

# Report on qualitative responses to Service User Satisfaction Survey – NAPT Pilot Sites

This report was compiled by Eleni Chambers

## Pilot Talking Treatment questionnaire, NAPT

### 1. Methods

#### 1.1 Data Management

All data were initially moved to the most appropriate section, regardless of where the comments were written on the returned questionnaires. The sections used were those as given in the questionnaire:

- Access to Talking Treatment
- Talking Treatment Outcomes
- Feedback on the Questionnaire

Any comments which were unclear or irrelevant were not included in the analyses of the Access to Talking Treatment or Talking Treatment Outcomes sections, and were removed from the data at the outset. They were grouped separately in table format as below (Table 1). They were however used in the section on the analysis of the Feedback on the Questionnaire if appropriate.

Data file	Service code	Comment
Access	1.1	No.
	1.1	Q2 - don't remember
	10.1	postal strike - letter was late
	16.4	Nothing to add.
Outcomes	7.1	Not yet
	16.1	N/A
	16.4	Q3: can't answer
	16.5	very much so

**Table 1. Data removed from access and outcomes sections**

#### 1.2 Data analysis

A full thematic analysis was carried out using methods as described by Braun and Clarke (2006), chosen because it is both rigorous and flexible in approach.

The following phases were carried out, based mainly on Braun and Clarke's description of the process (2006, p. 87):

<b>Phase</b>	<b>Description of the process</b>
1. Familiarising yourself with the data	Data management, reading and re-reading the data, noting down initial comments
2. Generating initial codes	Coding data in a systematic manner
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each theme
4. Reviewing themes	Checking if the themes work in relation to the coded extracts and the dataset, generating a thematic map of the analysis
5. Defining and naming themes	Ongoing analysis refining the specifics of each theme, generating clear definitions and names for each theme
6. Producing the report	Final opportunity for analysis, selection of extract examples, producing report

**Table 2. Phases of thematic analysis**

Braun and Clarke (2006) state that it is not uncommon to find authors describing themes “emerging” from the data. However, they describe this as being a “passive account of the process of analysis...that denies the active role the researcher always plays in identifying patterns/themes, selecting which are of interest, and reporting them” (p. 80). To address this issue, the researcher has explored their own perspectives while carrying out the analysis and these are discussed in a section at the end on reflexivity. In addition, an audit trail was kept of the different phases in separate documents.

Several decisions were made throughout the process, including what counted as a theme, in both the amount of data and its’ significance. This is discussed in more detail in the reflexivity section. Similarly, a decision was made to use an inductive approach to the analysis. Therefore, although the three main sections were derived from the format of the questionnaire, the themes were decided independently.

### **1.3 Researchers**

The data were analysed separately by two researchers in order to increase the rigour. The main researcher used the methods as described above and the secondary researcher used an approach outlined by **P. Burnard 1991**. The themes from both analyses were then triangulated. Both researchers identified similar themes, however the main researcher identified some additional themes. This was thought to be due to the emphasis placed on the user perspective by the main researcher, who was also a user of mental health services. Where this occurred a note has been made in the text.

## 2. Results

### 2.1 Access to Talking Treatment

Five main themes were identified, some including sub-themes:

- Waiting time
- Referral
- Choice
- Information
- Resources

The themes were collated and ordered in this manner to provide an understanding of the experiences of access to talking treatment from the initial referral onwards. More general issues related to access were captured in broader themes of choice, information and resources. All themes and sub-themes are shown in Diagram 1.

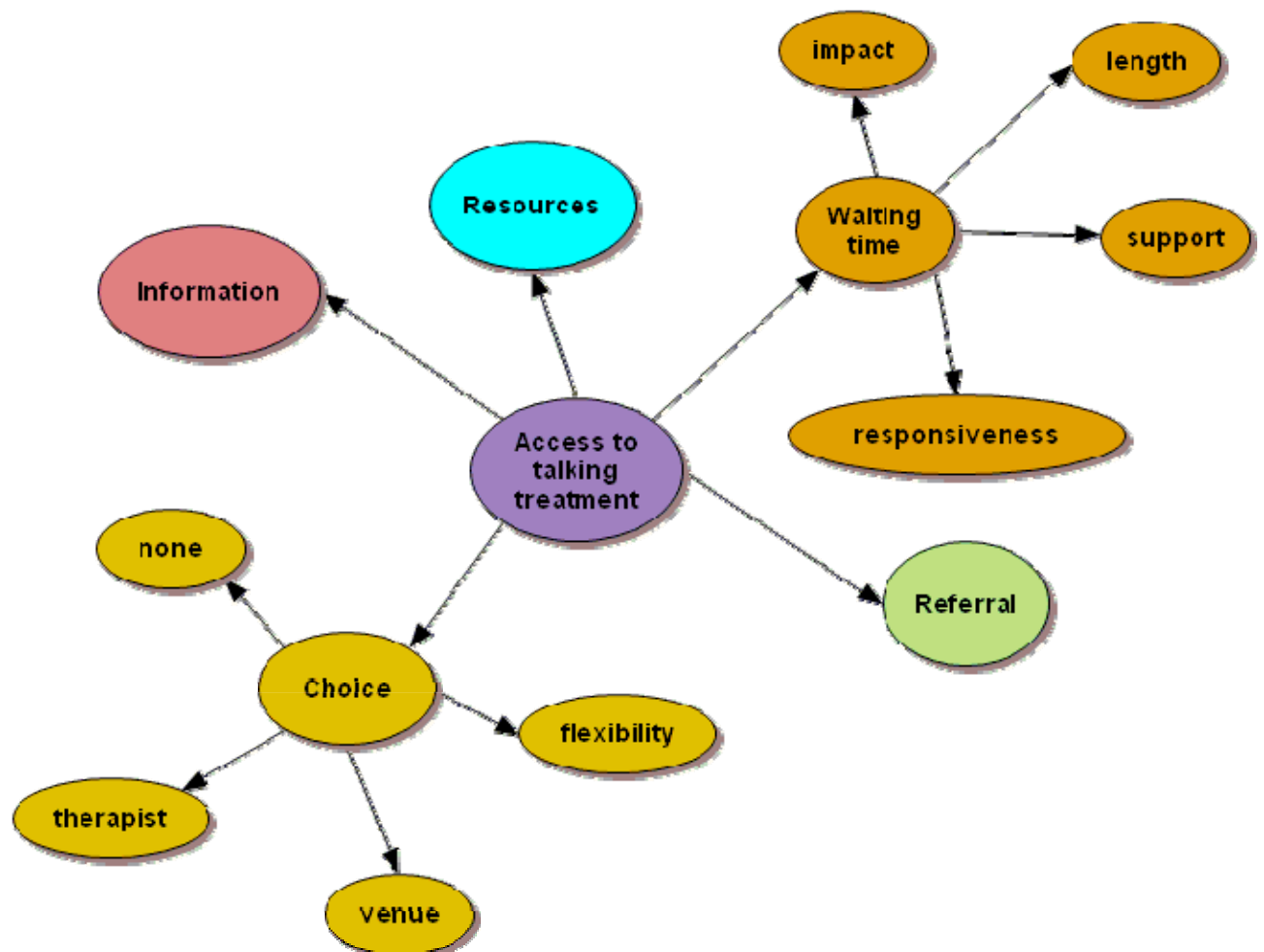


Diagram 1. Final thematic map of Access to Talking Treatment, showing 5 main themes

#### 2.1.1 Waiting time

The predominant theme throughout the section on access was waiting times, and within this the predominant subtheme was the length of the waiting time.

## **Length**

The clear majority of the respondents were concerned that they had had to wait for what they considered to be an unreasonable length of time. Waiting times of between approximately three and 18 months were cited, although in some cases it was unclear whether respondents were referring to the length of time it took to be referred and/or the actual time on the waiting list after the referral.

Many respondents expressed strong views on this, some specifically relating this to their mental health:

“17 months is a long way from reasonable”.

“Waiting times need to be addressed. When people are suicidal and desperate they need help as soon as possible. I feel a waiting time of 3 - 6 months is totally unacceptable. Some people could never make their first appointment as it could be too late!”

It was unclear in most cases whether any assessment of need and resulting prioritisation had been carried out, and what information had been given to people as a result:

“As I was having problems of feeling suicidal, I could have been seen earlier, but there was a waiting list”.

“I did feel that the waiting time was quite long and did struggle to get through until my treatment began. I just hope that the delay was to help others in much more need earlier”.

Some mentioned associated difficulties with having several assessments; sometimes these contradicted previous assessments and at other times they simply caused anxiety by themselves:

“The waiting time was awful – I was recalled several times to reassess my needs each time I wondered if I would be rejected”.

## **Responsiveness**

Several respondents raised the issue of the importance of the service being more responsive to their needs:

“I understand about the need for counselling and the demand on the service but when people are at their lowest point need for support is needed at that time and not 10 months later. I was very low but can understand how people at this point can end up taking their own life whilst waiting for support”.

“I was on the mend and back to work by the time my CBT sessions started. I would have got far more out of the treatment if I could have attended when I was at my worst”.

Participants felt that at times of crisis people should be seen more quickly and that in general the talking treatment would be more effective and they would have benefitted more if the treatment had been provided more immediately.

## **Impact**

Many participants explained how having to wait to receive a talking treatment had impacted on them. They wondered if their referral had been “forgotten or mislaid” because of the length of the waiting time. Some made suggestions for updating people on what was happening while they were waiting, while others had resorted to trying to find out what was happening themselves:

“Between contacting the service and actually seeing someone there was no communication which made me feel as though I had been discarded or 'lost' in paperwork”.

“I waited from September to May before I received an appointment. I made 3-4 phone calls before my appt was finalised”.

Several respondents described how the wait had made them feel worse and in some cases had other impacts also:

“Suffering from depression I felt it was essential to receive treatment asap and because of the time I had to wait until treatment began I felt it worsened the condition making me more alone and anxious”.

“I waited 18 months between my GP agreeing to refer me (for recurrent depressive illness) to being seen at [name of service]. There is no question that my circumstances worsened significantly while waiting...I finally paid for my own treatment after assaulting my partner & beginning to self-harm (not sth I'd done before)...I was not working at the time, and this got me into debt, but it saved my life, and my relationship. ...I remain furious that I had to wait so long and incur such costs (emotional more than financial) while my GP was happy to keep dishing out medication”.

## **Support**

Several respondents suggested that having other support while they were waiting for the talking treatment to start would have been beneficial. One participant had paid for a private service in the waiting period and another mentioned relying on her husband. However, the majority were reliant on NHS provided services and only some had received any interim support:

“Whilst in need in the 4 mths waiting period, it would have been very, very helpful for the service to have provided a 'mental health' person to make a weekly visit to me as coping at times was immensely difficult!”

“I had support from a low intensity worker and worked on guided self-help with Books on Prescription while on the waiting list. I appreciated the support, but was not able to discuss key issues with the low intensity worker, but had to wait a very long time to be able to discuss them with a psychotherapist”.

Related to the theme of waiting times was another significant theme, that of referral.

### **2.1.2 Referral**

Participants stated that they had been referred to talking treatments by their GP or Psychiatrist. Sometimes difficulties were mentioned that delayed the process such as professionals not knowing which type of treatment would be most appropriate,

uncertainties over which area or service was responsible for referrals getting “misaid in the system” and having to be chased up. One participant was referred to several different treatments at the same time causing them some confusion.

Some respondents expressed regret and frustration that they hadn’t been referred at an earlier point in time:

“I waited 6 years to start any form of treatment. In spite of asking to be referred/supported further at each appointment with my Psychiatrist”.

The referral process clearly affected both the overall waiting time and participants’ understanding of what they were being referred to. There was a recognition that the professional making the referral was key and several respondents described their experiences:

“...it depends 100% on the doctor you are with. My first didn't take it serious, so I went to the next one. He did all to refer me quickly. I went to a psychiatrist who took it all serious”.

“Before my current treatment started, my husband took me to A&E since he tried in vain to get help locally...once a report had been obtained from the hospital psychiatrist (who was wonderful!) I was put on the waiting list for local help after months of suffering for myself and my family”.

Participants also commented on the attitude of the professional who made the referral and raised issues about the manner in which they were spoken to and how it impacted on the referral process:

“On one occasion the GP greeted me with 'get on with it, you've got exactly ten minutes”.

“When a person asks for help it seems like no one listens to them, all people do is talk”.

### **2.1.3 Choice**

#### **None**

Some participants described being given no choice regarding either the day or time of their talking treatment. This was acceptable for some as the appointment times were suitable for them anyway or they weren’t currently working and had no other commitments. Some were able to change their work to fit in the appointments and another mentioned their husband being free on the day in order to take them. Various restrictions to choice were mentioned by respondents, and generally seemed to be understood:

“Due to the therapists full schedule I had to accept an appointment slot of his choosing”.

“It’s group therapy, so I understand inflexibility on time”.

#### **Flexibility**

Participants expressed mixed views about the flexibility offered, ranging from little flexibility to being able to change the date if they weren't able to attend. A few mentioned the waiting list in relation to this:

"I had one set time for Monday. If I wanted to change day or time I would have to of gone back on the waiting list, which I was not prepared to do, as it took guts to admit I needed help".

Some were given choices regarding the time but not the day, as the therapist was only available on certain days.

## **Venue**

A few participants raised concerns about the venue, stating that they were unable to get to the venue of their choosing, wanted a more central venue or needed to be a car owner and driver in order to get there. Sometimes respondents were able to deal with the difficulty with the help of others:

"It was out of the way for me to get to the location, so my therapist sorted it out for me to go to a local location for me, so I could see him there which I was thankful".

"No help in local area to location I live, given help by travelling to [place name] and in light of my problem feel this was not helpful having to rely on family and friends..."

## **Therapist**

Several respondents mentioned being seen by a trainee and in one case this had caused some difficulties:

"I was assessed by a trainee who decided I was not in need of any treatment and discharged me. I had to write and correct her assessment as she got many things wrong".

One participant had specifically asked for a female therapist but was still seeing a man; they hadn't wanted to change because they didn't want to upset the male therapist.

### **2.1.4 Information**

Some participants described being provided with information at the referral stage, including being told there was a waiting list. However, most had received little or no information regarding the process or the talking treatment itself, either at referral or later while on the waiting list:

"I was not aware it was CBT until I had my appointment".

Some described being completely unaware that any such treatments were available:

"...I didn't know I could ask for this therapy. It's almost 4 years that I have been suffering with this depression and feel that I could be much better by now".

Other respondents explained that because they didn't know what to expect or were anxious about starting treatment that this had a greater impact on them:

“...it might have been useful to have some information about what to expect prior to the first session – it might have made me feel less nervous”.

“With my initial letter for my first appointment, I could have done with a little more information as to what was expected”.

Several mentioned that they had taken the initiative and looked up information for themselves:

“...was told type of therapy, no explanation until first appointment. I went to library and read for myself type of therapy involved”.

There were some positive examples of information-giving cited:

“I was sent typed information about CBT, depression and panic attacks before I met my therapist. These pieces of information were very thoroughly explained”.

“The service and information that I received about my treatment, times and dates was outstanding”.

### **2.1.5 Resources<sup>1</sup>**

Many respondents raised the issue of scarce resources and stressed the need for more therapists to be available in order to increase access to talking treatments:

“I would have liked treatment to begin within 4 weeks ideally as I spent quite a while in turmoil. However I appreciate that in order to give users a quality service it is necessary to have to wait (unless of course they had unlimited funding which is not so!)”.

“The only thing I would change would be the amount of therapists that are available. I think that the government should provide more therapists”.

One participant thought that waiting lists for treatment for physical health conditions were shorter in comparison to those for mental health. Another raised an additional difficulty for an organisation that provided a specialist service for people who had experienced abuse, and described the resulting effects on people trying to access the service

“I feel strongly about the lack of opportunity for [organisation name] to promote their work and hence obtain funding in the way that more ‘socially acceptable’ charities are able to fundraise/advertise. Maybe if people were more aware of their work then the subject of abuse in [place name] may become more widely accepted making it easier for people to seek help if they knew they weren’t alone”.

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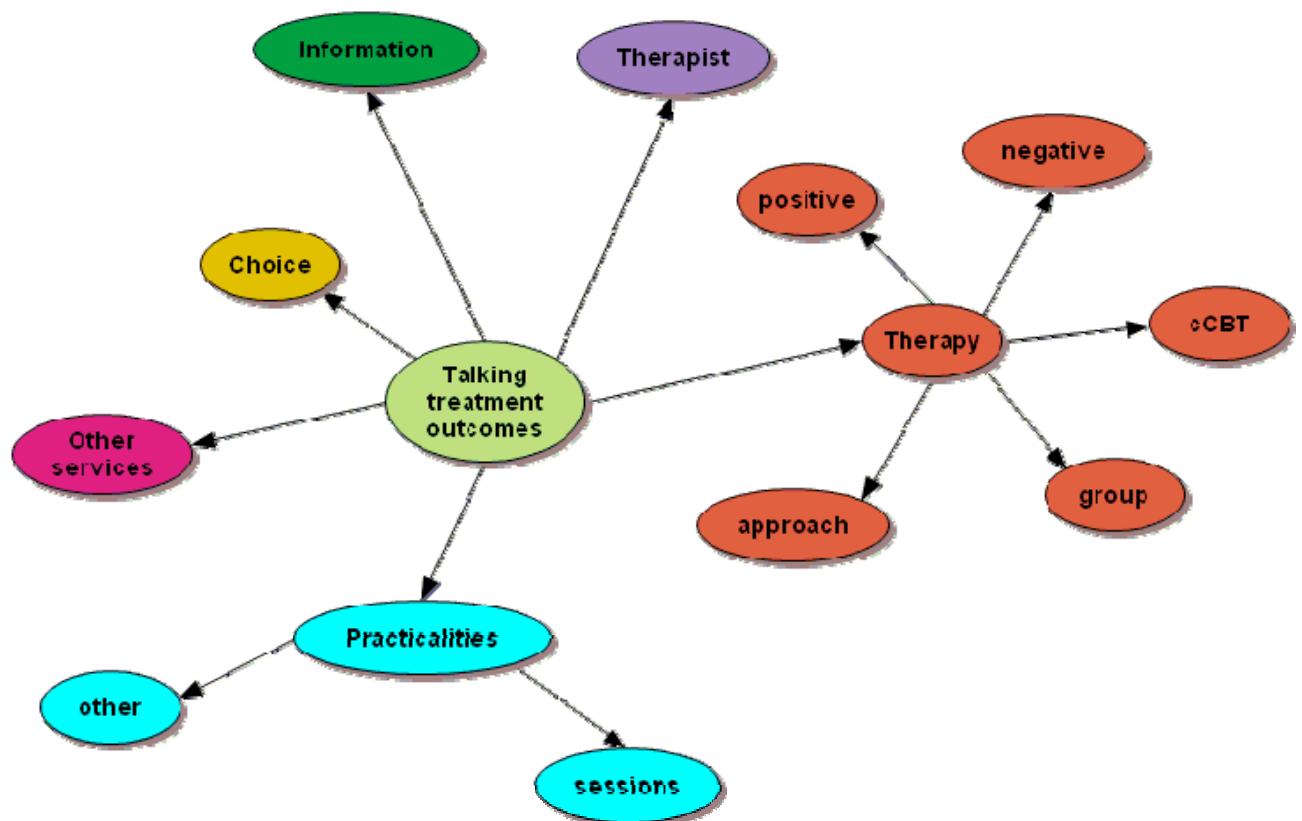
<sup>1</sup> The two researchers approached this theme with slightly different emphases. The secondary researcher highlighted positive comments about therapy and therapists above comments on the lack of resources. These issues were however far most strongly stressed in the section on outcomes below, where both researchers drew equal attention to this positive feedback.

## 2.2 Talking Treatment Outcomes

Six main themes were identified, some including sub-themes:

- Therapist
- Therapy
- Practicalities
- Other services
- Information
- Choice

Respondents commented on a wide range of issues related to their therapy in general and this section therefore does not focus solely on talking treatment outcomes and is far broader. It includes any comments related to the treatment received from the start of therapy onwards. The themes and sub-themes are shown in Diagram 2.



**Diagram 2. Final thematic map of Talking Treatment Outcomes, showing 6 main themes**

### 2.2.1 Therapist

The majority of respondents spoke positively about their therapist. Many of these were general comments, including expressions of how grateful they were:

“My therapist in [service], [name], is so good. I am so happy that I work with her. Just the thought that I am going to talk with her is helping me, makes me feel positive about the future...I am so thankful”.

“Thanks to my therapist I am finally getting better and think this is one of the best decisions I have ever made”.

“I am extremely happy with my current therapist and the way he encourages my personal recovery process. There is nothing I would like to change”.

Some participants highlighted particular skills and attributes they felt their therapist had. These included being encouraging and supportive, non-judgemental, sensitive, honest, understanding and listening. One respondent felt their therapist gave them confidence as they were not alone in dealing with their problems.

A few appreciated the flexibility that their therapist offered in terms of being available at other times and extending the length of sessions when needed; others mentioned the ability of the therapist to make the environment feel safe and comfortable. One respondent commented that they thought it would help to talk to someone who has actually been through the experience themselves.

Only one respondent spoke negatively of their therapist and this concerned their religion:

“I feel that my Christian faith is regarded with disdain. I feel this should not be the case, although I understand the reasons why”.

### **2.2.2 Therapy**

#### **Positive**

Most participants described their talking treatment as being beneficial overall and some spoke very positively about it but in general terms, for example: “I was at the bottom of my ladder, and now I am going up”. Others went into further detail and explained how it had helped but only to varying degrees and in specific aspects:

“I feel it has helped on a superficial level to manage day to day but not as a long-term solution”.

“This course did help me in some ways to think about my illness differently. However anxiety is still very strong”.

“Talking goes some way towards helping me try to understand the nature of my problems. It has helped create an awareness”.

Some mentioned not being able to talk to friends or family about their difficulties. Others relayed how they were sceptical at first regarding talking treatments or felt they had “little to give”, but after some time had realised it was helpful for them. Some were unable to comment because it was too soon in their treatment.

Some gave particular examples of how it had helped:

“Depression/anxiety have cost me my job (I was a teacher) but I am now able to do voluntary work as a Church Organist. At one stage I could not even listen to music, let alone perform in public”.

“Not only has the treatment helped me with the particular problem I presented with, it has also helped me keep a focus on my day-to-day niggles. I have also

been able to support a friend through a difficult time by suggesting some of the techniques to her”.

“My treatment has given me the space and the tools to think through my problems on an emotional and practical level, and the confidence to believe I can manage my problems myself”.

Other positive comments cited included being given an opportunity to express themselves and to “vent” their feelings about medical problems and other life events such as bereavements. Examples of positive outcomes include an increase in confidence, feeling able to think more clearly about issues, increasing awareness of their own behaviour, decreasing of symptoms such as suicidal thoughts and being able to continue using the techniques they had learnt after therapy had ended.

Some expressed hope for the future even though the treatment wasn’t currently benefitting them:

“I believe in theory the treatment will help, but I just don’t think I can be helped as an individual regardless what treatment I might get. Maybe I will begin to have more faith and confidence in myself as my therapist and I talk more in depth about my problems”.

### **Negative**

A minority expressed negative views about their talking treatment. One felt that it hadn’t helped them to understand their difficulties at all, although it hadn’t made them feel any worse either. Another believed that they already understood their problems but needed a practical solution. Some felt that the therapy had not addressed all of the difficulties they had, including depression and anxiety.

A few explained that the talking treatment didn’t help initially but it did after a while. One described this the other way round:

“was helping but seems to be getting worse again and don’t understand why?”

### **Approach<sup>2</sup>**

A few respondents mentioned different approaches to talking treatments, including CBT, psychodynamic, counselling, family therapy and Transactional Analysis. Some made criticisms of the approach they were currently receiving, stating they would have preferred a different one. Others felt a combination of approaches would be more beneficial:

“Needs to be a mixture. Cog – then psychodynamic”.

“Decisions should be made to have half counselling half CBT to enable the counsellor to seek out a underpinning problem and to agree a course of CBT after patient has agreed to the CBT”. Both forms would help much more”.

It is unclear what the level of awareness and understanding was of the majority of respondents as most did not comment on approach.

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<sup>2</sup> The main researcher in particular drew attention to this issue and the issues relating to the various therapy types below.

## **cCBT**

A few respondents explicitly mentioned their computerised cCBT course. Only a minority found it helpful with one stating:

“fantastic course; extremely beneficial; a very effective therapy for anxiety and depression”.

Most of those who had used cCBT said they wouldn't do the course again, partly because they felt they already knew what it had taught them, although they stated that it had given them confidence in putting the skills to use. One thought a listening ear would be more beneficial in comparison to “a brick wall all alone”. Another commented on the lack of privacy when doing the course at desks and how they felt frustrated with the software freezing.

One respondent didn't provide comments for the following reason:

“I'm not sure using a computer based training CBT is ‘talking therapy’ so if my input is relevant”.

## **Group**

Several respondents described attending therapy in a group setting however most said they didn't find it beneficial. One participant explained they couldn't go back to the group after they had left although they had valued the group: “it has taught me to thrive and not survive”. Another described it as therapeutic however it wasn't helpful to them in understanding their problem.

Others felt that it was hard to be heard in a group setting or that it was the group who helped each other with minimal intervention from the facilitator. One described her experiences of art therapy:

“At the end of each session we would discuss our work in a circle/group, for me the chance to talk one to one about my work would be very useful. At times I felt unable to talk about my work because it was so very painful and personal”.

## **2.2.3 Practicalities**

### **Sessions**

Several respondents commented on a limit in the number of sessions available, as short as 6 sessions in some cases. This was a significant issue for many people:

“...but just one comment that I think is very important to me; I found this service of great help for me unfortunately these services don't offer an open end and private services are very expensive. Would be very good for all of those people like me that need professional help (and cannot afford it) be able to get a longer term treatment”.

“I need more sessions to understand the issue and address it. I feel that progress was made, yet, the 6 sessions expired as we approached the issue”.

A few had been referred to other services to enable them to continue with the talking treatment, however they then had to go back on a waiting list again. One respondent

who had been referred to a group described their feelings: “now been waiting 6 months and wondering whether to back out...the gap feels very long”.

Others commented on the length of the session, wanting more than the allocated hour or wanting more frequent sessions than were offered.

### **Other**

A few respondents mentioned the venue where they received therapy and in most cases it was felt to be too “clinical”, small or depressing. One described the surroundings of the centre as “sad” and another commented that the room they used made them feel uncomfortable.

Only one described the venue positively:

“The atmosphere in the clinic is really nice. The staff are really friendly”.

Some spoke about the importance of continuity of care; one stated that if they were to see another therapist in the future they would like it to be the same person and another described how when their previous therapist had left they were transferred to another in the same team.

#### **2.2.4 Other services**

A few respondents described receiving other services alongside their talking treatment Information and were grateful for this. One wanted their GP to take more of an interest in how the talking treatment was going and another mentioned losing a service:

“I attend as I have no other support I have been discharged by my CPN since attending this group”.

One respondent commented that they would have liked their therapist to be trained in matters related to their career and education. Several referred to medical interventions such as medication and felt this was necessary at times. Others were grateful not to receive medication and to have been given the opportunity of a talking treatment instead.

One was concerned what would happen next:

“I am not sure what support is available to me after my sessions finish. It is easy to slip back into old habits as has happened during my treatment”.

#### **2.2.5 Information<sup>3</sup>**

There were mixed views expressed about the level of information offered. Several respondents commented that they would have liked more information about either their condition or the therapy:

“Not sure about my treatment, how does it really work...still feel like don't have enough information about it”.

“I believe I also suffer from S.A.D. I have never been asked about or told about S.A.D. by any of the therapy's I have tried”.

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<sup>3</sup> This theme was particularly stressed by the main researcher.

### **2.2.6 Choice**

Several respondents commented that they would have preferred trying a different therapy approach but that they weren't offered a choice:

"I haven't been offered anything else. So I don't know if it's the right kind of help".

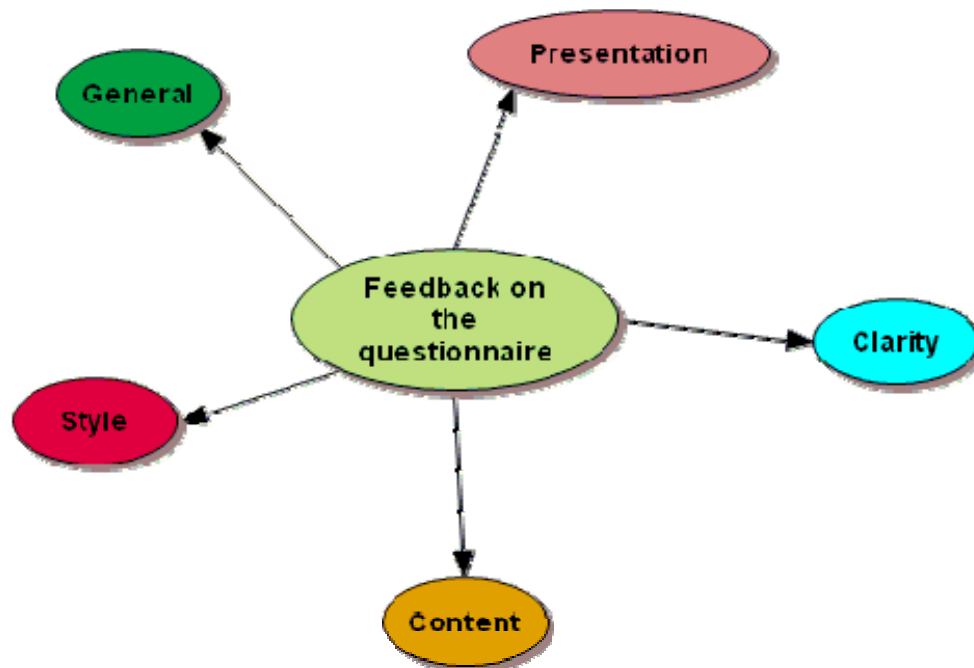
"I would like to have tried transactional analysis but this is not offered...I think from my reading on the subject that it could be helpful in my case".

One participant thought that their recovery would have been quicker if they had been able to afford to pay for another treatment and one wanted a female therapist but didn't receive this. One described their next choice as being face to face one to one CBT.

## 2.3 Feedback on the Questionnaire

Five main themes were identified, with no sub-themes:

- Presentation
- Clarity
- Content
- Style
- General



**Diagram 3. Final thematic map of Feedback on the Questionnaire, showing 5 main themes**

### 2.3.1 Presentation

All respondents who commented described the questionnaire as being clear and well laid out in appearance:

“The layout is good and its appearance is attractive”.

“The appearance and layout are pleasant and quite user-friendly”.

One stated that the yellow background was “easy on the eye”. There were no negative comments about the presentation of the questionnaire.

### 2.3.2 Clarity

The majority of participants found the questionnaire easy to read, understand and complete:

“...no big words to baffle you, so easy to read and understand. Thank you”.

“Good form – not too wordy – easy to follow – asked questions in the right way which made me think properly about answer”.

Other language used to describe the clarity included undaunting, straightforward, unambiguous and user-friendly.

Some respondents queried the wording used in particular questions. These are described in detail below:

- A, didn't know what the service code was
- B and throughout, thought the use of the phrase talking treatment was “quite specific to a professional person” and could be confusing to many people
- B, thought difficult to understand and could be explained more clearly in “layman's terms”
- D, thought was slightly confusing, suggested putting 0-3 months, 4-6 months, etc
- Q1.4, wanted to know what sort of information? (internet links, printed hand-outs, copies, book recommendation)
- Q2.1, didn't like the use of the word problem as it made them “feel unwell”. Suggested using the word issue instead

One respondent suggested that “an explanatory note as to the purpose of the survey” would be useful. In addition, a few participants said that some of the questions were not very clear and that the questionnaire should be made simpler, however, they didn't provide any further details.

### **2.3.3 Content**

There were mixed views regarding the content of the questionnaire. Some felt it was comprehensive and that no questions were missing. These respondents also stated that the questionnaire was concise, that there weren't too many questions and that they appreciated that. Some felt the content was appropriate and that the questions were “to the point”:

“The questions are very relevant and precise”.

“I think you have covered the right sorts of questions”.

Others felt that the questionnaire was too brief and too basic and questioned its purpose:

“Quite brief?? But if that's what's needed then fine”.

“Questions a bit 'basic'. Don't go into too much depth...don't know what their aims are”.

“By the very nature of question B the form has to be general – a more specific questionnaire may give better results”.

Several respondents made suggestions for additional questions that were not currently covered by the questionnaire. These are as follows:

- Time taken to travel to appointments
- Distance away from venue

- Environment of the venue and building
- Appropriateness of number of sessions
- Reason why attending for the talking treatment/content of what was discussed in sessions
- Any problems occurred during the talking treatment
- How successful the talking treatment has been
- What the user feels they can do if the relationship with the therapist isn't working
- Was there a choice of alternative therapist
- How the service could be improved
- What in the treatment was most and least helpful

Several comments were made concerning the difficulty of completing the form if the treatment received was group therapy or cCBT, as not all the questions were relevant or applicable. One respondent who had received cCBT explained that when completing the ARM-5, they had based their answers on their support worker rather than the computer. One said they were unsure whether to take part in the questionnaire:

"I'm not sure using a computer based training CBT is 'talking therapy' so if my input is relevant".

Some difficulties with completing the Background Information section were also raised. One respondent said they were unable to tick a box because there wasn't one that represented them. Specific comments were made regarding the gender section as it was not possible for one respondent to identify as either male or female.

One participant specifically wanted to name their therapist and organisation:

"It is a shame that there is no question about name of therapist I work with. My therapist in XXX, XXX is so good".

#### **2.3.4 Style**

This term is used to describe the type of methodology used in the questionnaire and related issues. Several respondents commented that it was sometimes difficult to give a yes or no answer. A few suggested that a box in between would be useful for "unsure" or "maybe" answers. The use of a rating scale was also mentioned.

A few of the respondents who gave feedback on the style said they preferred providing qualitative information and that this would make the questionnaire more appealing as it would be less "prescriptive", "abstract" and "numeric". One felt strongly about this and raised wider issues:

"The questionnaire is fine but can we please stop focusing on figures and targets in this country. It is not about administration, it's about delivering care to people when it's needed".

### **2.3.5 General**

Many respondents made general broad comments regarding the questionnaire, stating they found it was “fine” or “ok” and that no changes needed to be made to it:

“Your questionnaire appears to me to be perfectly adequate in every respect!”

Several commented that the questionnaire had enabled them to think about their talking treatment, which they described as useful and revealing:

“This form has brought this to the forefront for me. Thank you”.

“...quite enjoyable and made me think of the service on the whole”.

“I find the questionnaire very helpful”.

Many mentioned the timing of the questionnaire, saying that they were unable to answer some of the questions or make a “proper assessment/evaluation” as their talking treatment was still at an early stage:

“I cannot tell for sure as the course is ongoing”.

“I am only on my second session so the form I have completed does not really help. Perhaps when I am further on it would be more applicable?”

One respondent raised the opposite issue of not being able to remember if they were given a choice of different days or times for their treatment. Another explicitly commented that the questionnaire didn't take long to fill in.

One participant felt the questionnaire provided “only a snapshot of opinions” and suggested a before and after survey. Another commented on the fact that it was “just one more questionnaire”.

## 2.4 Reflexivity

The main researcher is a user of mental health services and has used a variety of talking treatments herself. She therefore brings her own perspectives into the process, as of course is the case with all researchers. At certain points in the analysis specific decisions were made.

For example, during the phase of reviewing the themes, it could be argued that there wasn't enough data to support the sub-themes under the main theme of choice in the Access to Talking Treatment section. In particular, only a small minority of respondents had commented on the themes of venue and therapist. However, coming from a user perspective, the analyst thought it important to include these as distinct sub-themes as the issue of choice is often thought to be important to service users.

In contrast, a main theme entitled "Feelings" was initially included in the Access section. However, when it came to writing up this theme it was felt that issues connected with respondents' feelings were already adequately covered in several of the previous themes; this theme was therefore removed at this stage.

The secondary researcher is not a user of mental health services although she has been a carer. Both researchers are experienced in research in the mental health field.

## 3. References

Braun, V. & Clarke, V. 2006, "Using thematic analysis in psychology", *Qualitative Research in Psychology*, vol. 3, no. 2, pp. 77-101.

**Burnard, 1991.** P. Burnard, 'A method of analysing interview transcripts in **qualitative research**', *Nurse Education Today* 11 6 (1991), 461-466.