professional as taking an active role within the IA, there seemed to be a specific remit of what they needed to do. For instance, statements that reflect action beyond IA were placed lower by participants, for example the professional providing psycho-education (49: -3), developing a formulation (38: 0) and offering their opinions (18: -2; 46: -2). It is possible that this understanding of IA views these activities unhelpful to service users within the current context and as outside the remit of IA, distinguishing IA from an intervention. This is congruent within an exemplar comment:

> *Psycho-education is an intervention.*

Considering that participants loading onto this factor perceived IA as a process that should be helpful to the service user, engender hope, and offer validation of their distress (31: +3; 45: +2; 53: +1), it is likely that the participants did not view these activities as achieving this:

> *Can't walk in and offer solutions.*

A further distinguishing belief was the agreement that a standard format needs to be followed during IA (28: +3) and a disagreement that questions need to be individualised (8: -2). However, overall this did not appear to be at the expense of IA being individualised. There was mild rejection of the professional setting the length and time of the IA (9: -2) or setting the agenda (22: -1).

> *Assessment is heavily influenced by social circumstance…if someone has not eaten, they are not going to be productive.*

A mutual understanding of difficulties was seen as important (16: +5). There was a strong belief that IA should focus on positive factors as well as difficulties (27: +4), it is possible that this position is to engender hope. There was mild disagreement that hobbies and interests should be explored (33: -1). However, the view of family and carers was seen as important (55: +2) which further supports the focus on current difficulties.

There was a strong rejection within Factor one that the outcome of the IA should be based on policy (13: -3) or the waiting list (51:-4). However, there was neutrality about whether it should be based purely on needs (7: 0). Although this initially suggests that participants viewed the basis of needs as neutral, exploring the exemplar comments suggests that it actually represents a conflict for the participants.

> *I do agree…but it doesn't happen like that because of service demands and limitations.*
>
> *It should be, but it wouldn't be.*
>
> *Conflict between what I think as a person and as a professional.*

It is possible that the neutral position is a consequence of the participants' ideal position being tempered by restrictions in service availability.

There was a belief that decisions regarding outcomes should be discussed at a team level (44: +2). In line with this position there was a strong rejection of the decisions being made in IA (10: -4). It is possible that the presence of conflict led participants to believe that decision at a team level was important:

> *Very important. Because one person may see things differently. Drawing on others expertise.*

Factor Two: "Efficiency of Process". Four participants loaded significantly onto Factor 2 which accounts for 8% of the variance (eigenvalue: 1.8). Participants loading onto this factor included two service users and two professionals, who defined themselves as clinical psychologists.

The core idea of Factor 2 appears to be a view that IA needs to be efficient to facilitate on-going treatment. Two statements which are distinguished within Factor two are that treatment should follow quickly after IA (5: +3) and the assessor should be the same person who offers treatment (6: +1).

There was a strong belief that the professional should know the referral details prior to the meeting (11: +5), discuss confidentiality (21: +4) and hear the service user's story directly (54: +4). This can be understood as indicating the importance of understanding and prior knowledge of the service user's difficulties and hearing details first hand facilitates mutual understanding, which was seen as of key importance within IA (16: +4). This is further supported by the importance placed on building good rapport (48: +4) but the relative unimportance of putting the service user at ease (24: -1; 3: -1) and making them feel safe (23: -1). In this way rapport could be understood as facilitating efficient information gathering. Mutual understanding therefore is of paramount importance even at the expense of the subjective experience of the service user.

The service user's difficulties were prioritised and information concerning physical health difficulties (40: -3) and interests/hobbies (33: -2) were not considered important in developing understanding. Further, gathering information about the family history (4: +2) and childhood (50: +3) was considered of importance. However, the view of carers/families was rejected (50: -3) and using questionnaires and measures was strongly rejected (26: -5) suggesting the valuing of the individualised perspectives. This is supported by the view that individualised questions are important (8: +2). This view of efficiency (i.e. only gathering necessary information through direct means) of information gathering is further supported by exemplar comments:

> *I want information but not necessarily detailed.*

Also, it is possible that the focus on what information was important to gather was informed by how participants conceptualised distress. The current factor was distinct in the view that IA should be conducted by a psychological practitioner (29: +3).

Factor Three: "Positive and a Self-Contained Relationship". Six participants loaded significantly onto Factor 3, which accounted for 6% of the total variance and had an eigenvalue of 1.3. Included within these participants was one service user, a psychological therapist, two consultant psychiatrists, and a psychologist. The factor primarily described the view that IA is understood as a process to facilitate a positive assessor/service user ''connection'' while gathering a general understanding of the individual. A distinguishing statement of this factor was the strong belief that it is a professional's role to validate distress and coping attempts (53: +5). Additionally, the role of the professional was seen as one to introduce themselves (39: +2), make the service user feel safe (23: +4), and at ease (24: +2), potentially through the display of warmth (19: +5). Considering the belief within the factor that a purpose of IA was to engage service users (36: +3), it is possible that these were seen as good strategies to facilitate engagement. Further, one service user participant described the sense of safety in allowing them "to feel free to talk". It is possible that this view could reflect that what makes people feel safe is that whatever they think will be valid and accepted. Additionally, it could reflect a want not to cause/experience distress within IA, for instance, one exemplar described the need to maintain "balance" between gathering details and avoiding re-traumatising service users.

Another theme within Factor 3 was that IA is a standalone process. This is supported by the idea that treatment doesn't necessarily need to follow quickly (5: -1) and that it does not need to be the same person who offers treatment (6: -2). It is possible that the positions taken within this factor were also influenced by a view that emotional containment was important. One participant described their thoughts about IA being the start of therapy:

> *Struggle with it. Although benefit not the start of the therapy…something separate.*

This supports the idea that IA is a distinct process within itself. Further, it is possible that the emphasis on rapport in absence of practitioner continuation indicates how these individuals conceptualise what is helpful: a connection within IA.

Similarly to Factor 2 there was rejection of the use of questionnaires (26: -3). However, the rationale behind this seems to be distinct. Participants described the use of questionnaires as "alienating" and reported that the "therapist relationship more important than measure". This suggests that questionnaires were seen as unimportant due to the possibility of interrupting the therapeutic relationship, further supporting the view of IA as a process to facilitate a positive connection.

Understanding service users' perspectives with clarity (34: +3) and mutuality (16: +3) was emphasised within Factor 3, including positive factors (27: +2) but rejecting that a large amount of time should be spent on risk (12: -4). It is possible that by feeling understood, or that difficulties are understandable, a sense of hope for amelioration of difficulties was engendered which was seen as an important focus within IA (45: +3). The focus on positive factors could reflect an attempt to provide a balance to the discussion of distressing topics. Both these support the idea that IA is about offering a positive experience of engendering hope; one participant described hope and engagement as "reciprocal".

There was strong rejection of the view that the assessor sets the agenda of IA (22: -4) and, to a lesser extent, that the length and time of IA be dictated by the assessor (9: -2) or from the outset of IA (42: -1). However, there was strong disagreement that service provision should be influenced by the waiting list (51: -5) or government policy (13: -5) or that decisions should be discussed at a team level (44: -2).

Factor 4: "Supply vs. Demand". Two participants loaded significantly onto Factor 4, which accounted for 6% of the total variance. Both participants were members of staff and within the clinical psychology profession one of whom had a management level of responsibility. Examination of statements suggested that participants who exemplified the factor viewed IA as an attempt to balance supply and demand: a process of allocating limited resources and an awareness of external factors impinging upon services.

Distinguishing statements for the factor included strong agreement that IA outcome should be influenced by the length of the waiting list (51: +5) and directed by governmental policy (13: +4). It is possible that to develop this view the participants are considering a wider context of service provision as suggested by the idea that a service should be offered purely based on needs (7: -5). This understanding of the factor is supported by exemplar comments:

> *We are living in rationed Britain…need to be tight in assessments and only offer treatment for people you think can offer a good return.*

The strong disagreement that service users should not have to repeat their story also distinguishes this factor from the others (47: -5). Further, this view is supported by a strong belief that it was important to hear the service user's account first hand (54: +5). In line with factor three, building rapport, the demonstration of warmth and validation of distress were seen as important (48: +2; 19: + 3; 53: +3).

Consensus statements and additional items of interest. Consensus statements represent views which do not distinguish between factors therefore; they were generally agreed or disagreed with by most participants (Donner, 2001). There was agreement that IA should be useful to the service user (31: +3; +1; +3; +2 respectively). Participants disagreed that the discussion and making of treatment plans was important within IA (35: -1; -1; -1; -2; 37: -1; -1; -2; -4) suggesting that these participants did not view them as useful. Although statistically not a consensus statement there was disagreement across all factors that diagnosis was important (2: -4; -2; -4; -2). However, there was agreement that it is important that the service user ask questions (43: +3; +3; +2; +3) which suggests that this was viewed as useful.

There was strong disagreement that the assessor needs to offer solutions (25: -4; -4; -2; -4). There was agreement that accuracy and clarity within IA was important (20: +2;

+3; +3; +4; 34: +2; +2; +3; +1). Finally, there was a tentative point of disagreement from the whole sample that IA was the start of therapy (1: 0; -2; -1; -2).

Discussion

In line with the aims of the study, professionals' and service users' understandings of IA were explored using Q methodology. Through the examination of factor arrays and systematic qualitative analysis (Watts & Stenner, 2012) four accounts of understandings of IA were identified and interpreted.

Given the strategic nature of the participant sample the findings are not considered an ''exhaustive'' account of understandings of IA (Stenner, Cooper, & Skevington, 2003). However, discussion of the factors in relation to existing literature will facilitate greater understanding of IA within mental health services and will explore the different accounts of professionals and service users.

Exploring the factors

Mental health professionals' role. The results suggested that participants viewed the role of the professional in IA differently across factors. For example, Factor one, which was the primary view held by participants appeared to emphasise the importance of listening while fulfilling other tasks and responding to the service user's context which suggests the role was viewed as that of an "active listener". Factor two emphasised the on-going relationship suggesting a view of the assessor as the "treatment provider". Factor three suggested that the professional was seen as a "carer". Finally, Factor four placed greater emphasis on IA determining the allocation of resources. This suggested an understanding of the role of professional as a ''gatekeeper'' (McEvoy, 2000). These differences do not necessarily equate to a detriment in service provision, as many approaches may meet service users' needs (Haaga, 2000). However, it is an important finding to tease out further as it has implications for team working and service user-clinician relationships.

One implication is that different expectations of the role lead to conflict which reduces therapeutic alliance and cohesion in team-working (Greenberg, Constantino, & Bruce, 2006; Mickan & Rodger, 2005). Differences in approach identified in the current study might explain the lack of consistency and service user's consequent dissatisfaction with IA demonstrated in previous research (Bhui, Chandran, & Sathyamoorthy, 2002; Hird, 2007).

Differences between mental health professional groups have been extensively explored (Nolan, Haque, Bourke, Dyke, 2004). For instance, research exploring IA has shown differences between professionals, professional groups, and service users (for example, Hird, 2007; Bhui, Entwistle, & Watt, 2002) and explored how these may impact on service delivery and outcomes (for example, Russell & Owens, 2010; McEvoy, Colgan, & Richards, 2002). In contrast, the current study also showed shared views across professional groups and service users – demonstrated by the range of professionals who loaded onto Factor one; and that service users within the study loaded onto Factors 1-3. One explanation for this finding is that inter-professional identities and differences and/or the clinician/service user divide are not as distinct as suggested in previous research. Additionally, it could indicate that IA requires pan-professional skills. Future research may focus on these commonalities as well as the differences.

Interestingly, convergence between professionals' and service users' views was not predicted by participants: professional participants reported that they believed that service users would disagree with professionals. However, factor exemplars demonstrated that this was not the case. Despite these commonalities between professional groups, differences across the whole sample were also demonstrated.

Decision-making. How decisions are made has been a contentious issue within healthcare, particularly within multidisciplinary teams (Xyrichis & Lowton, 2008). Participants' responses loading onto Factors 1-3 strongly disagreed that decisions such as who gets a service should be based on the length of the waiting list or directed by government policy. In contrast, Factor four participants strongly agreed that these issues were central to decision-making. However Factor four participants represented the view of only two individuals which suggests this position should be taken with caution (Watts & Stenner, 2012). There was disparity regarding whether decisions are made at an individual or team level, with participants loading onto Factor 3 disagreeing that a team level approach was a priority. This represents a complex picture of how people view decision-making.

Information gathering. Key to decision-making within mental healthcare is 'information exchange' (Bugge, Entwistle, & Watt, 2006) between service users and clinicians. In the current study there was a consensus that accurate information gathering was important, but the factors showed divergence about what information needs to be gathered. Current NHS policy emphasises the inclusion of family and carers within assessment (DoH, 2011). This was a view reflected in Factor one but not shared across all factors. It suggested that there are differences in what information is being used to make decisions which are consistent with previous research (Junghan et al, 2007; Self, Rigby, Leggett, & Paxton, 2008).

The role of diagnosis. Despite the dominance of a medical perspective within mental healthcare (Beresford, 2010) which can engender stigma (Ben-Zeev, Young, & Corrigan, 2010) participants across all factors disagreed that diagnosis was a priority within IA. This may represent a joint view from service users and clinicians to focus on individualised understandings of distress.

IA may not be seen as an appropriate forum for diagnostic assignment. However, the exemplar comments did not support this hypothesis, suggesting that diagnosis is considered an unhelpful basis for determining treatment and conferring therapeutic benefit. This is a positive finding as efforts to enhance patient- centred communication lead to improved outcomes, including engagement (Kreyenbuhl, Nossel, & Dixon 2009), which some individuals considered a key task of IA. Further, this position appears in line with government policy on personalised care (DoH, 2009).

Towards a Definition of IA

The above insights indicate the complexity in understandings of IA. This has not been demonstrated within existing literature and provides further support for the need of a consensus standard within IA. The current findings facilitate this by providing a basis for a tentative definition of IA as viewed by a range of mental health professionals and service users, primarily expressed within Factor 1. IA is a standardised but person-centred meeting between a mental health professional and a prospective service user. It aims to develop a mutual understanding of difficult and positive factors as viewed from the individual and if relevant their families'/carers' perspective. From the priorities generated by the participants, the focus of IA is to explain the role of the service and not to devise ongoing treatment plans or to diagnose.

Implications and Future Research

The disagreement with the view that collecting information through questionnaires and measures within this secondary care setting was appropriate within IA is interesting due to the emphasis on measuring outcomes in healthcare. Indeed, this is how most current interventions are assessed for effectiveness and NICE uses such evidence to inform guidelines. IA is often considered the appropriate 'baseline' to measure outcomes (Ecob et al 2004). Further, it provides a stark contrast to the view of questionnaires and measures within primary care services, where questionnaires are routinely used within each session (DoH, 2010). It is of particular interest as some participants (within Factor 3) linked the use of these measures to the interruption of the development of the therapeutic alliance, which has strong links to positive outcomes within mental health care (Lambert & Barley, 2001).

As mental health services undergo significant structural and financial changes (DoH, 2011) the focus of IA may shift to allocation of resources via questionnaires. This is in contrast to the desired way of working found during this study. It may be interesting to explore the impact of this shift in working style contemporaneously, perhaps through discursive approaches. These approaches would allow an exploration of IA and of how the views identified in the study are enacted in the implementation of the new care allocation approaches.

The finding about the relative unimportance of diagnosis within IA appears to represent a shift in the emphasis of the role of diagnosis in mental healthcare, particularly considering participants ascribing to this view included psychiatrists. This finding may be worthy of further exploration as the majority of evidence-based treatments are linked to diagnoses. This indicates a disparity between how research is developed and how clinicians and service users operate.

Limitations and Strengths

In contrast to previous research, a strength of the current study was the integration of service users' and clinicians' views. However the study had limitations, including the use of a questionnaire to initially generate the Q statements, the use of trainee clinical psychologist participants in the pilot phase and low numbers of service user participants in the Q sort phase. Those service users within the participant sample had experience of IA in services; therefore their views could have been shaped by the process. It is possible that there were alternative views that were not represented within the current study and, certainly, the diversity of the group was also affected by the removal of three individuals who did not load onto the four-factor structure. Exploring the views of individuals who had not been offered a service or disengaged following IA might develop the research base further.

Exploring ''implicit theories'' of practice can clarify understanding of what strategies are used at different time, thus giving further insight into clinical practice (Najavits, 2001). However, a difficulty of this approach is that it is not possible to identify whether these positions represent practice or opinion (Lister & Gardner, 2006). Therefore, the ''contextualising'' of the findings within wider research is necessary (Lister & Gardner, 2006; Stenner & Watts, 2005).

Within Q methodology the claim that findings are generalisable is sometimes deemed to be inappropriate (Watts & Stenner, 2012). However, there is an aim to provide resonance and transferability within similar settings. Considering that the participant sample was placed within a secondary care community mental health service, the findings would not be entirely transferable to other settings such as primary care or inpatient services. However, it is possible that the findings will resonate with other community mental health teams.

Conclusion

Q methodology provided a novel approach to conduct a preliminary exploration of the topic of IA. Further work is recommended in this area, as this study is the first to explore both clinicians of a wide range of professional designations and service user perspectives. This study has revealed differences in how individuals view the approach of the clinician, decision-making, and topics discussed within IA. However, these differences were not dependent on the designation of the participants. It is important that these findings are explored further due to the impact of IA on outcomes and therapeutic alliance.

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Appendix 1: Factor Arrays

Q statement	**Factor 1**	**Factor 2**	**Factor 3**	**Factor 4**
1 Initial assessment is the start of therapy	0	-2	-1	-2
2 It is important that a diagnosis is given	-4	-2	-4	-2
3 It is important that time is spent putting the service user at ease	+2	-1	+4	+1
4 It is important that detailed information is gathered about family history	0	+2	+1	0
5 Therapy or treatment should follow quickly after the initial assessment	-1	+3	-1	0
6 The professional doing the assessment should be the same person who offers therapy/support	-2	+1	-2	-3
7 The decision regarding whether a service can be offered should be based purely on the service user's needs	0	+2	+1	-5

Q statement	Factor 1	Factor 2	Factor 3	Factor 4
8 Questions in assessment should be individualized to the service user	-2	+2	+2	+2
9 The length of time of the assessment should be determined by the professional	-2	-2	-2	+1
10 The decision regarding future support with the service should be made within the assessment there and then	-4	-1	-3	-1
11 The professional should know about the details of the referral and the reasons behind it prior to the assessment	+5	+5	0	+2
12 A large part of the assessment should focus on risk	+1	-3	-4	0
13 Whether a service user receives a service should be directed by governmental policy	-3	-5	-5	+4
14 The professional should explain and discuss the role of the service with the service user	+5	+1	+1	0
15 Each professional should receive the same training to conduct an assessment	-1	0	-3	-2
16 It is important that mutual understanding of the service user's difficulties and experiences are developed between the service user and the professional	+4	+5	+3	0
17 The professional should focus on every aspect of the person's life	+1	0	-1	-1
18 The professional should offer their professional opinion within the initial assessment	-2	-2	0	+1
19 It is important for the professional to show warmth to the service user	+1	0	+5	+3
20 It is important that the professional gather an accurate picture of the client's situation and difficulties	+2	+3	+3	+4
21 It is important that confidentiality is discussed in detail	+4	+4	0	+2
22 The professional sets the agenda in discussing the service user's needs	-1	-3	-4	-1
23 It is the professionals' role to make the service user feel safe	+1	-1	+4	0
24 It is the professional's role to put the service user at ease	+3	-1	+2	+1
25 The professional should provide a solution to the service user's difficulties	-4	-4	-2	-4
26 An initial assessment needs to involve filling in questionnaires and measures	0	-5	-3	-2
27 An initial assessment should focus on positive factors as well as difficulties	+4	0	+2	0
28 The professional should follow and complete a standard format when undertaking the initial assessment	+3	0	-2	-3
29 It is important that the initial assessment is completed by a psychologist or trainee psychologist	-3	+3	-3	-2

Q statement	Factor 1	Factor 2	Factor 3	Factor 4
30 Assessment should be used to engage service users	-2	0	+2	0
31 The service user should leave with a sense that the assessment has been useful	+3	+1	+3	+2
32 Time should be spent discussing what therapy is or what it involves	0	+1	0	-1
33 The professional should find out about the service user's interests and hobbies	-1	-2	-1	-3
34 The professional should develop a clear understanding of the service user's point of view	+2	+2	+3	+1
35 Treatment plans should be discussed in initial assessment	-1	-1	-1	-2
36 A solution to the service user's difficulties should be an important focus of the initial assessment	-3	-3	0	-5
37 Treatment plans should be made in the initial assessment	-3	-1	-2	-4
38 A formulation of difficulties/an understanding of difficulties should be developed within an assessment	0	+2	+1	+3
39 The professional should spend time introducing themselves	+3	0	+2	+4
40 It is important that the professional gathers a clear understanding of the service user's physical health difficulties	0	-3	+1	-1
41 It is important that clinician members receive formal training focussing on initial assessment	+1	0	+1	+3
42 The purpose and length of the assessment is determined at the outset of the initial assessment	0	-1	-1	+2
43 The service user should have the opportunity to ask the professional questions	+3	+3	+2	+3
44 The decision regarding access to the service should be discussed at the team level rather than the individual level	+2	0	-2	+1
45 It is important that the session finishes with the service user having a sense of hope for the future	+2	+1	+3	0
46 The professional should offer their opinion about the difficulties	-2	+1	0	0
47 The service user should not have to repeat/ retell their story	-1	+2	-1	-4
48 It is important that a good rapport is developed between the service user and the professional	+1	+4	+4	+2
49 It is important that the professional provides psychoeducation on the client's difficulties	-3	-2	0	-3
50 It is important to find out about the service user's childhood	0	+3	+1	-1
51 The outcome of the assessment should be influenced by the length of the waiting list	-5	-4	-5	+5
52 It is important that the assessment is completed by an individual with medical training	-5	-4	-3	-3

Q statement	**Factor 1**	**Factor 2**	**Factor 3**	**Factor 4**
53 The professional should validate the client’s distress and attempts to cope	+1	+1	+5	+3
54 The professional should hear the service user’s story first hand	-1	+4	0	+5
55 Carer’s/family member’s opinion and thoughts on the difficulties are important to gather within the initial assessment	+2	-3	0	-1

Appendix 2: Factor Loadings for Each Factor

Participant/Q-sort	**Factor One**	**Factor Two**	**Factor Three**	**Factor Four**
1.	0.52*			
2.	0.74*			
3.	0.76*			
4.	0.50*			
5.	0.75*			
6.	0.49*			
7.	0.41			
8.	0.45	0.46		
9.		0.64*		
10.		0.64*		
11.		0.80*		
12.		0.60*		
13.			0.69*	
14.			0.80*	
15.			0.50*	
16.			0.60*	
17.			0.67*	
18.			0.84*	
19.				0.79*
20.				0.85*
21. First author	0.45		0.44	

* Defining sort ($p < 0.01$)