Improving psychological therapies for older adults by advancing understanding of patient preferences

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Foreword

The COVID-19 pandemic affected the planning and completion of the Major Research Project (MRP; Chapter 2). Due to pandemic related restrictions, the original intended project could not proceed as planned and appropriate adaptations were made.

There were no significant changes to the nature of the data collected from the two groups of participants recruited (i.e. patients and clinicians), but questionnaires were updated to include items of interest, related to COVID-19. The mode of assessment changed for patients only. It was originally planned that patients would complete study procedures in a face-to-face appointment with the researcher. However, due to restrictions on face-to-face contact, patients were instead asked to complete the questionnaire independently and were given the option of doing so electronically or using paper copies sent in the post. Furthermore, restrictions on research activity within NHS Scotland during the first COVID-19 lockdown delayed the process of getting ethics and R&D approval. This resulted in a considerably shorter recruitment period (6 weeks rather than the planned 7 months), and thus a smaller sample size was achieved than planned.

Chapter 1 Systematic Review

Remote delivery of psychological therapies for older adults experiencing mental health problems – a systematic review of outcome measures used to evaluate efficacy and effectiveness

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ABSTRACT

Background: The COVID-19 pandemic and related public health measures resulted in many services shifting to remote delivery of psychological therapies (i.e. delivery via telephone or video calls). Judging the 'effectiveness' of delivering psychological therapies to older adults (OAs) in this way, requires an understanding of how efficacy and effectiveness have been operationalised in previous research.

Aims: To describe and critically analyse the outcome measures that have been used to evaluate the efficacy/effectiveness of psychological therapies delivered remotely to OAs, in order to determine whether conclusions about efficacy/effectiveness depend on the outcome measure used.

Method: CINAHL, Psychological and Behavioural Sciences Collection, PsycINFO, Journals@Ovidfulltext and Medline were systematically searched in January 2021 to identify papers that empirically assessed the efficacy/effectiveness of psychological therapies delivered remotely to OAs. The CTAM was used to evaluate methodological quality of the included papers and their findings were integrated using narrative synthesis.

Results: Across the 19 included papers a wide range of clinical and process outcomes were used to assess efficacy/effectiveness. Synthesis of the strengths and weaknesses of primary outcomes of interest (i.e. depression, anxiety, functioning and process outcomes) highlighted issues with how these outcomes have been operationalised and the psychometric properties of certain measures with OAs.

Conclusion: There is no 'gold standard' way of measuring clinical or process outcomes with OAs and it is likely that conclusions about

efficacy/effectiveness of remotely delivered psychological therapies with OAs are strongly influenced by the measure used to assess outcome.

Keywords: Older Adults, Mental Health, Psychological Therapies, Telephone, Telehealth.

INTRODUCTION

Prior to the COVID-19 pandemic, telemedicine was an expanding area of research due to technological advances and its potential to reduce access to care barriers (Richardson et al., 2009). The COVID-19 pandemic saw the introduction of infection control measures, which led to unprecedented changes in how NHS services were delivered. Most psychology services shifted to remote, digital delivery of psychological therapies (i.e. delivery via telephone or video calls) to ensure continuity of service for patients with mental health problems. This resulted in increased interest in understanding patient preferences for, and the efficacy (i.e. performance under ideal, controlled conditions) and effectiveness (i.e. performance under 'real life' clinical conditions) of remotely delivered psychological therapies. However, this literature is severely limited and gaps in our understanding need to be addressed to determine how and whether this delivery method should continue beyond current crisis measures. In particular, good quality evidence is required to make informed choices about the effectiveness of delivering psychological therapies to specialist groups, such as older adults (OAs), in order to navigate the projected move towards delivering services remotely.

Tele-medicine

A review by Richardson et al. (2009) evaluated the various outcomes of tele-mental health research conducted between 2003 and 2008. Tele-mental health was defined as the delivery of mental health services using video-conferencing, although authors recognised that a wider definition would include telephone, internet and email delivery. Most of the 148 papers reviewed were feasibility studies, although six randomised controlled trials (RCTs) were

included. This review found that patients from a range of clinical populations and services rated tele-mental health acceptable and satisfactory, though it was not clear how these constructs were operationalised or if ratings would remain high in the presence of alternatives (e.g. in-person delivery). Furthermore, the review argued that studies often overemphasized the significance of process outcomes, equating them to clinical effectiveness. When clinical outcomes were measured in the reviewed studies, tele-mental health was found to be at least as efficacious as face-to-face services. However, reviewed studies with OAs as the target population were limited to diagnosing dementia and the assessment of cognitive functioning, rather than the delivery of psychological therapies.

A more recent Cochrane review explored the effectiveness, acceptability and cost of telemedicine, more broadly, when compared to usual care (Flodgren et al., 2015). Similar to Richardson et al. (2009), authors narrowly defined telemedicine as delivery via video-conferencing, whereas usual care included face-to-face and telephone consultations. Only 7 of the 93 RCTs reviewed focused on mental health or substance abuse difficulties. Overall, the review suggests that psychological therapies delivered over video-conferencing were as effective as face-to-face delivery.

Tele-medicine with OAs

Delivering healthcare remotely to OAs could overcome access to care barriers commonly experienced by this demographic, such as difficulties attending face-to-face appointments due to transportation difficulties, reduced mobility or increased frailty (Woodall et al., 2010). Furthermore, research into the effects of COVID-19 related public health measures (i.e. social distancing and self-isolation) predicted significant mental health implications for OAs,

which may increase their need for mental health support during and following the pandemic (BPS, 2020). Therefore, offering OAs the option of receiving psychological therapy via remote-delivery digital means would allow them to access this support without unnecessary exposure to the virus. Technology adoption among OAs has improved in recent years, but evidence suggests they remain disproportionately affected by digital exclusion (Anderson & Perrin, 2017). Multiple factors may affect OAs' abilities and/or willingness to engage with telemedicine, including communication needs (i.e. sensory, motor and/or cognitive impairments), limited access to technology and/or lack of confidence, knowledge and experience of using interactive technology (Lam et al., 2020; Stronge et al., 2007).

Despite their unique barriers to engagement with technology, literature on the use of telemedicine with OAs is lacking, but some evidence does exist. A systematic review by Batsis et al. (2019) examined the feasibility, acceptability and effectiveness of using telemedicine (defined as two-way video-conferencing) to deliver medical interventions to OAs. They reviewed 17 RCTs and concluded that telemedicine was feasible for use with and acceptable to OAs, and results in similar outcomes to in-person delivery. However, authors noted that the methodological quality of the reviewed studies was poor, and the interventions delivered only targeted specific physical health conditions. There is a high prevalence of mental health difficulties in the OA population (Andreas et al., 2017), yet no systematic review to date has focused on evaluating the efficacy/effectiveness of remotely delivered psychological therapies with OAs' or their preferences for this. Therefore, the data in this area needs to be

synthesized to ensure the provision of high-quality, evidence-based services to OAs with mental health problems, in line with NHS objectives.

A starting point for making judgements about 'effectiveness' is to understand how it has been operationalised in previous research. This systematic review aims to address this issue by examining the outcome measures that have been used in research to evaluate the efficacy/effectiveness of remotely delivered psychological therapies for treating mental health problems in OAs. It is hoped that this new understanding will highlight any potential difficulties of drawing conclusions about efficacy/effectiveness, which will help services decide whether to continue delivering psychological therapies remotely to OAs.

Research Questions

1. What outcome measures have been used to evaluate the efficacy/effectiveness of psychological therapies with OAs delivered remotely via telephone or video calls?
2. What are the strengths and weaknesses of commonly used outcome measures?
3. Do conclusions about efficacy/effectiveness depend on the outcome measure used?

METHODS

This systematic review followed PRISMA reporting guidance (Moher et al., 2009). These eligibility criteria were applied:

Inclusion Criteria

- Treatment studies including RCTs, quasi-experimental studies and single group treatment trials that measured outcome(s) pre- and post-intervention.
- OA participants (mean sample age ≥60) or studies that stratify by age.
- Individual psychological therapy targeting mental health problems/symptoms.
- Telephone or video-call delivery, with real-time clinician-patient interaction. Video-calls are considered the best alternative to face-to-face delivery, as they provide verbal and non-verbal information (Nieman & Oh, 2020), but telephone interventions were also included as they are more accessible to OAs (Lam et al., 2020).
- Empirical outcomes measured and method of assessment described.
- Published in English.

Exclusion criteria

- Single case studies, dissertations, review or discussion papers, books and book chapters.
- Psychological therapies targeting substance-abuse, physical health problems and/or lifestyle health behaviours.
- Interventions delivered to caregivers, unless directly targeting caregivers' mental health difficulties.
- Non-psychological mental health interventions (e.g. using digital technology for reviewing and revising medications)
- Interventions delivered in-person or by other digital/remote methods, including email, text messaging, mobile-apps or web-based interventions (e.g. Computerised Cognitive Behavioural Therapy). These delivery

methods are less suited for high-intensity or specialist psychological therapies, like those delivered to OAs (NES, 2015), given their limitations for recognising and managing risk and significant emotional distress.

Search Strategy

A systematic search of six electronic databases was conducted in January 2021 (no date restrictions applied): EBSCOhost - CINAHL, Psychological & Behavioral Sciences Collection and PsycINFO; Ovid - Journals@Ovidfulltext and Medline; and Cochrane Library.

Three groups of search terms were applied for each database, pertaining to: OAs, psychological therapies, and remote delivery methods (see Appendix 1.2 for an example of the search terms applied). Truncation and Medical Subject Headings were used where applicable, and results were combined using the Boolean operators 'OR' (within groups) and 'AND' (between groups).

Screening

Search identified citations were exported to EndNote X9 and duplicates removed. Titles and abstracts were screened for relevance. Full-texts of remaining papers were evaluated for eligibility by the author. A second reviewer (HM) screened a subset of papers and disagreements were resolved through discussion. Authors were contacted for two electronically inaccessible papers, but neither responded. Forward and backward citations of eligible papers were hand searched.

Data Extraction and Synthesis

Included papers were heterogeneous in nature, consequently narrative synthesis was identified as the most appropriate means of summarising and

integrating their findings (Grant & Booth, 2009). Popay et al. (2006) outlined key elements involved in narrative synthesis, which this review followed:

Preliminary synthesis of findings

The author extracted key information from the included papers into tables developed for this purpose (i.e. Tables 1 and 2).

Explore relationships in the data

Key study characteristics were explored to identify relationships between the papers in relation to the review questions.

Assess the robustness of the synthesis

The review questions were addressed and any difficulties drawing conclusions from the included papers' findings were highlighted.

Quality Appraisal

Methodological quality of the papers was evaluated using the Clinical Trial Assessment Measure (CTAM; Tarrier & Wykes, 2004). The CTAM was chosen because its six subscales address different design features highlighted in the CONSORT guidelines (Moher et al., 2003) as important for the validity of psychological therapies studies. These subscales are individually scored and contribute a different weighting towards an overall quality score for the paper (maximum of 100). The CTAM was developed for evaluating RCTs, but has been used with other study designs (e.g. Swan et al., 2017). Wykes et al. (2008) found it to be a reliable and valid measure, and selected scores of ≥65 to indicate adequate methodological quality.

The author rated all papers, and four papers (>20%) were second rated by an independent reviewer (DT). The concordance rate was 84% (discrepancies were resolved through discussion).

RESULTS

The search identified 1831 citations (once duplicates were removed). Title and abstract screening resulted in 136 papers and 117 of these were excluded after full-text screening (62% did not meet inclusion criteria for age). Nineteen papers fulfilled the eligibility criteria (see Figure 1): fifteen RCTs, one non-RCT and three case study series. Key paper characteristics are summarised in Table 1.

Sample Characteristics

Eight papers used the same sample as at least one other paper. Therefore, the 19 papers only represent 14 studies. A total of 2083 participants were included in this review, with a weighted mean age of 65.5 years (range=23-89); 78% of participants were female. Type and severity of participants' presenting mental health problems varied across papers, as did whether clinical levels were required for inclusion.

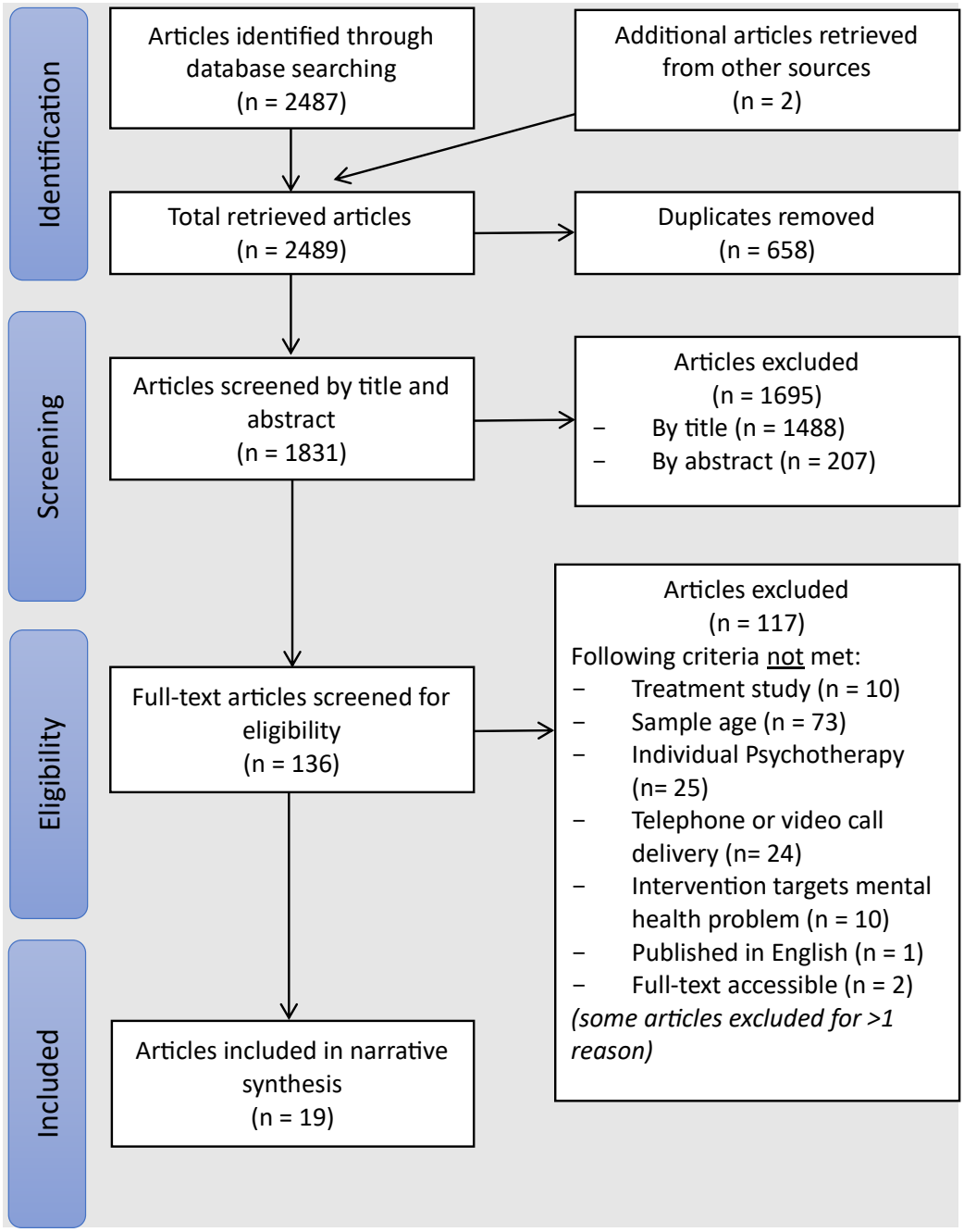

Figure 1: PRISMA Flow Diagram

Table 1: Paper Characteristics

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
Telephone Delivery											
Brenes et al. (2012)	RCT CBT-T(30) vs. info-only control(30)	69.1 (≥60)	83.3	73% White; 9% African American; 8% Native American; 2% Hispanic	In years CBT-T: M=14.4 (SD=1.6) Info-only: M=13.2 (SD=1.6)	(Co-)principal diagnosis of GAD, PD or ADNOS assessed with SCID.	PSWQ, STAI-T	ASI, BDI, HAM-A, ISI, SF-36	CSQ, WAI-S, participant adherence and investment questionnaire	• CBT-T had significantly greater reduction in worry, anxiety and insomnia. Worry gains maintained at 6-months. • Participant adherence and investment 'good' • Satisfaction and working alliance 'high'.	24
Brenes et al. (2015)	RCT CBT-T(70) vs. NST-T(71)	66.8 (60-87)	81.6	5.7% Black; 90% White; 3.5% other	5% HS unfinished, 13% HS or GED, 38% some college, 45% college degree	(Co-)principal diagnosis of GAD assessed by SCID*.	HAM-A, PSWQ-A	GAD-7, BDI	Treatment Credibility questionnaire, CSQ	• CBT-T had significantly greater decline in worry, GAD and depression. • Significant decline in general anxiety in both groups. No significant group difference. • Significantly more CBT-T participants had clinically meaningful reductions in worry. • CBT-T had higher satisfaction ratings.	80

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
Brenes et al. (2016)	RCT Same groups as Brenes et al. (2015); Brenes et al. (2017).	Same as Brenes et al. (2015); Brenes et al. (2017).						ISI, SF-36, PCT-D		• Significantly greater improvement in insomnia and QoL in CBT-T. Insomnia gains maintained at 15-months. • No significant group difference in disability scores.	34
Brenes et al. (2017)	RCT Same groups as Brenes et al. (2016); Brenes et al. (2015).	Same as Brenes et al. (2015); Brenes et al. (2017).					HAM-A, PSWQ-A	GAD-7, BDI		15-month follow-up: • Significantly greater decline in worry and anxiety in CBT-T. Significantly more CBT-T participants had clinically meaningful reductions in worry. • Significant decline in GAD and depression in both groups. No significant group difference.	67
Brenes et al. (2020)	RCT, preference trial	66.5 (≥60)	86.6	15% Black; 79% White;	16% HS unfinished, 8% some college,	Moderate to severe worry (Score	PSWQ-A, PROMIS-A, ISI			• Reduced worry and anxiety in both groups. No significant group difference.	40

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
	CBT-T(245) vs. Yoga(255)			6% other	21% associate/ technical, 31% Bachelor's degree, 23% Master's+	≥26 on PSWQ-A)				• Significantly greater improvements in insomnia in CBT-T. • Preference and selection effects non-significant.	
Wilz and Soellner (2016)	Non-RCT CBT-T(126) vs. PMR(53) vs. untreated control(50)	62	82.2	Not reported	96% finished HS	No burden of care or depression cut-off.	ADS, GBB-24 Non-standardised measures of emotional well-being and perceived health status.			• Emotional well-being improved significantly more in CBT-T vs. controls. • Body complaints reduced significantly in CBT-T vs. untreated control. • No significant group differences in depression or perceived health status. Six-month follow-up: • Significant improvements in perceived health status in CBT-T vs. untreated control.	63

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
										• Significant worsening in depression in PMR vs. CBT-T.	
Wilz et al. (2018)	RCT CBT-T(139) vs. TAU(134)	64.2 (23-91)	80.6	Not reported	4% primary or other, 65% secondary, 31% tertiary	None, but participants with diagnosed psychiatric disorder excluded.	ADS, GBB-24. Non-standardised measure of emotional well-being.	Not relevant		• CBT-T had significantly improved emotional wellbeing, fewer body complaints and reduced depression vs. TAU. • Emotional well-being improved at follow-up for CBT-T.	53
Barrera et al. (2017)	Case Series CBT-T(3)	65 (62-67)	0	100% White	9 years or finished HS	Depression and/or anxiety symptoms above clinical cut-off (GDS-S ≥5 and GAD-7 ≥8).	PHQ-8, GAD-7		Qualitative feedback on intervention acceptability.	• Participant 1: non-significant reduction in depression. No change in anxiety. • Participant 2: no significant change in depression. Clinically significant reduction in anxiety. • Participant 3: clinically significant reduction in depression. Non-significant reduction in anxiety.	29

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
										• Positive feedback re: acceptability.	
Doyle et al. (2017)	RCT CBT-T(54) vs. befriending(56)	68 (≥45)	64.8	Not reported	Finished HS: CBT-T:59%, befriending:67%	Score ≥8 on HADS or ≥10 on PHQ-9	PHQ-9, BAI.	Not relevant	CSQ, WAI-S.	• Only befriending had significant improvements in anxiety at post-intervention and follow-up. • Both groups had significant improvements in depression. CBT-T maintained significant difference at follow-up. • CBT-T significantly higher 'satisfaction' and working alliance.	80
Wuthrich and Rapee (2019)	Pilot RCT CBT-T(6) vs. WLC(5)	68.8 (56-85)	36	Not reported	Not reported	Depression and/or anxiety symptoms above clinical cut-off (GAI≥6 and GDS-S≥5).	GAI, GDS, WHOQOL.		Non-standardised rating scale for acceptability	• Significantly reduced depression in CBT-T. Gains maintained at one-month follow-up. Non-significant reduction in anxiety. • Anxiety significantly worsened in WLC from baseline to follow-up. • No changes in QoL.	25

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
										• CBT-T acceptability 'good'.	
Dobkin et al. (2020)	RCT CBT-T(37) vs. TAU(35)	65.2 (≥35)	51.4	Not reported	32% HS/some college, 36% college degree, 32% Graduate degree	MDD diagnosis assessed by SCID.	HAM-D (17-item)	BDI, HAM-A, SF-36.		• Significant group difference on primary and secondary outcomes, favouring CBT-T. • Effects maintained at 6-months.	51
VC Delivery											
Lazzari et al. (2011)	Case Series Tele-BA(3)	67.7 (64-73)	66.7	Not reported	Not reported	DSM-IV diagnosis of MDD or dysthymia and scores in clinical range on GDS.	GDS, PANAS, Q-LES-Q-18		Non-standardised satisfaction questionnaire.	• Clinically significant and reliable reduction in depression and negative affect for 2 participants at post-treatment and follow-up. • Positive affect improved or maintained for all. Change clinically significant for one participant. • QoL unchanged or maintained.	12

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
										• All 'satisfied' or 'very satisfied' with VC.	
Lichstein et al. (2013)	Case Series Tele-CBT(5)	65.8 (57-82)	80	100% White	In years: M=14 (SD=2)	Symptoms of insomnia or depression as determined by GP. Formal diagnosis not required.	CSD, ISI, HAM-D (17-item).		WAI-O and measure of treatment feasibility.	• Clinically significant improvements in insomnia and depression. Gains maintained or enhanced at two-month follow-up. • Treatment procedures "clear" or "very clear". • VC acceptability 'good'.	16
Choi et al. (2014a)	Pilot RCT Tele-PST(43) vs. in-person PST(42) vs. TS(36)	65.2 (50-89)	77.7	41% White, 34% Black, 25% Hispanic	Not reported	Moderate severe to severe depression (score ≥15 on HAM-D)	HAM-D (24-item)		TEI	• Tele-PST reported significantly higher acceptance than in-person PST. • Significantly lower depression in PST groups than TS at 12- and 24-week follow-up. • No significant difference in depression between PST conditions.	43

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
Choi et al. (2014b)	RCT Tele-PST(56) vs. in-person PST(63) vs. TS(39). Sample overlap with Choi et al. (2014a).	64.8 (≥50)	78.5	42% White, 33% African American/Black, 25% Hispanic	8% HS unfinished, 20% HS or GED, 34% some college, 14% college degree, 10% Graduate school	Same as Choi et al. (2014a)	HAM-D (24-item)	WHODAS II		• Significantly lower depression and disability scores in PST groups vs. TS at 12- and 24-weeks. Difference only significant for Tele-PST at 36-weeks. • No significant differences between PST conditions at 12- and 24-weeks, but Tele-PST depression scores significantly lower at 36-weeks.	62
Choi et al. (2016)	RCT Same groups as Choi et al. (2014b).	Same as Choi et al. (2014b)					HAM-D (suicidal ideation and hopelessness items)			• Tele-PST had significantly lower suicidal ideation ratings than TS across follow-ups. • No between-group difference in hopelessness.	56
Choi et al. (2020)	RCT Tele-BA(90) vs. Tele-	67.5 (≥50)	69.7	30% Black, 29% Hispanic	25% HS unfinished, 16% finished HS, 33%	Moderate severe to severe depression (score	HAM-D (24-item)	WHODAS II Other outcomes not		• Tele-BA and Tele-PST had significantly higher response and remission rates for	60

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		
	PST(93) vs. TS(94)			, 41% White	some college, 24% Bachelor's degree+	≥15 on HAM-D)		relevant to review.		depression and disability than TS. • Tele-PST significantly more effective than Tele-BA for depression. No significant group difference for disability.	
Egede et al. (2015)	RCT Tele-BA(120) vs. in-person BA(121)	63.9 (≥60)	2	60% White, 40% Black	In years: M=13.7 (SD=2.6)	Meet DSM-IV criteria for MDD.	GDS, BDI			• Tele-BA non-inferior to in-person BA in terms of response proportions for depression at 12-month follow-up. • Depression improved significantly in both groups. No significant group differences.	83
Egede et al. (2016)	RCT Same as Egede et al. (2015)	Same as Egede et al. (2015)							SF-36, CPOSS, Treatment credibility questionnaire, SDP questionnaire	• Significant group difference in QoL at 12-month follow-up only. • No other significant group differences.	78

*See Table 3 for details of outcome measures

**Results at post-intervention unless otherwise specified.

Citation	Design and Groups(n)	Sample Characteristics					Outcomes*			Main Findings**	CTAM total
		Age M (range)	% Female	Race/ Ethnicity	Education	MH Inclusion Criteria*	Primary	Secondary	Process		

Abbreviations: RCT, Randomised controlled trial; CBT, Cognitive Behavioural Therapy; CBT-T, telephone-delivered CBT; M, mean; SD, standard deviation; GAD, Generalised Anxiety Disorder; PD, Panic Disorder; ADNOS, Anxiety Disorder Not Otherwise Specified; SCID, Structured Clinical Interview for DSM-IV; DSM-IV, Diagnostic and statistical manual of mental disorders (American Psychiatric Association, 2000); NST-T, telephone-delivered non-directive supportive therapy; HS, High Scool; GED, Graduate Equivalency Degree; QoL, Quality of Life; PMR, Progressive Muscle Relaxation; TAU, Treatment as usual; HADS, Hospital Anxiety and Depression Scale; WLC, Wait-list control; VC, video-conferencing; Tele-, VC delivery; BA, Behavioural Activation; MDD, Major Depressive Disorder; PST, Problem Solving Therapy; TS, telephone support; SDP, Service Delivery Perception.

Table 2: Outcome measures used in the included papers

Name (Citation*)	Scale Abbreviation	Outcome Type	Description of Measure	Psychometric Properties with OAs**			Internal Consistency*** (Cronbach's α)	Included in n/19 Papers
				Adequate	Inadequate	Not Reported		
Mental Health Outcomes								
Allgemeine Depressionsskala (Hautzinger et al., 2012)	ADS	Depression	20-items Self-report			✓	Adults: 0.89-0.92	2
Anxiety Sensitivity Index (Peterson & Reiss, 1992)	ASI	Fear of anxiety symptoms	16-items Self-report	✓			OAs: 0.89 (Brenes et al., 2012).	1
Beck Anxiety Inventory (Beck et al., 1988)	BAI	Anxiety	21-items Self-report	✓			OAs: 0.9 (Kabacoff et al., 1997)	1
Beck Depression Inventory (Beck et al., 1979)	BDI	Depression	21-items Self-report	✓			OAs: 0.86-0.91 (Beck & Steer, 1987).	5
Consensus Sleep Diary (Carney et al., 2012)	CSD	Sleep quality/quantity.	Self-report			✓		1
Geriatric Anxiety Inventory (Pachana et al., 2007)	GAI	Anxiety	20-items Self-report	✓			OAs: 0.91-0.93	1
Generalised Anxiety Disorder scale 7-item (Spitzer et al., 2006)	GAD-7	GAD symptoms	7-items Self-report			✓	Adults: 0.92	3
Geriatric Depression Scale (short-form: Sheikh & Yesavage, 1986; Yesavage et al., 1982)	GDS	Depression	30-items Short-form: 15-items Self-report	✓				3
Hamilton Anxiety Rating Scale (Hamilton, 1959)	HAM-A	Anxiety	14-items Interviewer-rated	✓				4

Name (Citation*)	Scale Abbreviation	Outcome Type	Description of Measure	Psychometric Properties with OAs**			Internal Consistency*** (Cronbach's α)	Included in n/19 Papers
				Adequate	Inadequate	Not Reported		
Hamilton Rating Scale for Depression (Hamilton, 1960)	HAM-D	Depression.	Original: 17+4-items 24-item (Moberg et al., 2001) Interviewer-rated			✓		Original: 2 24-item: 4
Insomnia Severity Index (Morin, 1993)	ISI	Insomnia	7-items Self-report	✓			OAs: 0.86 (Brenes et al., 2012)	4
Positive and Negative Affect Scale (Watson et al., 1988)	PANAS	Overall mood.	20-items Self-report			✓	Adults: 0.85-0.89 (Crawford & Henry, 2004)	1
Patient-Reported Outcomes Measurement Information System (short form)-Anxiety (Pilkonis et al., 2011).	PROMIS-A	Anxiety	8-items Self-report			✓	Adults: 0.93	1
Patient Health Questionnaire (-8: Kroenke & Spitzer, 2002; -9: Kroenke et al., 2001)	PHQ	Depression	8- or 9-items 8-item version omits the suicide item Self-report			✓	PHQ-9, adults: 0.89	2
Penn State Worry Questionnaire (Abbreviated) (Meyer et al., 1990)	PSWQ	Worry	16-items Abbreviated: 8-items Self-report	✓			16-item, OAs: 0.75 (Brenes et al., 2012) 8-items, OAs: 0.89 (Crittendon & Hopko, 2006).	4
State-Trait Anxiety Inventory-Trait subscale	STAI-T	Non-physiological symptoms of anxiety.	20-items Self-report		✓ poor divergent		OAs: 0.51 (Brenes et al., 2012)	1

Name (Citation*)	Scale Abbreviation	Outcome Type	Description of Measure	Psychometric Properties with OAs**			Internal Consistency*** (Cronbach's α)	Included in n/19 Papers
				Adequate	Inadequate	Not Reported		
(Spielberger et al., 1970).					validity with depression (Kabacoff et al., 1997).			
Other Patient Outcomes								
Gießen Body Complaints List (Brähler et al., 2008)	GBB-24	Physical health complaints	24-items Self-report			✓	Adults: 0.94	2
Pepper Center Tool for Disability (Rejeski et al., 2008)	PCT-D	Perceived difficulties with mobility and functioning.	19-items Self-report	✓				1
Quality of life enjoyment and satisfaction questionnaire (Ritsner et al., 2005)	Q-LES-Q-18	QoL	18-items Self-report			✓	Adults: 0.74-0.94	1
Short-form Health Survey (Ware et al., 1993).	SF-36	QoL	36-items Self-report	✓			OAs: 0.80 (Lyons et al., 1994)	4
WHO Disability Assessment Schedule (WHO, 2000)	WHODAS II	Health and disability status	Short-form: 12-items Self-report			✓		2
WHO Quality of Life – brief (WHOQOL Group, 1998)	WHOQOL	QoL	26-items Self-report			✓	Adults: 0.77-0.87	1
Process Outcomes								
Client Satisfaction Questionnaire (Larsen et al., 1979)	CSQ	Satisfaction with treatment.	8-items Self-report	✓			OAs: 0.94 (Brenes et al., 2012)	3

Name (Citation*)	Scale Abbreviation	Outcome Type	Description of Measure	Psychometric Properties with OAs**			Internal Consistency*** (Cronbach's α)	Included in n/19 Papers
				Adequate	Inadequate	Not Reported		
Charleston Psychiatric Outpatient Satisfaction Scale (Pellegrin et al., 2001)	CPOSS	Satisfaction with service.	16-items Self-report			✓	Adults: 0.96	1
Treatment Credibility Questionnaire (Borkovec & Nau, 1972)		Patient beliefs about treatment and outcome.	4 questions Self-report			✓		2
Treatment Evaluation Inventory (Landreville & Guérette, 1998)	TEI	Treatment Acceptance.	11-items Self-report			✓	OAs: 0.82 (Choi et al., 2014a)	1
Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989)	WAI-S	Strength of WA from therapist or clinician perspective.	12-items Self-report			✓	OAs: 0.84-0.85 Brenes et al. (2012)	2
Working Alliance Inventory-Observer Rating Form (Tichenor & Hill, 1989)	WAI-O	Strength of WA	12-items Observer-rated			✓	Adults: 0.98	1

*Reference for internal consistency, unless otherwise specified.
**As reported in reviewed papers. Includes different types of reliability and/or validity. Correlation coefficients ≥0.7 deemed adequate.
***As reported in reviewed papers. Cronbach's α scores ≥0.7 deemed adequate.
Abbreviations: GAD, Generalised Anxiety Disorder; QoL, Quality of life; WA, working alliance.

Quality Appraisal

Total quality scores varied considerably across studies (range=16-83; see Table 1), which is partially attributable to study design. Case series and non-RCTs generally received lower scores, but there was also variation between RCTs (range=23-83). Papers that reported different outcomes for the same study received different scores (e.g. Brenes et al., 2016, 2017; Brenes et al., 2015), which suggests an issue with inadequate reporting and could explain some of the variance.

Five of the included papers were considered to have adequate methodological quality (score ≥65). However, caution is required when applying this arbitrary cut-off as the papers scored low on particular subscales (see Appendix 1.3 for CTAM subscale scores). Three of these papers assessed the efficacy of telephone-delivered CBT (CBT-T) for treating anxiety and depression in OAs (Brenes et al., 2017; Brenes et al., 2015; Doyle et al., 2017), whereas two assessed the efficacy of Behavioural Activation (BA) delivered over video-calls (Tele-BA) for treating depression in OAs (Egede et al., 2015; Egede et al., 2016). Overall, these papers' findings support remote delivery of psychological therapies to OAs, with few exceptions (see Table 1). However, they used 14 different standardised measures to assess common outcomes (i.e. depression, anxiety and satisfaction) and only nine of these have been validated with OAs.

Outcome Measures

Outcomes measured across the papers varied, and all used multiple measures (see Tables 1 and 2).

Clinical Outcomes:

The most reported mental health outcomes were depression and anxiety. The most frequently used measure of depression was the Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1960). Two versions of HAM-D were used: the original 17-item version, without its four supplementary items; and a 24-item version, which incorporates three psychological symptoms of depression (hopelessness, helplessness and worthlessness). The Beck Depression Inventory (BDI; Beck et al., 1979) was the second most frequently used measure of depression and was used in two higher quality papers (Brenes et al., 2015; Egede et al., 2015). It focuses more on the psychological symptoms of depression when compared with HAM-D, which puts greater emphasis on somatic symptoms.

Similar to depression, the measures used to assess anxiety operationalised the construct differently. For example, the most frequently used measure of anxiety, the Hamilton Anxiety Rating Scale (HAM-A; Hamilton, 1959), mainly focuses on somatic symptoms, whereas the State-Trait Anxiety Inventory-Trait (STAI-T) excludes them completely. The HAM-D and HAM-A are both interviewer-rated measures, but most measures used in the studies were self-report (83%).

Seven papers assessed non-mental health patient outcomes, including: quality of life (QoL) and disability/functioning. Measures of these constructs often overlap in content. For example, QoL was most commonly measured using the short-form health survey (SF-36; Ware et al., 1993), which assesses participants' health status and functioning. These factors also feature in

measures of disability, such as the World Health Organisation (WHO) Disability Assessment Schedule (WHODAS II; WHO, 2000).

Process Outcomes:

Nine papers assessed process outcomes in some format. Two standardised measures of satisfaction were used: The Client Satisfaction Questionnaire (CSQ; Larsen et al., 1979) and the Charleston Psychiatric Outpatient Satisfaction Scale (CPOSS; Pellegrin et al., 2001). The CSQ assesses participant satisfaction with treatment (e.g. length, quality and outcome) and was used in two higher quality papers (Brenes et al., 2015; Doyle et al., 2017). The CPOSS was used by one higher quality paper (Egede et al., 2016) and assesses participant satisfaction with service (e.g. waiting room appearance, clinic location and parking). CPOSS items are likely less relevant to remotely delivered services.

Six papers developed non-standardised questionnaires to assess process outcomes, and it was often unclear how they defined acceptance and/or satisfaction as they merely asked, “how acceptable was this treatment?” (e.g. Wuthrich & Rapee, 2019) or “how satisfised were you with video-conferencing?” (e.g. Lazzari et al., 2011).

DISCUSSION

This review aimed to describe and critically analyse the outcome measures that have been used to evaluate the efficacy/effectiveness of psychological therapies remotely-delivered to OAs, in order to assess their impact on interpreting findings from this research.

Main Findings

Heterogeneity in outcome measurement makes it difficult to compare across studies and this review has insufficient scope to critique the strengths and weaknesses of each measure. Harmonisation of outcome measurement is a challenge that extends across mental health science (Wolpert, 2020). To address this issue, the Wellcome Trust have introduced a core set of measures for use in mental health research with adults: Patient Health Questionnaire (PHQ-9) for depression; Generalised Anxiety Disorder scale (GAD-7) for anxiety and WHODAS for impact on functioning (Farber et al., 2020). In line with this approach, this review uses depression, anxiety and functioning as examples of commonly reported outcomes, to address the research questions. Process outcomes are also considered as we are interested in how OAs receive treatments and their preferences.

Depression

Measures varied in how they operationalised depression and placed greater weighting on different symptoms (e.g. somatic vs. psychological symptoms). The reviewed papers justified their use of different measures. For instance, Lazzari et al. (2011) argued that depression tends to be expressed more somatically in OAs than in younger adults, but other papers argued that psychological symptoms are more sensitive to depression in OAs (Moberg et al., 2001). This lack of consensus about how depression presents in OAs would benefit from further research.

Although HAM-D was the most frequently used measure of depression, it was not used by the four higher quality papers that targeted depression. Brenes et al. (2015) found CBT-T significantly improved BDI scores at post-intervention

compared to telephone-delivered non-directive supportive therapy (NST-T), but Brenes et al. (2017) found no significant group difference at 15-month follow-up. Egede et al. (2015) used the BDI and the Geriatric Depression Scale (GDS; Yesavage et al., 1982) to assess the comparative effects of Tele-BA and in-person BA. They found significant improvements in depression in both groups across follow-ups and concluded that Tele-BA was non-inferior to in-person BA. Using both the BDI and GDS to measure depression may improve the validity of these results, as when combined, these measures encompass more symptoms of depression. Furthermore, both measures have been found to have adequate internal consistency with OAs.

Doyle et al. (2017) was the only paper to use the Wellcome Trust's mandated measure of depression, PHQ-9. They compared CBT-T to befriending and found significant improvements in depression in both groups at post-intervention, but gains were only maintained for CBT-T at follow-up. The PHQ-9 has been found to have adequate internal consistency in the general adult population, but its psychometric properties with OAs are unknown. Furthermore, it is a relatively short measure and thus captures limited information about participants' difficulties (Fried, 2017).

Anxiety

Similar to depression, measures of anxiety operationalised the construct differently, putting greater emphasis on different symptoms. Two higher quality papers, Brenes et al. (2015) and Brenes et al. (2017) used HAM-A and GAD-7 to assess the effectiveness of CBT-T, compared to NST-T, and found different outcomes across the different measures (i.e. significant group difference for GAD-7 scores, but not HAM-A ratings at post-intervention. This pattern was

reversed at 15-week follow-up). Doyle et al. (2017) was the only other higher quality paper that assessed anxiety. They used the Beck Anxiety Inventory (BAI; Beck et al., 1979) to measure the effectiveness of CBT-T compared to befriending and found that only befriending resulted in significant improvements in anxiety at post-intervention and follow-up.

The variation in these results demonstrates how measures introduce bias, which affects interpretations about the efficacy of CBT-T in reducing anxiety. For instance, variations in findings could be attributed to how measures operationalise anxiety and/or their different psychometric properties. The BAI and HAM-A have been validated with OAs and shown adequate internal consistency, but the internal consistency of GAD-7 with OAs is unknown. Findings from these studies would benefit from replication with more established control groups (e.g. in-person delivery of the psychological therapy as the comparator).

Functioning

Despite functioning being recognised as a primary outcome for mental health research, it was only measured by three papers, all deemed to have inadequate methodological quality. Brenes et al. (2016) used the Pepper Center Tool for Disability (PCT-D; Rejeski et al., 2008) and found no difference between CBT-T and NST-T groups at post-intervention. However, Choi et al. (2014b) and Choi et al. (2020) used WHODAS and found significant improvements in functioning in Tele-BA and Problem Solving Therapy, delivered in-person and over video-calls, when compared to telephone-support. While the WHODAS has been widely validated (Üstün et al., 2010), the psychometric properties of the short-form, used in these studies, are unknown.

Therefore, caution is required when interpreting these positive results, and they would benefit from replication using a measure of functioning validated with OAs, such as the PCT-D.

Process

There seems to have been a shift in how process outcomes are measured in research, with a higher proportion of papers in the present study using standardised measures than in Richardson et al. (2009). However, similar to findings in Richardson et al. (2009), six papers developed non-standardised measures to assess process outcomes and it was often unclear how these papers had defined satisfaction or acceptance. This limits the ability to make valid and meaningful comparisons across studies (Larsen et al., 1979).

Participant ratings of acceptance and satisfaction were 'high' across papers, regardless of the method used to assess them. These findings are likely impacted by social desirability bias, which questions their significance (Larsen et al., 1979). Furthermore, the papers that measured acceptance or satisfaction with treatment only did so in the group receiving psychological therapy remotely or in comparison to a less established control. Therefore, it is unknown whether ratings would remain 'high' if other options were available (e.g. if participants were offered a choice between remote or in-person therapy). This would be a valuable area for future research, given previous findings that accommodating patient preferences for psychological therapy can improve adherence and outcomes (Swift et al., 2018).

Overall, this review highlights the challenges of defining mental health outcomes and suggests that outcome measures do impact the interpretation of the included papers' results. Each measure has strengths and weaknesses and

given the breadth and complexity of the outcomes being assessed, there is no 'perfect' measure. Attempts to standardise outcome measurement across mental health research (i.e. Wolpert, 2020) goes some way to resolving the difficulties faced in this review when attempting to compare findings across papers. However, such an approach raises the problem of the most widely used measure becoming 'gold standard', when it may not be the most appropriate. This was the case for the mandated measures in this review, given their psychometric properties with OAs are unknown. Furthermore, Patalay and Fried (2020) argued that this approach could discourage the measurement of other clinically meaningful outcomes or disregard meaningful findings from other measures.

Strengths and Limitations

A strength of this review is that it is the first to synthesise data relating to outcome measurement in psychological therapies efficacy research with OAs. While every effort was made to carry out a systematic and thorough literature search, limiting it to papers published in English and peer-reviewed journals may have excluded relevant papers and introduced publication bias. The exclusion of digital delivery methods other than telephone or video calls may also have excluded relevant papers with clinically meaningful findings.

Additionally, the selection of the CTAM for assessing methodological quality may have introduced further bias. The CTAM was developed for evaluating RCTs, and it could be argued that grading other study designs to the same standard is unfair. However, for mental health research findings to appropriately inform policy and practice, studies with adequate methodological quality are required, in line with CONSORT guidelines. Furthermore, the quality

appraisal process was largely completed by a sole researcher, which introduces subjectivity to CTAM scores. To limit possible experimenter bias, >20% of papers were second rated by an independent researcher. Also, due to difficulties comparing across papers and having no standardised way of weighting findings based on CTAM scores, this review focused on the higher quality papers for brevity. This may, however, have disregarded clinically meaningful findings in papers rated lower in quality.

Implications

Given the majority of the included papers had poor methodological quality and issues with sample representativeness, clinicians working with OAs need to be cautious about assuming the efficacy/effectiveness of remotely delivered psychological therapies. Many of the reviewed papers included participants younger than 60 years and with sub-clinical levels of mental health difficulties. Samples were also majority female and sample race/ethnicity was either not reported or lacked diversity. The latter is a significant limitation of this research given the disproportionate impact of digital poverty within Black, Asian and Minority Ethnic groups (Zhai, 2021). Furthermore, the included papers focused on treating anxiety and/or depression, and excluded participants presenting with multi-morbidity, suicidal ideation and/or less prevalent mental health difficulties, such as psychosis. Therefore, this review highlights a gap in the literature, which has significant implications for clinicians delivering psychological therapies remotely to this demographic.

Future research addressing these limitations and using outcome measures that have been standardised with OA clinical populations is required. Additionally, given the considerable variation in how mental health constructs

have been operationalised, a useful line of subsequent enquiry could be an in-depth critical analysis at component level of mental health outcome measures. This would support identification of a core set of measures for use in mental health research with OAs and would allow more meaningful conclusions about the efficacy of psychological therapies with OAs to be drawn.

This review also has implications for implementation science theory (e.g. Bauer et al., 2015), as it highlights a research-to-practice gap that needs to be addressed to support psychological services to adjust from face-to-face to remote/digital delivery. Tele-mental health research would benefit from implementation issues being considered earlier in the research process, so that further research is more aware of clinical contexts and thus more generalisable. To inform this process, MRC guidance on developing and evaluating complex interventions (Moore et al., 2015) could be followed.

Conclusion

There is currently no 'gold standard' way of measuring the efficacy/effectiveness of remotely delivered psychological therapies for OAs. Although there are some promising findings across the reviewed papers, given the discussion here about relative strengths and weaknesses of the various outcome measures used, and other methodological limitations across the papers, it is too early to conclude the efficacy/effectiveness of remotely delivered psychological therapies with OAs.

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Chapter 2 Major Research Project

A feasibility study examining treatment and outcome preferences of older adults (OAs) with mental health difficulties during COVID-19 and the effects of preferences on clinician decisions about treatment

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Plain Language Summary

Title: A feasibility study examining treatment and outcome preferences of older adults (OAs) with mental health difficulties during COVID-19 and the effects of preferences on clinician decisions about treatment

Background: Research has found that individuals who seek a talking therapy to improve their mental health have preferences about what they want therapy to involve (i.e. treatment preferences) and what they hope to gain from therapy (i.e. outcome preferences). However, there is no agreed upon method for eliciting preferences and research has found that therapists (from here on referred to as clinicians) do not always consider preferences when deciding which treatment approach would best address each individual's mental health needs (Stewart et al., 2018).

Aims: This study investigated the use of questionnaire methods for finding out 1) OAs' treatment and outcome preferences, and 2) if clinicians consider OAs' preferences when making decisions about treatment. We also aimed to describe OAs' and clinicians' responses to the questionnaires.

Methods: Two questionnaires were adapted from previous research for use in this study. OAs were recruited from NHS Lanarkshire Psychological Therapies for Older People service and asked to complete a questionnaire about their preferences for therapy (the Patient Preferences Questionnaire, PPQ). Clinicians who provide talking therapies to OAs were also recruited and asked to complete a questionnaire about their decision-making (the Clinicians Decision-Making Questionnaire, CDMQ). To assess how 'acceptable' each questionnaire was, participants were asked to give feedback about the length of the questionnaire, and whether the questions they were asked made sense and were relevant to them.

Main Findings: 18 OAs and 27 clinicians were recruited and completed the questionnaires. Both groups rated the questionnaires as 'acceptable'. OAs expressed a preference for therapy delivered in-person, rather than over video call. They also preferred to 'learn ways to be less self-critical' and to 'feel more confident' following therapy. Clinicians rated their own experience of delivering talking therapies to OAs as the factor that influenced their decision-making about treatment the most. They also considered OAs' preferences 'quite a lot' when making decisions. The factors that clinicians rated

as having the most influence on whether they incorporated OAs' preferences when making decisions were OAs' understanding of their mental health needs (i.e. insight), and if the OA had previous experience of receiving a talking therapy. Clinicians also stated that COVID-19 made it more difficult for them to accommodate OAs' preferences.

Conclusions: This study supports the use of questionnaires to find out about OAs' treatment and outcome preferences and gather data from clinicians about their decision-making. However, the sample was small and did not represent all OAs who may seek a talking therapy to improve their mental health. This limitation means caution should be used when interpreting questionnaire responses. Future research replicating the study with a larger, more representative sample would allow more meaningful conclusions to be drawn.

Key Reference: Stewart, R. E., Chambless, D. L., & Stirman, S. W. (2018). Decision making and the use of evidence-based practice: Is the three-legged stool balanced? *Practice Innovations*, *3*(1), 56-67.

ABSTRACT

Background: Evidence-based practice requires using the best research evidence, clinical expertise, and patient characteristics/preferences to inform the provision of appropriate interventions. Although accommodating patient treatment preferences can have a significant positive impact on psychotherapy attendance and outcome, they are often overlooked in clinical decision-making.

Aims: To establish the feasibility and acceptability of using self-report questionnaires to elicit older adults' (OAs) mental health treatment and outcome preferences and determine whether clinicians consider these preferences when selecting treatment. The secondary aim is to establish a preliminary understanding of participants' responses on the questionnaires.

Methods: Two questionnaires were adapted from previous research for this study. Patients were recruited from NHS Lanarkshire Psychological Therapies for Older People service and asked to complete a questionnaire about their preferences for psychological therapy. Clinicians who deliver psychological therapies to OAs were recruited and asked to complete a questionnaire about their decision-making. Participants also rated questionnaire acceptability.

Results: 18 patients and 27 clinicians were recruited. Patients expressed preferences for therapy delivered in-person. Their most preferred therapy task was 'learn ways to be less critical of me' and outcome was 'feel more confident'. Clinicians rated their clinical experience as the most influential factor in their decision-making about treatment. They also identified patient insight and previous experience of therapy as the factors with the most influence on whether they consider patient preferences in decision-making, and

reported that COVID-19 makes accommodating patient preferences more difficult.

Conclusions: questionnaires are a feasible and acceptable method of eliciting OAs' treatment and outcome preferences and gathering data about clinicians' decision-making.

Keywords: Patient preferences, older adults, decision-making, psychological therapy, evidence based practice

INTRODUCTION

The global population is ageing, and the proportion of people aged 60 and over is projected to double by 2050 (World Health Organisation [WHO], 2017). Approximately 23% of people in this age range present with a diagnosable mental health problem, with the most common difficulties are anxiety (11%) and depression (6%; Andreas et al., 2017). Older adults (OAs) can experience the same range of mental health difficulties as their younger counterparts (Volkert et al., 2013), but their risk factors for developing these difficulties may differ. For example, OAs are more likely to experience bereavement and/or functional decline (e.g. due to reduced mobility, chronic pain or increased frailty; WHO, 2017). Furthermore, the likelihood of experiencing multiple co-occurring mental and/or physical health difficulties increases with age (i.e. 'multi-morbidity'; Barnett et al., 2012), and can have a significant impact on quality of life, disability status and health care utilization (Marengoni et al., 2011). Therefore, OAs are recognised as a complex and heterogenous group, but their mental health needs are often overlooked in research and under-identified in clinical practice (Marengoni et al., 2011; WHO, 2017). This has resulted in their mental health difficulties predominantly being treated with medication and acts as a barrier to them accessing other treatments, such as psychological therapies (Royal College of Psychiatrists, 2018). Consequently, improving the provision of and access to effective mental health treatments for OAs has become a public health priority (WHO, 2017).

Obstacles to achieving this priority include increasing public expectations for healthcare and financial constraints, but changes to healthcare provision, such as 'realistic medicine' and 'person-centred care' hope to overcome these

barriers (e.g. Scottish Government, 2010). These approaches seek to change how services are delivered by introducing shared decision-making, aimed at determining what matters most to patients and developing a personalised approach to their care. These approaches also uphold the ethical principles of peoples' right to self-determination and autonomy (British Psychological Society [BPS], 2018). Mental health services need to adapt to meet the needs of this growing demographic and work jointly with patients to offer acceptable and beneficial interventions, including psychological therapies.

Evidence Based Practice (EBP)

Best practice in the treatment of mental health difficulties requires the provision of EBP. However, research describing the importance of delivering EBP is limited, and many key references are approximately two decades old (e.g. Sackett et al., 2000). Research examining the efficacy of psychological therapies for the treatment of mental health difficulties in OAs is also relatively limited, when compared to equivalent research with general adult clinical populations. To date, most research into the efficacy of psychological therapies for OAs has focused on Cognitive Behavioural Therapy (CBT) for depression or anxiety, which has been found to be as efficacious as other psychological treatments and more effective than waiting list controls (Cuijpers et al., 2009; Hofmann et al., 2012). There is also emerging evidence supporting the use of other psychological therapies with OAs, including Acceptance and Commitment Therapy (ACT; Luci et al., 2016; Wetherell et al., 2011). Having a range of empirically supported therapies (ESTs) for OAs, provides room for choice and preference accommodation. However, the recent focus on developing ESTs, and providing interventions in line with *'The Matrix'* (NES, 2015), has

deemphasized the importance of the two other critical components of EBP (as defined by Sackett et al, 2000), i.e. clinician expertise and patient preferences and values. This may explain the observed gap between research and practice (TenHave et al., 2003).

A small, but significant literature indicates that clinicians discount research evidence in favour of using their clinical experience to inform treatment decisions (Gyani et al., 2014; Safran et al., 2011; Stewart et al., 2018). Clinicians may have valid reasons for their reluctance to implement ESTs, such as small, unrepresentative samples in psychological treatment outcome studies (Corrigan & Salzer, 2003) and insufficient evidence to inform all treatment decisions (Stewart et al., 2018). However, there are well-documented flaws associated with clinicians relying solely on their experience when making decisions (e.g. Lilienfeld et al., 2013). A recent review of the factors that influence decision-making found that none of the surveyed clinicians based their treatment decisions on patient preferences (Stewart et al., 2018), despite evidence that patients and clinicians have differing views concerning the tasks and goals of treatment (Moritz et al., 2017). Therefore, work needs to be done to increase clinicians' awareness of research that highlights the importance of incorporating patient preferences when making decisions about their treatment.

Patient Preferences

Patient treatment preferences have been defined as 'the behaviours or attributes of the therapist or therapy that a client values or desires' (Swift et al., 2011, p. 151), and divided into three categories: therapy tasks, therapy format and therapist characteristics (Swift et al., 2018). Treatment preferences are thought to arise from previous experience, which influences patients' appraisal

of treatment options and subsequently their motivation to change and engage (Corrigan & Salzer, 2003). In their recent meta-analysis, Swift et al. (2018) found that accommodating client treatment preferences for psychotherapy resulted in less drop out and better outcomes. These results were in line with previous research (Swift et al., 2011), but some contradictory findings do exist (e.g. Leykin et al., 2007). Despite this variability in results, preferences likely have an indirect effect on outcome through factors such as engagement, adherence, and satisfaction (Winter & Barber, 2013).

To summarise, there is disproportionate attention given to ESTs in research and clinician experience in decision-making, at the expense of patient preferences (Stewart et al., 2018), despite findings suggesting they play a significant role in therapy attendance and outcomes (Swift et al., 2018). However, it is recognised that the literature addressing patient preferences is limited, and more recent and robust research is required, for example, to determine if existing findings are replicable with different patient groups. To date, little attention has been given to patients' preferred treatment outcomes (i.e. what they hope to gain from therapy; Eiring et al., 2015). Furthermore, studies have described the relative pros and cons of methods previously used to elicit patient preferences, but no preferred method has been identified (Ryan et al., 2001; Swift et al., 2018). In their systematic review of techniques used to elicit public preferences for healthcare, Ryan et al. (2001) recommended that research be carried out to test the available methods. Therefore, we aimed to test preference identification methods with OAs and examine if clinicians take account of these preferences when making decisions about treatment.

The Impact of Coronavirus Disease 2019 (COVID-19)

During the design of this study, COVID-19 was recognised as a global pandemic (World Health Organization, 2020) and public health measures, such as physical distancing and self-isolation, were introduced to contain the spread of the virus. OAs (age 70 and over) were declared a high risk group and encouraged to self-isolate following emerging data emphasising their increased mortality after contracting COVID-19 (NHS, 2020). According to the BPS' 'Faculty of the Psychology of Older People' (BPS-FPOP, 2020a), self-isolation was predicted to have significant mental health implications for OAs, including higher levels of mental distress and loneliness. BPS-FPOP (2020b) argued that the effects of self-isolation are more likely to have a detrimental, long-term effect on OAs' mental health the longer these symptoms and isolation persist. This view was supported by Brooks et al. (2020) in their review of the psychological impact of quarantine. They identified multiple stressors that can exacerbate the psychological effects of quarantine, ranging from boredom and inadequate information to infection fears and lack of essential supplies. Investigating the true impact of COVID-19 on the mental health of OAs is ongoing, but it is likely that OAs are experiencing a number of these stressors. Therefore, their recent experiences may influence their treatment and outcome preferences for psychological therapy in the future. Mental health services need to prepare for the most likely eventualities so that they can adequately meet the psychological needs of OAs going forward.

The UK government's restrictions on face-to-face contact led to the implementation of contingency plans within the NHS to ensure clinical contact with patients was maintained, as much as was reasonably practicable. For most

psychological services, this involved switching to remote delivery of psychological therapies via telephone or video calls. While technologically able OAs may adjust well to this change, digital delivery of psychological therapies may not suit all OAs (BPS-FPOP, 2020a). Therefore, it could become an access to care barrier, especially as remote delivery methods may remain at the core of service delivery within psychological services for OAs for some time. This study was therefore re-designed with COVID-19 and concomitant changes to service delivery in mind.

AIMS

The primary aim was to establish the feasibility and acceptability of using self-report questionnaires to elicit OAs' mental health treatment and outcome preferences and determine whether clinicians consider these preferences when selecting treatment. Hence, our focus is on understanding the response patterns from both people receiving services and the clinicians responsible for delivering psychological therapies. The secondary aim was to describe the mental health treatment and outcome preferences of OAs receiving psychological therapy during COVID-19 (including their preferences for remote delivery methods), and if clinicians account for patient preferences when selecting treatments.

Research Questions

<u>Feasibility:</u>

1) What are the recruitment rates of eligible participants?
    a) What proportion of participants are lost at each stage in the recruitment process?

b) What reasons are given for refusal/ineligibility?

Acceptability:

2) Is a self-report questionnaire, delivered remotely, an acceptable means of investigating OAs' treatment and outcome preferences/whether clinicians account for patient preferences when selecting treatments?
    a. Are participants able to understand the questionnaire items?
    b. Does the questionnaire take a reasonable amount of time to complete?
    c. Do participants think the questionnaire items are relevant to them?

Exploratory Analyses:

3) What are OAs' treatment and outcome preferences during COVID-19?
4) Do clinicians account for patient preferences when selecting treatment?
5) What factors influence clinicians' use of patient preferences when selecting treatments?

METHODS

Design

This study used a cross-sectional, quantitative design and aimed to describe the feasibility and acceptability of study procedures, in line with the Medical Research Council's guidance on process evaluation of complex interventions (Moore et al., 2015). Because variations in uptake of psychological therapies will be a major factor in determining treatment response, taking a complex intervention process evaluation approach is warranted.

Participants

Patient Participants

Patients were recruited from those receiving psychological therapy for a mental health problem within NHS Lanarkshire's Psychological Therapies for Older People (PTOP) and had the capacity to consent to research. PTOP typically accepts referrals of people aged 65 years or older, but younger patients presenting with issues related to ageing may also be seen and were thus eligible to participate. Patients whose command of English required an interpreter or who presented with significant current risk to themselves and/or others, were not eligible to participate.

Clinician Participants

Clinicians who deliver psychological therapy to OAs with mental health difficulties were recruited from OA psychology teams in three Scottish Health Boards: NHS Lanarkshire, NHS Greater Glasgow and Clyde and NHS Highlands. Therefore, this was a multi-site study.

Justification of Sample Size

Due to the feasibility focus of this study, and in line with NIHR (2019) guidance, no formal sample size calculations were completed. A target sample size of 30 patient participants, as previously recommended for feasibility studies (Browne, 1995), was thought sufficient to address the study questions. Similarly, the aim was to recruit as many eligible clinicians as possible, but a minimum of 30.

Procedures

Patients

Patients were recruited by clinician referral. PTOP clinicians (independent of the research team) informed eligible patients on their caseload about the study. The contact details of patients who expressed interest in taking part were passed on to the researcher, who sent them the Participant Information Sheet (PIS; Appendix 2.3) and consent form (Appendix 2.4) by their preferred method (i.e. by email or in the post). The researcher then contacted interested patients by telephone to arrange a suitable appointment time to discuss the study further. During this appointment, which occurred remotely by telephone, the researcher went through the PIS and consent form, to check understanding; re-confirmed eligibility, to ensure accuracy; and answered the patients' initial questions. Patients were advised that participation was voluntary, and they could withdraw at any time. They were given at least 24 hours to decide if they wished to participate.

It was originally planned that patients would complete the study procedures in a face-to-face appointment with the researcher, at an NHS site or in the participants' home (as required). However, study procedures were updated following COVID-19 and the introduction of social-distancing measures. Therefore, participants were given the choice of completing the study procedures electronically or using paper copies sent in the post. Participants opting to receive paper copies were provided with a stamped envelope so they could return completed questionnaires for free. All participants were required to provide online/written consent.

Clinicians

Clinicians were invited to participate via an email circulated on 30th November 2020 by the Heads of Older People Psychology (HOOPs) in each participating health board. The email contained information about the study (PIS; see Appendix 2.5) and a link to the questionnaire, hosted on Surveymonkey.com. The PIS informed clinicians that their participation was voluntary and completely anonymous. All participants were asked to provide online consent (see Appendix 2.6). A participation reminder email was sent a month after the original email was circulated, using the same process.

Data Collection

Patient Sociodemographic data

Sociodemographic data that has previously been associated with patient preferences was collected directly from patients as part of study procedures. This included age; sex; self-reported presenting problem and previous experience of psychological therapy.

Clinician Demographics

Previous research identified a number of clinician characteristics that influence whether they consider patient preferences when making clinical decisions, such as: their highest professional qualification, years of clinical experience, and main therapeutic modality (Gyani et al., 2014; Morrow-Bradley & Elliott, 1986; Safran et al., 2011; Stewart et al., 2018). This information was collected directly from clinicians as part of study procedures (see Appendix 2.7).

Measures

Two self-report questionnaires were adapted from previous research for this study.

Patient Preferences Questionnaire (PPQ; Appendix 2.8)

Patient participants were asked to complete the PPQ, a 51-item self-report measure of patients' preferences for various aspects of psychological therapy. The PPQ encompasses instructions and items from the *Psychotherapy Preferences and Experiences Questionnaire* (PEX; Clinton et al., 1999), a measure of preferences that has been found to have good internal consistency (Clinton & Sandell, 2014). However, the PEX has not been used with OAs. Therefore, the PPQ also incorporates items from a list of psychological therapy tasks and outcomes, developed as part of a previous preferences study with OAs in PTOP (Butrimaviciute, 2020). Butrimaviciute (2020) generated this list by identifying the key tasks involved in and expected outcomes of the psychological therapies recommended in the *Older Adult Mental Health Matrix* (NES, 2015), and the list was reviewed by PTOP clinicians (with experience of delivering psychological therapies to OAs).

PPQ items are grouped into four sub-sections: therapy delivery format, therapist characteristics and approach, psychotherapy tasks, and psychotherapy outcomes. Each item is preceded by the phrase 'I would prefer to…' and participants are asked to rate how much they agree with this statement using a Likert scale that ranges from 'Not at all' (scored as 1) to 'Completely' (scored as 6). The PPQ takes approximately 25 minutes to complete. Given that it was developed for this study and the feasibility/acceptability nature of the study, the PPQ has yet to be validated for

use with OAs. Further details of its' items and their origins can be found in Appendix 2.9.

Clinician Decision-Making Questionnaire (CDMQ; Appendix 2.10)

Clinician participants were asked to complete the CDMQ, a 26-item self-report questionnaire that aims to measure different factors that affect their decision-making. It has three subsections: the first section was adapted from Morrow-Bradley and Elliot (1986) and asks clinicians to rate the extent to which different factors impact on their decision-making when selecting treatments; the second section asks clinicians to rate the extent to which different factors influence whether they consider client preferences when selecting treatments; and, the third section was added during the COVID-19 pandemic to explore whether the concomitant changes to service provision have influenced clinicians' ability to accommodate patient preferences.

Clinicians are asked to rate how influential each factor is on their decision-making using a six-point scale that ranges from 'Not at all' (scored as 1) to 'More than any other factor' (scored as 6). This scale was used in Morrow-Bradley & Elliot (1986). The CDMQ takes approximately 20 minutes to complete. See Appendix 2.11 for further details of its' items and their origins.

Acceptability of Measures

Participants were asked three questions pertaining to the feasibility and acceptability of the measure they completed (i.e. PPQ or CDMQ). These questions addressed questionnaire length, understandability, and relevance.

Data Analysis

All data were analysed using SPSS, version 27. Descriptive statistics were used to address each of the study questions in turn.

Q1. The number of patients to progress through each stage of recruitment, along with their reasons for non-engagement/exclusion was recorded. Recruitment, response, and completion rates were calculated.

Q2. Descriptive statistics of participant responses regarding the length, understandability and relevance of the questionnaires were calculated and presented.

Q3, 4 and 5. Exploratory analyses were conducted with participants' responses on the questionnaires to obtain initial indications of response distributions.

Ethical Considerations

West of Scotland Research Ethics Service gave favourable opinion for the study (Ref: 20/WS/0143). NHS Research and Development Management Approval was also obtained from each participating health board. Copies of these approval letters are available in Appendix 2.2.

RESULTS

Feasibility

Patient Participants

Patient participants were recruited between 16th November and 31st December 2020. During this recruitment period, ninety-eight patients were receiving psychological therapy from fifteen PTOP clinicians and forty of these (40.8%) were informed about the study by their treating clinician. Clinicians'

main reasons for not discussing the study with a patient were case complexity (i.e. multi-morbidity, severe or enduring mental health difficulties and/or significant distress) and/or suicidality. Twenty-eight patients (70%) agreed to be contacted by the researcher to discuss the study further. Three of the referred patients were not contactable by phone and voicemail messages could not be left, due to data protection. Of the twenty-five patients (63%) whose eligibility was reassessed, twenty-one (53%) verbally agreed to participate, but only eighteen (45%) provided written consent and returned their completed questionnaires (Figure 2). The sample attrition rate from verbal consent to study completion was 14.3% (i.e. study response rate was 85.7%).

Patient demographic characteristics are summarised in Table 3 (data missing for two participants). Most participants were female, under the age of 85 and had previous experience of psychological therapy. Approximately half of the participants sought treatment for more than one co-morbid mental health problem.

Table 3: Sociodemographic information for Patient Participants in current therapy

	Responses* (n=16)
Age	
65-74	11(61.1)
75-84	5(27.8)
Sex:	
Female	11(61.1)
Male	5(27.8)
Presenting Problem**	
Low Mood	7(38.9)
Anxiety	13(72.2)
Loneliness	3(16.7)
Trauma	2(11.1)
Difficulties adjusting to a major life event	1(5.6)
Complicated grief	3(16.7)
Trouble sleeping	6(33.3)
Difficulties coping with a physical health condition	7(38.9)
Previous experience of psychological therapy	
Yes	10(55.6)
No	6(33.3)

*Values are n(%)

**Total percentage more than 100% as patients could select multiple responses

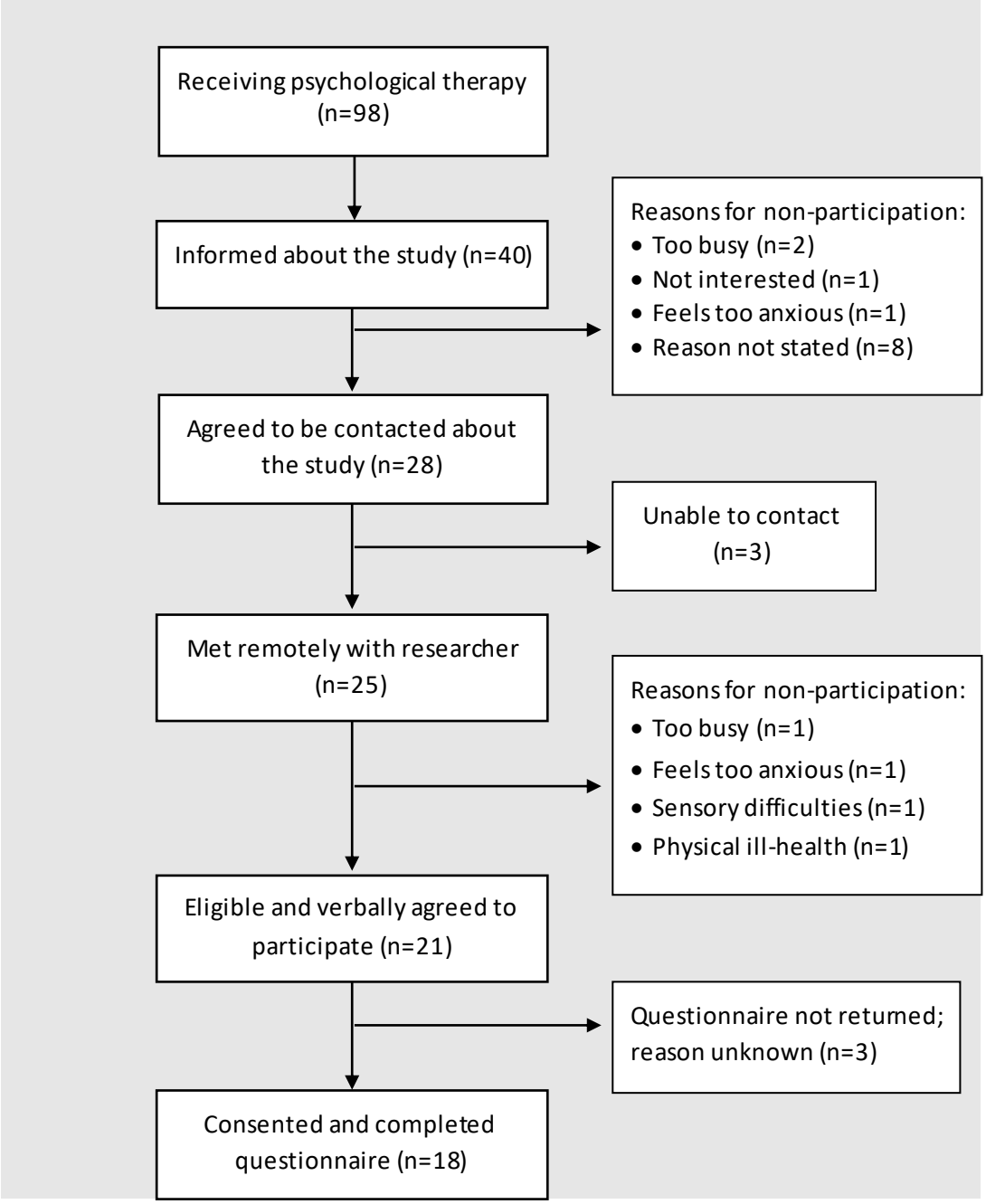

Figure 2: Patient flow through recruitment stages

Clinician Participants

Clinician participants were recruited between 30th November and 31st December 2020. It was estimated that 45 clinicians were eligible for recruitment from participating health boards during this time. Twenty-seven of these (60%)

provided online consent and started the CDMQ, but one discontinued the questionnaire prior to completion. Clinicians had between 1- and 17-years clinical experience (M=8.2, SD=4.7), and were mostly Clinical Psychologists (n=20, 76.9%). The other clinicians stated their highest level of qualification was a master's degree (n=5, 19.2%) or a Postgraduate diploma without a research component (n=1, 3.9%). Clinicians varied in terms of their main therapeutic modality: CBT was selected most frequently (n=11, 42.3%), followed by 'eclectic or integrative mix' (n=10, 38.5%); Acceptance and Commitment Therapy (n=3, 11.5%) and Compassion Focused Therapy (n=2, 7.7%).

Acceptability

Acceptability of PPQ

All respondents (n=18) rated the PPQ length as 'About Right' and its' items as relevant (n=16, 88.9%) or 'Sort of' relevant (n=2, 11.1%) to their circumstances. In addition, respondents rated the PPQ as 'Very Easy' (n=6, 33.3%), 'Easy' (n=7, 38.9%) or 'Okay' (n=5, 27.8%) to understand. Overall, patient participants seemed to find the PPQ acceptable.

Acceptability of CDMQ

Most clinicians rated the CDMQ length as 'About Right' (n=24, 88.9%), but two thought it was 'Too Short' (7.4%). Its' items were rated as relevant (n=23, 85.2%) or 'Sort of' relevant (n=3, 11.1%), and 'Very Easy' (n=18, 66.7%), 'Easy' (n=6, 22.2%) or 'Okay' (n=2, 7.4%) to understand. Therefore, acceptability of the CDMQ appeared to be good, despite data missing data for one clinician (completion rate = 96.3%).

Patient preferences

Response distributions for the PPQ's four sub-sections are explored below (frequency data for each item is available upon request).

Treatment preferences

Psychotherapy Delivery Format (see Table 4):

Patients' most preferred therapy format, on average, was individual face-to-face therapy in a clinic, followed by individual therapy over telephone and individual face-to-face therapy at home. Patient ratings for other delivery formats, including individual therapy over video call, were relatively low and group therapy over video call was the least preferred. However, participants seemed to vary in their preferences, which was illustrated by the dispersion of ratings (i.e. range) for each therapy format. Item completion rates for this subsection ranged from 78 to 94%.

Table 4: Preferences for therapy delivery format

	N	Mean(SD)	Mode	Range
Individual therapy over telephone	15	3.9(1.8)	6	5
Individual therapy over video call	14	2.6(2.1)	1	5
Individual, face-to-face therapy in clinic	17	4.1(1.9)	6	5
Individual, face-to-face therapy at home	15	3.4(2.2)	1	5
Group therapy over video call	16	1.6(1.1)	1	4
Self-help workbooks with remote therapist support	16	2.5(1.7)	1	5
Unguided Computerised-CBT	16	2.0(1.3)	1	4

Therapist Characteristics and approach (see Table 5):

On average, more participants preferred a female therapist to a male. In terms of therapist approach, the strongest preferences (in either direction) were 'a therapist who listens and tries to understand' (preferred) and 'a therapist who tells me what to do' (not preferred). Dispersion of scores (i.e. SD and range) on

these two items was low, demonstrating most participants held a strong preference for them. Item completion rates for this subsection ranged from 89 to 94%.

Table 5: Preferences for therapist characteristics and approach

	N	Mean(SD)	Mode	Range
Male Therapist	16	3.7(2.3)	6	5
Female Therapist	17	4.9(1.8)	6	5
A therapist who gives advice	17	5.0(1.1)	6	4
A therapist who provides practical support	17	4.8(1.7)	6	5
A therapist who is non-judgmental	16	5.4(0.9)	6	2
A therapist who tells me what to do	17	3.2(1.9)	1	5
A therapist who validates my experiences	17	4.8(1.5)	6	5
A therapist who listens and tries to understand	17	5.7(0.6)	6	2

Therapy Tasks (see table 6):

Based on mode values, participants considered most of these tasks important (‘6’ = ‘Completely’ prefer). ‘Learn ways to be less critical of me’ was the most preferred task and the task with the strongest preference. ‘Reflect on painful memories’ was the least preferred task in terms of mean value, but the mode demonstrates many participants preferred this ‘Completely’. Item completion rates for this subsection ranged from 89 to 94%.

Table 6: Preferences for therapy tasks

	N	Mean(SD)	Mode	Range
Notice and change unhelpful thoughts	17	5.2(1.4)	6	5
Notice and change unhelpful patterns of behaviour	17	5.2(1.5)	6	5
Learn to face situations I fear (reduce avoidance)	17	5.1(1.2)	6	4
Reflect on painful memories	16	4.2(1.8)	6	5
Learn ways to become more active	17	4.5(1.5)	5*	5
Learn strategies and skills to deal with problematic situations	17	5.2(0.9)	6	2
Learn to take my thoughts less seriously and be less caught up in them	17	5.1(1.2)	6	4
Learn to be ok with unwanted emotions, even if I can't get rid of them completely	17	4.9(1.3)	6	4
Learn meditation techniques	17	4.8(1.6)	6	5
Clarify my values	17	5.1(1.0)	6	3
Build kindness and self-compassion	17	5.0(1.0)	5	4
Learn ways to be less critical of me	18	5.3(0.8)	6	2
Explore links between earlier life and how this affects my life presently	18	4.7(1.5)	6	5
Learn skills for improving my relationships	18	4.4(1.6)	6	5
Develop skills to overcome loneliness	18	4.3(1.7)	5*	5
Talk over the course of my life	18	4.7(1.6)	6	5
Explore the loss of a loved one	17	4.4(1.7)	6	5
Talk about major life changes to help me adjust to them	18	4.5(1.6)	5*	5

*Multiple modes exist. The smallest value is shown.

Outcome preferences (Table 7)

Again, based on mode values, participants considered most of these outcomes important ('6' = 'Completely' prefer). According to means, the most preferred outcome was 'feel more confident' and the least preferred was 'feel less lonely'. However, a wide range of responses were selected for the latter. Item completion rates for this subsection ranged from 89 to 100%.

Table 7: Outcome Preferences

	N	Mean(SD)	Mode	Range
Have a sense of purpose and meaning in my life	16	5.3(1.1)	6	3
Feel more hopeful*	17	5.5(0.9)	6	3
Like myself	17	5.4(0.9)	6	3
Have more energy to do things	17	5.4(0.7)	6	2
Have improved relationships with others	17	4.9(1.2)	6	4
Feel less lonely*	17	4.3(1.8)	6	6
Have learned how to focus less on/worry less about my physical health	17	5.1(1.4)	6	6
Feel more able to cope with uncertainty*	17	5.0(1.2)	6	3
Sleep better	16	5.0(1.6)	6	5
Have more things to do in my week	17	4.6(1.3)	4	5
Feel less troubled by past memories	18	5.4(0.9)	6	3
Have learned to live with pain and other physical difficulties	17	5.1(1.4)	6	6
Feel more confident	17	5.6(0.6)	6	2
Be less bothered by worries	18	5.4(0.8)	6	2
Have learned how to manage my nerves and uncomfortable feelings in my body	18	5.1(1.4)	6	5
Have made sense of my life	17	5.1(1.1)	6	4
Have come to terms with the loss of somebody	17	4.8(1.1)	6	5
Have adjusted to major life changes	17	4.5(1.7)	6	5

*added in response to COVID-19 and the predicted impact of self-isolation

Clinician decision-making

Frequency data for clinicians' responses is available upon request.

Factors that influence clinicians' decision-making when selecting treatments (see Table 8)

This section of the CDMQ asked clinicians to rate the relative impact of various factors on their decision-making when selecting treatments. The mean ratings suggest that the factors with the most influence on clinicians' decision-making were their own experience with clients, best practice guidance and supervision/consultation with others. The least influential factor was clinicians'

own experience of being a client. In terms of patient preferences, clinicians were most influenced by patients' preferences for format of therapy, but preferences for therapy tasks and outcomes were considered 'moderately' influential, on average. Completion rate for this section of the CDMQ was 100%.

Table 8: Factors that influence clinicians' decision-making

	N	Mean(SD)	Mode	Range
Best Practice Guidance	27	4.6(0.8)	5	4
Quantitative Research	27	3.8(0.8)	4	3
Qualitative Research	27	3.0(0.9)	3	4
Information from CPD events	27	3.7(0.9)	3	3
Your own clinical experience with clients	27	4.7(0.7)	5	3
Your own experience of being a client	27	1.9(1.0)	1	3
Supervision/ consultation with others	27	4.6(0.8)	5	3
Client preferences for tasks of therapy	27	4.3(1.1)	4	4
Client preferences for format of therapy	27	4.4(1.2)	5	4
Client outcome preferences	27	4.3(0.9)	4	3

Factors that affect whether clinicians' take account of preferences (see Table 9)

Most factors had a mode value of '5', which means they were most frequently rated as having 'a great deal' of influence on whether clinicians consider patient preferences. The one exception to this was clinicians' 'own preference for treatment modality', which was rated to have the least influence on this decision. According to means, the factors with the most influence on whether clinicians consider patient preferences were client insight and previous experience of mental health support. The completion rate for this section of the CDMQ was 96%.

COVID-19 Questions

All respondents stated they had to make changes to the way they delivered psychological therapies in response to COVID-19 and related public health measures, and the majority (n=21; 77.8%) believed that changes (e.g.

remote methods of delivery), would continue with OAs following the relaxation of infection control measures. All but one respondent (92.6%) believed these changes had made it more difficult for them to accommodate patients' treatment preferences, including their preferences for delivery format and/or tasks of therapy.

Table 9: Factors that affect whether clinicians consider preferences

	N	Mean(SD)	Mode	Range
Type of Presenting Problem (PP)	26	4.2(1.1)	5	4
Severity of PP	26	4.3(0.8)	5	2
Case complexity	26	4.3(0.9)	5	3
Presence of co-morbidities	26	3.9(1.0)	5	3
Client insight into their difficulties	26	4.4(0.8)	5	2
Client's previous experience of mental health support	26	4.4(0.8)	5	3
Strength of client preferences	26	4.2(0.8)	5	2
Own preferences for treatment modality	26	3.4(0.9)	3	4

DISCUSSION

This study aimed to establish the feasibility and acceptability of using self-report questionnaires to elicit OAs' mental health treatment and outcome preferences and determine whether clinicians consider these preferences when selecting treatment. It also aimed to describe preliminary data from participants' responses to the questionnaires.

Feasibility and Acceptability

Patient Participants

Eighteen patients were recruited into the study. The majority of OAs receiving psychological therapy within PTOP during the recruitment period were not informed about the study. Clinicians justified their decision not to refer

certain patients based on their clinical complexity and/or concerns about risk. The latter is likely due to the study's exclusion criteria, but patients with complex difficulties who do not present with risk could have been referred. Some clinicians raised concerns about the PPQ length and questioned its appropriateness for OAs due to issues with response burden (i.e. the effort required to answer a questionnaire). Evidence supporting the association between questionnaire length and response burden is limited (Rolstad et al., 2011), and the PPQ length was justified by the feasibility/acceptability focus of this study. It is possible that individual clinicians' attitudes about research in general, the study procedures and what is appropriate for OAs may have influenced who they informed about the study and led to unequal opportunities to participate across the service.

Other barriers to recruitment were inconvenience (e.g. busy time of year), difficulties contacting patients by phone and physical illness. Patients' reasons for non-engagement and dropout were not always stated and could indicate issues with study feasibility. Furthermore, one interested patient was unable to participate independently due to them being registered blind and living alone, and the researcher did not have ethical approval to assist their completion of the questionnaire. Due to OAs commonly presenting with sensory difficulties (Scottish Government, 2014), this issue requires careful consideration in future research to ensure equal opportunity to participate.

To our knowledge this is the first study to use a self-report questionnaire to measure treatment and outcome preferences for psychological therapies with OAs. Overall acceptance of the PPQ was good and ratings of relevance and understandability were high. In addition, despite concerns raised by clinicians

about the length of the PPQ, all patients rated it to be ‘about right’. However, item completion rates varied across the PPQ (range: 78-100%) and represented missing data from seven participants. Reasons for missing data are unknown but could indicate an issue with questionnaire acceptance. For instance, participants possibly skipped items that did not apply to them rather than stating a low preference. This could suggest that PPQ instructions need to be amended for clarity, though item completion is generally a recognised problem in research that uses posted questionnaires with OAs (Palonen et al., 2016).

Clinician Participants

Twenty-seven clinicians were recruited across the four week recruitment period, which is slightly below the target sample. We hoped to recruit as many clinicians as possible from across all Scottish Health Boards, but HOOPs in only three health boards had agreed to circulate the CDMQ before ethics submission. This significantly reduced the number of clinicians available for recruitment. In terms of study acceptability, most clinicians rated the CDMQ length as ‘about right’ and they generally felt the items were relevant to them and easy to understand. One clinician discontinued the CDMQ prior to completion, but the forced-choice format of the online questionnaire meant that data was otherwise complete. Overall, data suggests that acceptability of the CDMQ was good.

Patient Preferences

There are several limitations that should be considered when interpreting these preliminary findings, including the potential impact of outliers due to the small sample size and social desirability bias due to the self-report nature of the PPQ. Furthermore, the dispersion of ratings on individual items highlights

heterogeneity in patient preferences, which is a known difficulty when attempting to generalise preferences findings (Meara et al., 2019). However, some patterns in the data warrant closer analysis and discussion, provided below.

In terms of psychotherapy delivery format, patients showed a strong preference for in-person or telephone therapy over remote, digital options, which included computerised CBT and video-call delivered therapy. This poses a challenge to the Scottish Government's (2020) *COVID-19 Mental Health Transition and Recovery Plan* to OAs. This plan recognises that OAs may not have access to digital technologies, but it does not describe how services should meet OAs' mental health needs without the use of digital therapy. Beyond policy implications, services may be restricted in their ability to offer in-person therapy during and after COVID-19. This limits their ability to accommodate this preference, which could have implications for therapy adherence, engagement and outcome, in line with previously reported findings (Swift et al., 2018). The present study did not record whether participants had experience of psychological therapy delivered remotely. This would be a useful line of subsequent enquiry given previous research found that experience influences preferences (Corrigan & Salzer, 2003). Increased understanding of 'if and why' preferences change with experience of remote therapy could be used to determine how best to present this option to OAs who are ambivalent about engaging remotely.

Patients expressed a preference for a therapist of a particular sex, with most preferring female therapists. This comports with previous studies (Pikus & Heavey, 1996), but is devalued by participants' ability to express a strong

preference for both sexes simultaneously in this study. This highlights the limitations of using a questionnaire to elicit preferences, as it does not mimic the trade-offs inherent in real life decision-making.

On average, patients showed positive preferences for most tasks, which demonstrates the clinical utility of the therapy modalities represented in the PPQ, with OAs. For instance, the most preferred task was 'learning ways to reduce self-criticism', which could be met through the provision of psychological therapies that specifically incorporate this task. However, this was one of two PPQ items that relates to Compassion Focused Therapy (CFT; Gilbert, 2010), the efficacy of which is yet to be established with OAs. Therefore, this illustrates a gap between clinical need and research, which would benefit from exploration.

There was little variance in the mean values for outcome preferences, suggesting they were all desired by participants to some extent. Three outcomes were added to the PPQ in response to COVID-19, and the predicted impact of self-isolation on OAs' mental health. These items included: 'feel more hopeful', which was the second most preferred outcome on average; and 'feel less lonely', which was the least preferred outcome on average. These preferences could be guided by participants' presenting problems. For instance, the majority of the sample self-identified anxiety as one of their reasons for seeking treatment, which is often associated with worries about worst case scenarios. Therefore, psychological therapy that targets anxiety may result in them feeling more hopeful. Fewer participants identified depression as one of their reasons for seeking treatment, which could explain why feeling less lonely was a less preferred outcome, as the two are often related.

Clinician Decision-making

EBP has three components: ESTs, clinician expertise and patient characteristics/preferences (Sackett et al., 2000). Clinicians identified their own clinical experience as the component that has the most influence on their decision-making when selecting treatments, followed by published best practice guidance. These finding are consistent with previous research that found clinicians favour their own clinical experience over research evidence when making treatment decisions (Gyani et al., 2014; Safran et al., 2011; Stewart et al., 2018). However, clinicians in this study rated patient preferences to have 'quite a lot' of influence on their decision-making about treatments, which contrasts to prior research finding the opposite (e.g. Stewart et al., 2018). It is possible that the self-report nature of the CDMQ may have introduced social desirability bias to these results.

Factors that influence whether clinicians considered patient preferences were also investigated with the CDMQ and the most influential factors were client insight and previous experience of mental health support. However, due to the way this question is worded (i.e. 'How much does this factor influence whether I consider client preferences when selecting appropriate treatments?'), it is unclear if clinicians are more or less likely to accommodate patient preferences based on these factors. This relationship could be explored in future research.

Additional items were added to the CDMQ to explore the impact of COVID-19 on psychological services for OAs. Most clinicians believed that changes in service provision such as remote and/or digital delivery of therapy would continue to be used following COVID-19 and that these changes made it

more difficult for them to accommodate patient preferences for delivery format. This further illustrates the mismatch between what services can offer during and after COVID-19 and the preferences of OAs seeking treatment.

Strengths and Limitations

This study demonstrates the feasibility of recruiting OAs and clinicians to research during the COVID-19 pandemic. However, as with all small n, feasibility studies, caution is required when interpreting the preliminary findings due to the potential impact of outliers and heterogeneity of responses. Additionally, the exclusion of patients with greater clinical risk and/or complexity potentially introduced selection bias, raising issues with sample representativeness. It is possible that the excluded patients represent a 'harder to reach' group and thus understanding their treatment and outcome preferences would support services to offer them acceptable interventions. Data on participant race/ethnicity was also not collected, further limiting the interpretation and generalisability of results.

The fact that clinicians identified eligible patients from their caseload is another limitation of this study. In addition to being a barrier to recruiting certain clients, it could have introduced power imbalance issues in therapeutic relationships. For instance, although patients were assured that non-participation would not affect their current or future NHS care, they may have felt obligated to participate. Timing of recruitment is another limitation, in that all participants were engaged in psychological therapy when approached about participating. The study could have highlighted discrepancies between patients' preferences and what they were receiving, but the impact of this on their engagement and/or progress in therapy is unknown.

The questionnaires themselves also have limitations. Firstly, the PPQ did not consider patient preferences for therapists of a particular race/ethnicity, and other protected characteristics, as services are unlikely to accommodate such preferences for ethical reasons (i.e. to prevent discrimination). However, it could have been valuable to explore the existence of these preferences, as certain patients may have valid, therapeutic reasons for needing them accommodated. Secondly, we aimed to identify an efficient means of eliciting patient preferences, and the development and trialling of the PPQ was a good starting point, but formal feedback from participants about questionnaire format and language was not elicited. Therefore, we do not know how patient participants felt about the language used in the questionnaire (e.g. do they prefer 'talking therapy' to 'psychotherapy'?). It will be important to elicit such feedback as the questionnaire continues to be refined. Lastly, as items in the PPQ were largely based on *Matrix* recommended psychological therapies for OAs (NES, 2015), content is lacking on underrepresented presenting problems, such as psychosis. This is a significant limitation of the PPQ, as it does not encompass items relevant to all difficulties experienced by treatment-seeking OAs, and further highlights the gap between ESTs available for use with OAs and clinical need.

Implications and Future Research

The preliminary findings from PPQ data highlight the limitations associated with clinicians only basing their treatment decisions on 'the best available research evidence', which is usually interpreted as the findings of randomised controlled trials (RCTs). While these findings may evidence the efficacy of different therapeutic approaches in reducing mental health

symptoms, they fail to account for patient preferences. The current study suggests that patients' preferred outcomes (e.g. 'to feel more confident') differ to those assessed and reported in RCTs, and those routinely monitored in clinical practice. This finding comports with existing research into Patient Reported Outcome Measures (PROMs; e.g. Kingsley & Patel, 2017), which recognises the limitations of symptom improvement outcomes and the importance of understanding what matters to patients for improving service quality. Consequently, mental health funders are increasingly moving towards exploring and achieving patient identified outcomes (Hooper et al., 2020) and, once refined, the PPQ could support this by identifying outcomes of importance for OAs and informing appropriate selection of PROMs.

To refine the PPQ, future research should address the research questions with a larger, more representative sample, across a longer recruitment period. This research needs to consider means of improving patient referral rates, data completion for the PPQ and access to OAs with sensory impairments. The present study suggests that clinicians may have reservations about discussing research opportunities with clients with complex difficulties, regardless of their supposed eligibility. To address this recruitment barrier, future research will either need to increase clinician buy-in and understanding of the study rationale, or recruit via other methods (e.g. identify eligible patients through referral databases). To maximise data completion, Palonen et al. (2016) recommended collecting data in the presence of the researcher, as was the intended plan for this study prior to COVID-19. However, face-to-face appointments for research may not be feasible during and after COVID-19, and would introduce the usual barriers to recruiting OAs (e.g. physical frailty limiting

ability to attend appointments; Woodall et al., 2010). Instead, patients could complete the questionnaires in a remote appointment with the researcher held over telephone or video call (based on preference). Patient feedback on the format and language used in the PPQ should also be elicited.

Such research could address issues with measure standardisation and may reveal patterns in the data that were not observable due to the small sample in this study. This data could assist clinicians and researchers to better understand OAs treatment and outcome preferences and adapt services accordingly.

Conclusion

This study aimed to assess the feasibility and acceptability of using self-report questionnaires to elicit OAs treatment and outcome preferences and factors that influence clinicians' decision-making when selecting treatment. A reasonable number of patient and clinician participants were recruited despite challenges related to the COVID-19 pandemic. Acceptability of the questionnaires was good, but replication of the patient arm of this study with a larger sample would allow more meaningful interpretation of questionnaire data.

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APPENDICES

Appendix 1.1 Author guidelines for *Counselling and Psychotherapy Research*

(https://onlinelibrary.wiley.com/page/journal/17461405/homepage/ForAuthors.html)

The *Counselling and Psychotheray Research (CPR)* considers all manuscripts on the strict condition that:

- the manuscript is your own original work, and does not duplicate any other previously published work, including your own previously published work.
- the manuscript has been submitted only to *CPR: Linking research with practice*; it is not currently under consideration or peer review or accepted for publication or in press or published elsewhere.
- the manuscript contains nothing that is abusive, defamatory, libellous, obscene, fraudulent, or illegal.

Manuscript preparation

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and

reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

- The title page of the manuscript, including statements relating to our ethics and integrity policies:
    - data availability statement
    - funding statement
    - conflict of interest disclosure
    - ethics approval statement
    - patient consent statement
    - permission to reproduce material from other sources
    - clinical trial registration

1. General guidelines

- Manuscripts are accepted in English. British English spelling and punctuation are preferred. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of words or more should be indented.
- A typical manuscript will not exceed 7,500 words including tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- We also consider Brief Research Reports, that is, short descriptions of original research that make a single point, have a simple design or a limited number of variables, and make an important contribution to knowledge. Their text should not exceed 1500 words, they can include one table or figure, and up to 20 references.

- The American Psychological Association (APA) guidelines, revised according to the 7th edition, must be used to cite and reference sources.
- Articles must be typed in 12-point Ariel font and double-spaced throughout including the reference section, with wide (3 cm) margins. All pages must be numbered.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:

  - For single agency grants: "This work was supported by the [Funding Agency] under Grant [number xxxx]."
  - For multiple agency grants: "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."

- Abstracts of 250 words are required for all manuscripts submitted.
- Each manuscript should have 4 to 6 keywords.
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it.
- Each paper should include brief points on the implications of the findings: three Implications for Practice and one Implication for Policy.
- Section headings should be concise.

- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorised by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors. Please supply a short biographical note for each author (50 - 100 words).
- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research. For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors must not embed equations or image files within their manuscript.

2. Figures

- Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
- Figures must be saved separate to text. Please do not embed figures in the manuscript file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly. The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

Appendix 1.2 Annotated search strategy

A line-by-line search strategy was used for all databases. The example below shows how terms for the three groups were applied to EBSCOhost CINAHL (1937-present), when searched on 23/01/2021.

Table 10: Annotated search strategy

#	Searches
S1	(MH "Aged+")
[S1 is a subject heading for the population i.e. group 1: OAs]	
S2	TI older adult* OR AB older adult*
S3	TI older people OR AB older people
S4	TI older person* OR AB older person*
S5	TI older patient* OR AB older patient*
S6	TI elderly OR AB elderly
[S2-6 are textwords for OAs]	
S7	S1 OR S2 OR S3 OR S4 OR S5 OR S6
[S7 is the OAs group]	
S8	(MH "Psychotherapy+")
[S8 is a subject heading for the intervention i.e. group 2: psychological therapies]	
S9	TI cognitive behavio#ral therap* OR AB cognitive behavio#ral therap*
S10	TI psychodynamic psychotherap* OR AB psychodynamic psychotherap*
S11	TI psychological therap* OR AB psychological therap*
S12	TI psychological intervention* OR AB psychological intervention*
S13	TI CBT OR AB CBT
S14	TI cognitive therap* OR AB cognitive therap*
S15	TI behavio#ral therap* OR AB behavio#ral therap*
S16	TI acceptance n2 commitment therap* OR AB acceptance n2 commitment therap*
S17	TI dialectical behavio#ral therap* OR AB dialectical behavio#ral therap*
S18	TI compassion focused therap* OR AB compassion focused therap*
S19	TI interpersonal therap* OR AB interpersonal therap*
S20	TI mindfulness-based cognitive therap* OR AB mindfulness-based cognitive therap*
S21	TI schema therap* OR AB schema therap*
S22	TI problem-solving therap* OR AB problem-solving therap*
[S8-22 are textwords for psychological therapies]	
S23	S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22
[S23 is the psychological therapies group]	

#	Searches
S24	(MH "Telemedicine+")
S25	MH "Videoconferencing")
S26	(MH "Telephone+")
S27	(MH "Telepsychiatry")
[S24-27 are subject headings for intervention format i.e. group 3: remote delivery]	
S28	TI video conferenc* OR AB video conferenc*
S29	TI Telehealth OR AB Telehealth
S30	TI tele-mental health OR AB tele-mental health
S31	TI telemental health OR AB telemental health
S32	TI telepsychiatry OR AB telepsychiatry
S33	TI telepsychology OR AB telepsychology
S34	TI telepsychotherapy OR AB telepsychotherapy
S35	TI telecounseling OR AB telecounseling
S36	TI video call* OR AB video call*
[S28-S36 are textwords for remote delivery]	
S37	S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36
[S37 is the remote delivery group]	
S38	S7 AND S23 AND S37
[S38 all groups combined]	

Appendix 1.3 CTAM subscale scores

	Sample (Max 10)		Allocation (Max 16)			Assessment (Max 32)					Control (Max 16)	Analysis (Max 15)		Treatment (Max 11)			CTAM Total (Max 100)
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	
Brenes et al. (2012)	0	5	0	0	0	0	6	10	0	0	0	0	0	3	0	0	24
Brenes et al. (2015)	0	5	10	3	0	10	6	10	0	0	10	5	10	3	3	5	80
Brenes et al. (2016)	0	5	0	0	0	0	6	0	0	0	10	5	0	0	3	5	34
Brenes et al. (2017)	0	5	10	3	0	10	6	10	0	0	10	5	0	0	3	5	67
Brenes et al. (2020)	0	5	10	3	0	0	6	0	0	0	0	5	0	3	3	5	40
Wilz and Soellner (2016)	0	5	0	3	3	10	3	10	3	0	10	5	0	3	3	5	63
Wilz et al. (2018)	0	5	10	3	0	10	3	0	0	0	6	5	0	3	3	5	53
Barrera et al. (2017)	2	0	0	0	0	10	6	0	0	0	0	5	0	3	3	0	29
Doyle et al. (2017)	2	5	10	3	3	10	6	10	0	0	10	0	10	3	3	5	80
Wuthrich and Rapee (2019)	0	0	10	3	0	0	6	0	0	0	0	0	0	3	3	0	25
Dobkin et al. (2020)	0	5	0	3	0	10	6	10	0	0	6	5	0	3	3	0	51
Lazzari et al. (2011)	0	0	0	0	0	0	6	0	0	0	0	0	0	3	3	0	12
Lichstein et al. (2013)	2	0	0	0	0	0	3	0	0	0	0	0	0	3	3	5	16
Choi et al. (2014a)	2	5	0	0	0	0	6	0	0	0	10	5	10	0	0	5	43
Choi et al. (2014b)	2	5	10	3	0	0	6	0	0	0	10	5	10	3	3	5	62
Choi et al. (2016)	2	5	10	0	0	10	6	0	0	0	10	0	10	3	0	0	56
Choi et al. (2020)	2	5	10	3	3	0	6	0	0	0	10	5	10	3	3	0	60
Egede et al. (2015)	0	5	10	3	3	10	6	10	0	0	10	5	10	3	3	5	83
Egede et al. (2016)	0	5	10	3	3	10	6	10	0	0	10	0	10	3	3	5	78

Appendix 2.1 MRP Proposal

Assessment: MRP Proposal

Title: A feasibility study examining treatment and outcome preferences of older adults with mental health difficulties and the effects of preferences on clinician decisions about treatment options.

Matriculation number: 0704820c

Date: 27/01/2020

Version: 9

Actual wordcount: 3421

Max word count: 3000

ABSTRACT

Background: Evidence-based practice requires using the best available research evidence, in conjunction with clinical expertise and patient characteristics/preferences, to inform the provision of appropriate interventions. Although patient treatment preferences have a significant positive impact on psychotherapy attendance and outcome, they are often overlooked in clinical decision-making.

Aims: To establish the feasibility and acceptability of using self-report questionnaires to elicit older adults' (OA) mental health treatment and outcome preferences and determine whether clinicians consider these preferences when selecting treatment. The secondary aim is to establish a preliminary understanding of OA' mental health treatment and outcome preferences, and how clinicians account for patient preferences when selecting treatments.

Methods: Patients (over 65) and clinicians will be recruited from NHS Lanarkshire and asked to complete questionnaires (feasibility and acceptability testing) and gain preliminary descriptive data from responses to the questionnaires.

Applications: Findings will improve methods for understanding treatment and outcome preferences in OAs. This will help clinicians in services better understand what OAs prioritise when seeking treatment and what they think about psychological treatment options.

INTRODUCTION

Background

Scotland has an ageing population; with a 50% increase in over 60s projected by 2033 (Scottish Government, 2010). People in this age range often present with multiple psychological and physical comorbidities (NHS Education Scotland [NES], 2015). Consequently, improving the provision of and access to health and social care services, including mental health services, for older adults (OA; age 65+) is a priority for the (Scottish Government, 2017, 2019).

There are several barriers to achieving this priority, including increasing public expectations and financial constraints, but the Scottish Government hopes to overcome these by promoting the provision of 'realistic medicine' and 'person-centred care' (Scottish Government, 2018). These approaches seek to change how services are delivered by introducing shared decision-making, aimed at determining what matters most to individual patients and developing a personalised approach to their care. These strategies also uphold the ethical principles of peoples' right to self-determination and autonomy (e.g. British Psychological Society [BPS], 2018). Therefore, mental health services across Scotland need to adapt to this growing demographic and work jointly with patients to offer acceptable and beneficial interventions, including psychological therapies.

Evidence Based Practice (EBP)

Working within NHS Scotland mandates the delivery of EBP for the treatment of mental health difficulties (Gyani et al., 2014), which remains at the core of best practice. To date, most research into the efficacy of psychological therapies for OA has focused on Cognitive Behavioural Therapy (CBT) for depression or anxiety, which has been found to be as efficacious as other treatments and more effective than waiting list controls (Cuijpers et al., 2009; Hofmann et al., 2012). There is also emerging evidence supporting the use of other psychological therapies with OA, including Acceptance and Commitment Therapy (ACT; Luci et al., 2016; Wetherell et al., 2011), expanding the number of empirically supported therapies (ESTs) available to them. However, the recent emphasis on developing ESTs, and providing interventions in line with the guidance outlined in *'The Matrix'* (NES, 2015), has resulted in a reductionist view of EBP, largely neglecting its two other critical components: clinical expertise and patient characteristics (Sackett et al., 2000). This may explain the observed gap between research and practice (TenHave et al., 2003).

A small, but significant literature has accumulated indicating that clinicians discount research evidence in favour of using their clinical experience to inform treatment decisions (e.g. Gyani et al., 2014; Safran et al., 2011; Stewart et al., 2018). Clinicians may have valid reasons for their reluctance to implement ESTs, such as small, unrepresentative samples in psychological treatment outcome studies (Corrigan & Salzer, 2003) and insufficient evidence to inform all treatment decisions (Stewart et al., 2018). However, there are well-documented flaws associated with clinicians relying solely on their experience when making decisions (e.g. Lilienfeld et al., 2013). Furthermore, patients and

clinicians have been found to have differing views concerning the tasks and goals of treatment (Moritz et al., 2017), but a recent review of the factors that influence decision-making found that none of the surveyed clinicians based their treatment decisions on patient preferences (Stewart et al., 2018). Therefore, clinicians' current approach to decision-making disregards patients' expertise (Mühlbacher & Juhnke, 2013) and the emerging research that highlights the importance of patient preferences.

Patient Preferences

Patient preferences can be defined as "the behaviours or attributes of the therapist or therapy that a client values or desires" (Swift et al., 2011, p. 151), and divided into three categories: therapy tasks, therapy format and therapist characteristics (Swift et al., 2018). Treatment preferences are thought to arise from previous experience, which influences patients' appraisal of treatment options and subsequently their motivation to change and degree of engagement (Corrigan & Salzer, 2003). In their recent meta-analysis, Swift et al. (2018) examined the effects of accommodating client treatment preferences on psychotherapy dropout and outcome and found a small but significant effect in favour of clients who received their preferred treatment. These results were in line with previous research (e.g. Swift et al., 2011), but some contradictory findings do exist (e.g. Leykin et al., 2007 - found no significant impact of matching patients to their preferred treatment on outcome or dropout). Despite this variability in results, preferences are likely to have an indirect effect on outcome through factors such as engagement, adherence and satisfaction (Winter & Barber, 2013).

To summarise, there is disproportionate attention given to ESTs in research and clinician experience in decision-making, at the expense of patient preferences (Stewart et al., 2018), despite findings suggesting they play a significant role in therapy attendance and outcomes (Swift et al., 2018). Additional research is required to determine if these findings are replicable with different patient groups. To date, little attention has been given to patients' preferred treatment outcomes (i.e. what they hope to gain from therapy; Eiring et al., 2015). Furthermore, studies have described the relative pros and cons of a variety of methods that have been used to elicit patient preferences, but no preferred method has been identified (Ryan et al., 2001; Swift et al., 2018). In their systematic review of techniques used to elicit public preferences for healthcare, Ryan et al. (2001) recommended that research be carried out to test the available methods. Therefore, we will test preference identification methods with OAs and examine how clinicians take account of these preferences when planning treatment.

AIMS

To establish the feasibility and acceptability of using self-report questionnaires to elicit OA' mental health treatment and outcome preferences and determine whether clinicians consider these preferences when selecting treatment. The secondary aim is to describe OA' mental health treatment and outcome preferences, and how clinicians account for patient preferences when selecting treatments.

Study Questions:

Feasibility:

1. What are the recruitment rates of eligible participants?
    a. What proportion of participants are lost at each stage in the recruitment process?
    b. What reasons are given for refusal/ineligibility?

Acceptability:

2. Is a self-report questionnaire an acceptable means of investigating OA' treatment and outcome preferences/whether clinicians account for patient preferences when selecting treatments?
    a. Are participants able to understand the questionnaire items?
    b. Does the questionnaire take a reasonable amount of time to complete or does it create a burden for the participants?
    c. Do participants think the questionnaire items are relevant to them?

Exploratory Analyses:

3. What are OA' treatment and outcome preferences?
4. Do clinicians account for patient preferences when selecting treatment?
5. What factors influence clinicians' use of patient preferences when selecting treatments?

PLAN OF INVESTIGATION

Participants

Two groups of participants will be recruited from NHS Lanarkshire (NHSL): Patients and Clinicians.

Patient participants:

Patient participants will be recruited from patients referred directly to community-held psychological therapy groups or to the Psychological Therapies for Older People service (PTOP) for individual psychological therapy.

Recruitment Procedures:

All patients whose referral to a group is screened as appropriate (i.e. meets the group referral criteria) attend a pre-group assessment with a group facilitator. Similarly, patients referred for individual therapy undergo an initial assessment with a clinician. Patients will either be informed of the study by their group facilitator/treating clinician (who are not part of the research team) at the end of their initial assessment (if they are deemed appropriate for group/individual psychotherapy) or in their final psychotherapy session. Patients who are interested in taking part will be provided with the participant information sheet (PIS) and consent form, and asked whether the Researcher can contact them to discuss the study. The Researcher will then contact consenting patients to discuss the study in more detail; answer their initial questions; ask if they wish to participate and check if they meet the eligibility criteria. If so, an appointment will be arranged to obtain written consent and carry out study procedures.

Clinician Participants

PTOP staff will be contacted via email to provide them with information about the study (PIS) and invite them to participate in a web-based questionnaire.

Within the email, they will be informed that the questionnaire is anonymous and provided with a secure link to the questionnaire website. After a month, they will be emailed a participation reminder. All participants will be asked to provide online consent and advised they are free to withdraw from the study at any point. If this process does not yield sufficient respondents, there is the possibility of circulating the questionnaire via the British Psychological Society's 'Faculty of the Psychology for Older People', with the aim of recruiting clinicians from OA psychology teams across the UK.

Inclusion and Exclusion Criteria

Patient Inclusion Criteria:

- Capacity to consent to research
- Age 65+
- Living in the community
- Mental health difficulty that meets NHSL PTOP referral criteria for group/individual psychological therapy.

Patient Exclusion Criteria:

- Insufficient English language skills to allow meaningful participation.
- Diagnosis of learning disability or cognitive impairment; mental state disturbance (e.g. acute psychosis) or substance abuse, if it prevents meaningful participation in psychological therapy.
- Present with risk to self or others during psychological therapy or contact with researcher.

Clinician Inclusion Criteria:

- Working face-to-face therapeutically with people age 65+ with mental health difficulties. Will include Clinical Psychologists, Psychological Therapists and CBT Therapists.

Design

This feasibility study is descriptive and exploratory in nature. It uses a cross-sectional, quantitative design and aims to describe the feasibility and acceptability of study procedures, in line with MRC guidance on developing and evaluating complex interventions (Moore et al., 2015).

Study Procedure

Data Collection

Measures

Two self-report questionnaires were developed for this study, but adapted from previous research:

- The 'Patient Preferences Questionnaire' (PPQ; Appendix A) is a 48-item measure of patients' preferences for various tasks and goals of therapy and characteristics known to affect the TR. The PPQ is flexibly constructed so that it can be used at two distinct points in time (i.e. before and after treatment). Further details of its' items and their origins can be found in Appendix B. The PPQ will be reviewed by PTOP staff (with experience and expertise of the OA population presenting to mental health services) prior to submitting for ethics.

- The ‘Clinician Decision-Making Questionnaire’ (CDMQ; Appendix C) has 26-items and aims to identify to what extent clinicians account for patient preferences when selecting appropriate treatments, and the factors that influence this decision. Further details of its’ items and their origins can be found in Appendix D.

There are three questions pertaining to feasibility and acceptability at the end of each self-report questionnaire. These address questionnaire length; understandability and relevance.

Patient questionnaires will be given to participants to complete during their appointment with the main researcher, who will provide support, as required. Clinician questionnaires will be administered as described under ‘Recruitment Procedures’.

The total number of patients assessed by and discharged from PTOP within the recruitment period will be recorded, along with the number of patients to progress through each recruitment stage (as outlined below). Reasons for refusal/ineligibility will be recorded, where appropriate.

Recruitment stages:

1. Patient informed of study by group facilitator/treating clinician
2. Patient agreed researcher can contact them
3. Patient telephone screened by researcher
4. Patient attended appointment with researcher
5. Patient provided written consent and completed questionnaire.

Sociodemographic information (age, gender, reason for referral and previous experience of psychological therapy) will be collected for patient participants during their appointment with the researcher.

Data Analysis

Data analysis will be largely descriptive as we aim to describe the feasibility and acceptability of the self-report questionnaires. Descriptive information regarding the sociodemographic characteristics of patient participants will be summarised and all data will be stored and analysed using SPSS. Each study question will be addressed in turn (referred to by their assigned number under 'Study Questions' above).

Q1. Recruitment rates, refusal rates and the proportion of patients lost at each recruitment stage will be calculated. Reasons for refusal or ineligibility will be presented alongside this data.

Q2. Descriptive statistics of participant responses regarding the length, understandability and relevance of the questionnaires will be presented.

Q3, 4 and 5. Exploratory data analyses will be conducted with the data gathered from participants' responses on the questionnaires to obtain initial indications of response distributions.

Justification of Sample Size

Due to the nature of this study and its aim to explore the feasibility of recruiting eligible participants, no formal sample size calculations are required in line with NIHR (2019) guidance. Therefore, a target sample size of 30 patient

participants, as previously recommended for feasibility studies (Browne, 1995), is likely to be sufficient to address the research questions.

It is hoped that all 15 PTOP clinicians who deliver psychological therapy will be recruited as participants. Also see the contingency process outlined under 'Recruitment Procedures'.

SETTINGS/EQUIPMENT

Appointments between the researcher and patient participants will be held in NHSL clinic rooms, in the same location as the participants' group/individual therapy (where possible).

Equipment Required	Source
Patients	
PIS and Consent Forms	Printing Costs
Self-report questionnaires	Printing Costs
Clinicians	
PIS and Consent Forms	Via email
Self-report questionnaire	Free survey build website

HEALTH AND SAFETY ISSUES

Researcher Safety

Data collection will take place on NHSL sites and within working hours when other staff are available in the building. The researcher is familiar with local health and safety policies and knows how to access support, if needed.

Participant Safety

Study procedures will be carried out within NHSL settings that are designed to meet NHSL health and safety regulations, and, where possible, will be familiar to individual patients.

There is a small possibility that the topic of investigation could be emotive to participants. They will be informed that they may take a break, or withdraw, from the study at any point. The researcher is trained in dealing with mental health related distress and will be able to assess for any presenting risk. If, during their contact with the researcher, participants present with active risk to themselves and/or others, the PTOP risk assessment and management protocol will be followed.

ETHICAL ISSUES

The procedure of this study is not associated with significant distress. The PIS will detail the study, patient confidentiality and anonymity, and written/online consent will be sought from all participants. Patients' capacity to consent to and participate in this study will be continuously assessed throughout the duration of their contact with PTOP and the Researcher, in line with the Adults with Incapacity (Scotland) Act 2000. Confidentiality and its limits will be introduced at the start of psychological therapy, and participants will be informed that they can opt out or leave the study at any time, with no repercussions.

Data will be managed in accordance with the Data Protection Act 2018, Caldicott Principles and guidance outlined in NHS Scotland's Confidentiality Code of Practice Guidelines (2012).

TIMETABLE – see *Appendix E*

PRACTICAL APPLICATIONS

Considering patient preferences when designing and selecting treatments facilitates the delivery of true EBP, realistic medicine and person-centred care. This study's findings will inform researchers and clinicians of the feasibility and acceptability of using questionnaires to elicit OA' preferences and collect data on clinicians' decision-making. This information, alongside the preliminary analyses of participant responses to the questionnaires, will inform whether proceeding with a pilot study (focused on analysing questionnaire data) is advisable and will allow for revision of the questionnaires, as required. Consequently, if the questionnaires are deemed feasible, this study will help services better understand what OAs prioritise when seeking treatment and what they think about psychological treatment options.

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Appendix 2.2 Project Approval Letters

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

Professor Hamish McLeod
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West of Scotland REC 3
Research Ethics
Clinical Research and Development
Ward 11
Dykebar Hospital
Grahamston Road
Paisley PA2 7DE

Date 30 October 2020
Direct line 0141 314 0212
E-mail WoSREC3@ggc.scot.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

Dear Professor McLeod

Study title:	**A feasibility study examining treatment and outcome preferences of older adults (OAs) with mental health difficulties during COVID-19 and the effects of preferences on clinician decisions about treatment.**
REC reference:	**20/WS/0143**
Protocol number:	**4**
IRAS project ID:	**281149**

The Research Ethics Committee reviewed the above application at the meeting held on 22 October 2020. Thank you for attending to discuss the application.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Number	Condition	Response from the applicant (this table may be copied and pasted into the response letter from the applicant following the REC Opinion)
1	In the letter to participants, there is a typographical error in the first paragraph ("be telephone"). This should be amended. Clean and tracked copies of updated documents should be submitted for our records.	

The REC also made the following recommendations.

Number	Recommendation	Response from the applicant (this table may be copied and pasted into the response letter from the applicant following the REC Opinion)
1	In the Clinical Decision-Making Questionnaire, question 26 ("Build kindness and compassion; learn ways to be less critical of me.") should be separated into two separate questions.	

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.
For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Registration is a legal requirement for clinical trials of investigational medicinal products (CTIMPs), except for phase I trials in healthy volunteers (these must still register as a condition of the REC favourable opinion).

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

You should notify the REC of the registration details. We routinely audit applications for compliance with these conditions.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC Sites

The favourable opinion applies to all NHS/HSC sites taking part in the study taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland)being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
IRAS Application Form [IRAS_Form_21092020]		15 September 2020
Letter from sponsor [NHS Lanarkshire R&D Sponsor Confirmation_L20037]	NA	01 April 2020
Letters of invitation to participant [Letter to Patients]	1	10 August 2020
Non-validated questionnaire [Clinician Decision-Making Questionnaire]	2	04 May 2020
Non-validated questionnaire [Clinician Decision Making Questionnaire - Manual]	2	04 May 2020
Non-validated questionnaire [Patient Preferences Questionnaire]	2	06 July 2020
Non-validated questionnaire [Patient Preferences Questionnaire - Manual]	2	06 July 2020
Participant consent form [Consent Form - Patient Participant]	2	06 July 2020
Participant consent form [Consent Form - Clinician Participant]	2	06 July 2020
Participant information sheet (PIS) [Participant Information Sheet - Patients]	3	10 August 2020
Participant information sheet (PIS) [Participant Information Sheet - Clinicians]	3	10 August 2020
Referee's report or other scientific critique report [Independent Blind Review and Related Correspondence]	NA	29 January 2020

Document	*Version*	*Date*
Referee's report or other scientific critique report [DClinPsy - Proceed to ethics letter]	NA	07 February 2020
Referee's report or other scientific critique report [NHS Lanarkshire Peer Review Assessment Form]	NA	15 July 2020
Research protocol or project proposal [Protocol]	4	04 September 2020
Summary CV for Chief Investigator (CI) [McLeod - Brief CV - IRAS]	1	21 September 2020
Summary CV for student [Principal Investigator CV]	1	13 July 2020

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

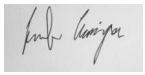
HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 281149	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely



Jennifer Lorigan
REC Manager
on behalf of
Dr Anne-Louise Cunnington
Chair

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

Miss Rachel Cross
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West of Scotland REC 3
Research Ethics
Clinical Research and Development
Ward 11
Dykebar Hospital
Grahamston Road
Paisley PA2 7DE

Date 06 November 2020
Direct line 0141 314 0212
E-mail WoSREC3@ggc.scot.nhs.uk

Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

Dear Miss Cross

Study title:	**A feasibility study examining treatment and outcome preferences of older adults (OAs) with mental health difficulties during COVID-19 and the effects of preferences on clinician decisions about treatment.**
REC reference:	**20/WS/0143**
Protocol number:	**4**
IRAS project ID:	**281149**

Thank you for your letter of 05 November 2020. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 30 October 2020

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Letters of invitation to participant [Letter to Patients (Tracked)]	2	05 November 2020
Letters of invitation to participant [Letter to Patients]	2	05 November 2020
Non-validated questionnaire [Patient Preferences Questionnaire (Tracked)]	3	05 November 2020
Non-validated questionnaire [Patient Preferences Questionnaire]	3	05 November 2020
Protocol [Protocol (Tracked)]	5	05 November 2020
Research protocol or project proposal [Protocol]	5	05 November 2020
Response to Additional Conditions Met		05 November 2020

Approved documents

The final list of approved documentation for the study is therefore as follows:

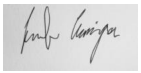
Document	*Version*	*Date*
IRAS Application Form [IRAS_Form_21092020]		15 September 2020
Letter from sponsor [NHS Lanarkshire R&D Sponsor Confirmation_L20037]	NA	01 April 2020
Letters of invitation to participant [Letter to Patients (Tracked)]	2	05 November 2020
Letters of invitation to participant [Letter to Patients]	2	05 November 2020
Non-validated questionnaire [Patient Preferences Questionnaire (Tracked)]	3	05 November 2020
Non-validated questionnaire [Patient Preferences Questionnaire]	3	05 November 2020
Participant consent form [Consent Form - Patient Participant]	2	06 July 2020
Participant consent form [Consent Form - Clinician Participant]	2	06 July 2020
Participant information sheet (PIS) [Participant Information Sheet - Patients]	3	10 August 2020
Participant information sheet (PIS) [Participant Information Sheet - Clinicians]	3	10 August 2020
Protocol [Protocol (Tracked)]	5	05 November 2020
Referee's report or other scientific critique report [Independent Blind Review and Related Correspondence]	NA	29 January 2020
Referee's report or other scientific critique report [DClinPsy - Proceed to ethics letter]	NA	07 February 2020
Referee's report or other scientific critique report [NHS Lanarkshire Peer Review Assessment Form]	NA	15 July 2020
Research protocol or project proposal [Protocol]	5	05 November 2020
Response to Additional Conditions Met		05 November 2020
Summary CV for Chief Investigator (CI) [McLeod - Brief CV - IRAS]	1	21 September 2020
Summary CV for student [Principal Investigator CV]	1	13 July 2020

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices

at all participating sites.

IRAS Project ID: 281149	Please quote this number on all correspondence

Yours sincerely



Jennifer Lorigan
REC Manager

Copy to: Prof Hamish McLeod
Lead Nation: Scotland nhsg.NRSPCC@nhs.net

Dr Hamish McLeod
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Date 16/Nov/2020
Enquiries to Cynthia Dolier, R&D Facilitator
Direct Line 01236 712460
Email cynthia.dolier@lanarkshire.scot.nhs.uk

Dear Dr McLeod

Project title: A feasibility study examining treatment and outcome preferences of older adults (OAs) with mental health difficulties during COVID-19 and the effects of preferences on clinician decisions about treatment

R&D ID: L20037

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire as detailed below:

NAME	TITLE	ROLE	NHSL SITE TO WHICH APPROVAL APPLIES
Rachel Cross	Trainee Clinical Psychologist	Principal Investigator	NHS Lanarkshire

As you are aware, NHS Lanarkshire has agreed to be the Sponsor for your study. On its behalf, the R&D Department has a number of responsibilities; these include ensuring that you understand your own role as Chief Investigator of this study. To help with this we have outlined the responsibilities of the Chief Investigator in the attached document for you information.

All research projects within NHS Lanarkshire will be subject to annual audit via a questionnaire that we will ask you to complete. In addition, we are required to carry out formal monitoring of a proportion of projects, in particular those projects that are Sponsored by NHS Lanarkshire. In either case, you will find it helpful to maintain a well organised Site File. You may find it helpful to use the folder that we have included for that purpose.

Cont...

For the study to be carried out you are subject to the following conditions:

- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and relevant UK and EU Data Protection legislation.
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: http://www.show.scot.nhs.uk/cso/ or the Research & Development Intranet site: http://firstport/sites/randd/default.aspx.
- You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.
- Clinical trial agreements (if applicable), or any other agreements in relation to the study, have been signed off by all relevant signatories.
- You must contact the Lead Nation Coordinating Centre if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary.
- You notify the R&D Department if any additional researchers become involved in the project within NHS Lanarkshire
- You notify the R&D Department when you have completed your research, or if you decide to terminate it prematurely.
- You must send brief annual reports followed by a final report and summary to the R&D office in hard copy and electronic formats as well as any publications.
- If the research involves any investigators who are not employed by NHS Lanarkshire, but who will be dealing with NHS Lanarkshire patients, there may be a requirement for an SCRO check and occupational health assessment. If this is the case then please contact the R&D Department to make arrangements for this to be undertaken and an honorary contract issued.

I trust these conditions are acceptable to you.

Yours sincerely

Raymond Hamill – Senior R&D Manager

c.c.

NAME	TITLE	CONTACT ADDRESS	ROLE
Rachel Cross	Trainee Clinical Psychologist	Rachel.Cross@lanarkshire.scot.nhs.uk r.cross.1@research.gla.ac.uk	Principal Investigator
Dr Philip Smith	Clinical Psychologist	philipsmith3@nhs.net	Sponsor Contact
Frances McCulloch	R&D Governance Facilitator	frances.mcculloch@lanarkshire.scot.nhs.uk	Named Contact

Responsibilities as Sponsor

Site File

As an aid to the conduct of your study we will provide a Site File that Rachel may wish to use. As Sponsor of the study we are required to carry out audit of all project, and to conduct detailed monitoring visits for a proportion (approximately 10%) - The study Site File should help you ensure that you have the relevant documentation to assist in this process. If your project is selected for monitoring, we will contact you well in advance to arrange a suitable time.

Our responsibilities as Sponsor are defined within the Research Governance Framework for Health and Community Care. A summary of these, along with those of the Chief Investigator, is provided in the following table for your information.

RESPONSIBILITIES OF CHIEF INVESTIGATOR	NHSL RESPONSIBILITIES AS SPONSOR
Obtain relevant / appropriate Research Ethics opinion. Obtain NHSL Research Management Approval. Ensure that the members of the research team have the necessary expertise, experience and education to perform their roles. Ensure the necessary resources are available for the study. Act in accordance with regulations set out by your professional body(s) and the conditions of your employment contract. Identify archiving arrangements at the study outset. Record and review significant developments that may affect the study, particularly those which put the safety of the individuals at risk or affect the scientific direction and report to the sponsor as appropriate. Record, report and review all untoward medical occurrence (adverse events or reactions) including classification of causality, seriousness and expectedness. Notify R&D and appropriate REC of significant news, changes, amendments and modifications to the study. Maintain a record of all incidents, providing an annual report to the sponsor. Inform REC and R&D of the study end. Maintain a log of archived documents and their location. Inform R&D of any publications arising from the study or dissemination of findings. Inform R&D of any potential Intellectual Property.	Assess adequateness of the independent, expert review. Ensure that the Chief/Principle Investigator has the necessary expertise, experience and education to conduct the study. Provide a formal written agreement of sponsorship conditions, and notification of confirmation of the sponsorship role. Provide NHS indemnity to the Chief Investigator and research team. Provide mechanisms and processes to exploit any potential Intellectual Property. Project monitoring commensurate with risk. Make available local, national and international guidelines, regulations and legislation governing research in the UK. Provide ongoing advice and guidance to promote quality study management and conduct. Determine the acceptability of the archive arrangements proposed by the Chief Investigator and, if the archive facility becomes unsuitable, provide alternative arrangements. Determine length of archive/retention period for essential study documents and subsequent destruction date

Dr Beth Sage
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12 November 2020 NHS Highland RD&I Ref: **HIGHLAND 1705**
NRSPCC Ref: **NRS20/281149**

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rachel.cross@lanarkshire.scot.nhs.uk

Dear Ms R Cross,

Management Approval for Non-Commercial Research

I am pleased to tell you that you now have Management Approval for the research project entitled: **'A feasibility study examining treatment and outcome preferences of older adults (OAs) with mental health difficulties during COVID-19 and the effects of preferences on clinician decisions about treatment. [Protocol V4 04/09/2020].**

I acknowledge that:

- The project is sponsored by NHS Lanarkshire.
- The project has no external funding.
- Ethics approval for the project has been obtained from the West of Scotland Research Ethics Committee (Reference Number: 20/WS/0143)
- The project has a signed Organisational Information Document.

The following conditions apply:

- The responsibility for monitoring and auditing this project lies with NHS Lanarkshire.

- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the UK Policy Framework for Health and Social Care Research (2018, V3.3 07/11/17, however prior written notice of audit will be given.
- Any researchers coming into NHS Highland for the purposes of carrying out research with patients will require a Letter of Access before starting the study at this site. Please contact a member of the RD&I Governance team at nhsh.nhshighlandresearchpassports@nhs.scot for further assistance, if this is required.
- The paperwork concerning all incidents, adverse events and serious adverse events thought to be attributable to a participant's involvement in this project should be notified to the NHS Highland RD&I Governance team. Please email documents to RD&I Facilitator at nhsh.RandD@nhs.scot.
- You are reminded that all amendments (substantial or non-substantial) to the protocol and associated study documents or to the REC application should be notified to the NHS Highland RD&I Office to obtain amendment approval (nhsh.RandD@nhs.scot). Guidance can be found at https://www.nhsresearchscotland.org.uk/services/permissions-co-ordinating-centre/permissions
- If applicable, monthly recruitment rates should be notified to the NHS Highland RD&I Office, detailing date of recruitment and the participant trial ID number. This should be done by e-mail on the first week of the following month, to Debbie McDonald, Data Manager (deborah.mcdonald@nhs.scot). Please quote your RD&I Highland reference number (Highland 1705).
- Please report any other changes in resources used, or staff involved in the project, to the NHS Highland RD&I Office (nhsh.RandD@nhs.scot).

Please quote your RD&I Highland reference number (Highland 1705) on all correspondence.

Yours sincerely

Frances Hines.

Frances Hines
RD&I Manager

cc Jo Fraser, RD&I Administration Assistant, NHS Highland Research, Development & Innovation Division, Ground Floor Phase 3, Centre for Health Science, Old Perth Road, Inverness, IV2 3JH

Professor Hamish McLeod, Institute of Health and Wellbeing
University of Glasgow, 1st Floor Administration Building, Gartnavel Royal Hospital, 1055 Great Western Road G12 0XH hamish.mcleod@glasgow.ac.uk

Jim Law, Consultant Clinical Neuropsychologist, Head of Clinical Psychology Services for Older People, jim.law@nhs.scot

Administrator: Mr Scott Broadley
Telephone Number: 0141 314 4001
E-Mail: Scott.Broadley@ggc.scot.nhs.uk
Website: https://www.nhsggc.org.uk/about-us/professional-support-sites/research-development/

Research & Innovation
Dykebar Hospital, Ward 11
Grahamston Road
Paisley, PA2 7DE
Scotland, UK

12 November 2020

Miss Rachel Cross
Institute of Health and Wellbeing
University of Glasgow
1st Floor, Administration Building
Gartnavel Royal Hospital,
1055 Great Western Road, G12 0XH

NHS GG&C Board Approval

Dear Miss Rachel Cross,

Study Title:	OAs' preferences and their effects on clinicians' decision-making
Principal Investigator:	Miss Rachel Cross
GG&C HB site	Belmont Centre - Stobhill Hospital
Sponsor	NHS Lanarkshire
R&D reference:	GN20MH494
REC reference:	20/WS/0143
Protocol no: (including version and date)	Version 5, 05/11/2020

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004

    a. During the life span of the study GGHB requires the following information relating to this site
        i. Notification of any potential serious breaches.
        ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
   a. First study participant should be recruited within 30 days of approval date.
   b. Recruitment Numbers on a monthly basis
   c. Any change to local research team staff should be notified to R&D team
   d. Any amendments – Substantial or Non Substantial
   e. Notification of Trial/study end including final recruitment figures
   f. Final Report & Copies of Publications/Abstracts
   g. You must work in accordance with the current NHS GG&C COVID19 guidelines and principles.

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

Scott Broadley

Mr Scott Broadley
Senior Research Administrator

Appendix 2.3 Participant information sheet for patients (V3, 10/08/2020)

Participant Information Sheet – Patient Participant

Study Title: Older adults' preferences and their effects on clinicians' decision-making

Who is conducting the research?

This study is being carried out by:

- Rachel Cross, Trainee Clinical Psychologist and Principal Investigator (University of Glasgow, NHS Lanarkshire)
- Prof Hamish McLeod, Chief Investigator and Professor of Clinical Psychology (University of Glasgow)
- Dr Philip Smith, Clinical Psychologist and Local Lead Collaborator (NHS Lanarkshire)

Invitation

You are invited to take part in a research study. Before you decide if you would like to participate it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. One of the researchers will go through this information sheet with you and answer any questions you have. This can be done on the phone or by video call and should take about 15 minutes. It is important that you take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

Patients hold preferences about what psychological therapy should involve, how their therapist should behave and what they want to gain from therapy. Research suggests that accommodating these treatment and outcome preferences can have a positive impact on attendance at therapy appointments and clinical outcomes. However, there is currently no agreed upon method for eliciting patient preferences and they are often overlooked by Clinicians when they are making decisions about treatment. This study will

explore whether it is possible to use questionnaires to elicit older adults' treatment and outcome preferences and to determine whether clinicians consider these preferences when selecting treatment.

Older adults are disproportionately likely to be affected by measures implemented by the UK government to contain the spread of COVID-19. Physical distancing and self-isolation measures may impact on older adults' mental health and could therefore influence their treatment and outcome preferences for psychological therapy. Government restrictions on face-to-face contact also led psychological services to adopt remote delivery of psychological therapies (i.e. delivery via telephone or video calls). We have designed this study with these changes in mind. We hope to increase understanding of how older adults want to be seen and treated and what they hope to gain from therapy, during COVID-19. We also want to identify any additional difficulties faced by clinicians, given the current circumstances, when trying to consider and accommodate patient preferences.

Why have I been invited?
We are looking for participants accessing NHS Lanarkshire mental health services for older people because they are experiencing a psychological problem. Participants can either be about to begin, currently receiving or recently finished group or individual psychological therapy. We asked clinicians who deliver psychological therapies to identify people who may be interested in taking part in this research.

Do I have to take part?
No, participation is voluntary and it is up to you to decide whether or not to take part. If you decide to participate, you will be asked to sign a consent form. You are free to withdraw from the study at any time and without giving a reason. We will not use data from questionnaires where the participant has chosen to withdraw. Deciding not to take part or withdrawing from the study will not affect any treatment that you are currently receiving or any that you may need in the future.

What would taking part involve?
If you decide to take part, you will be invited to complete a questionnaire about your treatment and outcome preferences for

psychological therapy. You will be asked to rate your preferences using a scale. Please note that some of the treatment options listed in the questionnaire may not be available or suitable for your difficulties. We will also ask for some information about you (e.g. age, gender, reason for seeking treatment) and your experience of completing the questionnaire. It will take approximately 25 minutes to answer all the study questions.

You will be given a choice of completing the questionnaire electronically (via the internet or email) or on paper (sent to you in the mail). If you opt for paper copies, you will be sent a stamped envelope to return the forms by post. Please note, if you are currently 'shielding' due to COVID-19 you may need someone else to post these documents on your behalf. Regardless of how you choose to participate, you will be asked to read and sign a consent form before starting the questionnaire.

What are the disadvantages and risks of taking part?
There are minimal risks associated with taking part. There is a time burden, as we ask you to complete a questionnaire. When filling it out, difficult thoughts or feelings may arise when thinking of the answers. Similarly, you may experience some emotional distress when thinking about what you hope will be different after psychological therapy. These reactions are all within the scope of the kinds of experiences that people referred for psychological therapy experience. If you become distressed while completing the questionnaire, please feel free to withdraw. If you become distressed as a result of completing this study, we suggest that you contact NHS24 (telephone 111) or your healthcare provider.

What are the possible benefits of taking part?
There are no direct benefits to you personally. Some people find the experience of participating in research interesting and some people enjoy contributing to the accumulation of new knowledge. The information you give will be used to improve mental health services in the future.

Will my taking part in this study be kept confidential?
All information collected for the duration of this study will be kept strictly confidential. You will be assigned an anonymous participant ID, which will be used in place of your name throughout the study so that you cannot be identified from the information that you provide.

Data will be stored on a password protected and encrypted computer and only the researchers will have access to the anonymised data. Any record of your personal information (e.g. home or email address) will be destroyed at the end of the study.

What will happen to the results of the study?
The results of the study will be written into a report and submitted to the University of Glasgow as part of Rachel Cross's requirements for the Doctorate in Clinical Psychology. It is possible that this report will also be published in an academic journal. A summary of this report will be distributed to the older adult mental health teams within NHS Lanarkshire, which can be shared with you if you are interested in knowing the results of the study.

Who is organising and funding this research?
The research is organised via the University of Glasgow and is supported by NHS Lanarkshire. There is no commercial funding associated with this research.

Who has reviewed the study?
All research in the NHS is reviewed by an independent group of people called a Research Ethics Committee to protect your interests. The West of Scotland Ethics Committee has reviewed this study and favourable opinion has been given.

If you have any further questions
If you have any further questions or concerns about the study, please contact the main researcher, using the contact details provided below.

If you would like more information about the study and wish to speak with someone who is not closely linked to the study, please contact Dr Breda Cullen, DClinPsy Programme Research Director, University of Glasgow, email: Breda.Cullen@glasgow.ac.uk.

If you have a complaint about any aspect of the study
If you are unhappy about any aspect of the study and wish to make a complaint, please contact the main researcher in the first instance. The normal NHS complaint procedure is also available for you. The contact person for making a complaint in NHS Lanarkshire is: Laura Jack, NHS Lanarkshire Headquarters, Kirklands Hospital, Fallside Road, Bothwell, G71 8BB, Tel: 01698 858321, Email: laura.bryan@lanarkshire.scot.nhs.uk.

Contact details

If you would like further information, you can contact:

Rachel Cross, Trainee Clinical Psychologist and Main Researcher
Institute of Health and Wellbeing – University of Glasgow
1st Floor, Admin Building
Gartnavel Royal Hospital
1055 Great Western Rd
Glasgow, G12 0XH
Tel: 01698 210021
Email: r.cross.1@research.gla.ac.uk

Appendix 2.4 Consent form for patients (V2, 06/07/2020)

Patient Participant Consent Form

Study Title:	Older adults' preferences and their effects on clinicians' decision-making
Researchers:	Rachel Cross, Prof Hamish McLeod, Dr Philip Smith
Contact Details:	Mental Health & Wellbeing – University of Glasgow 1st Floor, Administration Building Gartnavel Royal Hospital 1055 Great Western Road Glasgow, G12 0XH Email: r.cross.1@research.gla.ac.uk

Please read and initial the following statements to ensure you understand all the information before proceeding.

	Initial in box
1. I have read and understood the Participant Information Sheet dated 10/08/2020 Version 3 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my medical care or legal rights being affected.	☐
3. I understand that all data collected in this study will be anonymised and kept confidential.	☐
4. I agree to information about my age, gender, reasons for seeking treatment and previous experience of psychological therapy being collected. I understand that I will not be identifiable from this data.	☐

5. I understand that the anonymised data may be looked at by individuals from University of Glasgow and from regulatory authorities. ☐
6. I understand that the results of this study will be written into a report for others to read, but that no individual's data will be outlined in this report. ☐
7. I agree to take part in this study. ☐

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Name of Participant	Date	Signature

When completed, keep 1 copy for yourself and send 1 copy back to the researcher.

Appendix 2.5 Participant information sheet for clinicians (V3, 10/08/2020)

Participant Information Sheet – Clinician Participant

Study Title: Older adults' preferences and their effects on clinicians' decision-making

Who is conducting the research?

This study is being carried out by:

- Rachel Cross, Trainee Clinical Psychologist and Principal Investigator (University of Glasgow, NHS Lanarkshire)
- Prof Hamish McLeod, Chief Investigator and Professor of Clinical Psychology (University of Glasgow)
- Dr Philip Smith, Clinical Psychologist and Local Lead Collaborator (NHS Lanarkshire)

Invitation

You are being invited to take part in a research study. Before you decide if you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Contact details for the research team are provided below should you wish to ask any questions.

What is the purpose of the study?

Research suggests that patients hold preferences about what psychological therapy should involve, how their therapist should behave and what they want to gain from therapy. Accommodating these treatment and outcome preferences has been found to have a positive impact on psychological therapy attendance and outcomes. However, patient preferences are often not considered in clinical decision-making for various reasons, including there being no standardised method for eliciting them.

This study will explore the feasibility and acceptability of using questionnaires to elicit older adults' (OAs) treatment and outcome preferences and determine whether clinicians consider these preferences when selecting treatment.

OAs are disproportionately likely to be affected by physical distancing and self-isolation measures implemented by the UK government to contain the spread of COVID-19. These measures may have significant mental health implications and could therefore influence OA's treatment and outcome preferences for psychological therapy. Government restrictions on face-to-face contact also led psychological services to adopt remote delivery of psychological therapies (i.e.

delivery via telephone or video calls). We have designed this study with these changes in mind. We hope to increase understanding of OAs' treatment and outcome preferences during COVID-19 (including their preferences for remote service delivery), and identify any additional difficulties faced by clinicians, given the current circumstances, when trying to consider and accommodate patient preferences.

Why have I been invited?
We are looking for clinicians who provide psychological therapy to older adults (age 65 or over) with mental health difficulties. We are inviting (Trainee) Clinical Psychologists; (Trainee) Clinical Associates in Applied Psychology and CBT/Psychological Therapists to participate.

Do I have to take part?
No, participation is entirely voluntary. It is up to you to decide whether or not to take part. If you decide to participate, you will be asked to sign an online consent form. You are free to withdraw from the study by closing the online survey. You do not need to give a reason. We will not use data from surveys where the participant has chosen to withdraw.

What would taking part involve?
If you decide to take part, you are invited to complete an online questionnaire about factors that affect your clinical decision-making, which will take approximately 20 minutes to complete. We will also ask for sociodemographic data that has previously been shown to play a role in determining clinicians' consideration of patient treatment and outcome preferences. You can access the questionnaire via the link provided in the invitation email, which will take you to the study webpage. Before completing the questionnaire, you will be asked to electronically sign an online consent form. All of the information you provide will be anonymous, your identity will be concealed and kept confidential.

What are the disadvantages and risk of taking part?
There is no risk of harm involved in taking part in this research project. There is a time burden associated with taking part as we ask you to complete a questionnaire.

What are the possible benefits of taking part?
There are no direct benefits. You may find the experience of taking part in research interesting or you might enjoy contributing to the accumulation of new knowledge about ways to improve service delivery. We hope that our findings will improve methods for understanding treatment and outcome preferences in older adults, which will help clinicians in services better understand what older adults prioritise when seeking treatment and what they think about psychological treatment options. This will facilitate the delivery of true evidence-based practice.

Will my taking part in this study be kept confidential?
All information that is collected about you during the course of the research will be kept strictly confidential. You will be assigned a participant ID so that your

responses are separated from your personally identifiable information. Data will be stored on a password protected and encrypted computer and only the researchers will have access to the anonymised data.

What will happen to the results of the study?
The results of the study will be written into a report and submitted to the University of Glasgow as part of Rachel Cross' requirements for the Doctorate in Clinical Psychology. The final thesis will be available through the University of Glasgow's Library and will be published on the University's Enlighten service which is accessible to the wider public to promote research dissemination. It is possible that this report will also be published in an academic journal.

Who is organising and funding this research?
The research is organised via the University of Glasgow and is sponsored by NHS Lanarkshire. There is no commercial funding associated with this research.

Who has reviewed the study?
The West of Scotland Research Ethics Committee has reviewed this study and favourable opinion has been given.

If you have any further questions
If you have any further questions or concerns about the study, please contact the main researcher, using the contact details provided below.

If you would like more information about the study and wish to speak with someone who is not closely linked to the study, please contact Dr Breda Cullen, DClinPsy Programme Research Director, University of Glasgow, email: Breda.Cullen@glasgow.ac.uk.

If you have a complaint about any aspect of the study
If you are unhappy about any aspect of the study and wish to make a complaint, please contact the researcher in the first instance. The University of Glasgow complaints procedure is also available to you. The contact person for making a complaint is Dr Breda Cullen, DClinPsy Programme Research Director, University of Glasgow, email: Breda.Cullen@glasgow.ac.uk.

Contact details
If you would like further information, you can contact:

Rachel Cross, Trainee Clinical Psychologist and Main Researcher:
Institute of Health and Wellbeing – University of Glasgow
1st Floor, Admin Building
Gartnavel Royal Hospital
1055 Great Western Rd
Glasgow, G12 0XH
Tel: 01698 210021
Email: r.cross.1@research.gla.ac.uk

Appendix 2.6 Consent form for clinicians (V2, 06/07/2020)

Clinician Participant Consent Form

Study Title:	Older adults' preferences and their effects on clinicians' decision-making.
Researchers:	Rachel Cross, Prof Hamish McLeod, Dr Philip Smith
Contact Details:	Mental Health & Wellbeing – University of Glasgow 1st Floor, Administration Building Gartnavel Royal Hospital 1055 Great Western Road Glasgow, G12 0XH Tel: 01698 210021 Email: r.cross.1@research.gla.ac.uk

Please read and tick the following statements to ensure you understand all the information before proceeding.

1. I have read and understood the Participant Information Sheet dated 10/08/2020 Version 3 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I understand that all data collected in this study will be anonymised and kept confidential. ☐
4. I understand that the anonymised data may be looked at by individuals from University of Glasgow and from regulatory authorities. ☐
5. I understand that the results of this study will be written into a report for others to read, but that no individual's data will be outlined in this report. ☐
6. I consent to taking part in this study. ☐

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Name of Participant	Date	Signature

Appendix 2.7 Clinician demographics questionnaire

Participant ID Number: _____

Date: _____

The following Sociodemographic information is being collected as previous research has associated it with clinical decision-making. Please answer the following questions in turn.

What is your highest professional qualification? Please place a cross (X) in the box to the right of the response alternative that suits best. Choose only one response.

Highest Professional Qualification	**Cross (X)**
Undergraduate degree	
Master's degree	
Postgraduate Diploma (without the requirement for independent research)	
Doctorate (research)	
Doctorate in Clinical Psychology	
Doctorate in Counselling Psychology	
Other	
If other please state:	

How many years of clinical experience do you have of delivering psychological therapy?

What is the <u>main</u> therapy modality that you use when delivering individual therapy? Please place a cross (X) in the box to the right of the response alternative that suits best. Choose only one response.

Main Therapy Modality	**Cross (X)**
Cognitive Behavioural Therapy	
Compassion Focused Therapy	
Acceptance Commitment Therapy	
Psychodynamic Psychotherapy	
Schema Therapy	
Eclectic or integrative mix	
Humanistic	
Other	

Appendix 2.8 Patient Preferences Questionnaire (PPQ)

Participant ID Number: _____

Date: _____

This questionnaire contains a number of statements regarding the hopes and desires one can have before and during psychotherapy. Read each statement in turn and consider to what extent you agree or disagree at the present time. In other words, think about how well each statement fits with your current preferences. Please place a cross (X) in the box under the response alternative that suits best. Only choose one response for each statement.

The question for you to consider is: What would you prefer if you were in psychotherapy?

Example: In psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
Talk about things that are bothering me				X		

Treatment Options - What would you prefer if you were in psychotherapy?

In psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
1. Have weekly or fortnightly telephone contact with a therapist on a 1-to-1 basis.						
2. Have weekly or fortnightly video call contact with a therapist on a 1-to-1 basis.						
3. Have weekly or fortnightly face-to-face contact with a therapist on a 1-to-1 basis, in a clinic setting.						

In psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
4. Have weekly or fortnightly face-to-face contact with a therapist on a 1-to-1 basis, at my home.						
5. Enter a group therapy that is held weekly over video call, where I will be taught skills to cope with my difficulties.						
6. Work through written booklets to help me cope with my difficulties, with occasional telephone or video call support from a professional.						
7. Access a course of self-help through a computer to teach me to notice and change unhelpful patterns of thoughts, feelings and behaviours.						
8. Have a male therapist						
9. Have a female therapist						
10 Have a therapist who gives me advice						
11 Have a therapist who provides practical support						
12 Have a therapist who is non-judgemental						
13 Have a therapist who tells me what to do						

In psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
14 Have a therapist who validates my experiences						
15 Have a therapist who listens to me and tries to understand						
16 Notice and change unhelpful thoughts; learn to think differently						
17 Notice and change unhelpful habits or patterns of behaviour						
18 Learn to face situations that I fear or have been avoiding						
19 Reflect on painful memories						
20 Look at ways I could become more active						
21 Learn strategies and skills to deal with problematic situations						
22 Learn to take my thoughts less seriously and be less caught up in them						
23 Learn to be ok with unwanted emotions, even if I can't get rid of them completely						
24 Learn meditation techniques						
25 Clarify my values – what is important to me in life and what kind of person I want to be						

In psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
26 Build kindness and self-compassion						
27 Learn ways to be less critical of me						
28 Explore links between earlier life, including events in childhood, and how this affects my life presently						
29 Learn skills for improving my relationships						
30 Develop skills to support me to overcome my feelings of loneliness						
31 Talk over the course of my life, to put things in perspective and gain a sense of peace about the past						
32 Explore the loss of a loved one						
33 Talk about major life changes to help me adjust to them (e.g. retirement or self-isolating due to COVID-19).						

Treatment Outcomes – What would you prefer to gain from psychotherapy?

After completing psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
34 Have a sense of purpose and meaning in my life						

After completing psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
35 Feel more hopeful						
36 Like myself						
37 Have more energy to do things						
38 Have improved relationships with others						
39 Feel less lonely						
40 Have learned how to focus less on/worry less about my physical health						
41 Feel more able to cope with uncertainty						
42 Sleep better						
43 Have more things to do in my week						
44 Feel less troubled by memories from the past						
45 Have learned to live with pain and other physical difficulties						
46 Feel more confident						
47 Be less bothered by worries						
48 Have learned how to manage my nerves and uncomfortable feelings in my body (e.g. sickness in stomach)						
49 Have made sense of my life						
50 Have come to terms with the loss of somebody						

After completing psychotherapy, I would prefer to:	I agree…					
	Not at all	Very little	Somewhat	Moderately	Quite a lot	Completely
51 Have adjusted to major life changes (e.g. retirement)						

Please answer the following questions about your experience of completing this questionnaire. Tick the box that best suits your experience of completing the questionnaire. Choose only one response.

1. The length of this questionnaire was:

   Too long ☐ Too short ☐ Just right ☐

2. The questions asked above seemed relevant to me and my circumstances:

   Yes ☐ No ☐ Sort of ☐

3. How easy was it to understand the questions and what was being asked of you?

Very easy ☐ Easy ☐ Okay ☐ Difficult ☐ Very difficult ☐

Appendix 2.9 Patient Preferences Questionnaire Manual

The *Patient Preferences Questionnaire* (PPQ) is a 51-item measure of patients' preferences for various tasks and goals of psychotherapy and characteristics known to affect the therapeutic relationship. Each item is rated on a 6-point Likert scale, and describes something that can occur during various forms of psychotherapy.

Item Origins

The PPQ was developed from other measures, previously used to collect data on patients' preferences, and adapted for use with older adults (OAs). It encompasses instructions and items from the *Psychotherapy Preferences and Experiences Questionnaire* (PEX, version P1; Clinton et al., 1999). The PEX manual (Clinton & Sandell, 2014) describes it as a measure of patient preferences for and experiences of different aspects of various psychological therapies. Several versions of the PEX have been developed, implemented and validated since its inception in 1996 (Clinton & Sandell, 2014). Version P1 of the PEX (PEX-P1; Clinton et al., 1999) has 50-items that are grouped into five sub-scales, which have been found to have good internal consistency (Cronbach's alpha values range between 0.83 and 0.86; Clinton & Sandell, 2014). However, to the author's knowledge, the PEX has not been used in studies with OAs. Additionally, Cooper and Norcross (2016) argued that despite its name, the PEX measures patients' perceived helpfulness of each of its items, rather than their preference for these items.

For these reasons, the PPQ also incorporates items from a list of psychotherapy tasks and outcomes, developed as part of another study of OAs' preferences carried out within NHS Lanarkshire's 'Psychological Therapies for Older People' (PTOP) service (Butrimaviciute, 2020). Butrimaviciute (2020) generated this list by identifying the key tasks involved in and expected outcomes of the psychological therapies recommended in the *Older Adult Mental Health Matrix* (NES, 2015), and the list was reviewed by PTOP staff (with experience of delivering psychological therapies to OAs presenting to mental health services).

PPQ Construction

Items are grouped into four sub-sections:

- Psychotherapy delivery (items 1 to 7)

Items in this section assess patients' preferences for different therapy delivery formats offered within PTOP (i.e. individual therapy; group therapy; support self-help and online CBT), and they were originally taken from Butrimaviciute's (2020) study. However, the items were adapted to reflect changes to PTOP service provision during the COVID-19 pandemic, which meant therapy was increasingly delivered remotely via digital methods, such as telephone or video calls.

- Therapist characteristics and approach (items 8 to 15)

Items in this section relate to therapist characteristics and approach i.e. items that have the potential to influence the therapeutic relationship. Items 8 and 9 were developed based on the *Cooper-Norcross Inventory for Preferences* (C-NIP; Cooper & Norcross, 2016). Similar to the PPQ, C-NIP was developed following review of existing measures of preferences (including the PEX). It is a 40-item measure of patient preferences, which dedicated 7-items to therapist characteristics, such as therapist gender, racial and religious background and sexual orientation. Within PTOP, and NHS Lanarkshire as a whole, it is unlikely that patient preferences for the latter three characteristics would be accommodated (for ethical reasons), and therefore they were not included in the PPQ. Pikus & Heavey (2008) found that some patients hold particular preferences regarding therapist gender, with the majority of their female participants preferring a female therapist. Although their male participants were less likely to state a preference for a particular therapist gender, those who did were also more likely to prefer a female. PTOP as a team has a mix of male and female therapists and may be able to accommodate patient preferences for therapist gender. Preference accommodation is associated with improved engagement and better outcomes (Swift et al., 2018), hence the inclusion of items 8 and 9.

Items 10 to 14 were developed from items included in the PEX, while item 15 was developed from Butrimaviciute's (2020) list. This item was

reworded from “tell my story and be listened to and understood” to “Have a therapist who listens to me and tries to understand”, so that it fit the ‘Therapist characteristics and approach’ section of the PPQ as opposed to the ‘Psychotherapy tasks’ section, as listening can be thought of as a non-specific factor in therapy, rather than a task.

- Psychotherapy tasks (16 to 32)

Items is this section were taken directly from the list of treatment tasks developed by Butrimaviciute (2020). They describe the main tasks (i.e. things the patient and/or therapist do in therapy) involved in the delivery of the psychological therapies recommended in *The Matrix* (NES, 2015) for treating mental health difficulties in an OA population. These therapies include CBT and ACT, which are both delivered by PTOP clinicians.

- Psychotherapy outcomes (items 33 to 51)

This section was included to elicit patient outcome preferences. Most of these items were developed in Butrimaviciute’s (2020) study, but items 34, 38 and 40 were added during the COVID-19 pandemic to capture the potential impact of self-isolation on OAs’ outcome preferences. The items capture realistic outcomes that Matrix (NES, 2015) recommended psychological therapies can achieve within an OA population.

COVID-19 related items

The PPQ was updated to reflect changes to psychological service provision during COVID-19 and reflect the potential impact of self-isolation on OAs’ treatment and outcome preferences. Items 1 and 2 were added to explore OAs’ preferences for remote delivery options (i.e. telephone or video call appointments), as face-to-face appointments in a clinic setting (item 3) and home visits (item 4) are currently only provided to high risk clients who cannot engage remotely. Similarly, items 35, 39 and 41 were added to reflect the suspected impact of self-isolation on OAs’ outcome preferences.

Question Structure

The PPQ initially asks participants ‘What would you prefer if you were in psychotherapy?’ This question is an adaptation of the PEX-P1’s question: “What would you best be helped by if you were in psychotherapy?” (Clinton,

Sandell & Knutssön-Johns, 1999). It changes the questionnaires' focus from "helpfulness beliefs" (Sandell et al., 2011) to preferences. The PPQ's second question 'What would you prefer to gain from psychotherapy?' is asked prior to the 'Psychotherapy outcomes' sub-section, in order to gain an understanding of patients' preferred treatment outcomes. Outcome preferences were not included in the PEX, or other measures of patient preferences, despite emerging evidence that they differ from the outcomes clinicians' want to achieve for their patients (Eiring et al., 2015; Zimmermann et al., 2013).

Similar to the PEX (Clinton & Sandell, 2014), there are two versions of the PPQ which allows it to be used flexibly across different time points (i.e. before, during and after therapy). Individual items are identical across the two versions, but the instructions and the object of ratings differ:

- PPQ-1 can be administered before or during therapy and asks patients to rate the extent to which they would prefer different items.
- PPQ-2 can be administered following the completion of a course of psychotherapy and asks patients to rate the extent to which they preferred different items.

Please note that three additional questions have been added to the end of the PPQ for this feasibility study, which aim to gather data on the feasibility and acceptability of the questionnaire to the respondents.

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Appendix 2.10 Clinicians Decision-Making Questionnaire (CDMQ)

Participant ID Number: _____

Date: _____

Please read the following statements and rate the extent to which each factor influences your treatment selection. Place a cross (X) in box under the response alternative that suits best. Choose only one response for each statement.

To what extent do the following factors influence your treatment selection?

		Not at all	Minimally	Some	Quite a lot	A great deal	More than any other factor
1.	Best practice guidelines (as outlined in the MATRIX, SIGN or NICE Guidelines)						
2.	Quantitative Research e.g. RCTs and meta-analytic evidence						
3.	Qualitative Research e.g. published case studies						
4.	Information obtained from conferences, training events and/or workshops						
5.	Your own clinical experience with clients						
6.	Your own experience of being a client						
7.	Supervision / consultation with others						
8.	Client preferences for tasks of therapy (e.g. cognitive restructuring; mindfulness; behaviour change)						
9.	Client preferences for format of therapy (e.g. group or individual, face-to-face or digital)						
10.	Client outcome preferences						

Below is a list of factors that may influence your decision whether to consider client preferences (or not) when deciding on and selecting appropriate treatments. Please read each reason and rate how much each one influences whether you consider client preferences when selecting appropriate treatments. Place a cross (X) in box under the response alternative that suits best. Choose only one response for each statement.

How much does this factor influence whether I consider client preferences when selecting appropriate treatments?

		Not at all	Minimally	Some	Quite a lot	A great deal	More than any other factor
11.	Type of presenting difficulty						
12.	The severity of the client's presentation						
13.	Case complexity						
14.	Presence of co-morbidities						
15.	Client insight						
16.	Client's previous experience of mental health support						
17.	The strength of client preferences						
18.	My preference for a particular treatment modality						

19. Were you required to make changes to the way you deliver psychological therapy in response to COVID-19 and the related government restrictions?

Yes ☐ No ☐

20. If yes, do you think these changes (e.g. remote methods of delivery) will continue to be used with older adults following the relaxation of COVID-19 restrictions?

Yes ☐ No ☐

21. Have government imposed physical distancing measures made it more difficult for you to accommodate clients' treatment preferences (i.e. their preferences for delivery format and/or tasks of therapy)?

Yes ☐ No ☐

22. Have government imposed physical distancing measures made it more difficult for you to accommodate clients' outcomes preferences (i.e. what they hope to gain from therapy)?

Yes ☐ No ☐

Please answer the following questions about your experience of completing this questionnaire. Place a cross (X) in the box to the right of the response alternative that suits best. Choose only one response.

23. The length of this questionnaire was:

Too long ☐ Too short ☐ Just right ☐

24. The questions asked above seemed relevant to me and my circumstances:

Yes ☐ No ☐ Sort of ☐

25. How easy was it to understand the questions and what was being asked of you?

Very easy ☐ Easy ☐ Okay ☐ Difficult ☐ Very difficult ☐

Appendix 2.11 Clinician Decision-Making Questionnaire Manual

The Clinician Decision-Making Questionnaire (CDMQ) is an 22-item measure of factors that influence clinicians' decision-making in psychotherapy. It was developed specifically for this study, based on methods used in previous research (Gyani et al., 2014; Safran et al., 2011; Stewart et al., 2018), and their findings. The CDMQ has three distinct sub-sections, which are described below along with their encompassed items.

Section 1: Factors that influence treatment selection (items 1 to 10)

This section was adapted from the survey used in Morrow-Bradley & Elliot (1986), which asked clinicians to rate 'the extent to which [different factors] had an impact on [clinicians'] practice'. Items 1 to 9 represent different factors that are known to influence clinicians' decision-making when selecting treatment and were developed from questions asked in Safran et al. (2011) and Gyani et al. (2014), who also investigated factors that influence clinical decision-making. Clinicians are asked to read items 1 to 9 and rate the extent to which these factors influence their treatment selection, using a six-point scale that ranges from 'not at all' to 'more than any other factor'. The 6-point scale used was taken from Morrow-Bradley & Elliot's (1986) study.

Section 2: Factors that influence clinicians' decision whether to consider client preferences (items 11 to 18)

Items in this section represent different factors that may influence clinicians' decision whether to consider client preferences (or not) when deciding on and selecting appropriate treatments. Clinicians are asked to read items 11 to 18 and rate how much each factor influences this decision, using the six-point scale (outlined above).

Section 3: Impact of COVID-19 of preference accommodation (items 19-22)

Items in this section were added during the COVID-19 pandemic in response to the related changes to how psychological therapies are delivered

(i.e. remote delivery of psychological therapies via digital methods). The items aim to understand whether COVID-19 and concomitant restrictions on face-to-face contact with clients influenced Clinicians' ability to accommodate client preferences.

Please note that three additional questions have been added to the end of the CDMQ for this feasibility study, which aim to gather data on the feasibility and acceptability of the questionnaire to the respondents.

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