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Psychologically Satisfying: Exploring Client Experiences with Dynamics of Shared Decision-Making in Care from Prescribing Psychologists

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PSYCHOLOGICALLY SATISFYING: EXPLORING CLIENT EXPERIENCES WITH
DYNAMICS OF SHARED DECISION-MAKING IN CARE FROM PRESCRIBING
PSYCHOLOGISTS

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DYNAMICS OF SHARED DECISION-MAKING IN CARE FROM PRESCRIBING
PSYCHOLOGISTS

by

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Thank you to everyone who has helped and supported me on my academic journey. Friend, peer, competitive frienemy, mentor, sounding board, strategizer, pep talker, caller-out of procrastination, late-night dial-a-philosopher, loved one or intimidating person that I was simply afraid to disappoint—so many people wore so many hats that I cannot credit you all by name or role, but please know that I am extremely grateful to you and recognize the help you gave me in reaching this point. Now, let the next chapter begin!

ABSTRACT

The purpose of this study was to explore the field of prescribing psychology as it is practiced by providers and experienced by clients in New Mexico. Prescribing psychology is an emerging field of hybrid mental healthcare in which psychologists with special post-doctoral training can obtain prescriptive authority in certain jurisdictions. The study sought to take a client-centered approach to investigating the type and quality of care provided to clients by prescribing psychologists (RxPs). This study included a provider survey of knowledge, attitudes, and practices regarding health literacy and shared decision-making, and a client survey of satisfaction and experiences with care from RxPs. Results suggest that while prescribing psychologists (RxPs) may not use active strategies for promoting health literacy among their clients, pursuant to shared decision-making (SDM), they do feel trained and able to implement this latter client-centered practice with their patients. Furthermore, among the study sample, a majority of mental health care service users receiving care from RxPs reported that they were extremely satisfied with their care from these providers, particularly with regards to SDM. Analysis of the client survey data also suggests that RxPs are amenable to helping clients with social determinants of health, as well as their psychiatric needs. Additionally, qualitative analysis of open-ended comments provided for the client survey indicate that clients appreciate their RxPs for their hybrid skillsets, with a majority emphasizing the importance of the empathic skills these providers bring with them from the field of psychology to the practice of prescribing mental health care. This study is the first of its kind to take a client-centered and in-depth approach to exploring care delivered by RxPs and experienced by their clients, and thusly makes a major contribution to the literature.

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CHAPTER 1: INTRODUCTION

The research investigated client experiences and satisfaction with the mental health care provided to them by New Mexico prescribing psychologists (RxPs), an approach to evaluating the quality of care RxPs provide as a reflection of the non-traditional educational pathways they take to prescriptive authority. The educational requirements to practice as an RxP are key to distinguishing this profession from that of traditional prescribing mental health professionals, such as psychiatrists or nurses. RxPs do not obtain their prescriptive authority by attending medical or nursing school; instead, RxPs complete a doctoral degree in psychology and a postdoctoral graduate degree in psychopharmacology, along with a practicum and the prerequisites to doctoral study (Muse & McGrath, 2010).

The educational relevance of this research is that (1) it will take the first research-based look at the details of RxPs' non-traditional educational pathways to prescriptive authority and (2) how this may impact the quality of care they provide to their clients; and (3) how health literacy—as a practice that reflects informal science learning and “doing” by patients” and facilitation by health care providers—occurs and/or is experienced by the clients of RxPs. To achieve these goals, the proposed research consists of three data collection phases: a survey of RxPs in New Mexico regarding their academic and professional preparation and perceived skills and use thereof in their practices; a survey of clients with regards to their varied experiences and perceptions of the care they receive from RxPs; and interviews with clients of RxPs as to their varied experiences and perceptions of health literacy in relationship to their care provided by RxPs.

Thus, the research is premised on the integration of many things: prescribing psychologists as mental health care providers who take a non-traditional educational pathway to prescriptive authority and about whom little research but much speculation exists; client satisfaction as an indicator of health care quality; quality as a reflection of health care providers' education, shared decision-making (SDM) as an indicator of quality health care; health literacy as a necessary precursor to SDM; and health literacy as informal science learning and doing on the part of patients and facilitated by health care providers. All of these concepts fit nicely within co-production theory as an explanatory model applied to service encounters.

Therefore, in this introduction, I will briefly explain the major premises and connections there between upon which this research draws. Further details and in-depth discussion of literature related to the proposed research are provided in subsequent chapters of this proposal. Because this research ultimately draws upon the integration of many different concepts and ideas, it is difficult to present each one sequentially while making clear how it fits into the overall picture. Therefore, please bear with the author, as each idea presented leads in some way to the next. Diagrams will be provided throughout this introduction to help illustrate the connections being articulated. Before this overview commences, a brief note about terminology is in order.

Terminology, Power, Providers, and Patients in Health Care

Many topics and issues in this proposal are related to the power dynamics of health care encounters. The most immediate and fundamental actors (or agents enacting the dynamics of power) in any health care encounter are (1) the person seeking treatment and (2) the person from whom someone else seeks treatment. Just as there are many broad frames through which

to analyze health care in America—such as medical models, business models, social models, legal models, public health models, complementary and alternative care models, etc.—there are many different terms applied to these key, dualistic actors. The use of the “patient-doctor” terminology evokes medical frames, “client/consumer-provider” evokes business frames, “health service user—services/care provider” evokes social frames, and so on. Each pairing of terminology for the actors involved implicitly suggests the way in which power is constructed, portrayed, and discussed within a given frame and related literature. The present proposal draws from the integration of three health care frames and thus, necessarily, the interchange between terminology used in different frames. These three perspectives and accompanying terminology are those of the medical, business, and social frames. My personal preference is for terminology from the social frame—the terms “[health] service user” and “[health] care/services provider”—because I feel that these two terms convey a more interactive and potentially equitable sense of health care as a process. However, because this proposal integrates three different ways of viewing health care encounters, certain terminology is more appropriate when describing certain concepts, while as these concepts are integrated, it eventually becomes impossible to avoid the use of certain frame-specific terminology interchangeably. Therefore, within this proposal, the terms “client/consumer/service user/patient,” each represent hyponyms of “person seeking health care,” but come to be used synonymously, while the same is true for “physician/provider/doctor” as hyponyms of “person from whom someone else seeks treatment.” Having now explained this, I will commence with discussing satisfaction, quality, and co-production.

Satisfaction, Quality, and Co-Production

As indicated in Figure 1, these three concepts are related and build from one another.

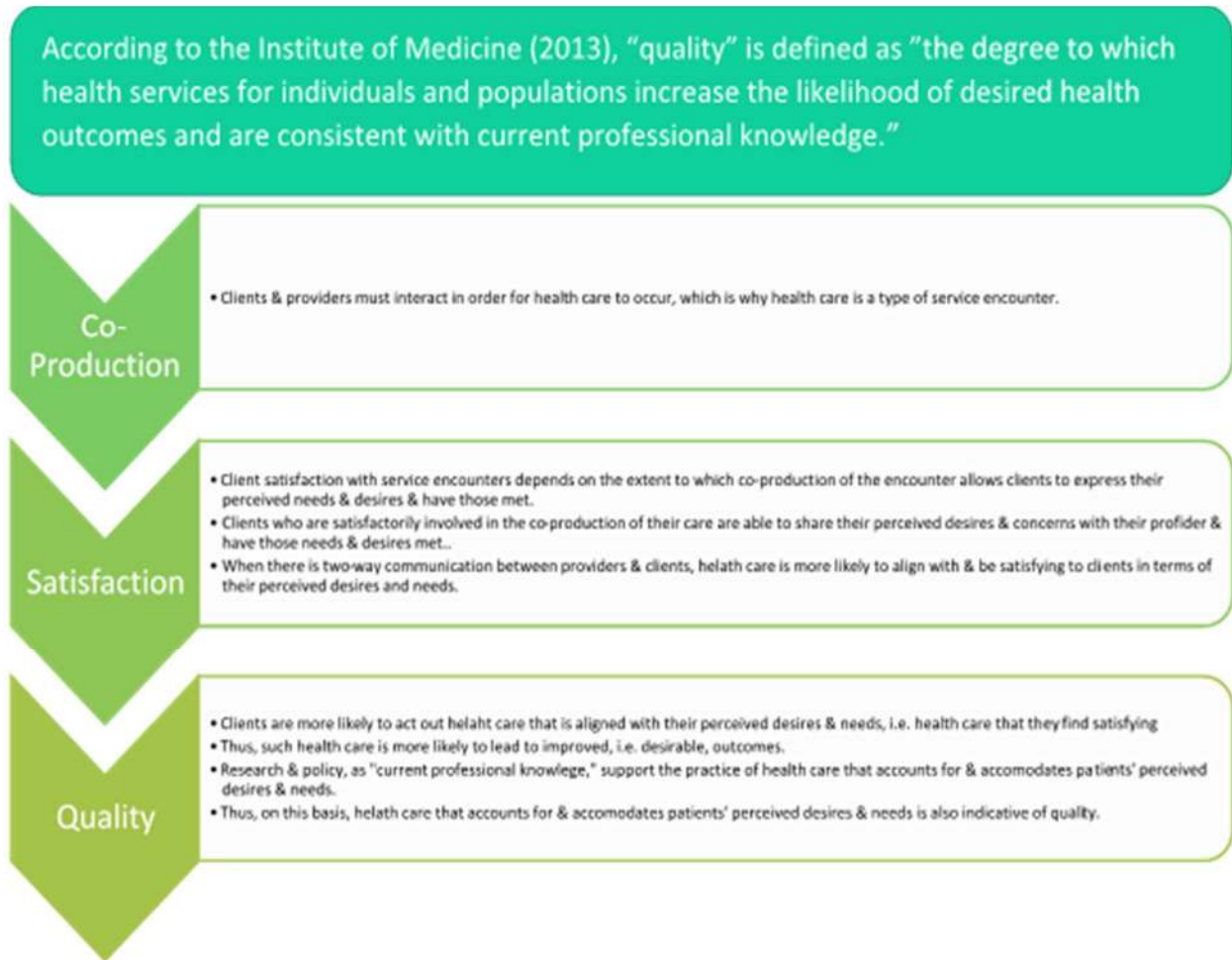


Figure 1: Relationship Between Co-Production, Satisfaction, and Quality

Figure 1 summarizes the relationship between these concepts. In the next three subsections, quality, satisfaction, and co-production in health care are explained in more detail. Although Figure 1 positions co-production as the first concept, it is easier to explain the connections between the three concepts if quality and then satisfaction are defined before co-production. Therefore, that is the order taken for the organization of the following subsections.

Quality as a concept in health care. In everyday parlance or in the general business literature, the meaning of the word “quality” might seem ambiguous, because different factors are involved in decisions and feelings about different products. However, in service encounters, which include health care, the service is the product and so the interaction itself and results of the interaction are the basis on which quality can be determined (Bitner et al., 1997). Therefore, in health care, quality is simply outcome-based. According to the Institute of Medicine (2013), “quality” is defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (no page number).

Satisfaction as a concept in health care. Similarly, the term “satisfaction” might seem vague, if it is taken without context. However, in the context of health care encounters, satisfaction is an established measure of quality, in the sense that both are related to co-production and to health care outcomes. Satisfaction is usually posited as a multidimensional construct, encompassing simultaneous measures of perceptions and values (Kravitz, 1998). Therefore, from a health care research standpoint, “satisfaction” essentially refers to the degree to which a consumer feels that a product or service encounter has met the consumer’s expectations. Also inherent in the health care service encounter is the expectation that a consumer seeks care because he or she has some notion of a need that needs to be met; however, it is important to realize and remember that a patient’s perception of his or her needs—the ones that motivate them to seek health care—may not be the same as those perceived by the physician (Curtis et al., 2010; Makoul & Clayman, 2006; Kravitz, 1998). Herein, co-production lies at the crux of the connections between client satisfaction, quality, health care encounters, health care outcomes, and SDM.

Co-production as a theory explaining satisfaction as a measure of quality in health care. Co-production is a theoretical framework for analyzing service encounters that has been specifically researched and applied in health care. Because co-production focuses on the interactive nature of service encounters, it provides a basis for understanding and measuring satisfaction as an indicator of quality in health care encounters. In health care, both the provider and patient are inherently involved in creating the service encounter. As in other types of service encounters, the degree to which clients are engaged to their level of liking in co-producing a health care encounter is positively associated with their satisfaction. This is because client satisfaction in health care is an indication of the extent to which the interaction with the health care provider met the expectations and desires that the client brought with them to the encounter (Kravitz, 1998).

Quality and satisfaction are inextricably entwined in the co-production of health care service encounters, because quality in health care is outcome-based and outcomes are dependent on clients. Outcomes are based on clients in two, also intertwined ways: (1) outcomes are defined in terms of the health status of the client. (2) Clients usually have to act, in some way, on physician instructions in order to obtain a health care outcome—get a test, take medicine, make lifestyle changes, etc. The encounter itself is not the actual outcome that is reflected in the Institute of Medicine definition of quality—achieving a “desired health outcomes” (Institute of Medicine, 2013) is the actual basis on which quality is calculated. But whose desired outcome? The patient’s or the physician’s? If there has been no discussion—no discussion and sharing of decision-making about what is desired from seeking health care and what is needed to achieve these desired goals—then research shows that it is unlikely that patients’ and physicians’ ideas will align (De las Cuevas, Peñate, & de Rivera, 2014; Curtis et

al., 2010; Deegan & Drake, 2006; Drake, Deegan, & Rapp, 2010). This lack of alignment leads to low patient satisfaction because their clients' perceived needs and desires are not met, and importantly, to poor patient outcomes—in other words, to poor health care quality (Institute of Medicine, 2013; De las Cuevas, Peñate, & de Rivera, 2014; O'Hare et al., 2014, Kravitz, 1998). Inversely, alignment between patients' desired level of participation and autonomy in health care decision making and what actually occurs is associated with better health outcomes and higher patient satisfaction, particularly in mental health care (De las Cuevas, Peñate, & de Rivera, 2014; Mohammed et al., 2014; Lindhiem et al., 2014; Das et al., 2014).

Health Literacy, Shared Decision-Making, Co-Production, and Quality in Health Care

Health literacy and SDM are two additional concepts related to co-production and quality in health care. They are also related to providers' education, informal science, and to the proposed research. Health literacy, SDM, providers' education, and informal science have not been discussed yet. In the next four subsections these concepts will be discussed so as to explain the relationships portrayed in Figure 2.

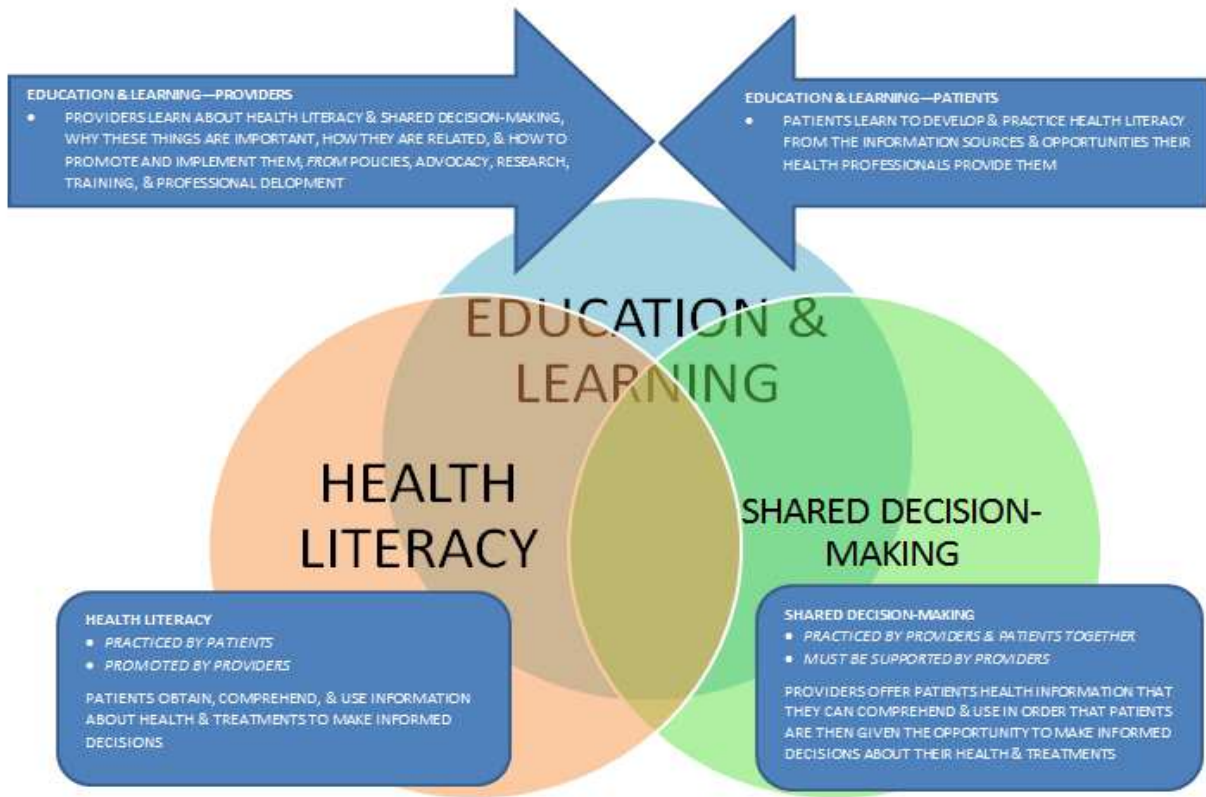


Figure 2: Relationship Between Health Literacy, SDM, Education & Learning

Shared decision-making. As discussed and depicted above in Figure 2, mismatch between provider and client beliefs, assumptions, and expectations about the purpose and outcomes of a health care encounter springs from a lack of SDM—a lack of communication and power-sharing in terms of determining what patients want from health care and are able and willing to do in pursuit of their health care goals (Goldolphin, 2009). SDM reflects the level of co-production involved in creating health care service encounters (Care Quality Commission [CQC], 2014b). The reason that this lack of alignment is associated with poor patient outcomes is also related to co-production and is threefold: (1) patients are unlikely to act on health care instructions that do not address their perceived needs and desires; (2) patients are unlikely to change their perceived desires and needs simply because a doctor tells a

patient that the doctor's perceptions are better; (3) patients are unlikely to carry out physician instructions if the physician has not explained to them why doing so meets their desires and needs. Thus, because health care encounters are co-produced, these reasons directly impact patient satisfaction with health care encounters while simultaneously impacting health care quality.

Health literacy. Also, because communication and alignment of desires that lead to action are at the core of the co-production of quality health care, clients need to be given the opportunity to become and act as informed decision-makers in their health care. Becoming informed about, so as to take part in, health care decisions, is known as “health literacy” (Institute of Medicine, 2014).

Health care providers are responsible for providing clients with information about their health care decisions and options, as well as the providers' professional recommendation and reasoning thereof for certain options; together with discussing patient's preferences, concerns, and logic thereof in an informative but equitable manner, this amounts to promoting clients' health literacy (Makoul & Clayman, 2007; Goldolphin, 2009; HHS, 2010). When clients make informed decisions related to their health, such as through SDM, they are practicing health literacy (Makoul & Clayman, 2007; Hoffman et al., 2014).

The actual practicing of health literacy is reflected in shared informed decision-making. The Mayo Clinic Shared Decision Making National Resource Center (2014) summarizes these connections between health literacy, SDM, co-production, and health care quality:

While clinicians know information about the disease, tests and treatments, the patient knows information about their body, their circumstances, their goals for life and

healthcare. It is only collaborating on making decisions together that the ideal of evidence-based medicine can come true. This process of sharing in the decision-making tasks involves developing a partnership based on empathy, exchanging information about the available options, deliberating while considering the potential consequences of each one, and making a decision by consensus. This process -- sometimes called patient-centered decision making, empathic decision making, or shared decision making -- demands the best of systems of care, clinicians, and patients...

Research shows that health communication is usually not deliberately designed to promote health literacy and thus is unintelligible to 9 out of 10 American adults (U.S. Department of Health and Human Services [HHS], 2010). At the same time, research shows that and that individuals with low health literacy are more likely to suffer poor health outcomes, such as disease progression, increased likelihood of emergency room visits, medication non-adherence, decreased likelihood of recommended health screenings and preventive care, and mortality (Berkman et al., 2011a; Paasche-Orlow & Wolfe, 2007; Berkman et al., 2011b).

Health literacy and informal science. Health literacy is also related to informal science. Informal science is, like literacy, a variable skillset that is practiced in many different settings (Feder et al., 2009); what makes it informal is that it is acquired and practiced outside of formal learning environments, of which health care is a major context in the lives of adults (Feder et al., 2009). Practicing health literacy through SDM is an example of patients “doing informal science;” the role of providers is that they promote health literacy, meaning that providers act as informal science educators (Feder et al., 2009; Makoul & Clayman, 2006; Godolphin, 2009).

Providers' education, health literacy, and shared decision-making. The Mayo Clinic Shared Decision Making National Resource Center (2014) acknowledges that while SDM is increasingly supported by health care research and policy, it still remains “an ideal.” This is especially true in psychiatry; research shows that most mental health service users are competent and desire very much to engage in SDM but are rarely given the opportunity to do so (Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2007; Curtis et al., 2010). Psychiatrists remain openly resistant to SDM, citing time constraints, paternalistic attitudes, and bias against the decisional capabilities of mental health service users (Fukui et al., 2014). However, the merit of each of these justifications for the pervasive provider-resistance to implementing SDM in psychiatry has been discredited (Fukui et al., 2014; Auerbach, 2000; De las Cuevas, Peñate, & de Rivera, 2014).

Rather, research and policy initiatives indicate this provider resistance to SDM stems from deficits in medical schooling and continuing education requirements for physicians and nurses (HHS, 2010; Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2007; Gulbrandsen et al., 2014; Bonfils et al., 2014). Simply put, these traditional pathways to prescriptive authority fail to convey the attitudes and skills needed to promote health literacy and by extension, implement SDM—particularly in the field of psychiatry, where provider-centric care and extreme power imbalances have an exceptionally evident and entrenched history of being institutionalized as the entitled privilege of medical “experts” over the mentally “unsound”—thus making SDM counterintuitive for health care providers (Mahone et al., 2011; Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2007; Curtis et al., 2010).

Moreover, while it may not be intuitive, common, or popular among providers, mounting research shows that SDM and health literacy are associated with better outcomes in

mental and other types of health care (Fukui et al., 2014; Lindhiem et al., 2014; Mohammed et al., 2014; Center for Disease Control [CDC], 2014a; Goldolphin, 2009; Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2007; Curtis et al., 2010; Berkman et al., 2011a; Berkman et al., 2011b). Thus, the lack of SDM in psychiatric care is indicative of poor quality because this behavior is not in keeping with the second part of the Institute of Medicine (2013) definition of quality in health care: it is not “consistent with current professional knowledge.” Current professional research and policy clearly indicates that health literacy and SDM are feasible and appropriate in all fields of health care, including mental health, and that SDM and health literacy are associated with quality and satisfaction by means of leading to improved health care outcomes (Fukui et al., 2014; Lindhiem et al., 2014; Mohammed et al., 2014; CDC, 2014a; Goldolphin, 2009; Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2007; Curtis et al., 2010). This suggests that provider training, or a lack thereof, in the mechanisms and merits of promoting health literacy and implementing SDM, translates into client satisfaction and health care quality.

Now that health literacy, SDM, the “promoting” and “doing” of these activities, and their relationship to providers’ education have been briefly discussed, Figure 3 can be presented. Figure 3 illustrates the relationship established in the literature regarding providers’ education and training, health literacy, SDM, and health care outcomes.

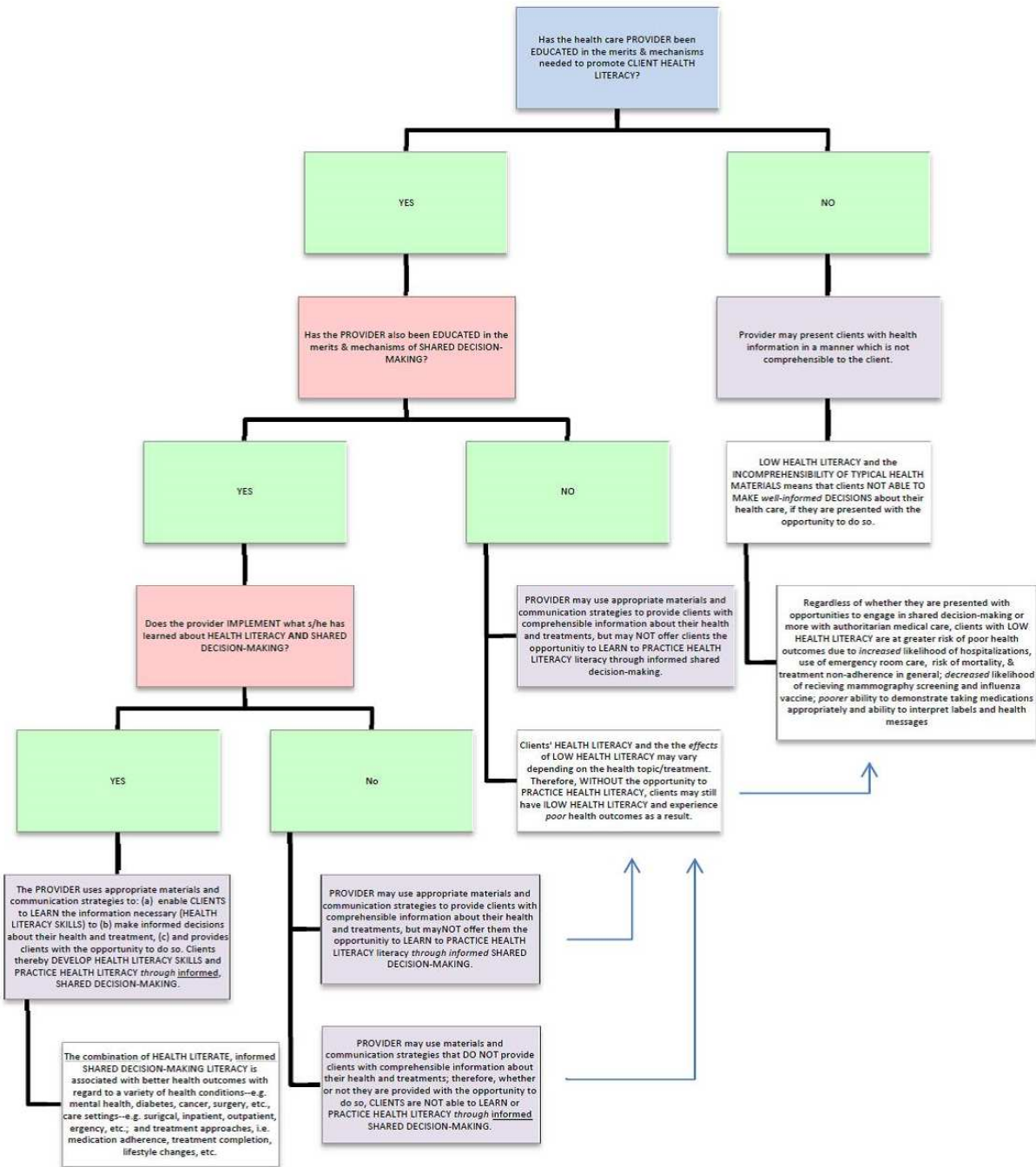


Figure 3: Relationship Between Providers’ Education, Health Literacy, SDM, & Healthcare Outcomes

In Figure 3, it can be seen that if one element of providers’ training or practice is missing, subsequent processes are unlikely to occur and entirely desirable health care outcomes are also

unlikely. This is another way of connecting satisfaction with SDM and health literacy experiences with quality in health care.

Gap in Satisfaction Research in Mental Health Care

A final topic worth mentioning here is that there is a general dearth of satisfaction research in psychiatric care. As explained throughout this introduction, client satisfaction is an established measure of quality in health care, one that is used in most medical specialties and in general care (Centers for Medicare and Medicaid Services [CMS], 2014; Kravitz, 1998; Morris, Jahangir, & Sethi, 2013). However, compared to other areas of health care, psychiatry, has as a field, appears from the literature to have neglected to research their clients' satisfaction with care in the same way as have providers' of other types of health care. It is possible that the reasons proffered by providers for not implementing SDM in psychiatric care may also underlie the lack of satisfaction surveys in mental health care—i.e. providers who do not implement SDM because they feel it is not appropriate for their clients, whether because the provider questions the decisional capacity of their clients or because of other assumptions, may also assume that it is not worthwhile to ask whether a client is satisfied with their experience of the mental health care they received.

However, the literature makes it clear that mental health service users should not be excluded from participating in satisfaction research; as with SDM, the nature of psychiatric conditions do not provide a valid premise for disregarding client satisfaction with mental health care (CMS, 2014; De las Cuevas, Peñate, & de Rivera, 2014). In fact, clients' satisfaction with co-produced elements of care is significantly positively correlated with certain key, but difficult-to-obtain outcomes in mental health care, such as medication adherence (De las Cuevas, Peñate, & de Rivera, 2014; Mohammed et al., 2014; Lindhiem et

al., 2014; Das et al., 2014). This makes client satisfaction with the interactive elements of health care encounters all the more valuable and important in mental health care, as a tool for researching and improving the quality of care that is provided to these health service users.

Among the few “satisfaction” surveys administered to the clients of prescribing mental health professionals, several focus on clients’ satisfaction with specific medications (e.g. Bowskill et al., 2007; Gharabawi et al., 2006; Chue, 2006). This approach does not represent health care quality satisfaction research; it is more akin to drug trials. This type of “satisfaction” research eschews co-production as the basis for satisfaction as measure of quality in health care, producing information that is irrelevant to the purposes and premises of health service user satisfaction research.

Thus, while questions have been raised from within the field of psychiatry as to the quality of care provided by RxPs, it is important to note that little meaningful data exists regarding U.S. clients’ satisfaction and its extension to the quality of care that psychiatrists themselves provide to mental health service users.

Significance of the Research

While little research exists about prescribing psychologists, it is postulated that their unique educational pathways to prescriptive authority lead them to circumvent the deficiencies related to SDM and health literacy that found in medical school, and thereby may actually lead them to provide what would amount to high quality care. Speculation has nonetheless been voiced that because they are non-traditionally trained prescribing mental health professionals, RxPs may provide poor quality care to their clients (e.g. Walker, 2002; Merrick, 2007; Lavoie & Barone, 2006; Lavoie & Fleet, 2002).

Thus, by focusing on client satisfaction with elements of shared decision making in the mental health care provided by RxPs, the proposed research seeks to make a significant contribution to both health science and education research by contributing evidence-based findings to this debate. In doing so and by taking a client-centered approach, the proposed research will also seek to help remediate the paucity of client satisfaction research regarding health care encounters with prescribing mental health professionals.

Implications of the Research

There are many potential implications to the proposed research, as it addresses several gaps in existing literature and relates to important policy issues. First and foremost, since the profession of prescribing psychology is still contested by professionals and legislators, albeit mostly on the basis of speculation, this study can help inform this conversation and guide the development of evidence-informed policies. In doing this, the proposed research also has implications for mental health care in general, since there is a severe shortage of prescribing mental health professionals throughout the majority of the U.S. that will continue into the foreseeable future, as there are continuously fewer medical students enrolling in psychiatric specialties (McGuiness, 2012; Caccavale, Reeves, & Wiggins, 2012; Ax et al., 2008; McDowell et al., 2010; Thomas & Hozler, 2006). Thus health care quality research that informs discussions and policies regarding prescriptive authority is also applicable to informing decisions about how to remediate these shortages.

Since SDM and health literacy are already supported by health-related evidence as well as policies, this research may help inform educational policies and programs. RxPs undertake educational pathways to prescriptive authority that differ from those of traditional medical professionals, such as psychiatrists. The proposed research may indicate that the experiences of

mental health services users who seek treatment from RxPs differs from that established in the literature for patients of psychiatrists, i.e. in terms of SDM or health literacy. If this is the case, differences may be attributable to the alternate educational pathways RxPs take to obtain prescriptive authority, and training programs for other prescribing mental health professionals might benefit from the insights that such findings would provide. This is an important implication, as existing strategies to promote SDM and health literacy have not been successful enough, particularly in mental health, and the reasons providers espouse for this indicate the need for innovative focus on certain aspects of providers' education and professional development.

This research relates directly to policies supporting the implementation of SDM and health literacy in mental health care and will provide a much-needed point of reference for marking progress towards compliance with these policies in this field of health care. In doing so, it will also help remediate the paucity of literature addressing client satisfaction with SDM as a measure of mental health care quality. In evaluating quality in mental health care, this research will provide a basis upon which to expand research and practice through further attention to and exploration of links between satisfaction, SDM, and positive outcomes in mental health care.

This research could produce a tailored, viable satisfaction evaluation instrument based on the principles of co-production as it applies specifically to U.S. mental health care. Patient-centered instruments attending to SDM and health literacy appear lacking in U.S. mental health care quality research. By surveying mental health service users as to their satisfaction with their care, the proposed research may provide an example upon which more inclusive and equitable means of measures of quality can be normatively integrated into mental health care.

Together with existing policies that emphasize the need for SDM and health literacy as parts of health care practice, evidence for the acceptability and validity of a patient-centered approach to assessing quality in mental health care could help undermine the model of paternalism that continues to pervade mental health care training programs and practice.

CHAPTER 2: THEORETICAL AND PARADIGMATIC PERSPECTIVES

The purpose of this section is to explain the frameworks, perspectives, and theories underlying the research, so that the connections and premises for the following goals are clarified. The proposed research looks at prescribing psychologists and their clients in terms of their different roles in promoting, demonstrating, and enacting informal and formal learning and education. Briefly summarized, the goals of this research are with regards to prescribing psychologists and their clients. Briefly summarized, the goals of this research are to:

- (1) evaluate client satisfaction on the basis that it is a measure of quality of care;
- (2) investigate the varied experiences of clients with regards to SDM and its necessary precursor, health literacy;
- (3) investigate the unique and varied academic backgrounds of prescribing psychologists;
- (4) consider how findings from goals 1-3 may be related.

In support of these goals, the following subsections detail the paradigms, perspectives, theories, and concepts underlying the premises, strategies, concepts, and the connections between them within the context of the proposed research. These include pragmatist theory and the pragmatic paradigm; sequential quantitative to qualitative mixed-methods design; informal science education; health education; literacy; health literacy; coproduction; and SDM. Because the proposed research draws upon many different perspectives, key information about these concepts will be highlighted in the proceeding sections, with an emphasis on building the basis for their connections to one another. Key connections between formal and informal education, health literacy, SDM, and the proposed research will be highlighted at the end of this chapter,

following the review of the detailed information needed to best understand them. I will start by discussing pragmatist theory and the pragmatic paradigm.

Pragmatist Theories of Truth

Pragmatism is a philosophical tradition stemming from a pragmatic theory of truth. Pragmatic theories of truth were first developed by Pierce, Dewey, and James in America around 1870 and later in Europe, by Schiller (although Schiller referred to his philosophies as “humanism”) (Hookway, 2013). Pragmatic theories of truth are based on the pragmatic maxim, stated as follows by Peirce (1878): “consider what effects, that might conceivably have practical bearings, we conceive the object of our conception to have. Then, our conception of these effects is the whole of our conception of the object” (p. 293). Pragmatic theories of truth link certain things together, such as: cognition, thought, and language; truth-seeking and practical implications; truth-seeking and justification; and truth and verification.

Pragmatic theories of truth are based on ideas about inferences. For Pierce, everything that is known and knowable is an example and a consequence of sign relationships; all thoughts are signs (Peirce, 1906; 1905). Signs also extend themselves as the basic premises of language. Truth stems from sign relations and from inferences developed through inquiry, while inquiry transforms signs by creating new relationships between them (Peirce, 1906; 1905). In the course of positing this process as a foundation of thought and knowledge, Peirce also used it to develop the concept of semiosis (Atkin, 2010). Other pragmatic theorists built from Peirce’s premises about thoughts and language as representations and constituents of reality.

Dewey builds on the idea of consciousness and knowledge of reality as mediated by thought that is based on inferential sign relationships that are inferential in that they are “representative,” in the mind, of the external world. Dewey explains how this relationship between consciousness and signs is the basis for knowing things. Dewey (1905) writes that,

States of consciousness, sensations and ideas as cognitive, exist as tools, bridges, cues, functions -whatever one pleases-to affect a realistic presentation of things, in which there are no intervening states of consciousness as veils, or representatives. Known things, as known, are direct presentations in the most diaphanous medium conceivable. And if getting knowledge, as distinct from having it, involves representatives, pragmatism carries with it a reinterpretation, and a realistic interpretation, of 'states of consciousness' as representations. They are practically or effectively, not transcendently, representative... They are symbols, in short, and are known and used as such. Knowledge, even getting knowledge, must rest on facts or things (p. 325)

Dewey (1938) also describes inquiry in terms of it being the process of transforming the discretely symbolic or ethereal into something more cohesive and concrete, writing that “inquiry is the controlled or directed transformation of an indeterminate situation into one that is so determinate in its constituent distinctions and relations as to convert the elements of the original situation into a unified whole” (p. 108).

Peirce and Dewey make clear their positions that all thought, and therefore knowledge and processes of knowing, are inferential to the point of being symbolic (in the colloquial use of the term). However, for Dewey and Pierce as well as for James and Schiller, the role of inference in the construction of truth goes farther. The types and temporality of inferences that

can be made are also characterizing factors as to the nature of truth in pragmatic theories. Here though, a divide emerges between the definitions of truth given by the different philosophers.

For Dewey and Pierce, truth is absolute. Also, for Dewey and Peirce, at least in the hypothetical, inferential processes, properly conducted (generally interpreted from Dewey's and Pierce's writings to mean "through the scientific method"), can produce absolute truths. Pierce (1905; 1906) maintained that, given enough time, all rational inferential processes will arrive at the same conclusions, determining "truth." Peirce (1878) writes that,

Different minds may set out with the most antagonistic views, but the progress of investigation carries them by a force outside of themselves to one and the same conclusion. This activity of thought by which we are carried, not where we wish, but to a foreordained goal, is like the operation of destiny. No modification of the point of view taken, no selection of other facts for study, no natural bent of mind even, can enable a man to escape the predestinate opinion. This great law is embodied in the conception of truth and reality. (p. 407)

Similarly, Dewey (1938) maintained that true things are trustworthy and reliable and remain so in each situation. For Dewey and Pierce, though, the ability to reach the point of absolute truth is limited by temporality, so in actual practice, although inference is the basis by which all thought is given meaning, it is not really possible to ascribe something the absolute designation of being "true."

For James and Schiller, truth is not inherently static because it is inherently situational. For James, truth is determined by its utility, specific to solving the problem of a given person's given situation (1909; 1907). Truth is still based on inferential reasoning; however, truth is

determined based on whether it can be verified by observed results over the course of time in the context of practice in which an inferred idea is applied. In other words, for James, truth is utility of an idea specific to a person's situation, as verified by observations over the course of time as to what happens when that idea is applied to practice (1909; 1907).

For Schiller (1910; 1912), truth is also based on utility in the context of specific problems. For Schiller, truth is relative and can vary or be "unmade" over the course of time as problems change and as thoughts about the most useful solution to prior problems also change. Inferences about the most useful ideas with regard to a problem one day may change the next day as a result of being confronted with new problems; therefore truth is mutable (Schiller, 1910, 1912). For Schiller and James, then, the need for verification is also a determining factor in the designation of what constitutes "truth," and this verification pertains to the inferences that constitute thought processes. However, because truth is also based on situational utility, for James and Schiller, truth is experiential. For James, consistency of experience over time verifies something as true. For Schiller, truth can be transformed through verification by experience over time.

The inclusion of relativity as components of James' and Schiller's definitions of truth has led to some criticisms, from Dewey as well as from more recent contributors to pragmatic theory, like Rorty (1998) and Putnam (1981). Rorty (1998) and Putnam (1981) both find fault with the concept of truth relative to time. Rorty (1998) states that the concept of "true then, but not now" is a "pointless" and "weird" "elocution" (p. 2). Putnam (1981) illustrates this, stating that,

The statement 'The earth is flat' was, very likely, rationally acceptable 3000 years ago; but it is not rationally acceptable today. Yet it would be wrong to say that 'the earth is

flat' was true 3,000 years ago; for that would mean that the earth has changed its shape.
(p. 55)

Indeed, Putnam's (1981) example does make the concept of relative truth seem "pointless" and "weird" (Rorty, 1998), but mostly because it and the adage Rorty gives as another example both ignore Schiller's and James' inclusion of utility as another component of their definitions for truth. If one considers the utility of truth as a necessary component of its definition, then it makes sense that for all practical—yea, pragmatic—purposes for which such knowledge could be used 3,000 years ago, saying "the world is flat" was true...for certain people or groups of people. It should be noted, however, that anthropological findings keep indicating that we really have no idea what was going on with sea travel (and therefore different individuals' or groups' assumptions about the shape of the earth) for as far back as 50,000 or more years ago, so it is probably an "untrue" untrue even in a pragmatic sense to say that 3,000 years ago, the statement "the earth is flat" was "true," without any qualifying context; it is factually ethnocentric. This also highlights the situational relevance of truth as maintained by Schiller and James. Moreover, when various forms of verification—such as observations of star patterns and the phenomena of people who sailed off into the horizon returning to report that there were apparently no edges to fall off of—inferred to people that the earth was not flat, new inferences about the shape of the earth were developed, verified, and determined to be "true" for practical purposes. From this perspective, determining and stating the shape of the earth can therefore be considered to support the suppositions of pragmatic theories of truth.

Putnam (1981) attempts to clarify his critique of James' and Schillers' pragmatic theories of truth, first stating that "truth cannot simply *be* rational acceptability for one fundamental reason; truth is supposed to be a property of a statement that cannot be lost,

whereas justification can be lost” (p. 55). While this does seem to make sense, Putnam is ever-self-critiquing his own philosophical ideas, and more recently expressed a pluralistic view of philosophy that contradicts this contention with pragmatic theories of truth. In 1997, Putnam took the stance that confusion stemming from philosophers’ linguistic appropriation and application of everyday terminology to new contexts lies at the heart of most philosophical problems. Both these views of Putnam (1981; 1997) return in part to the premises of early pragmatists that language, thought, and consciousness are co-constructive in nature and ultimately fundamental to defining “true” ideas.

Early pragmatists contributed to the ideas of Habermas (1976) and by extension to the development of conceptualization of language as practice- and context-based. Furthermore, together Dewey, Peirce, Schiller, and James developed pragmatism into epistemology and ontology. According to Feilzer (2010), pragmatism offers an “...alternative worldview to those of positivism/postpositivism and constructivism and focuses on the problem to be researched and the consequences of the research” (p. 7). Moreover, “pragmatism, when regarded as an alternative paradigm, sidesteps the contentious issues of truth and reality, accepts, philosophically, that there are singular and multiple realities that are open to empirical inquiry and orients itself toward solving practical problems in the “real world.” (Feilzer, 2010, p. 8)

This orientation and view of pragmatism and the pragmatic paradigm are shared by the researcher of this proposal. Furthermore, the proposed research is mixed-methods, for reasons that will be subsequently discussed in further detail, and the pragmatic paradigm is the only paradigm uniquely suited to support mixed-methods research. Thus, the pragmatic paradigm and these justifications are discussed in further detail below and throughout the remainder of this section of the proposal. Thus, I next discuss the pragmatic paradigm.

Pragmatic Paradigm

Because it is the only paradigm intended specifically for the purpose of accommodating mixed-methods research, the pragmatic paradigm is essential to the proposed research. The pragmatic paradigm is named as such because it rejects the notion of an inherent dichotomy between quantitative and qualitative research approaches (Onwuegbuzie, Johnson, & Collins, 2009; MacKenzie & Knipe, 2006). According to Onwuegbuzie, Johnson, and Collins (2009), the pragmatism paradigm is ontologically based on recognition

[of] multiple realities (i.e. subjective, objective, intersubjective); rejects traditional dualisms (e.g. subjectivism vs. objectivism; facts vs. values); high regard for the reality and influence of the inner world of human experiences in action; [and that] current truth, meaning, and knowledge are tentative and changing. (p. 122)

According to MacKenzie and Knipe (2006), literature perpetuates the misnomer that “...research, which applies the positivist or postpositivist paradigm, tends to predominantly use quantitative approaches (methods) to data collection and analysis, though not necessarily exclusively, while the interpretivist/constructivist paradigm generally operates using predominantly qualitative methods” (p. 199). Similarly, Onwuegbuzie, Johnson, and Collins (2009) acknowledge that research literature and various descriptions of paradigmatic orientations continue to propagate the “incompatibility thesis,” in which it is asserted that quantitative and qualitative research epistemologies and methodologies are wholly incompatible and segregated in practice from one another. Moreover, in paradigmatic approaches identified as qualitative, if quantitative approaches are used at all, they are usually delimited to descriptive statistics and the quantification of qualitative data; in paradigmatic approaches identified as quantitative, if qualitative approaches are used at all, it is usually to

develop frequency counts or to develop quantitative instruments (Onwuegbuzie, Johnson, & Collins, 2009).

Proponents of mixed-methodological approaches therefore point to the pragmatic paradigm as a third methodological movement, one that allows for the reconciliation and more thorough integration of qualitative and quantitative research approaches and elements of the paradigms in which they are situated (MacKenzie & Knipe, 2006; Onwuegbuzie, Johnson, & Collins, 2009; Cameron, 2011; Johnson, Onwuegbuzie, & Turner, 2000). Proponents of the pragmatic paradigm maintain that qualitative and quantitative perspectives were unnecessarily juxtaposed in the context of “paradigm wars” (Cameron, 2011).

The pragmatic paradigm emphasizes the value of combining “methods and ideas that helps one optimally frame, address, and provide tentative answers to one’s research questions” (Johnson, Onwuegbuzie, & Turner, 2007, p. 125). As opposed to qualitative or quantitative paradigms, within the pragmatic paradigm, researchers can draw upon the full range of qualitative and quantitative research methodologies (Johnson, Onwuegbuzie, & Turner, 2007; MacKenzie & Knipe, 2006; Onwuegbuzie, Johnson, & Collins, 2009).

Critics of the pragmatic paradigm and of mixed-methodological research have (1) accused the pragmatic paradigm of eclecticism, (2) have argued that it is more of a bridge between philosophy and methodology than a paradigm, and (3) have rejected it outright because it does not align with either of the two original sides of the paradigm wars (Cameron, 2011; Johnson, Onwuegbuzie, & Turner, 2007). In response to the third criticism, this is a circular and therefore fallible logic rooted in the *a priori* incompatibility thesis (Onwuegbuzie, Johnson, & Collins, 2009). In response to the second criticism, it belies the social processes by which epistemological and ontological orientations beget methods and methods become

methodologies and methodologies become encapsulated and widely acknowledged enough to be considered paradigms; what is considered “...a bridge between philosophy and methodology” today, or by one person, may be readily recognized as a paradigm tomorrow or by someone else today (researchgate.net, 2014; Kinash, 2006). This is related directly to the refutation of the first critique. In response to the first critique, it should be noted that eclecticism is an accepted part of other, action-oriented paradigms, such as health education (Glanz, Rimer, & Lewis, 2002) and cannot accurately be deemed an inherently negative attribute of a paradigm.

Citing eclecticism as a critique presumes the superiority of other, more established or familiar paradigms, such as positivism, postpositivism, interpretivism, and constructivism. It can be argued that the eclecticism of mixed-methodological research is “neither inherently uncritical nor unreflective” (Køppe, 2012, p. 1), nor is it inherently negative (Køppe, 2012). Furthermore, it can be argued that eclecticism can be reasonably viewed as an indication of the evolution of existing paradigms and scientific theories (Køppe, 2012). According to Køppe (2012), “eclecticism is precisely the name for those “inter-theoretical” relations which, in the long run, develop scientific description and understanding by relating their objects to other objects, or other properties of these objects” (p. 2). Køppe (2012) contends that research methodologies are essentially different ways of knowing and constructing knowledge, which each delimit themselves to investigating different characteristics relevant and defining for a given scientific project. Køppe (2012) explains that

Scientific development often occurs as an eclectic process through which interfaces with other disciplines are cultivated and investigated and inspire to expansions and new, idea-focused formations. In this way, it can be understood that those

characteristics by which a given discipline defines its topics are enlarged by other characteristics, carved out by other demarcations. If one insists that the real object is something other than the recognized object, then different disciplines' demarcations of the real object from their recognized object will exactly comprise different sections of the characteristics which the real object constitutes. In this way, the shared amount will constitute the most precise agreement between the recognized object of the real object.

(p. 9)

Therefore, according to K ppe (2012), "since scientific development progresses very eclectically, then one simply cannot claim that eclecticism is negative and ought to be avoided. In its way, eclecticism is neither good nor bad—it is an existential condition for scientific development" (p. 9). The pragmatic paradigm embraces multiple ways of knowing and of constructing knowledge, and therefore supports expansion of research modalities for the better understanding of complex concepts and phenomena. The very critiques of the pragmatic paradigm are its strengths.

The proposed research will utilize both quantitative and qualitative methodologies and data. The goal is to gather multifaceted information about client perceptions of their experiences with prescribing mental health professionals in New Mexico and about possible ways in which providers' educational pathways may extend to their practices, in general and with specific regard to certain education-related initiatives within health care. The pragmatic paradigm is best-suited to encompass the interdisciplinary and inter-methodological nature and goals of the proposed research.

The researcher agrees with the philosophical underpinnings of the pragmatic model, particularly those of situation utility in the pursuit of truth and in the selection of method, as

well as with K ppe’s (2012) defense of the utility and inevitability of eclecticism as a means for evolving scientific theory. The researcher believes the world is infinitely complex and therefore no single way of knowing or of constructing knowledge is inherently or universally privileged above others in its correctness, aptitudes, accuracy, or other epistemological and ontological components. Therefore, the researcher believes that a research approach that supports and integrates multiple ways of knowing and/or of constructing knowledge is probably best for most research, as this would provide a more comprehensive picture than would any paradigmatically purist approach.

If the researcher does in fact believe in one universal truth, it is that the “incompatibility thesis” between qualitative and quantitative research methods is erroneous and that no such divide is inherently necessary nor conducive to better research, though at times this may be the case. The researcher also feels that critiques of the pragmatic paradigm on the grounds of eclecticism or on the basis that it eschews the incompatibility thesis reflect a hegemonic, discursive, and thus social construction of science. They are further undermined by K ppe’s (2012) explanation of the contributions of pragmatism to scientific evolution, or to the stagnation and eventual irrelevancy of scientific theories that refuse to draw upon the potential merits of eclecticism. The researcher believes in practice-oriented research, such as that which has utility to informing a given situation or context, as well as health education research paradigms, and thus, in the context of the proposed research, the use of the pragmatic paradigm. The researcher believes in an expanded version of the utilitarian adage “do the best that you can with the time you have and the resources available”; to the researcher, this does not exclude social justice issues, but means valuing and drawing upon the full range of tools at your disposal—including both qualitative and quantitative methods, multiple ways of knowing,

and a broad spectrum, and their respective paradigms of origin as warranted. These are much the same premises underlying the pragmatic paradigm as are presented by Onwuegbuzie and Leech (2005). Therefore, the researcher self-identifies as a pragmatist and thus feels that the pragmatic paradigm is that which best suits the proposed research and the paradigmatic beliefs and predilections of the researcher. Having discussed pragmatist theory and the pragmatic paradigm, I will now move on to a discussion of the research design that will be used in the proposed research.

Exploratory Sequential Mixed-Methods Design

The pragmatic paradigm can support a variety of mixed-methodology research designs (MacKenzie & Knipe, 2006; Onwuegbuzie, Johnson, & Collins, 2009; Johnson, Onwuegbuzie, & Turner, 2007; Leech & Onwuegbuzie, 2009), with different degrees of concurrence and mixing of qualitative and quantitative approaches (Leech & Onwuegbuzie, 2009). Drawing from among Leech's and Onwuegbuzie's (2009) typologies of mixed-methods research, the proposed research will utilize a sequential, quantitative to qualitative mixed-methods design, with the goal that the qualitative research results complement or clarify the quantitative findings. Decisions about the weighting of quantitative and qualitative data within the sequential mixed-methodology model employed will be made at the data analysis stage. Because so little research has been conducted with regard to the practice of prescribing psychologists, and none has been conducted with regard, to the clients of prescribing psychologists the proposed research is intended to be exploratory in nature. Results are intended to capture diverse, albeit preliminary, data about the varied experiences of the clients of prescribing psychologists trained to practice in New Mexico. The modes of inquiry chosen for the proposed research are intended to complement one another in order to provide a broad

understanding of client experiences with prescribing psychologists in New Mexico as well as qualitative correlations to education-related provider-mediated initiatives and extensions of providers' training into practice. Next, because it is also related to the proposed research in terms of both the subject matter—mental health care—and theory—the utility- and practice-orientation of pragmatism and the pragmatic paradigm—I will discuss health education and its various components and perspectives.

Health Education

Health education is above all else practice-oriented. Therefore, health education and the more recent term, “health promotion,” are inextricably related concepts; health promotion is merely a more specific term for the ultimate goal of health education (Green & Krueter, 1991; Glanz, Rimer, & Viswanath, 2008; Catford & Nutbeam, 1984; Seymour, 1984). Green, a leading researcher and author, highlights the synchronicity of “health education” and “health promotion.” According to Green, “health education” can be defined as “any combination of learning experiences designed to facilitate voluntary adaptations of behaviors conducive to health” (Green, Krueter, Partridge, & Deeds, 1980). This definition is widely adopted within other health education publications (Glanz, Rimer, & Viswanath, 2008). Similarly, across many publications, Green defines “health promotion” as “any combination of health education and related organizational, economic, and environmental supports for behavior of individuals, groups, or communities conducive to health” (Green & Anderson, 1986; Green & Krueter, 1991; 1999). Thus, “health education” and “health promotion” are essentially interchangeable and inextricably codependent concepts. For the purposes of this paper, the term “health education” will be used to reference the entire concept of “learning and educating for the purpose of promoting health.”

Health education is a field that uses many theories, but all have the end-goal of promoting behavior change or maintaining healthy behaviors (Glanz, Rimer, & Lewis, 2002; Catford & Nutbeam, 1984; French & Adams, 1986). Health education is concerned with issues of quality of life as much as with promoting generally accepted measures of medical success, for example, encouraging and enabling mobility-limited individuals to socially engage with surrounding communities (quality of life), or reducing mortality from chronic preventable diseases (an accepted measure of medical success). In order to achieve these and other goals, health education also takes up advocacy, community organizing, and the techniques of critical analysis to address issues such as mental illness stigmatization, environmental justice, disaster preparedness and response (Gotham, 2007; Wyatt & Abel, 2007; Minkler, 2000; Glanz, Rimer, & Lewis, 2002; Brown et al., 2002; Brulle & Pellow, 2006). Mental health care, in particular, is a key area in which issues and interventions related to access, quality, public policies, reduced stigmatization of service users, and reduction of provider shortages—to name only a few—feature prominently as concerns and agendas relevant to health education and promotion (e.g. National Institute of Mental Health, 2014; World Health Organization, 2001; National Alliance for the Mentally Ill, 2014; World Health Organization, 2013). Understanding the paradigms, theoretical orientations, and scope of health education and promotion is important to the proposed research, because mental health care has reciprocal educational components and implications for providers as well as clients and health education is readily designed to address this dynamic. Thus, the foundations, perspectives, and paradigms of health education are discussed next.

Health education foundations and perspectives. Health education is its own field, but its theoretical and pragmatic roots are eclectic. Health education draws from medicine, critical

theory, social marketing and other aspects of business, learning theory, psychology, sociology, medicine, logical positivism, constructivism, and other fields (Glanz, Rimer, & Viswanath, 2008; Glanz, Rimer, & Lewis, 2002). Being dually informed by constructivism and logical positivism means that health education and its theories can be inductive, deductive, and abductive, originating from a logical positivist perspective but having evolved to emphasize constructivism and social justice (Glanz, Rimer, & Viswanath, 2008; Glanz, Rimer, & Lewis, 2002, French & Adams, 1986). Because health education is action-oriented, power is an inherent dynamic of this field; historically, as with medicine, well-meaning but paternalistic public health policies have raised concerns over how power should be exerted in the pursuit of health education and promotion and by whom (Glanz, Rimer, & Lewis, 2002). Therefore today, the predominant paradigm in health education relies on behavioral approaches that seek to reduce constraints against change and promote informed decision-making (Glanz, Rimer, & Lewis, 2002). Participatory, patient-centered health education, including SDM between patients and their health care providers are approaches to health education derived from a critical focus on client empowerment (Godolphin, 2009; French & Adams, 1986). These health education approaches are evidence-based and theory-based and have been shown to improve health outcomes (Arora, 2003; Epstein & Street, 2007); as such, they have been widely adopted into health policies, some of which will be discussed in more depth in a separate portion of this literature review (e.g. HHS, 2010; CDC, 2014a; HHS, 2001).

Furthermore, health education is not the exclusive domain of medical practitioners; rather, in order to promote informed decision-making and effective behavior change, health education integrates interdisciplinary theory, research, and practice into its own field, which in turn is ultimately relevant to all individuals, organizations, and communities.

Scope of health education. Health education may colloquially be conceived of as targeting the “lay public,” individuals not trained in health or medicine. However, by definition, health education does not exclude public health and health care workers from its scope, in that these professionals must also be educated in order to successfully promote health education among the general populace.

According to Glanz, Rimer, and Lewis (2002), health education, as “in-service training for health care providers [is]...all part of health care today. The changing nature of health service delivery has stimulated greater emphasis on health education in physician’s offices, health maintenance organizations, public health clinics, and hospitals” (p. 12). Furthermore,

For health education to be effective, it should be designed with an understanding of the recipients, or target audiences, and their health and social characteristics as well as their beliefs, attitudes, values, skills, and past behaviors. These audiences consist of people who may be reached as individuals, in groups, through organizations, as communities or sociopolitical entities, or through some combination of these. They may be health professionals, clients, people at risk for a disease, or patients. (Glanz, Rimer, & Lewis, 2002, p. 13)

Thus, while the primary goal of health education is behavioral change or maintenance of existing behaviors conducive to health, its avenues for facilitating this may include, among other activities, research, policy-making, advocacy, media, marketing, and community organizing, in addition to action-oriented education targeting individuals, groups, organizations, and larger populations (Glanz, Rimer, & Viswanath, 2008; Glanz, Rimer, & Lewis, 2002; Minkler, Vasquez, Tajik, & Peterson, 2008; Arcury, Quandt, & Russell, 2002).

In sum, effective health education is ultimately theory-based, evidence-based, and best-practices based (Glanz, Rimer, and Viswanath, 2008; Glanz, Rimer, & Lewis, 2002; Ammerman, Lindquist, Lohr, and Hersey, 2002). Health education theories are eclectic and adaptable, drawing on and synthesizing behavioral research and theories from many disciplines. First and foremost, health education and its theories are intended to be practicable (Glanz, Rimer, & Lewis, 2002). Research in health education is conducted with the ultimate goal being that it informs health education practice (Glanz, Rimer, Lewis, 2002). This makes health education inherently aligned with pragmatist theory and the pragmatic paradigm, as well as the use of mixed-methods research, when a combination of approaches is best suited to answering and/or evaluating certain research questions.

In the next section, literacy and health literacy are discussed. These concepts intersect with health education, while also bridging into a discussion of the connections between mental health care providers' education and patient-centered practices that also reflect certain types of education and learning.

Literacy and Health Literacy

There are two competing models of literacy: autonomous and ideological (Street, 2006; Street & Besnier, 1994). Defining and distinguishing between these two models is to the proposed research because health literacy develops from within the latter model (ideological) and efforts to promote health literacy therefore stem from key premises unique to that model. This subsection will define the autonomous and ideological models of literacy, multimodality and multiliteracies, and explain the connections between health literacy, the ideological model of literacy, multiliteracies, and multimodality.

Models of literacy. In the older, autonomous model, literacy is comprised of two skills—reading and writing of text—which can exist without any further context in terms of the what, where, when, who, how, or why of their use; literacy in the autonomous model is thus posited as being a neutral and benign skillset (Street & Besnier, 1994; Street, 2006). Illiteracy, low literacy, or poor literacy skills in the autonomous model therefore indicate difficulty deciphering or creating text materials (Street, 2006).

The ideological model maintains that literacy can never be divorced from context, because “...literacy is a social practice, not simply a technical and neutral skill; that it is always embedded in socially constructed epistemological principles” (Street, 2006, p. 2). The ideological model maintains that literacy practices vary between different cultures and contexts in terms of the what, where, when, who, how, and why of their use. Literacy in the ideological model is about knowledge: the ways in which people address literacy skills “...are themselves rooted in conceptions of knowledge, identity, being” (Street, 2006, p. 2). According to Street (2006), the ideological model is named so because it views literacy as

...always embedded in social practices, Literacy, in this sense, is always contested, both its meanings and its practices, hence particular versions of it are always ‘ideological’, they are always rooted in a particular world-view and a desire for that view of literacy to dominate and to marginalise others. (p. 2)

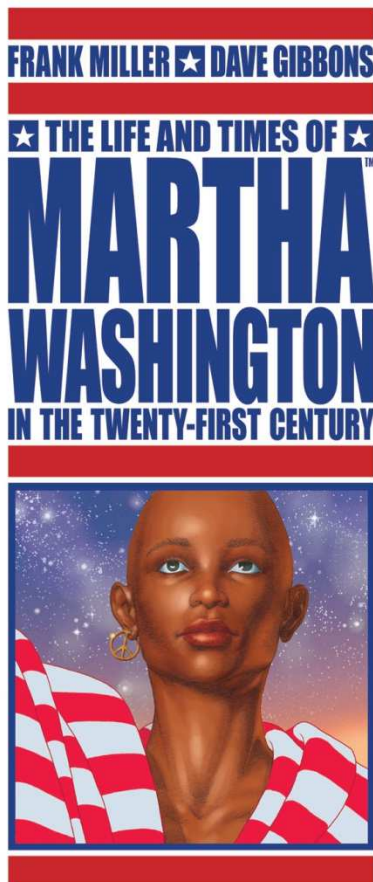
Thus, the ideological model implies that the autonomous model is itself an ideology about literacy, rather than a true representation of literacy as it actually occurs as a practice with context.

Multiliteracies and multimodality. In the ideological model, different literacy practices interact to create new and hybrid literacies (Street, 2006). The ideological model acknowledges reading and writing as literacy skills, but ideological models of literacy also include the concepts of multiliteracies and multimodality, which extend our understanding of literacy practices beyond the context of text and print or writing as the sole mode and medium of literacy practices (Street, 2006, New London Group, 1996). Instead, the New London Group (1996) argues that,

...literacy pedagogy now must account for the burgeoning variety of text forms associated with information and multimedia technologies. This includes understanding and competent control of representational forms that are becoming increasingly significant in the overall communications environment, such as visual images and their relationship to the written word. (no page number)

According to the New London Group (1996), the term “multiliteracies” refers to the skills needed to process and create communicative materials across and drawing upon a variety of modalities, or mediums, e.g. internet, print, written, verbal, text messaging, television, radio, and other communication interfaces, and text; audio; video; visual non-text (such as signs, symbols, imagery, etc.), and intertextuality (references to existing materials, signs, or systems of communication). Multiliteracies interact with multiple modalities to communicate meaning and are therefore inextricably related (New London Group, 1996). Thus, multimodal multiliteracies are essential for understanding and functioning in the world, because of the plurality of different literacy practices that converge within the social contexts that always must situate literacy events and practices within the ideological model. Technology, from ancient writing systems and materials to the present-day behemoth of information and

communication systems that is the internet, require people to use different literacies and modalities to decode and create meaning. Reading and writing of text on materials such as stone or paper are examples, but so is this excerpt from a blog (jazintellect.wordpress.com, 2013¹):



Note that the excerpt is an image, and the image includes text and non-text. The non-text includes images comprised of lines and color, which serve to depict and communicate, through signs and symbols, a young woman wearing an earring that is associated with “peace” and an American flag. Based on the text within the excerpt, the American historical figure it references, and on lines and color comprising the image of the woman and the background, it might also be construed that this is a book cover, rather than a photograph or a movie advertisement and that something patriotic or nationalist about America is being insinuated. All of this meaning is communicated through the use of multiliteracies,

e.g. visual literacy, textual literacy, intertextual literacy, and digital literacy. Together, the use of these literacies to create and interpret meaning also represents multimodality, because visual

¹The reference information for the book in this excerpt is:
Miller, F. & Gibbons, D. (2010). The life and times of Martha Washington in the twenty-first century.
Milwaukee, OR: Dark Horse Books.

and textual linguistic systems are being combined with historical and social references, and then delivered over the medium of internet to make and communicate meaning (New London Group, 1996).

According to the New London Group (1996), “in a profound sense, all meaning-making is multimodal” (no page number) and as the blog excerpt above indicates, the internet is a great example for explaining this e.g., all textual systems are also visual or tactile; when text appears online it is also digital; when language is spoken it is also audio; when audio language is played online it is also digital; lines and color are used to design spaces and create images; photographs are combined with text and sound to create meaning; online, lines, color, sound, and different types of images are also used to design spaces and create meaning, and so on (New London Group, 1996).

The New London Group (1996) treatise on the existence of multiple, multimodal literacies, including reading and writing, that are interrelated to each other, has supported the identification of other “literacies” that span many mediums and subject matters, e.g. information literacy, cultural literacy, technology literacy, statistical literacy, health literacy, etc. (1996). These multiliteracies are termed as forms of literacy because each refers to the ability to understand and use, and in some cases, to also create information within social, historical, cultural, political contexts in which communication takes place (HHS, 2010; National Network of Libraries of Medicine, 2014; Shapiro & Hughes, 1996; Zarcadoolas, Pleasant, & Greer, 2006; Knobel, 1999; American Library Association, 2014).

Understanding multiliteracies and multimodality within the ideological model of literacy is important to understanding the concept of health literacy and U.S. policies seeking

to promote health literacy. Health literacy and its connections to multimodal multiliteracies and the proposed research are discussed henceforth.

Health literacy. In the National Action Plan to Improve Health Literacy (U.S. Department of Health and Human Services [HHS], 2010), health literacy is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (p. 1). Thus, health literacy falls within ideological models of literacy, in which literacy is viewed as a dynamic set of social practices best understood in situ (Street & Besnier, 1994; Street, 2006; Hall, Smith, & Wicaksono, 2013; Barton, 2007). Health literacy is related to other literacies, namely information literacy (HHS, 2010). According to the American Library Association (2014), which develops national standards for information literacy, “information literacy is a set of abilities requiring individuals to recognize when information is needed and have the ability to locate, evaluate, and use effectively the needed information” (no page number). As an extension of information literacy, health literacy refers to much more than the ability to read. According to the National Network of Libraries of Medicine (2014),

Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. For example, it includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems.
(no page number)

The National Action Plan to Improve Health Literacy (HHS, 2010) also emphasizes the multimodal nature of health literacy, recommending that physicians present patients with

information using multimedia. Research suggests that most multimedia health information may be more comprehensible to most Americans than text-only information, largely due to the fact that people have become particularly accustomed to practicing information literacy with multimedia (HHS, 2010). While low skills in the literacy practices of reading and writing may contribute to some individuals' low health literacy skills, the National Action Plan to Improve Health Literacy (HHS, 2010) maintains that even most individuals with medium to high reading and writing skills find most written medical information unusable (HHS, 2010).

This means that medical literacy is a special subset of health literacy, one which entails competence with medical jargon rather than medical meaning, and that this "medical literacy" is acquired by medical professionals through their unique training to work in medical fields. According to the National Action Plan to Improve Health Literacy (HHS, 2010), this medical literacy remains both uncommon among and inaccessible to individuals not trained as medical professional, namely the majority of individuals in the U.S. An effective way to make the information typically conveyed by medical jargon and modality accessible to the general public, whether they possess low or high reading and writing literacy skills, is to communicate it via multimedia and non-jargon language (HHS, 2010). If health information is made accessible to the general public, laypeople can be provided with opportunities to learn and practice health literacy, such as through SDM.

Thus, various forms of literacy and literacy practices are related respectively, to clients' informal and providers' education. Health literacy is clearly representative of literacies as practice; health literacy is *practiced* by patients and therefore must be *promoted* through the support of health care providers. A more in-depth review of health literacy research follows,

with the intention that it further clarifies connections between education, health literacy, and SDM in the context of the proposed research.

Health literacy research, theoretical and practical connections, and policy. Health literacy is positively correlated with improved health outcomes for a variety of chronic health conditions (HHS, 2010; CDC, 2014a; Gerber et al, 2005; Smith et al, 2009; Berkman et al., 2004). Inversely, low health literacy is correlated with worse health outcomes for a variety of chronic health conditions (HHS, 2010; National Institute of Health, 2014; Berkman et al., 2004). This is due in part to a positive relationship between health literacy and patient self-efficacy to follow through with health care recommendations and decisions, and in part due to a positive relationship between health literacy, patient involvement in SDM about their care, and between SDM and positive treatment outcomes (HHS, 2010; Makoul & Clayman, 2006; CDC, 2014a; Berkman et al, 2004). Health literacy moderates a patient's ability to engage in informed decision-making about their care as well as their ability to enact the decisions they make (HHS, 2010; Makoul & Clayman, 2006). For example, physicians have conversations with clients about impending treatment decisions that must be made, clients must be able to understand the pros and cons of each option, or the reasons as to why there may not be any options, as well as the reasons for the physician's recommendation of a particular treatment (Makoul & Clayman, 2006; Godolphin, 2009). In other words, a patient must be able to demonstrate health literacy in the context of a particular situation in order to make informed decisions about the situation.

In health care, it is important to remember that health literacy is *practiced* by patients, and *promoted* by providers and by other sources from which people receive health information. In the context of service encounters with health care workers, health care providers promote

health literacy in their patients by providing them with or directing them towards the information the patient needs to make informed decisions about their care and to facilitate good health on an everyday basis. According to the National Action Plan to Improve Health Literacy (2010),

Public policy is increasingly focused on the role of consumers (the public) in managing their own health in partnership with health care providers. To make appropriate health decisions and act on them, people must locate health information, evaluate the information for credibility and quality, and analyze risks and benefits. (p. 3)

In this way, it is clear that health literacy is also a necessary cornerstone for the practice of SDM in health care, which is supported by other policies and documents discussed elsewhere in this paper.

Building on the aforementioned notions of healthy literacy as dynamic social practices enacted by consumers, the National Action Plan to Improve Health Literacy (2010) as well as other public agendas and policies, such as Healthy People 2010 and Healthy People 2020 (CDC, 2014a; U.S. Department of Health and Human Services [HHS], 2001), have identified health care and public health professionals as key moderators of health literacy. However, the National Action Plan to Improve Health Literacy (HHS, 2010), Healthy People 2010 (HHS, 2001), and Healthy People 2020 (CDC, 2014a) each note that those responsible for facilitating health literacy have failed to adequately do so. According to the National Action Plan to Improve Health Literacy (HHS, 2010),

Two decades of research indicate that today's health information is presented in a way that isn't usable by most Americans. Nearly 9 out of 10 adults have difficulty using the

everyday health information that is routinely available in our health care facilities, retail outlets, media, and communities. (p. 1)

Healthy People 2020 (CDC, 2014a) points to this problem through its goals and objectives, which were extended from Healthy People 2010 (HHS, 2001), as they were not achieved by that milestone. Some of the health literacy-related goals of Healthy People 2020 include:

- HC/HIT-1 (Developmental) Improve the health literacy of the population
- HC/HIT-3 Increase the proportion of persons who report that their health care providers always involved them in decisions about their health care as much as they wanted
- HC/HIT-4 (Developmental) Increase the proportion of patients whose doctor recommends personalized health information resources to help them manage their health
- HC/HIT-8 Increase the proportion of quality, health-related websites
- HC/HIT-11 (Developmental) Increase the proportion of meaningful users of health information technology (HIT) (CDC, 2014a)

Clearly, per the goals espoused in Health People 2020 and the overall purpose of the National Action Plan to Improve Health Literacy, a great deal of responsibility for promoting health literacy falls to health care providers and other purveyors of health information for public consumption (HHS, 2010; CDC, 2014a). However, there are recognized barriers that prevent providers' from doing so successfully, and these pertain to the education providers receive.

Health literacy practices and providers' education. According to the National Action Plan to Improve Health Literacy, (HHS, 2010), “few health care professionals receive much formal training in communication, particularly in working with people with limited literacy” (p. 25). Indeed, an entire section of the Action Plan (HHS, 2010) focuses on promoting alterations to providers’ continuing education programs to include explicit training in evidence-based modes and mores of health communication with clients and with evidence-based strategies for designing health information materials and venues. Such educational objectives are essential to achieving national goals of improving health literacy because medical school does not comprehensively training aspiring physicians in how to facilitate health literacy. According to the National Action Plan to Improve Health Literacy (HHS, 2010), the current credentialing exam for medical students “...does not address how limited health literacy affects interactions with patients” (p. 25). Furthermore, “...most health care professionals already in practice have not had formal training in improving communication skills...” (p. 25). These deficits in physicians’ training persist in spite of campaigns like the National Action Plan to Improve Health Literacy (HHS, 2010) and Health People 2010 and 2020 (CDC, 2014a; HHS, 2001), and despite the strategies and recommendations directed at physicians and their training programs that are put forth by and to coincide with these campaigns (HHS, 2010; CDC, 2014a).

One caveat to these concerns about providers’ lack of training in health literacy is directly relevant to the proposed research. While the assertion that “few health care professionals receive much formal training in communication, particularly in working with people with limited literacy” (HHS, 2010; p. 25) is certainly true for health care trained primarily through educational pathways grounded in biomedicine, such as for psychiatrists, it

is not wholly true of health care practitioners with grounding in psychology. Such is the extent to which psychological practice is dialogic that it is often referred to as “talk therapy” (Gideon, Hancock, & Nelstrop, 2009); as such, psychologists actually receive a great deal of training in communication. Although such training may not be specific to working with clients with low literacy skills in reading and writing, the notion of psychology as “talk therapy” indicates that psychologists, and therefore prescribing psychologists, likely have more training in verbal communication that is at least applicable to contexts in which clients have low reading and writing literacy skills than do other psychiatrists.

In addition to communication as a fundamental premise of psychology practice, a key component of psychologists’ practice that hinges on successful communication between clients and providers is the therapeutic alliance (Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2006; Lindhiem et al., 2014). Simply put, a therapeutic alliance means that a provider and client build their relationship on the basis of a preliminary, direct discussion of each party’s goals and expectations of the therapeutic process and what therapy will entail; this is therefore also an example of SDM (Deegan & Drake, 2006; Lindhiem et al., 2014). From this point, therapy moves and the therapeutic alliance moves forward with the understanding that similar conversations can be initiated by either the therapist or client at the inclination of either party. In the course of developing the therapeutic alliance, many aspects of health literacy are addressed as matters of course, so that informed decision-making and agreement between a client and a provider is possible (CDC, 2014a). Psychologists receive explicit training in how to develop a therapeutic alliance with their clients (Deegan & Drake, 2006). Thus, the therapeutic alliance is another example of how psychologists receive training in how to share

decision making and convey health related information to their clients (Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2006; Lindhiem et al., 2014).

Jorm (2011) writes about the contributions psychologists are trained to make in terms of promoting public mental health literacy. Mental health literacy refers to a subset of health literacy specifically pertaining to reducing stigma and misinformation about mental illnesses, their symptoms, treatment, and interventions among the general public (Jorm, 2011).

However, in general, research evaluating the health literacy-promoting practices of psychiatrists or psychologists appears to be lacking. The proposed research will investigate address issues of health literacy in the following ways. First, the consumer satisfaction survey will gauge client experiences with prescribing mental health providers' health literacy promoting practices; this will provide a picture of what is happening in relationship to the national health literacy educational initiatives as espoused in Healthy People 2020 (CDC, 2014a) and the National Action Plan to Improve Health Literacy (HHS, 2010). Second, because health literacy promoting behaviors are connected to the training providers receive, or lack thereof, in their educational pathways (HHS, 2010), the proposed research seeks to examine whether there appear to be correlations between educational programs for psychotropic prescriptive authority in New Mexico and providers' health literacy-related behaviors in their practice with clients. As clients are the focus of both mental health care practice and health literacy education initiatives, it is logical to examine their perceptions of providers' health literacy promoting behaviors as the end-point extension of said providers' education and training. Thirdly, as is discussed more elsewhere in this proposal, SDM is also a national agenda that is predicated on providers' training and on their promotion of health

literacy; thus, data collected via surveys and interviews will provide insight into possible correlations between providers' training and SDM models of practice in mental health.

Promoting and practicing health literacy are requisite elements of SDM, which is another focus of the proposed research. Thus, having now discussed literacy and health literacy, it is possible to discuss SDM and to highlight how it connects providers' education and training to educational practices involving clients.

Shared Decision Making (SDM)

The term "shared decision making" (SDM) was first defined by a presidential Commission, "the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research" (Makoul & Clayman, 2006). In a report produced by this commission, SDM is described as a partnership of mutual engagement and respect by providers and patients (Abram et al., 1982). The report defines SDM descriptively, as follows:

It will usually consist of discussions between professional and patient that bring the knowledge, concerns, and perspective of each to the process of seeking agreement on a course of treatment. Simply put, this means that the physician or other health professional invites the patient to participate in a dialogue in which the professional seeks to help the patient understand the medical situation and available courses of action, and the patient conveys his or her concerns and wishes. This does not involve a mechanical recitation of abstruse medical information, but should include disclosures that give the patient an understanding of his or her condition and an appreciation of its consequences. (p. 38)

By the definition given by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Abram et al, 1982) definition, SDM makes demands of both the practitioners and the patient. According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Abram et al., 1982),

Shared decision making requires that a practitioner seek not only to understand each patient's needs and develop reasonable alternatives to meet those needs, but also to present the alternatives in a way that enables patients to choose one they prefer. To participate in this process, patients must engage in a dialogue with the practitioner and make their views on well-being clear. (p. 44)

According to Elwyn et al. (2012), SDM has been more succinctly defined as “an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences” (p. 1361). SDM is one example of the paradigmatic shift in health education towards participatory models of health care service. The SDM model has been posited in response to ethical, legal, and evidence-based challenges to paternalistic, provider-centered frameworks and has been supported by the consumer/survivor movement (Curtis et al., 2010; Godolphin, 2009; Deegan & Drake, 2006; Drake, Deegan & Rapp, 2010).

According to Drake, Deegan, and Rapp (2009), shared decision making in mental health care,

...is an alternative to the wounding practice of medical paternalism, because it honors and values the voices of people with diagnoses...shared decision making is predicated on speaking up during the consultation. Instead of isolating people in their experience

of suffering and resilience, shared decision making is about *sharing* and collaborating as partners with medical practitioners. (p. 9)

SDM is a specific paradigm of health care practice designed to be empowering to clients, to undermine paternalistic approaches to health care, and predicated upon health literacy practices. SDM therefore draws from critical perspectives in general and from health education and promotion and literacy.

The SDM model and its paradigmatic evolution are supported by various government policies, documents, and initiatives. In addition to “the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,” there is the “Consumer Bill of Rights and Responsibility,” written by the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Agency for Healthcare Research and Quality [AHRQ], 1998). According to the Consumer Bill of Rights (ARHQ, 1998), these recommendations include that,

Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

In order to ensure consumers' right and ability to participate in treatment decisions, health care professionals should:

- Provide patients with easily understood information and opportunity to decide among treatment options consistent with the informed consent process. Specifically,

- Discuss all treatment options with a patient in a culturally competent manner, including the option of no treatment at all.
- Ensure that persons with disabilities have effective communications with members of the health system in making such decisions.
- Discuss all current treatments a consumer may be undergoing, including those alternative treatments that are self-administered.
- Discuss all risks, benefits, and consequences to treatment or nontreatment.
- Give patients the opportunity to refuse treatment and to express preferences about future treatment decisions.
- Discuss the use of advance directives -- both living wills and durable powers of attorney for health care -- with patients and their designated family members.
- Abide by the decisions made by their patients and/or their designated representatives consistent with the informed consent process. (Chapter 4, no page number)

The Advisory Commission (AHRQ, 1998) also paired these and other consumer rights with consumer responsibilities that emphasize the shared burden of responsibility in the shared decision making model of care:

In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment. (Chapter 8, no page number)

Among others, such responsibilities identified by the Advisory Commission (AHRQ, 1998) include:

- Become involved in specific health care decisions.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Show respect for other patients and health workers. (AHQR, 1998, Chapter 8, no page numbers)

While this bill of rights was never codified into law, the recommendations developed by the Advisory Commission (AHRQ, 1998) are evident in the goals of Health People 2020 (CDC, 2014a). The goals of Health People 2020 are, in turn, extensions and reiterations of Healthy People 2010 goals (HHS, 2001), as the problems the 2010 goals were meant to address persisted at benchmark year 2010. In addition to the aforementioned goals relating to health literacy, some of the goals of Healthy People 2020 (CDC, 2014a) that relate to SDM include:

- HC/HIT-2 Increase the proportion of persons who report that their health care providers have satisfactory communication skills
- HC/HIT-2.1 Increase the proportion of persons who report that their health care providers always listened carefully to them
- HC/HIT-2.2 Increase the proportion of persons who report that their health care providers always explained things so they could understand them

- HC/HIT-2.3 Increase the proportion of persons who report that their health care providers always showed respect for what they had to say
 - HC/HIT-2.4 Increase the proportion of persons who report that their health care providers always spent enough time with them
 - HC/HIT-3 Increase the proportion of persons who report that their health care providers always involved them in decisions about their health care as much as they wanted.
- (CDC, 2014a, no page number)

Thus, SDM emerges from a consumer rights and responsibilities perspective, premised on client-provider co-production of health literacy and outcomes in health care.

In a report produced by this the President's Commission for the Study of Ethical Problems in Medicine and Biomedicine and Behavioral Research (Abram et al., 1982), SDM is described as a partnership of mutual engagement and respect by providers and patients, which therefore makes demands of both the client and the provider (Abram et al., 1982). According to the Commission (Abram et al., 1982),

Shared decision making requires that a practitioner seek not only to understand each patient's needs and develop reasonable alternatives to meet those needs, but also to present the alternatives in a way that enables patients to choose one they prefer. To participate in this process, patients must engage in a dialogue with the practitioner and make their views on well-being clear. (p. 44)

Other researchers have operationalized the various definitions of SDM into steps that practitioners and researchers can follow. Makoul and Clayman (2006) conducted research and analysis of SDM in health care in order to develop an integrative model of shared decision

making that would be relevant across different clinical contexts, types of decisions, and levels of involvement. According to Makoul and Clayman (2006) and Godolphin (20009), SDM is contingent upon the following steps occurring:

1. Patients and providers must first define and/or explain the problem that needs to be addressed.
2. A presentation of options should follow. Physicians should review options, if options exist, and patients should raise options of which they may be aware.
3. Physicians and patients should discuss the pros and cons of options raised and each party should articulate different perspectives they may have on the relative importance of benefits, risks, and costs, including convenience and opportunity cost. Patients should indicate their values and preferences by sharing their ideas, concerns, and outcomes expectations with their providers. Physicians should likewise convey their knowledge and recommendations in the context of the decision at hand.
4. In assessing the viability of options, patient's ability and/or self-efficacy to follow through with a plan is an important but often underemphasized middle step in the SDM process. This discussion should occur during the stage at which options and preferences are discussed.

Makoul and Clayman (2006) also maintain that both patients and providers should check one another's understanding of the facts and perspectives espoused within the conversation on an ongoing basis, so that further clarification can be provided as needed. This is directly related to health literacy, and to the act of providers promoting health literacy on the part of their patients (Makoul & Clayman, 2006). The final steps of the SDM process, as outlined by Makoul and Clayman (2006), involve decision-making and/or follow-up

discussions between patients and providers about decision making. Thus, if a decision is made at an appointment, this is the fifth step in the process. However, decisions may be deferred to a later appointment, and thus the last part of the process may include two steps, and is described as “physicians and patients arrange follow-up to track the outcome of decisions that have been made or reach resolution on those that have not” (p. 306). Thus, the gist of SDM is straightforward, although the process takes effort and skills on both the part of the provider and the part of patient. Makoul and Clayman (2006) also highlight the overlap between the process of SDM and development of the therapeutic alliance.

Makoul and Clayman (2006) emphasize that “the importance of checking and clarifying understanding has been reinforced by research on health literacy” (p. 306). Certainly, shared decision making is predicated upon patient’s abilities to make informed decisions (HHS, 2010; Abram et al, 1983; Godolphin, 2009). According to Godolphin (2009), “simply put, a key component of patient-centered care is shared and informed decision-making” (p. e186). The rationale for the assertion of patient rights to SDM in health care directly responds to the paternalistic nature of provider-centered medical practice. The Consumer Bill of Rights (AHQR, 1998) states that,

Consumers depend on health care professionals to provide them with expert consultation and advice on how to stay healthy or how to cure or palliate their health and medical problems. Unlike many other consumer transactions, the asymmetry of information between consumer and health care provider often is great. (Chapter 4, no page number)

However, although the National Action Plan to Improve Health Literacy (HHS, 2010) focuses on patient-centered literacy practices as research-based, rights-based, and ethics-based

goals that should be adopted by health care providers, the report does little to explicitly acknowledge professional resistance to accepting the possibility and implications of patients as competent and informed decision-makers in health care.

Physician resistance to SDM as an implication and application of successful health literacy is deep-seeded and reflects the historically paternalistic system of health care, especially mental health care, in the U.S. (Curtis et al., 2010; Drake, Deegan, & Rapp, 2010; Woltmann & Whitley, 2010). Despite national emphasis on the use of SDM and promotion of health literacy in *all* health care settings (CDC, 2014a), provider resistance to participating in these overlapping initiatives persists. According to Auerbach (2000),

Arguments that have been presented for limiting patient involvement in their own care include: (a) patients usually do not have the cognitive capacity or background for processing the information needed to make an informed decision (i.e. understanding risks and values associated with potential outcomes); (b) patients are not objective about their health status and thus cannot be expected to make rational decisions about treatment; and (c) patients are inconsistent and unreliable in making medical decisions. (p. 246).

In a comprehensive review of literature that helped spur support and further research advocating the use of the SDM model, Auerbach (2000) thoroughly debunks each of these arguments and shows them to be myths. Auerbach (2000) cites research that conclusively indicates that physicians are no more objective in the decisions they would make on patients' behalfs than are the patients themselves. Auerbach (2000) also points to a bevy of research indicating that with basic attentiveness to patients' health literacy in topics relevant to health care decisions they are faced with, patients can and do consistently make well-reasoned and objective health care decisions for themselves. Auerbach (2000) preemptively attends to an

additional concern not yet explicitly voiced in literature but certainly of merit, which is the time needed to ensure patients' health literacy in support of shared decision making; Auerbach (2000) references ample research that suggests that the time needed to do so is minimal and would not place an undue burden on providers. Finally, Auerbach (2000) indicates that emerging research connected better health outcomes with use of the shared decision making model. In general, Auerbach (2000) makes one of the earliest and most thorough cases for the implementation of shared decision making across different health fields. Later research has failed to contradict the points that Auerbach (2000) made, and have extended them explicitly to mental health care.

In a later study of barriers to implementing shared decision making, Gravel et al. (2008) report that time constraints, physician-determined perceptions that SDM is not applicable to certain patients because of patient characteristics, and clinical situation are the most frequent excuses for neglecting to implement SDM in medical practices. These are not dissimilar from those provided and debunked by Auerbach (2000).

Shared decision-making in mental health care. According to Curtis et al. (2010), mental health care is particularly and professionally resistant to adopting SDM, even though the approach is policy-, best practices- and evidence-based. Curtis et al. (2010) write that “the tradition of provider-centric decision making continues in many contemporary mental health settings. Knowledge is seen as resident in experts who make assessments and determine what treatments are in the best interest of individuals receiving services” (p. 15). Furthermore, in mental health care settings, “the involvement of individuals is often limited to accepting the expert’s opinion, seeking a second expert opinion, or rejecting treatment altogether” (Curtis et al., 2010, p. 15). Limiting, paternalistic behaviors such as these are not unique to mental health

care; as Auerbach (2000) points out, they have historically been imbedded within all of U.S. medical practice. However, in mental health care, they have been particularly pervasive, as “this paternalism has been reinforced by legal constraints; use of coercion, including involuntary treatment; and assumptions about the ability or interest of people to engage in decision making about treatment or other important personal concerns” (Curtis et al., 2010, p. 15). However, with the exception of legal enforcement of treatment for mental health care, these factors are hardly different from the excuses provided by Auerbach (2000) for medicine in general. Fukui et al. (2014) indicate that three general barriers have prevented SDM in psychiatry “concerns about decisional capabilities...providers’ paternalistic views...and time constraints” (p. 1). It is notable that among these three reasons, the first is nearly identical to Auerbach’s (2000) acknowledgement of the concern that patients “do not have the cognitive capacity or background for processing the information needed to make an informed decision” (p. 246) and Gravel et al.’s (2008) conclusions that physician-determined judgments of client characteristics make clients unsuitable candidates for SDM.

Despite these persistent concerns, research in addition to Auerbach’s (2000) also shows that implementing SDM is need not be hampered by common time constraints or patient characteristics, in mental health or in other medical fields (Schauer, Everett, & del Vecchio, 2010). Furthermore, other reasons given for not implementing SDM in mental health care are essentially operational or preferential and thus responsibility for them lies mainly with providers and how they comport themselves in patient interactions.

According to Deegan and Drake (2006), SDM is particularly apt for mental health care because it undermines the validity of these concerns. Deegan and Drake (2006) write that,

Choice, self-determination, and empowerment are foundational values for people with disabilities, including people with psychiatric disabilities...Shared decision making is a clinical model that upholds these values. It helps to bridge the empirical evidence base...with the unique concerns, values, and life context of the individual client. (p. 1636)

In doing this, SDM empowers patients to have more control over their behavior than simply to adhere to inherently disempowering compliance approaches to care that pressure patients to choose merely between complying completely, completely declining to comply, or seeking a new provider when differences in treatment preferences arise (Curtis et al., 2010).

Moreover, despite several decades worth of research indicating difficulty and resistance on the part of providers to implementing elements of SDM in mental health care, allowing patients to have as much control as possible over their mental health care is supported as a best practices approach to mental health in a variety of policies, e.g. by the National Association of Social Workers (1999); by the Sowers & Quality Management Committee of the American Association of Community Psychiatrists (2005); by the United States Psychiatric Rehabilitation Association (2007); by advocacy groups such as Mental Health America (2004) and the National Alliance for the Mentally Ill (2006); and by state mental health authorities (Woltmann & Whitley, 2010). Research also suggests that SDM is positively correlated with client satisfaction in mental health care encounters (Swanson et al., 2007) and that satisfaction in mental health care encounters is associated with positive health outcomes (Lindhiem et al., 2014; Mohammed et al., 2014).

The proposed research will investigate patient perceptions of providers' practice of SDM components. This investigation will seek to highlight connections between SDM and

health literacy as two codependent practices linked to providers' education. Survey and interview data will explore client experiences with elements of SDM and health literacy as facilitated by prescribing psychologists; data about the educational pathways prescribing psychologists pursue prior to seeking prescriptive authority in New Mexico may help connect client experiences of SDM and health literacy promoting practices facilitated by their providers to unique training their providers may have received.

Having now discussed the interactive dynamics that connect providers and clients as well as health literacy and SDM, I will discuss consumer co-production as a theory and explanatory framework that foregrounds a great deal of consumer satisfaction research, including the proposed research and its instruments (Bitner et al., 1997; Care Quality Commission, 2014). First, I will briefly discuss consumer satisfaction research in health care and then I will explain its basis in co-production theory and then, the connections between co-production theory and other components of the proposed research.

Consumer Satisfaction Research in Health Care

Consumer satisfaction research is common in most fields of health care, e.g. oncology, ophthalmology, surgery, transplants medicine, diabetes management, etc. (Colombo et al., 2009; Gourdjji, McVey, & Loiselle, 2003; Ingram & Chung, 1997; Gallant & Coutts, 2003). Client satisfaction is positively associated with health outcomes in a variety of medical encounters, and as such consumer satisfaction research in health care is usually premised on quality improvement efforts (Gallant & Coutts, 2003; Colombo et al., 2009; Gourdjji, McVey, & Loiselle, 2003; Ingram & Chung, 1997). In fact, many health care outcome evaluations and evaluation guides emphasize the including consumer satisfaction surveys as a necessary component of outcome measurement (e.g. Wright, 1999; Grol, 2001; Centers for Medicare and

Medicaid Services, 2014; Agency for Health Care Research and Quality, 2009; Al-Abri & Al-Balushi, 2013).

However, this is not the case with U.S. mental health care. There are very few publications from the last 30 years with regard to client satisfaction research conducted in outpatient U.S. mental health care. Moreover, much of the limited recent literature that is deemed “satisfaction research in psychiatry” is actually studies of patients’ satisfaction with particular medications, rather than health service encounters (e.g. Gray et al., 2005; Gharabawi et al., 2006; Chue, 2006). This type of “consumer satisfaction research” entirely absconds the theoretical premises of consumer satisfaction as a measure of the quality of care providers provide and misrepresents evaluations of mental health care quality.

Coproduction theory is the basis of sound consumer satisfaction research for service encounters, such as those in health care. Coproduction theory also underlies the interactive dynamic of SDM and supports its positive correlation with health outcomes in mental health and other fields. For this and other related reasons, the theory and framework of coproduction is essential to proposed research. Thus, the principles and implications of coproduction are discussed henceforth.

Consumer Co-Production and Patient Satisfaction as a Measure of Quality of Care

Two important contributions to the basis for the proposed research are derived in full or in part from the field and context of business. The first is the concept of “co-production” in service encounters. The second is the perspective that patients are in fact consumers within the health care service industry. The significance and relevance of these contributions are discussed henceforth.

Consumer co-production of service experiences. In the present research, co-production serves three very important, interrelated purposes. First, is that it establishes the theoretical grounds for client satisfaction to serve as a valid measure of the quality of health care people receive. Second, is that it also provides a framework for SDM as an interactive process highly indicative of co-production. Third, is the culmination of the first two reasons: co-production foregrounds SDM as a specific type of interaction that can and should occur in mental health care, and the measurement of client satisfaction and experiences with SDM with their mental health care providers as a measure of the quality of care providers are delivering. In order to emphasize the second and third purposes, I will begin by explaining the first.

Bitner, Faranda, Hubbert, and Zeithalm (1997) posit early theorization and frameworks regarding “co-production.” According to Bitner et al. (1997),

Service experiences are the outcomes of interactions between organizations, related systems/processes, service employees and customers...in many services customers themselves have vital roles to play in creating service outcomes and ultimately enhancing or detracting from their own satisfaction and the value received. (Bitner et al., 1997, p. 193)

In this introductory description of co-production theory, Bitner et al. (1997) highlight its relevance to health care providers and health care services (Bitner et al., 1997). Bitner et al. (1997) maintain that the co-production by consumers and service providers of experiences and satisfaction

...is true whether the customer is an end consumer (for example, consumers of health care, education, personal care, or legal services) or a business (for example,

organizations purchasing maintenance, insurance, computer consulting or training services). In all of these examples, customers themselves participate at some level in creating the service and ensuring their own satisfaction. (Bitner et al., 1997, p. 193)

Thus, co-production theory is essentially constructivist in that it maintains that the outcome of service interactions is a process mediated by the knowledge, expectations, experiences, and contributions of the consumer as well as by similar dynamics on the part of the service industry provider (Bitner et al., 1997).

Bitner et al. (1997) offer two frameworks for understanding consumer co-production in service industry experiences. These include a framework for examining three levels of customer participation in service experiences and a framework for understanding three roles customers can play in service delivery (Bitner et al., 1997).

In the first framework they offer, Bitner et al. (1997) categorize the three levels of customer participation in service interactions as “low,” “moderate,” and “high,” identifying annual health screenings as an example of a service context require “moderate” consumer participation, while counseling falls into the “high” category. Bitner et al. (1997) also indicate that other types of health care services fall within these two categories as well, given that in health care, consumers are actually

...involved in co-creating the service (high level of participation). For such services, customers have essential production roles that, if not fulfilled, will affect the nature of the service outcome. All forms of education, training and health maintenance fit this profile. Unless the customer does something (e.g. studies, exercises, eats the right foods), the service provider cannot effectively deliver the service outcome. (p. 195)

Bitner et al. (1997) base their framework for understanding levels of customer participation on years of business research advocating that organizations view service customers as “partial” employees or as “productive resources.” Bitner et al. (1997) maintain that this perspective expands notions of what is important and who is a contributor of ideas and inputs within a service organization, to include customers. To illustrate this, Bitner et al. (1997) provide examples from medicine:

For example, in contributing information and effort in the diagnoses of their ailments, patients of a healthcare organization are part of the service production process. If they provide accurate information in a timely fashion, physicians will be more efficient and accurate in their diagnoses. Thus, the quality of the information patients provide can ultimately affect the quality of the outcome. Furthermore, in most cases, if patients follow their physician’s advice, they will be less likely to return for follow-up treatment, further increasing the healthcare organization’s productivity. (p. 197)

Bitner et al. (1997) also highlight the relationship between quality of care, customer satisfaction, and co-production in service experiences with references to health care. Bitner et al. (1997) write that

Effective customer participation can increase the likelihood that needs are met and that the benefits the customer is seeking are actually attained. This is particularly apparent for services such as health care, education, personal fitness, weight loss, and others where the service outcome is highly dependent on customer participation. In these cases, the customer is an integral part of the service and unless he/she performs his/her role effectively, the desired service outcome is not possible. (pp. 197-198)

While Bitner et al. (1997) are among the first to make the point, other authors writing about co-production theory and its implications for service industries concur that co-production is essential to such processes and is fundamentally related to consumer satisfaction with such experiences.

Customer engagement in co-production of the service experience places some responsibility for the outcome on the consumer (Bitner et al., 1997; Etgar, 2008; Kotz & Plessis, 2003; Goldman, Mitra, & Moorman, 2012). Because of this, research indicates that when consumers are engaged at the appropriate levels of co-production their sense of shared responsibility for the outcome of service encounters results in mitigation of dissatisfaction if the outcome fails to fully meet their expectations, needs, and affectations, while satisfaction with positive outcomes is increased (Bitner et al, 1997). Goldman, Mitra, and Moorman (2012) write that,

When customers provide resource inputs or participate in the production process, the resulting accumulated information has a positive impact on ‘will’ expectations which improves attribute perceptions...co-production may shift ‘ideal’ expectations toward what customers perceive...co-production reduces ‘will’ uncertainty because customers have more knowledge of a co-produced attribute’s performance. This increases the influence of ‘will’ expectations. These positive impacts of co-production provide insights into why evaluated aggregate quality often increases through co-production. (p. 13)

The positive impacts of co-production are related to the roles customers play in particular service encounters. Bitner et al. (1997) identify three such roles relevant to co-

production and consumer satisfaction and present them as components of their second framework for understanding and apply co-production theory in service industries:

- (1) the customer as productive resource;
- (2) the customer as contributor to quality, satisfaction and value; and
- (3) the customer as competitor to the service organization. (p. 195)

Bitner et al. (1997), as well as later authors, primarily emphasize the importance of responding to the first two roles, when analyzing service encounters for quality. Identifying and responding to the customer's role in service encounters is one way to ensure that consumers are offered the opportunity for appropriate levels of engagement and opportunities to contribute to their own satisfaction. Kotze and Plessier (2003) write that

While the level of required customer participation differs across service settings, active participation is unavoidable in the case of human service organisations... Customers are an integral part of the service delivery system in these settings and also the primary products or vehicles for demonstrating that the desired service outcomes have been achieved... Unless customers perform their "co-production" roles effectively, the desired outcomes will not be realised. (p. 187)

Of course, service users may wish to engage in co-production at different levels (Kotze & Plessier, 2003), and may thus be relevant to evaluations of client satisfaction with the delivery of services. Perhaps more important, however, is the fact that customers can only perform their co-production roles effectively if the opportunity to do so is provided to them. Clients who would like to be more engaged in the co-production of services they receive but who are not, may therefore express greater dissatisfaction with experiences of services in

which their co-production was not solicited (Bitner et al., 1997; Kotze & Plessier, 2003). In mental health, research has consistently found that clients would like to be more involved in their care (e.g. Curtis et al., 2010; Drake, Deegan, & Rapp, 2010; Adams, Drake, & Woldord, 2007), indicating that satisfaction may be related to models for promoting co-production, such as SDM.

Researchers studying co-production theory in service industries often frame the inputs that consumers can contribute as being information and action, while the outputs are satisfaction as an indicator of service encounter quality, especially including moderate-to-high co-participation encounters such as health care services (Bitner et al., 1997; Etgar, 2008; Kotze & Plessier, 2003). By emphasizing recognition and attention to the inherent role clients play in service encounters, co-production theory links consumer satisfaction with consumer engagement. Co-production frameworks encourage health care providers and policy-makers to encourage and attend to client participation in health care encounters (Bitner et al., 1997).

Co-production theory also gives an explanation for the use of consumer satisfaction as a means of measuring quality of care. Goldman, Mitra, and Moorman (2012) identify six ways in which co-production affects consumer satisfaction with services. In these descriptions, “will expectations” “...are the attribute performance levels a customer predicts or believes an offering is going to deliver” (Golder, Mitra, & Moorman, 2012, p. 4). “Accumulated information” refers to and consists of “...stored customer knowledge accrued from a customer’s own experiences, other customers’ experiences, firm strategies (e.g., customer relationship and brand strategies), media reports, and quality signals associated with each attribute” (Golder, Mitra, & Moorman, 2012, p. 4).

According to Golder, Mitra, and Moorman (2012), the first way in which co-production affects consumer satisfaction with service encounters is that “when customers contribute to produced attributes...delivered attributes are more likely to approximate what customers want” p. 13). Simply put, this refers to the fact that when consumers are engaged in producing the services they desire, the services are more likely to meet the expectations of the client. Consumer satisfaction and co-production are also correlated in that “... involvement in co-production should increase customer measurement knowledge and motivation. When this happens, customers will place more emphasis on perceived attributes and less emphasis on ‘will’ expectations because they are more likely to perceive accurately the attributes firms deliver” Golder, Mitra, & Moorman, 2012, p. 13). In other words, customers who are engaged in the co-production of services they receive are more likely to be satisfied with the service because they develop and use more realistic expectations about what the service can deliver. The third connection Golder, Mitra, and Moorman (2012) identify between satisfaction and co-production assumes that service providers will respond to the expectations about the service that clients voice. Golder, Mitra, and Moorman (2012) write that “co-production enables firms to monitor customers’ emotions, which allows managers to adjust produced attributes in real time...This may involve changing the level of an existing attribute...or adding new attributes...to accommodate a customer” (p. 13). While in reality this may not always be the case, in order to promote equity in health care partnerships between clients and providers, it should certainly be a goal. The fourth connection identified by Golder, Mitra, and Moorman (2012) is that “when customers provide resource inputs or participate in the production process, the resulting accumulated information has a positive impact on ‘will’ expectations, which improves attribute perceptions” (p. 13). This coincides with the second connection,

meaning that consumers' involvement in the co-production of services they receive alters their expectations of said services, by providing them with new information upon which to base their expectations and satisfaction judgments. Also related to these two connections between co-production and satisfaction is the fifth connection between these concepts. Golder, Mitra, and Moorman (2012) indicate that "co-production may shift 'ideal' expectations toward what customers perceive" (p. 13). Again, this explains the influence of co-production on satisfaction through the development of expectations. The final connection between satisfaction and service co-production identified by Golder, Mitra, and Moorman (2012) is also related to expectations, in that it addresses the fact that consumers may have varied expectations of a service's performance. Golder, Mitra, and Moorman (2012) write that "co-production reduces 'will' uncertainty because customers have more knowledge of a co-produced attribute's performance. This increases the influence of 'will' expectations" (p. 13). Golder, Mitra, and Moorman (2012) maintain that these six factors provide insight into why co-production is associated with increased evaluations of aggregate satisfaction with a service. Moreover, these six factors not only support the evaluation of consumer satisfaction with services, but support doing so, at least in part, in connection with an evaluation of consumer perceptions of the degree of their involvement and opportunity for involvement in co-producing said experiences.

Thus, co-production theory provides a consumer-centered perspective from which to evaluate client satisfaction with different services and service experiences. Co-production research and frameworks intersect with health education theories, research, and policy. As described elsewhere in this paper, in recent decades, such research, policy, and theory has gravitated away from support for paternalistic models of health care service provision in favor of support for SDM as a model for health care, including mental health services (HHS, 2010;

Abram et al., 1982; AHRQ, 1998; CDC, 2014a). Research suggests that SDM is equally feasible and effective in mental health care as in other medical settings, as mental health care service users are no different from other consumers or patients in terms of being co-producers of their [mental health care] service experiences (Bitner et al., 1997; Curtis et al., 2010; Fukui et al., 2014). Mental health care service users have treatment preferences, would like to receive information about their treatment options, and would like the opportunity to influence decisions about their treatment, although these needs are often ignored by their psychiatrists (Curtis et al., 2010; Drake, Deegan, & Rapp, 2010; Adams, Drake, & Woldord, 2007). Nonetheless, mental health service users can influence the co-production of even the most paternalistically constrained encounter with their health care providers by terminating the relationship, discontinuing a treatment, misrepresenting treatment adherence, and other means of resistance and information management (Lindhiem et al, 2014; Curtis et al., 2010). These behaviors are commonly inferred by traditional prescribing mental health care providers as the basis for providers to avoid the promotion of health literacy and its extension to SDM in mental health care (Fukui et al., 2014; Auerbach, 2001; Lindhiem et al., 2014).

Importantly however, research actually indicates that by embracing the implications of co-production for understanding and improving client satisfaction with service encounters in mental health care, client satisfaction with their treatment improves concurrent with their treatment adherence and outcomes (Fukui et al., 2014; Swanson et al, 2007; Elwyn et al., 2012; Mohammed et al., 2014; Lindhiem et al, 2014; Trenaman, 2014). Together with the idea that client satisfaction indicates successful business transactions, in health care and other service encounters, this connection between client satisfaction and outcomes forms the basis for

consumer satisfaction as a measure of quality (Bitner et al., 1997; Lindhiem et al., 2014; Mohammed et al., 2014).

Co-production, satisfaction, SDM, and outcomes. Consumer satisfaction research and co-production frameworks indicate that consumer satisfaction and concurrent outcomes in mental health (and other types of) care are influenced by the simultaneous processes of health literacy promotion and SDM (Mohammed et al., 2014; Lindhiem et al., 2014; Bitner et al., 1997; Goldman, Mitra, & Mooreman, 2012). Mohammed et al. (2014) and Lindhiem et al. (2014) each conducted meta-analyses of the literature linking consumer satisfaction, health literacy, and SDM in mental health care. Both studies conclude that satisfaction is correlated with providers' communication of health care information and options, especially for chronic conditions such as are common in mental health care (Mohammed et al., 2014; Lindhiem et al., 2014). Lindhiem et al. (2014) present statistically significant evidence gathered exclusively from studies of mental health care, in which consumer satisfaction is found to be positively correlated with treatment outcomes on the basis of the combination of providers' communication in terms of facilitating health literacy and SDM. Consumers who reported that their providers promoted health literacy and then implemented SDM—allowing clients to make *informed* decisions about their care—reported greater satisfaction with their mental health *and* demonstrated better treatment outcomes, including medication adherence, treatment completion, and symptom reduction (Lindhiem et al., 2014). Mohammed et al. (2014) and Lindhiem et al. (2014) conclude that these findings support the use of client satisfaction as a valid measure of the quality of care they have received.

Consumer co-production frameworks also help connect consumer satisfaction and measures of quality of care. Research indicates that clients and providers may differ on their

initial definitions of positive treatment outcomes: in mental health care, clients may be frame such definitions in terms of quality of life, while providers may frame such issues in terms of reduction of symptoms (Lindhiem et al., 2014; Mohammed et al., 2014; Curtis et al., 2010). However, because consumers are inherently involved in creating their health care experiences, such as by the information they provide, their ability and willingness to engage in various treatments, their attendance at subsequent appointments, etc., and because consumers who are involved in their care through decision-making may take more responsibility for the outcome of their treatment (Bitner et al, 1997; Kotze & Plessier; Goldman, Mitra, & Moorman, 2012), it is unsurprising that when informed SDM is implemented in mental health care settings, goals and treatments can be more successfully aligned between both parties.

Existing research connecting health literacy, SDM, and mental health care quality indicate some deficits in the general research (no such research currently exists specific to prescribing psychologists). Mohammed et al. (2014) emphasize the many components and different approaches to defining and measuring consumer experiences and satisfaction with health providers' communication behaviors. These authors conclude that instruments currently used to evaluate U.S. consumers satisfaction with health care are insufficient for capturing the communication elements important to health literacy promotion and SDM (Mohammed et al., 2014). Lindhiem et al. (2014) also suggest that there are methodological issues and inconsistencies with current approaches to measuring consumer satisfaction with health literacy promotion and SDM and suggest that new instruments should be utilized.

Together with literature linking consumer satisfaction, quality of care, health literacy, and SDM, consumer co-production ties in education. Without proper training and preparation, neither clients nor service providers can successfully engage in co-production of the health

care services (Bitner et al., 1997; Kotze & Plessier, 2003). Clients benefit more from the combination of health literacy promotion and SDM than from SDM on its own; furthermore, clients served by providers explicitly trained in SDM benefit more than those served by providers without such training (Lindhiem et al., 2014).

The proposed research expand on consumer co-production perspective and the research by Lindhiem et al. (2014) and Mohammed et al. (2014), linking health literacy, SDM, consumer satisfaction, and quality together in the context of mental health care. The proposed research will evaluate consumer satisfaction as a measure of the quality of care they receive from prescribing psychologists.

The proposed research will utilize a survey instrument originally developed and vetted on behalf of the British National Health Service (NHS). The Care Quality Commission, the Royal College of Psychiatrists, and the Improving Access to Psychological Treatments (IAPT) Programme are among the many groups that inform the development of NHS mental health care satisfaction surveys, including the survey that will be used in the proposed research (Gideon, Hancock, & Nelstrop, 2009; CQC, 2014b; IAPT Programme, 2014). The survey that will be used in the proposed research was developed and vetted for NHS specifically for the purpose of evaluating mental health care service users' satisfaction with their care and their providers' efforts to promote informed SDM as components of treatment practice (CQC, 2014b; Gideon, Hancock, & Nelstrop, 2009). This instrument attends to a concern expressed by Mohammed et al. (2014), which is that instruments used in existing research to evaluate consumer satisfaction do not ask questions pertaining to SDM. The NHS survey asks several questions related to satisfaction with components of SDM. The survey also inquires about satisfaction related to health literacy. The qualitative interviews will collect further, more

detailed information about client experiences with health literacy as a factor in the mental health care they receive from prescribing psychologists. Thus, consumer co-production and other business-oriented literature offers a basis upon which the proposed research seeks to connect policy, education, consumers, providers, satisfaction, quality, and health care in the context of prescribing psychologists in New Mexico.

Informal Science Education

After discussing related concepts such as literacy, health literacy, and SDM in-depth, it is worthwhile to briefly discuss informal science education. According to Feder et al. (2009), “experiences in informal environments for science learning are typically characterized as learner-motivated, guided by learner interests, voluntary, personal, ongoing, contextually relevant, collaborative, nonlinear, and open-ended” (p. 25). Informal science education is an important concept to the proposed research because health literacy an example of informal science. Moreover, research and practices for the purposes of informal science also highlight the connections being drawn in the proposed research between different types of learning (formal and informal), different types of actors in the health literacy process (providers and clients), and certain approaches to looking at interactions between these concepts. These contributions are highlighted in this subsection.

Health literacy is both developed and practiced within informal contexts, making it both an informal science learning process and practice. Feder et al. (2009) explicitly emphasize that health concerns, health promotion, and encounters are common contexts that are very conducive to informal science learning and education, a process they also refer to as “science literacy.” According to Feder et al. (2009),

In many situations, scientific content, ways of thinking, and practices are opportunistically encountered and identified, without any particular prior intention to learn about science. In this way, science learning is simply woven into the fabric of the everyday activities or problems. An individual could be asked to make a health-related decision, contingent on a set of scientific concepts and complex underlying models, while keeping a routine doctor's appointment. (p. 93)

In this quotation, Feder et al. (2009) highlight the dynamic connections between promoting, developing, and practicing health literacy as part of shared, informed decision-making in health care encounters. As discussed, the Action Plan to Improve Health Literacy (HHS, 2010) emphasizes the importance of using multimodal, multimedia tools to help promote health literacy, regardless of patients' literacy skills in reading and writing print materials. Feder et al. (2009) indicate that one reason for this is that many U.S. adults are already accustomed to informally learning and doing science through such mediums. Rather than being overly simplistic, multimedia is a familiar and accessible way for people to draw upon various literacy practices in order to obtain necessary or desired health information in a format that is comprehensible to them. Feder et al. (2009) write about that:

Just as children learn science in everyday settings, so do adults. The clearest examples are health- and environment-related information. In seeking information about these [health] issues, adults often turn to various sources besides such traditional experts as health practitioners. Additional modes of health information-seeking now commonly include the mass media and the use of local experts. The use of mass media for health information is well documented. (p. 104)

Thus, many people already seek to develop health literacy through multimodal multimedia sources. As does the National Action Plan to Improve Health Literacy and Healthy People 2020 (CDC, 2014a), Feder et al. (2009) stress that it is the responsibility of health care providers charged with promoting health literacy that they take the lead in providing people with access to credible sources of this type of informal science learning. Within the context of informal science, people in scientific occupations or authority positions, such as health care providers, are also charged with the responsibility of creating contexts in which science literacy can be informally practiced as well as learned (Feder et al., 2009). This extends itself to a more discussion of how informal science helps highlight the different roles that education, learning, and agents thereof play within the context of health literacy.

Informal science, health literacy, and practice. Among these relevant contributions are the concepts of what informal science means and involves. As with literacy in the ideological model, informal science is comprised of dynamic practices—such as behaviors and events—rather than discreet, finite skills and processes that exist without context (Feder et al., 2009; Street, 2006). With informal science, there is education—the ways by which individuals informally learn about and “to do” (promote) science. Thus, the terms “promote” and “practice” health literacy derive not only from the ideological model of literacy but also from an understanding of informal science.

Although scientific information can be formally taught, this is not enough; it is essential to society and everyday life that people also “do” science and learn about science informally (Feder et al., 2009). Thus, it is the responsibility of facilitators to *promote* informal science learning, so that people can practice science informally (Feder et al., 2009). As will be

emphasized throughout this paper, the same terminology is applicable to health literacy: health care providers' *promote* health literacy, so that their clients can *practice* health literacy.

Successful informal science education and learning is an inherently collaborative process between educators—those who promote learning—and clients—those who practice informal science learning and doing. According to Feder et al. (2009), “the type of shared agency that allows for collaborative establishment of goals and standards for success can extend to multiple aspects of informal learning activities” (p. 57). In the proposed study, health literacy, as a prerequisite to SDM, is an informal learning activity. With informal science, facilitators must promote both the learning and doing of science. Health literacy, as a form of informal science, should be acquired as well as practiced in medical encounters. Shared decision-making is one way that clients can practice health literacy; health literacy learning is needed so that SDM meets its premise of also being an informed decision-making (Makoul & Clayman, 2006; Godolphin, 2009).

Informal science and evaluation. Another important contribution to the proposed research is that research about informal science emphasizes the inapplicability of traditional assessments to the evaluation of informal science learning and education contexts (Feder et al., 2009; Friedman, 2008). Traditional assessments of learning outcomes are ill-suited to measuring informal science learning simply because they are too formal; formal pretest-posttest approaches or even posttest-only fact-check assessments are usually off-putting to individuals who are engaging in learning informally, whereas evaluations of satisfaction, attitudes, behavioral intentions, and general knowledge are better received and suited to informal science learning and education (Feder et al., 2009; Friedman, 2008). According to Feder et al. (2009),

E-mail or phone interviews, often done weeks, months, or even years after a visit or program, are particularly important in informal learning environments because they are often the only way to test two key assumptions: (1) that the experiences are highly memorable and (2) that learners integrate the experiences into the rest of their lives and build on them over time. Typical follow-up questions probe these two aspects of the learning by asking what the participants remember about their experience and what they have done in relation to the content since. (p. 65)

In the proposed research, the client surveys will gather information related to satisfaction with providers' promotion of health literacy and SDM, two contexts related to informal science learning and doing. The qualitative interviews will gather more detailed information on these client experiences, particularly with regard to health literacy.

Formal preparation and informally promoting science. Perhaps the most important connection between informal science learning and the proposed research is this: health literacy is an example of informal science learning that is promoted through informal science education, but the ability of those responsible for promoting this type of informal science education effectively appears to be dependent on formal training. Therefore, informal and formal education are linked together in the present research, with clients' experiences with informal science learning and doing opportunities being evaluated as a correlate of providers' formal education.

Figure 1, which is provided in the introduction to this document, helps illustrate the connection between providers' formal education and the informal science opportunities that health literacy and SDM represent for patients. To clarify further and review what has been covered in this literature section so far, health literacy is a form of science education and

learning that is typically developed and practiced outside of school settings; this makes it informal (Feder et al., 2009).

Medical literacy, on the other hand, is a subset of health literacy that is not widely acquired or practiced by individuals who have not undertaken formal medical schooling; although medical literacy is a subset of health literacy and health and medical literacy seek to convey the same information, medical literacy is distinguishable from health literacy on the basis of its use of medical jargon (HHS, 2010). People who have not had formal science education in medicine may understand or be able to understand health information but not medical jargon; this is why health literacy must be promoted by medical care providers as a translation of medical jargon (HHS, 2010; CDC, 2014a). This positions providers as informal science educators and clients as informal science learners, in their pursuit of health literacy. Shared decision-making is an approach to health care practice that requires health literacy on the part of clients; it is therefore dependent upon the informal science education, learning, and doing of consumers.

Existing research suggests that efforts to promote health literacy and SDM through policy directives have largely failed to elicit more positive attitudes or changes in behavior towards either informal science activity among physicians, particularly psychiatrists (HHS, 2010; Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2006; Fukui, 2014).

Psychologists undertake different educational pathways than do physicians, and emerging research suggests that this difference in their formal training better prepares them as facilitators of informal science education and learning, compared to physicians (Drake, Deegan, & Rapp, 2010; Deegan & Drake, 2006; Lindhiem et al., 2014). As a means of evaluating the impact of providers' formal education on their practice as prescribing mental

health professionals, the proposed research will investigate client experiences with the informal science learning and education contexts of health literacy and SDM. Client experiences with health literacy promotion and its extension to SDM are also validated measures of the quality of care they receive from health care providers, further supporting this approach to investigating how providers' formal education may translate into informal science education and learning among their patients.

In sum, the basic premise is that formal training in the value and processes of implementing health literacy and SDM appear to be necessary for informally doing so (Lindhiem et al., 2014; HHS, 2010).

Tying It All Together: Educational Relevance

In this section, the educational relevance of the proposed research is explained. Supporting literature is reviewed. Broadly stated, the proposed research intersects with education from two angles: patient-centered health education and mental health care providers' education. The proposed research seeks to address both educational angles via investigation of client experiences and satisfaction. This approach is intended to allow for client experiences with different providers and different types of providers to be quantified, qualitatively explored, and correlated with the respective educational pathways different types of prescribing mental health professionals in New Mexico.

In addition to collecting data about other aspects of client experiences and satisfaction with the care they receive from prescribing mental health providers in New Mexico, the proposed survey will gather data about client-provider experiences with components of health literacy and SDM. Interviews with mental health service users will provide additional details

concordant with the survey. A review of educational documents (mainly syllabi and degree plans) used to outline the training requirements for two different pathways to prescriptive authority in New Mexico will help frame the data collected from surveys and interviews in terms of possible correlations between client experiences and their providers' education and training.

Because the survey and interviews will only be administered to mental health care service users and not to their providers, it is not intended to be an objective measure of a definitive reality in terms of what actually did or did not happen during clients' treatment sessions with their providers. From the paradigmatic perspective of constructivism, to assert the possibility of doing so is not possible, as reality is moderated by lived experiences and client-provider interactions inherently involve at least two-different lived experiences and thus, two different interpretations of what occurred (Deegan, 2007). Therefore, in taking an approach guided by consumer co-production theory in mental health service experiences, the proposed research focuses on the perceived experiences of clients.

Summary of Research and Paradigmatic Relevance to Education

Because current laws dictating the pathways by which psychologists can gain prescriptive authority all include education and training requirements (Muse & McGrath, 2010), this legislation is by its very tenets a series of educational initiatives. However, the primary focus of the proposed study is not directly related to analysis of these educational policies. Rather, the proposed study aims to assess client experiences and satisfaction with mental health service providers as evaluation measures of their providers' training in mental health care and compliance with various national education-related initiatives. These include SDM and health literacy (HHS, 2010; CDC, 2014a; HHS, 2001; Abram et al., 1982). Health

literacy, SDM, patient education, and provider education go hand in hand with one another: health literacy is an educational agenda, perspective, and process that providers should promote and help facilitate on the part of their client-patients. Health literacy, in turn, is a relevant component of patients' abilities to actually partake in SDM; enabling clients to make informed decisions about their treatment options is a form of health literacy education, while allowing them to do so is an element of SDM. Put a different way, without health literacy, patients cannot make informed decisions about their treatment options, even if they are provided the opportunity; therefore, providers need to ensure that their patients have health literacy and are health literate about their treatment options. According to Drake, Deegan, and Rapp (2010), "real choice is predicated on having access to unbiased information about psychiatric treatment and alternatives to treatment. Having a voice and making an informed choice in treatment may seem like a given. But this has not always been the case" (p. 10).

Indeed, literature indicates that psychiatry has been and still remains among the most paternalistic of medical disciplines; literature about the experiences of mental health care service users indicates that their opportunities for involvement in the care they receive from psychiatrists and other traditional prescribing mental health care providers are often essentially non-existent (Drake, Deegan, & Rapp, 2010; Fukui et al., 2014; Curtis et al., 2014). Research continues to report that psychiatrists remain strongly resistant to promoting health literacy or implementing SDM in their practices (Drake, Deegan, & Rapp, 2010; Curtis et al., 2010; Auerbach, 2001; Fukui et al., 2014).

Psychiatrists generally offer paternalistic and time-oriented explanations for the persistence of this resistance, in spite of evidence and policies debunking the validity and ethicality of such reasoning (Fukui et al., 2014; Auerbach, 2001; Lindhiem et al., 2014).

Because health policies support mental health care clients' rights to SDM and its necessary precursor, health literacy, these failures represent significant ethical and professional failures on the part of health professionals who perpetuate them. Moreover, this status quo remains among traditional prescribing mental health professionals, despite evidence suggesting that this paternalistic approach to mental health care does not promote health literacy and is not conducive to SDM and that treatment delivered without SDM is more likely to be unsuccessful because it does not take clients' preferences or concerns into account (Lindhiem et al., 2014; Mohammed et al., 2014).

Policy documents (HHS, 2010; Fukui et al., 2014) suggest that traditional educational pathways for psychiatrists and other physicians may contribute to the perpetuation of paternalistic approaches to medical practice, those which preclude effective approaches to health literacy and its extension to SDM. Research and policies indicate that psychiatrists and other physicians do not receive instruction in the evidence-based merits or mechanisms of promoting health literacy or implementing SDM (HHS, 2010; Fukui et al., 2014). Similarly, psychiatrists do not receive explicit training in delivering and valuing approaches to patient interaction that are relevant to promoting health literacy (HHS, 2010). Rather, psychiatrists continue to receive training in approaches that are conducive to patient “management”—that phrase being indicative of this in and of itself—that perpetuate a paternalistic, disempowering, authoritarian approach to providing mental health care (Drake, Deegan, & Rapp, 2010; Curtis et al., 2010; Godolphin, 2009; Deegan & Drake, 2006).

Traditional pathways to prescriptive authority, such as those undertaken by physicians, is predominated by a near-exclusive focus on biology and biomedical approaches to understanding and treating health issues. This occurs at the expense of medical school or

continuing education related to communication skills, biopsychosocial and other evidence-based models of health, illness, treatment, and behaviors that lend themselves to accepting the necessity and validity of promoting health literacy and SDM among all health care clients, including mental health service users (HHS, 2010).

Prescribing Psychology: The Possibility for a Different Approach?

However, prescribing psychologists undertake educational pathways to prescriptive authority that are unique from those of psychiatrists and other traditional prescribing mental health professionals. Prior to completing postdoctoral degrees in psychopharmacology, prescribing psychologists trained in psychopharmacology in New Mexico must complete a doctorate in clinical or counseling psychology, as well as academic preparation prerequisite to that degree (NMSU, 2014). A variety of APA guidelines, accreditation standards, and curriculum recommendations indicate that the academic and professional preparation prescribing psychologists undergo in order to obtain prescriptive authority includes training in communication, biopsychosocial models, and other health-related concepts that transcend the biomedical focus of medical school training for psychiatrists and other physicians (APA, 2013a; APA, 2013b).

Ironically, even as research points to deficits in medical education not present in psychology education, psychiatrists try to frame this diversity in prescribing psychologists' academic and professional preparation as a potential precursor to incompetence; psychiatrists use this unsubstantiated line of reasoning as psychiatry's primary argument in opposition to prescriptive authority for psychologists. However, in reality, it would seem that this argument more clearly highlights psychiatrists' antipathy towards any possible implementation of SDM and other counterhegemonic practices in mental health care.

In sum, given that SDM is rooted in communication, collaboration, and health literacy, it seems that prescribing and other psychologists are likely better equipped and more apt to implement SDM and to promote health literacy in their practices as mental health care professionals than are psychiatrists (Makoul & Clayman, 2006; HHS, 2010; Drake, Deegan, & Rapp, 2010; Drake & Deegan, 2006). In the context of prescribing psychologists and psychiatrists, this line of thinking returns to the issue of satisfaction measures as proxies for quality of care, as well as to the argument that clients are consumers of the services and co-production opportunities made available to them by their providers' training and practice preferences.

Since several studies indicate that mental health clients would like to be [more] involved in their care (e.g. Curtis et al., 2010; Drake, Deegan, & Rapp, 2010; Adams, Drake, & Woldord, 2007), and require health literacy as well as providers with training in SDM to do so, and because SDM is an evidence-based and policy-supported treatment approach, client satisfaction on measures pertaining to whether their providers are perceived to engage in practices related to promoting and supporting health literacy and SDM are valid avenues of inquiry in general and as proxies for quality of care in practice. Furthermore, because of the policy initiatives for promoting both SDM and health literacy as agendas in U.S. medical practice, evaluation of client satisfaction with providers in terms of providers' efforts to promote SDM and health literacy are worthy avenues of assessment in and of themselves. Finally, as patient-client satisfaction is positively correlated with treatment outcomes, assessing client satisfaction with SDM and health literacy as well as other aspects of treatment is also meaningful and may be considered to be measures providers' competence.

Analysis of New Mexico prescribing psychologists' educational pathways to prescriptive authority through the provider survey will provide new information about the academic preparation undertaken by these hybrid mental health professionals. Uncovering this information is important because the literature hitherto focuses only on biomedical credit hours required of prescribing psychologists in comparison to biomedical credit hours completed by physicians. Such comparisons are often made in an effort by other prescribing mental health professionals, chiefly psychiatrists, to discredit the medical competency of prescribing psychologists. However, with one exception (Muse & McGrath, 2010), no comparisons examine how the diversity of prescribing psychologists' training may improve their ability to care for patients by complying with evidence-based and advocacy-based initiatives such as health literacy and SDM. Policy (HHS, 2010) does suggest that psychiatrists and other physicians lack training in the merits and mechanisms of promoting health literacy and SDM, while literature suggests the nature of study to practice psychology may entail specialized focus on skills for doing so (Lindhiem et al., 2014; Drake, Deegan, & Rapp, 2010; Drake & Deegan, 2006). The client survey and interviews in the present study will examine clients' experiences with health literacy and SDM and their satisfaction with their providers as a measure of the quality of care they receive from prescribing psychologists. Therefore, together with provider survey data garnering unique insight into the academic backgrounds and self-perceived skills of prescribing psychologists this may allow for connections to be drawn between patient experiences, satisfaction as a proxy for quality of care, provider adherence to health policies, and prescribing psychologists' education and training experiences and perceived competencies. This may provide information useful to informing the development of educational programs for prescribing mental health professionals, which align with

government mandates as well as evidence-based research that encourage providers to promote health literacy and SDM in health care.

The aforementioned review of literature addresses the existing literature, paradigms, and perspectives underlying the proposed research. With review in mind, the evaluation of client satisfaction per the designated survey and interview protocols is summarily relevant to education and education research due to the following tenets and connections:

1. As an emerging academic pathway, the cross-disciplinary nature of pathways to prescriptive authority to psychologists remains controversial but under-researched. The proposed research will gather details, hitherto not discussed in literature, of New Mexico prescribing psychologists' academic backgrounds and training.
2. Furthermore, the proposed research will address a more pressing gap in the literature regarding prescribing psychologists. The primary argument espoused against prescriptive authority for psychologists has been that their training does not render them competent to prescribe psychotropic medications. Consumer satisfaction is an established measure for measuring quality of care and is related to patient outcomes in mental health. Therefore, measuring client satisfaction with prescribing psychologists is one way of contributing to the gap in literature regarding the quality of care provided by prescribing psychologists.
3. For health care providers, quality of care is considered to be an outcome measure for the education they undertake. Consumer satisfaction is an established proxy for quality of care. Therefore, measuring consumer experiences and satisfaction with various aspects of their health care is one way of investigating the impacts and outcomes of providers' education. Measuring consumer satisfaction is also a measure of the quality

of care they receive. Only one government evaluation of a training program with 10 participants (American College of Neuropsychopharmacology [ACNP], 1998) has attempted to evaluate the quality of care that prescribing psychologists provide as an outcome or impact of their training as mental health providers with prescriptive authority. This study did not report satisfaction or perceptions of quality from patient perspectives or with regard to certain national initiatives such as health literacy or SDM. Therefore, the proposed research will contribute novel information about the quality of care that prescribing psychologists are able to deliver as an outcome or impact of their unique education and training.

4. Health literacy is highly indicative, in multiple ways, of the ideological model of literacy and of connections between the ideological model of literacy and science education. Health literacy is *promoted* by health care providers and is *practiced* by health service users. Health literacy is *promoted* as a form of informal science education, and therefore the practice of health literacy demonstrates informal science learning and informal ways of doing science. Therefore, providers act as educators and clients act as learners. Health literacy is readily demonstrable in the context of SDM.
5. Promoting health literacy is a national educational initiative, one which is given significant importance in policies because it foregrounds consumers' abilities to engage in SDM and SDM is policy-supported on the grounds of patient rights and positive health outcomes. The National Action Plan to Improve Health Literacy (HHS, 2010) and Healthy People 2020 (CDC, 2014a) indicate that, to facilitate health literacy, health care providers must ensure that their patients are provided with comprehensible

information and the opportunity for collaborative dialogue and decision-making based on the pros, cons and alternatives to any given treatment or health decision.

6. SDM is also a government-supported initiative, one that is also backed by advocacy efforts, best practices, and research. SDM is intended to empower health care consumers with the right to involvement and choice in the health care they receive. SDM is predicated on consumers' ability to make educated and informed choices, i.e., the promotion and practice of health literacy.
7. Although SDM and health literacy are national prerogatives, only recently have they been given any formal attention in the medical school curriculum—the traditional pathway to prescriptive authority for mental health providers. There are no continuing education requirements that address health literacy or SDM for psychiatrists who are already licensed. Literature about the experiences of mental health service users suggests that these deficits lead to paternalistic care by psychiatrists that reflects neither SDM nor health literacy policy initiatives.
8. To the contrary, literature suggests that psychologists may receive a great deal of academic preparation and/or training specifically oriented towards the implementation of SDM and the facilitation of its necessary precursor, health literacy. Therefore, because prescribing psychologists must hold at least a doctorate in psychology before they can obtain prescriptive authority, it is not only possible that they are sufficiently prepared to deliver high quality care with regards to SDM and health literacy, but that they are even more likely and/or better equipped to do so than are their arch-nemeses on the battleground over psychotropic prescriptive authority, psychiatrists.

9. Thus, evaluating the experiences and satisfaction of prescribing psychologists' clients with regard to SDM and health literacy will contribute to research about the competence of prescribing psychologists (and thus the debate over the adequacy of their education) from a novel angle.
10. Also, because the proposed research will investigate the experiences and perceptions of prescribing psychologists' clients with regard to health literacy and SDM, the research will also serve to investigate informal science practice education, informal science learning, and doing informal science through the practicing of multiliteracies.

In this chapter, I have discussed pragmatist theory and the pragmatic paradigm; sequential quantitative to qualitative mixed-methods design; informal science education; health education; literacy; health literacy; coproduction; and SDM. The purpose of this discussion has been to articulate the perspectives, paradigms, and premises of the proposed research and to build the above-listed connections to education. Some details of the proposed research methodology were provided in this section so as to better illustrate how the concepts being described related to one another and to the proposed research. In the next chapter, I will describe the research methodology in full detail.

CHAPTER 3: METHODOLOGY

This study gathered details on the academic backgrounds of New Mexico (NM) prescribing psychologists (RxPs), as well as data on their self-perceived health literacy practices and knowledge and attitudes towards shared decision-making (SDM). This paralleled investigation into the client experiences and satisfaction with the mental health care provided to them by NM RxPs. A client survey was used to gather information from the perspective of service users regarding the care they received from RxPs practicing in New Mexico. Interviews with service users who had previously seen other types of mental health care providers were also attempted with the goal of gathering further information as to clients' comparative experiences of care from different types of mental health care providers.

The overarching goals of this project were to develop a profile of NM RxPs according to the three topics in the provider survey, so as to better inform our understanding of the interdisciplinary skillsets these professionals bring with them to their work as prescribing mental health professionals (PMHPs), whilst also collecting information from the clients of RxPs on their experiences and satisfaction with patient-centered mental health care. These foci parallel lacunae in the research literature: firstly, there is a dearth of research regarding the field of prescribing psychology and its practitioners. Secondly, very few studies have asked mental health care service users (MHCSUs) about their satisfaction with their PMHPs in general, and even fewer have focused on their experiences, satisfaction, and quality of care according to patient-centered dynamics, such as SDM, or even preliminary practices needed to facilitate informed SDM, such as health literacy. The significance of these gaps, as well as the oddness that either exists at all, are explicated both earlier and later in this document, and are only summarized here for the purposes of contextualizing the project design and guiding

research questions, and reminding the reader of the reasoning behind these things. Having done so, the research questions and study design now be explained.

Research Questions

The research questions that guided this study were as follows:

1. What are some details of New Mexico prescribing psychologists' educational backgrounds and self-perceived communication skills and behaviors?
2. What are the varied experiences of clients of prescribing psychologists in New Mexico?
 - a. What are the experiences of clients of prescribing psychologists in New Mexico with regard to provider-mediated health literacy and shared decision-making practices?
3. How do clients of prescribing psychologists feel about the care they received from these professionals?
4. How might the experiences of New Mexico prescribing psychologists' clients reflect the training undertaken, skills, and/or behaviors espoused by these providers?
5. What is the utility of using the NHS survey to measure client satisfaction among the clients of New Mexico prescribing psychologists?

Research Design

This study is informed by the pragmatic paradigm, which, according to Weaver (2018), “focuses on ‘what works’ rather than what might be considered absolutely and objectively ‘true’ or ‘real’” (p. 1287). As such, the pragmatic paradigm can support a variety of research designs and analytical approaches with varying degrees of concurrence and mixing of

qualitative and quantitative approaches (Leech & Onwuegbuzie, 2009; Pratt, 2016; MacKenzie & Knipe, 2006). Moreover, this paradigm is suited to research done in real-world settings and with practical applications (Weaver, 2018; Pratt, 2016).

By design, then, this project was intended to include mixed methods of data collection and analysis. Specifically, it was designed to be an exploratory sequential mixed-methods study (Leech & Onwuegbuzie's, 2009) in which qualitative data was obtained in order to complement and further explore initial, quantitative data. The original study design involved three phases of data collection and two different participant groups, providers and clients. Many deliberations went into these design decisions, including philosophical, practical, and ethical considerations adjacent to answering the research questions. However, as Brannen (2008) notes while arguing the need for mixed methods researchers to critically reflect on and write about their practice and design decisions, "the possibilities and constraints of the research process, including those encountered during the data analysis phase, may divert the original plan and intention" (p. 57). Such is the case with the present study: unanticipated challenges arose during the implementation stages that necessitated adaptive changes to the research design and subsequent analyses. Thus, this section first begins with a brief overview of the original, tri-phasic exploratory sequential mixed-methods research design and reasoning for these decisions, in order to then explain what changes became necessary and summarize the final structure of the project.

Proposed Design and Analysis

The original exploratory, sequential, mixed-methods design of this study consisted of three phases of data collection and two different groups of participants: first, a survey of practicing RxPs licensed in New Mexico (the "provider survey"); second, a survey of the

clients of NM RxPs (the “client survey”); and third, semi-structured interviews with a subset of clients who participated in the survey (“client interviews”).

Design rationale. A sequential quantitative to qualitative mixed-methods design was chosen for this research so that preliminary, quantitative data would be collected first. Collecting quantitative data first was intended to serve two purposes. Quantitative data collected from the provider survey would be considered in the final data analysis phase of the research, in connection with other data collected from client surveys and client interviews. Also, quantitative data from the client surveys would be used to guide the development of questions for the qualitative interviews. The purpose of the provider surveys was therefore also twofold: (1) to elucidate new details about the academic diversity and preparation of New Mexico prescribing psychologists; (2) to collect information—in connection to providers’ self-reported training and behaviors—that could be used to situate and consider the data collected from clients about their experiences with providers, in terms of practices that may be related to the providers’ education. The primary source of qualitative data was anticipated to be the semi-structured interviews with clients, which would be informed by the results of the client survey.

Sampling Plans and Instruments

The first phase of this project was a provider survey phase, and was anticipated to take no more than a few months, followed by client survey and interview phases each lasting three months or less. This study was designed to target the whole population of RxPs in New Mexico, but evolved to rely somewhat on convenience sampling, beginning with and stemming from New Mexico’s State Psychologist Association (PSA). PSA is New Mexico’s professional organization for RxPs. An RxP and PSA member, Dr. Chris Vento, was part of the researcher’s dissertation committee, and suggested this organization would be a good outlet through which

to connect to the RxP workforce in the state, which, based on PSA membership, was estimated to be only about 45 individuals near the time when the study would begin. Furthermore, based on anecdotal reports from this organization, a high degree of enthusiasm and support for research on the profession was anticipated. So for these reasons, and because PSA maintained contact information for its membership, the original intent was to only offer the provider survey online and to advertise it through the organization by means of its member listserve.

Following the provider survey phase, the original plan was that the client survey would subsequently be advertised by practicing New Mexico RxPs via word of mouth and passive advertisement materials in their offices, such as posters, paper surveys in pre-stamped self-addressed return envelopes, and take-home cards containing a hyperlink to complete the survey online. While acknowledging that response rates would probably vary depending on practice size and client interest, it was anticipated that the same RxPs who participated in the provider survey would assist in promoting and distributing the surveys to their service users, so as to gather a statewide survey sample of at least 100 clients (and no cap), with an ideal rate of at least 10 clients per provider.

The third and final phase of the study was to consist of semi-structured interviews with a subset of clients who completed the survey, in order to gain deeper insight into their experiences as clients of hybrid mental health professionals. The original research proposal included some potential questions for the semi-structured interviews but maintained that these would ultimately be determined based on a preliminary analysis of the client survey (Phase Two) data. The ideal sample size for this phase was capped at 15 participants.

Provider survey. The provider survey was a simple instrument designed by the researcher to gather information from practicing NM RxPs on their academic backgrounds and

self-perceived knowledge, attitudes, and practices regarding SDM and health literacy. It consisted primarily of close-ended multiple choice or list-an-answer type questions. The text of the provider survey can be found in Appendix A: Survey Instruments. The provider survey instrument included a definition of SDM taken from Healthwise (2014) and the Mayo Clinic Shared Decision Making National Resource Center (2014).²

Client survey. Like the provider survey, the client survey also consisted mainly of close-ended multiple choice or list-an-answer type questions; it was designed to investigate care experiences and satisfaction, including with elements of SDM and health literacy. However, it was not created in its entirety by the present researcher, but was instead adapted from a pre-existing instrument, the Community Mental Health Survey, 2014. This instrument and its background as relates to the present study is described below.

Background of the Client Survey Instrument

As indicated above, the client survey instrument used in this study was based on a slightly modified version of the Community Mental Health Survey, 2014 (National Health Service [NHS], 2014). The Community Mental Health Care Survey is developed, implemented, analyzed, and reported annually through a joint endeavor between England's National Health Service (NHS) and Care Quality Commission (CQC); its purpose is to assess client care experiences and satisfaction with mental health services delivered by NHS practitioners working within certain outpatient mental health care offices in England (CQC,

2 Because the survey was designed for online implementation, references to these sources did not fit with its formatting and as such, are only credited here.

2019). Use and adaptation of the instrument as described herein is granted under an open government licence (National Archives, n.d.). Though not originally designed for use with RxPs or in the United States, there were several advantages to this instrument that made it uniquely suited for use and evaluation within the present research study and which played into the research and analysis plans. These are discussed henceforth.

First and foremost is that the client survey is designed to measure the satisfaction of mental health care service users as a means of gauging quality of care (Picker Institute of Europe [PIE], 2014). First developed in 2003, it is also revised and re-piloted annually based on an extensive stakeholder review process involving clients, providers, policy experts, academics, and regulators (PIE, 2014; CQC, 2014). In light of the sparse literature available on client satisfaction with mental health services, this makes the NHS survey one of the most well-established and thoroughly vetted instruments available.

Secondly, the NHS client survey is designed to evaluate satisfaction and experiences with psychiatric and psychological care as though they were delivered by a single provider (PIE, 2014). This is not the result of care provided by hybrid professionals such as RxPs; rather, the decision to treat psychiatric and psychological care providers as a single entity came because mental health service users collaborated in the development of the NHS client survey. These stakeholders emphasized the fact that their experiences with mental health care services were so integrated as to make it difficult to distinguish between separate providers or settings for primary and secondary psychiatric and psychological care (PIE, 2014). Thus, although the impetus for designing the survey to ask about psychological and psychiatric care as though both services were available from the same individual was different from the actual context of NM RxPs, the result is functionally ideal and more importantly, unique.

That is to say, besides the NHS survey, no other instrument available at the time this study commenced seemed designed to look at psychiatric and psychological care as though they were options deliverable from the same provider. This makes the NHS client survey especially appropriate for use among the clients of RxPs psychologists, since prescribing psychologists are the only U.S. mental health care providers with both the training and authority to deliver psychological *and* psychiatric treatment to their patients.

Third is that the survey reflects attention to several of the theoretical principles underlying this research within its questions for measuring satisfaction and quality. The NHS survey is designed on the theory of co-production of care, which aligns with the concept of SDM as well as the need to engage with clients' health literacy levels and practices (PIE, 2014). The iterative stakeholder revision process also enhances the client-centeredness of the NHS survey instrument; Gideon, Hancock, and Nelstrop (2009) describe how several questions were ultimately revised to reflect specific service user perspectives and sensitivities that were not even considered by the expert developers prior to the survey's extensive focus group testing. This makes the NHS instrument one that is not only designed *for* clients, but *by* clients. Therefore, although client satisfaction and SDM remain critically understudied in mental health care in the U.S., the NHS instrument addresses both, and assumes they should be prerogatives of comprehensive, high quality mental health care practice.

Support for the validity of the client survey instrument. Last but not least among pertinent factors is that the NHS survey is designed to be used across multiple outpatient mental health care facilities and comes with analytical guidance. It is designed to produce individual and comparative statistics about the quality of care being provided (PIE, 2014). Questions on the NHS survey can be individually scored as well as combined into and

analyzed as constructs. The survey instrument is therefore intended to provide data in response to individual questions as well as to be multidimensional (PIE, 2014). The constructs in the NHS instrument include: coproduction of care (i.e., SDM); service provision; wider life and needs; organizing care; and medicines (PIE, 2014). However, the survey used in the present study omitted the questions comprising the “organizing care” construct, due to the fact that they were specific to care managements within the NHS system and have no parallel in typical U.S. practice.

Statistical benchmarks published by the PIE and the CQC regarding the NHS survey are based on English population and system norms (CQC, 2014b). This information is provided by the PIE for the purposes of informing the analysis and interpretation of data gathered via the NHS survey as per its intended uses in the England, but limits the extent to which the instrument’s reliability and validity could be predicted and compared upon its implementation in the United States. For these reasons, the research planned to follow the PIE and CQC procedures for analyzing the data, but did not seek to draw statistical comparisons between its use in England and in the United States.

Thus, notwithstanding these analytical delimitations, the NHS survey appeared ideal for client research relative to RxPs and as an exception to the overall mental health satisfaction literature (or lack thereof), evaluation of its efficacy within the U.S.-RxP context was also included as a research question within the present study. As an exploratory study, the proposed research aimed to evaluate the merits of the survey adapted to this context. These adaptations are summarized below.

Preparation of the NHS client survey instrument. In order to maintain the integrity of this instrument, priority was placed on making only minor adaptations to the 2014 NHS

survey. The original question order and general layout was maintained, except as noted above. Changes focused primarily on modifying the instrument for American spelling, vernacular, and health care context. The actual survey instrument used in this study (i.e., as modified from the original) can be found in Appendix A: Survey Instruments.

At the same time, consideration was also given to the reading difficulty of the client survey instrument. The average U.S. adult reads at an 8th grade level (Davis, & Wolf, 2004); however, sizeable subsets of this population read at a 5th grade level or lower (Joint Commission, 2006). Moreover, previous research indicates that even among college-educated individuals, literacy in health and medical terminology is lower than expected (Lerner, Jehle, Janicke, & Moscati, 2000). Thus, to ensure readability for most U.S. adults, recommendations suggest the target reading difficulty of health materials should fall within a 5th to 8th grade level (Stossel, Segar, Gliatto, Fallar, & Karani, 2012). After completing the modifications described above, the instrument was assessed for reading difficulty and determined to read at an 8th-grade level on the Flesch-Kinkaid scale, thus falling within the upper limit of these recommendations. Far more substantial and content-related changes would have been required in order to further reduce the reading difficulty of the client survey instrument, fundamentally altering it from its NHS-approved and tested form. In the face of this inadvisable option, the client survey instrument was therefore left further unaltered.

Client interviews. The client survey included an opt-in form for clients to indicate their willingness to participate in an interview. The data collection plan was to contact clients who self-referred for the interview until either a suitable number of participants (capped at a maximum of 15) had participated or until each client who showed interest had been contacted at least once, whichever occurred first.

Anticipated Data Analysis Procedures

According to the original research design, data from the three stages of collection would be analyzed separately and together, as appropriate, in order to address each of the research questions outlined at the beginning of this chapter. The anticipated approaches to achieving this are described below.

Provider survey data. Because the provider survey was originally designed for online administration, it was anticipated that the provider survey data would be submitted online and therefore collated electronically. The plan was to analyze this data quantitatively to develop descriptive statistics about the educational backgrounds and self-perceived behaviors of prescribing psychologists in New Mexico as a group and to allow for the possibility of additional inferential statistical testing or of matching this data with that derived from the client survey data in order to make comparative connections between these two data sets, dependent on sample sizes.

Client survey data. Data analysis plans for the client survey primarily stemmed from the guidelines provided for the original NHS instrument, i.e. in terms of coding, and in terms of population weighting, modified z-scores, ranges, and comparisons between providers (PIE, 2014). The guidelines indicate data requirements and procedures for doing so, which vary depending on sample size, as well alternative data analysis strategies for certain sampling (CQC, 2014b). In addition, plans were made to analyze data from the client survey in at least two other ways. First was to calculate descriptive statistics about the satisfaction measures for all of the pooled client survey data and, if a sufficient number of responses are received from the clients of a given provider, comparable descriptive statistics would also be calculated on the basis of the client survey data by provider, so as to provide satisfaction statistics that are

comparative between providers. Second, based on the pooling of client survey data, inferential statistical tests would be conducted in order to assess the dimensionality, reliability, and consistency of the survey instrument. Additional descriptive and inferential statistics and tests would also be calculated as feasible and appropriate.

Client interview data. Client interviews were to be transcribed and analyzed qualitatively, using approaches such as Gee's (1999) guidelines for discourse analysis, with the anticipation of a critical focus. As described, the intent was to analyze this data along with that obtained in the other two phases, in order to elucidate a more detailed understanding of the quantitative data from the provider and client surveys.

Important Contextual Factors

Several unforeseen difficulties affected the planned design of the study. Most of these changes are explained in detail the Data Collection Procedures and Data Analysis sections that follow this one. To summarize, however, when implemented via the original protocols, a low response rate to each survey instrument necessitated that they be implemented in-person by the researcher. This extended the data collection timeline for each phase of the research, which resulted in the research coinciding with other important, external events.

Specifically, the second and third phases of data collection, which both focused on the clients of RxPs in New Mexico, coincided with the escalating impact of a state-level disruption in New Mexico's mental health care system. This context ultimately exerted ripple effects throughout this study, from recruitment to analysis. As such, these contextual events are briefly described here, in order to situate the study and its outcomes.

Disruption of the New Mexico Mental Health Care System

In 2013, New Mexico Governor Susanna Martinez accused 15 of the State's behavioral health providers of fraudulent billing totaling approximately \$36 million, and suspended all of their reimbursements for services billed under Medicaid (Haussaman, 2016). Comprising some of the largest Core Service Agencies³ within the state, these 15 providers served an estimated 30,000 clients (Haussaman, 2016). Moreover, as mental health and substance abuse treatment providers, their clientele drew predominantly high-need, low-income populations, constituting approximately 87% of such spending for Medicaid and non-Medicaid behavioral health services in the previous year (Balderas, 2015).

Consequently, most of the providers named in the allegations were forced to cease operations in New Mexico for the duration of the State's investigation, some of them quite abruptly (Haussaman, 2016). Although out-of-state organizations were contracted to fill the provider shortage and continuity of care crises this situation created, they too faced reimbursement difficulties and by the end of 2013, four of the five had left or begun preparations to exit the New Mexico market (Baker, 2016).

An investigation by New Mexico Attorney General Hector Balderas called into question the veracity of State's evidence against the New Mexico providers, and by 2017, all had been cleared of any criminal wrongdoing (Terrell, 2017). However, as of the time of

³ According to the New Mexico Human Services Department (2012), "a Core Service Agency (CSA) coordinates care and provides essential services to children, youth and adults who have a serious mental illness, severe emotional disturbance, or dependence on alcohol or drugs" (p. 1).

writing in late 2018, only a few of the accused providers have reopened practices in New Mexico, and in some cases, their operations are still constrained by reimbursement claims that remain unresolved within the courts. Moreover, there has been a large overall increase in the number of New Mexicans seeking mental health care since the implementation of the Affordable Care Act (ACA) (Kennicott, 2015). As a result of these factors, critical provider shortages, which were exacerbated by the initial disruption in Medicaid reimbursements, persist throughout the state (HRSA, 2018).

Impact on the Study

In terms of recruitment, this situation constrained the opportunities, interest, and ability of RxPs to accommodate the on-site administration of the client survey, since the closure of 15 practices statewide placed a great deal of pressure on those mental health providers who remained in New Mexico. As such, and in light of the already-extended timeline needed to adjust for in-person data collection, it was only possible to recruit two sites whereat to administer the client survey.

Furthermore, the effects of these closures on mental health care service users became pertinent to data analysis. During the client survey phase, it became evident from handwritten answers where open-ended responses were not solicited and from oral administration that the instrument had not been designed to account for the possibility that a client might switch providers due to such a closure event. Thus, analytical considerations were made to account for this data, in terms of coding and discussion. The details of these changes are discussed in subsequent sections of this report.

Implemented Data Collection Procedures

This section describes the final design of the study and where appropriate, further details the reasoning for changes from the original.

Final Recruitment Protocols and Research Timeline

When implemented via the original protocols, a low response rate to each survey instrument necessitated that they each be administered in-person by the researcher. This resulted in an extended data collection timeline, and in the case of the client survey, resulted in some unexpected response data. Furthermore, the extended data collection timeline coincided with an unforeseen state-level events that disrupted mental health care services throughout New Mexico, and is reflected in the data and likely, the outcomes of the various phases of recruitment.

Provider survey recruitment, and administration. Initially, recruitment for the provider survey went as planned, with the online version of the instrument being advertised, repeatedly, via the professional organization for NM RxPs and over the course of several months. This resulted in eight completed surveys. Based on PSA's estimation⁴ that 45 RxPs were working in

⁴ To reiterate, PSA's estimation was based on its membership. As the state's only organization tailored to help meet the special licensing needs of its RxPs, who were unlikely to be able to complete these requirements through other organizations, PSA was thought (as reported to the researcher by its leadership) to include in its membership all the practitioners working within NM. For the same reasons (a need to maintain membership in order to meet NM RxP licensing renewal requirements), it was thought that PSA could provide a more accurate headcount of NM's RxP workforce than what might be compiled from the New Mexico Licensing and Regulations Department (NMLRD). While NMLRD does maintain a publicly accessible databases of RxP certifications it has granted, it does not provide location or contact information for individuals listed, nor is it updated when someone moves, retires, or stops practicing for other reasons, so long as their license is active.

the state, this response rate was significantly lower than anticipated or desired. Therefore, permission was obtained by the IRB to administer a paper version of the online survey instrument in-person at SPA's annual event for RxP continuing education units (CEUs) held in the spring of 2016, approximately seven months after the initial launch of the online version. After a brief explanation of the survey's purpose by the researcher and an organization member⁵ attendees were given the survey during a break between speakers. Surveys were collected afterwards and manually entered for data analysis into an Excel sheet matching that which was generated by the online survey. Following the administration of the provider survey at the 2016 conference, no further attempts at provider recruitment were made. The combined response rate from the online and paper administration of this instrument resulted in a total of sample size of 12 provider surveys.

Notes about provider workforce estimation and survey response. This final total response rate for the provider survey (n=12) was far less than what was estimated (n~45) at the start of this project and in its IRB materials. Several issues turned out to indicate that the expected number of participants, 45, was probably an overestimation of NM's RxP workforce, while other factors played into recruitment for the provider survey at the SPA 2016 CEU event. These will be explained henceforth.

To reiterate, PSA's estimation was based on its membership. As the state's only organization tailored to help meet the special licensing needs of its RxPs, who were unlikely to

⁵ This member was the aforementioned Dr. Chis Vento, who was on the researcher's dissertation committee and assisted with the development and implementation of the project.

be able to complete these requirements through other organizations, PSA was thought (as reported to the researcher by its leadership) to include in its membership all the practitioners working within NM. For the same reasons (a need to maintain membership in order to meet NM RxP licensing renewal requirements), it was thought that PSA could provide a more accurate headcount of NM's RxP workforce than what might be compiled from the New Mexico Licensing and Regulations Department (NMLRD). While NMLRD does maintain a publicly accessible databases of RxP certifications it has granted, it does not provide location or contact information for individuals listed, nor is it updated when someone moves, retires, or stops practicing for other reasons, so long as their license is active. Additionally, this database is meant for verifying the licensing status of an individual, and requires increasingly cumbersome security verifications if attempts are made to check the records of several individuals in a given day, making bulk collection of data difficult.

In retrospect, though, verification of all RxP licenses granted in New Mexico cross-referenced with the time this study commenced the provider survey (2015) indicate that only 38 individuals were non-provisionally licensed in the state, and that one other individual gained this status by the time the provider survey was administered at the 2016 SPA CEU event in May 2016 (NMLRD, 2019). Thus, had this been completed earlier, it may have pointed to 45 practitioners being an overestimation of the number of providers who could be expected to participate in the survey, and/or hinted at some other issues that arose to help explain where that higher number may have come from.

Most of these other issues related to the inflated number of anticipated providers were connected to the SPA CEU event. Because the event provided continuing education units (CEUs) specific to RxPs and their licensing requirements, its organizers stated beforehand that

they expected most, if not all, of the RxPs licensed in New Mexico to attend, and so dissemination of the survey at this event would result in the maximum possible market exposure. Approximately 30 mental health providers (MHPS) attended this event; when asked about the difference between this turnout and the estimated 45 RxPs in the state, one of the event's coordinators indicated that some SPA members had recently retired and were no longer in need of CEUs, while other members were not yet at a stage where they needed CEUs. It also seemed from informal conversations with attendees that some of their colleagues were simply absent, their reasons unexplained, while at least two attendees were not actually RxPs but MHPs of other types who were attending for their own reasons. Lastly, when the survey was being explained and distributed at the SPA CEU event, it was explained to the audience of attendees that it was only for RxPs practicing in New Mexico and at this point several (~3-4) individuals who had been preparing to complete it then declined. Two of these individuals came to the researcher afterwards and explained that they had declined because they actually practiced in a Midwestern state for IHS, but completed RxP licensing requirements in NM. This explanation made sense, but perhaps should have been foreseen by the research in estimating the number of providers working within NM, given that RxPs can work in the federal services (APA, 2017), but that at this time (May 2016), the only other state that may have had similar infrastructure (e.g. a professional organization or licensing regulations) in place for accommodating RxPs was Louisiana. These two RxPs also suggested that some of the other individuals present who had declined were in similar work situations, including for the VA and other IHS offices. Thus, it turned out that not all of the attendees were eligible to participate in the survey, and some of those who were eligible had already done it online. Still, this leaves some individuals at the SPA CEU event who for unknown reasons, did not

complete the provider survey. It also does not fully explain why, as reported below, 15 providers signed up to distribute the client survey, although at least one individual who did not do the provider survey because they were not an RxP themselves took some on behalf of the RxP with whom they shared a clinic, and it is possible others did the same.

Client survey recruitment and administration. The 2016 New Mexico RxP SPA CEU event was also taken as an opportunity to recruit providers to advertise and distribute the client survey, as per the original research design. While only 12 providers completed the survey, 15 were registered to help distribute the client survey. While it was not possible to determine exactly who signed up to distribute the client surveys but did not complete the provider instrument, this discrepancy most likely stems from a combination of factors: individuals who thought they had completed the provider survey online survey but actually had not; those who served clients in NM through a telemedicine platform but did not consider themselves a NM RxP and thus self-excluded from the provider survey; and non-RxP attendees who registered their employer(s).

In any case, of the 15 providers (or their representatives) who indicated their willingness to distribute client surveys was given a minimum of 15 paper client surveys in pre-addressed, stamped return envelopes; 30 or more take-home cards with the link for the online client survey; and recruitment posters with hanging materials to advertise the survey in their offices. Some providers indicated that they operated more than one location or had a large clientele, and were given more supplies accordingly. The survey distribution and participant incentive structure was explained, and providers were supplied with the researcher's contact information and told that more supplies would be sent if they ran out. Over the first six months immediately following the distribution of the client survey materials to providers, one person

completed the survey online and approximately 20 paper surveys were returned by mail from six different locations statewide. However, all but seven of the paper surveys returned during this time period turned out to be completely blank; the reasons for why they were mailed back were never revealed. The bulk of paper surveys, completed or blank, were returned during the first three months of the client survey phase. After this three-month point, when the number of returned surveys was observed to be declining, participating providers were contacted to find out if they needed more paper surveys or advertising materials, but none indicated they did. After six months it was determined that a new client survey recruitment strategy was needed in order to obtain a sufficient response rate.

In developing an alternative recruitment strategy for the client survey, anecdotal feedback was sought from participating providers. This feedback indicated that the reading difficulty of the client survey instrument might be a hindrance to completion, and that it would be better if the researcher administered the survey orally to clients while onsite at an RxP practice. Permission was obtained from the institutional research review board (IRB) as well as from two practitioners to administer the client survey in this manner. One practitioner was located in an urban area within the state, while the other was located in a semi-rural area that served those from more isolated areas.

Onsite administration of the client survey instrument by the researcher thusly commenced in each respective location in 2017. During one multi-day period at each site, respectively, the researcher approached or was approached by clients who came for an appointment with the site's RxP. The researcher offered to read each question to the client or to provide assistance as needed if the client wished to fill out the survey on their own. All but two clients approached this way opted to have the researcher to read the questions aloud to them,

indicating that the survey instrument was indeed written at a literacy level that was too difficult for most of the target population. Response rates to this form of administration (in-person, verbally), which were nearly 100% at each practice, indicated that reading and writing skills (textual literacy) may have been the primary barrier to interest and completion, during the earlier iteration of the client survey administration.

In sum, this client survey recruitment strategy yielded a drastically higher response rate, and some unforeseen data boons, although it necessarily skewed the site sampling in such a way as to preclude generalizable data about New Mexico's RxP clientele as a whole, even had the sample size been large enough. That is, in total, 30 client surveys were obtained, with the majority being gathered through oral administration of the instrument at these two sites. In terms of unforeseen data, oral administration of the survey yielded highly detailed, sometimes lengthy and in-depth responses from participants, in response to what had been intended as close-ended multiple choice questions. Essentially, a number of survey respondents provided interview-level detail in response to the survey prompts; but, as no provisions had been made to record the survey administration, so audio recordings of this were not taken. However, these data were recorded in shorthand on the instruments and as fieldnotes and observations by the researcher; field notes were written up within a few days of administering the client interviews and kept with the surveys. Later, both the field notes and shorthand notes were explicated and incorporated into the open-ended questions at the end of each survey and into the data analysis.

Client interviews. In alignment with the exploratory, quantitative to qualitative design of the study, revisions were also made to the client interview protocol. Based on a preliminary analysis of the client survey data, it became clear from the amount of detail being provided in response questions about finding and switching providers, open-ended questions, and to SDM-

related questions that the interviews should be delimited to those individuals who had seen a previous mental health provider prior to care under an RxP and that the interview questions should be tailored to focus more on SDM than health literacy practices. Moreover, the interview protocol was designed to be only semi-structured, leaving leeway in terms of questions. So, because the primary impetus for looking at health literacy was because it forms a basis for *informed* SDM (Makoul & Clayman, 2007; Hoffman et al., 2014), the researcher still anticipated the possibility of inquiring to a lesser extent about whether, and how, various care experiences may have been coincided with health literacy practices.

Thus, regulatory permission was obtained to be more selective in the interview process than was originally planned for. The new criteria included having seen a previous mental health provider (of any kind, not necessarily one with prescriptive authority), in addition to having indicated interest in participating in the interview phase. This eliminated fewer than five potential interview participants and left a remaining pool of about 10 (this number is approximate because some individuals who indicated interest nonetheless provided incomplete contact information). Where information permitted, multiple attempts were made to contact each of these potential interview participants; of those contacted, two made arrangements for interviews and one completed the interview. Thus, the final sample size for this phase of the study was, like that of the earlier two, substantially smaller than anticipated in the original design; however, time constraints, as well as the self-referral by survey recruitment design, precluded additional sampling.

Data Analysis

As noted above, response rates to each of the three phases of the research were lower than anticipated at the outset of the study. This necessarily delimited data analysis in various ways. The final methods of data analysis are therefore summarized below, and the results obtained from them follow in the next chapter of this dissertation. Thereafter, the implications of the results towards answering this study's research questions are discussed in a separate chapter.

Provider Survey Data. Besides the aforementioned alterations to the provider survey protocol, which necessitated manual input of the data collected via paper versions of the survey, the anticipated data analysis procedures for producing a demographic and academic profile of NM RxPs were followed for this phase of the research study. That is, the demographic data was analyzed to produce descriptive statistics about the population (Lund & Lund, 2018); academic data was open-coded and organized into themes to allow for synopsis (Saldaña, 2016); and responses to the multiple-choice health literacy and SDM questions were analyzed to produce summary statistics on the practices and policy of the providers who completed the survey instrument.

Client Survey Data

As was always the intention of the survey instrument, it served to collect both qualitative and quantitative data. However, the qualitative data that was ultimately collected was different both in content and in length from what was anticipated. Therefore, qualitative analytical procedures will be discussed first, followed by quantitative ones.

Qualitative client survey data. As discussed above, several clients who completed orally administered surveys responded to questions in great detail, or shared other unsolicited but relevant information with the researcher, often to a much greater extent than the close-ended answers were set to capture. This data was therefore documented within the three open-ended questions at the end, with other observations recorded through researcher fieldnotes and written up afterwards. During analysis, this data was reviewed from an open-coding standpoint (Saldaña, 2016), and where themes emerged that fit with close-ended survey questions, the data was transferred there and analyzed quantitatively. Some details of this are provided in the next section. The data remaining within the open-ended responses, as well as that recorded through the researcher's fieldnotes, were synthesized and further analyzed using open-coding.

Finally, of further analytical note is that none of this data would have been obtained had the instrument not been administered by the researcher in a one-on-one context (a change that was implemented for literacy reasons, not to collect this type of data). Thus, the implications of this for future applications of the research instrument are discussed as an implementation assessment related to the project.

Quantitative client survey data. Close-ended data from the survey was cleaned and coded (Tabachnick & Fidell, 2012). This included reviewing the data recorded in the open-ended questions during oral administration of the instrument and coding some reoccurring elements from into the close-ended survey responses as appropriate; this preliminary analysis led to the creation of some additional response categories not included on the client survey instrument during implementation. The reasoning, details, and implications of the creation of these categories is further discussed in the upcoming chapters of this dissertation, as they

reflect implementation findings relative to the client survey instrument's utility in the given context of this research study (one of the questions guiding this research).

Three types of analyses were performed on the quantitative data thusly derived from the client survey: calculations to provide demographic details of the service user participants; frequency analyses; and construct reliability analyses. This combination of tests paralleled, to the extent possible given the small sample size obtained, the analyses suggested by the guides developed for the original survey instrument.

Demographics. Some descriptive statistics towards producing a participant profile for each of the two main practices surveyed were derived from the client questionnaire. Responses that could not be attributed to either of these two specific practices were excluded from these analyses. A general description of the total client survey sample, which included these responses, was also calculated.

Frequency analyses. In addition to these standard statistics for describing the sample population, various questions within the client survey were analyzed to produce calculations of the frequency and in some cases, cross-tabulations of different responses. This type of analysis is also considered descriptive (Tabachnick & Fidell, 2012) in that it can provide evidence of associations between variables but no indication of whether these associations are statistically significant.

Construct reliability analyses. Finally, segments of the survey data were analyzed for construct reliability via Cronbach's alpha, Guttman's lambda 6, and McDonald's omega (Reville, 2018). These tests assess the extent to which scale questions in a survey measure the intended concept. The closer the value to one, the better the questions align with the concept

being measured. Further justification for the use of these measures is presented in the results chapter.

Where question structure, number, and response rates allowed, construct reliability analyses firstly followed according to each of the sections retained from the original survey instrument; in addition, a construct proposed by the researcher comprised of intersectional questions was also analyzed. Further details about these construct reliability analyses follows in the next chapter. Dimensional analyses of the validity of the instruments, such as exploratory factor analysis, were precluded by the small total sample size, which was also compounded by the fact that not all sections of the survey applied to all participants, and therefore some questions were only answered by a subset of respondents.

Client Interview Data

Because only one client interview was obtained, it was not appropriate to analyze it as originally planned. However, in one instance, data from this very limited sample nonetheless shed new light on other findings in the study and is thusly discussed in situ where relevant. However, given the dearth of data on client experiences with RxPs, this single client interview as well as other data collected via this study, limited though it may be, contributes to our understanding of this topic.

CHAPTER 4: DATA & RESULTS

Results Part I: Provider Survey

The initial phase of the study consisted of a provider survey designed to gain information from New Mexico RxPs as to their: (1) detailed academic backgrounds and credentials, not just those they held related to psychology; (2) health literacy practices for communicating treatment information to clients; and (3) familiarity with shared decision-making (SDM) and attitudes towards using it with their clients.

The first of these focal areas was chosen in a simple effort to gather more details about the academic pathways RxPs take on their journeys to prescriptive authority. While a doctorate in psychology is a given for RxPs, and as such, a master's in the same discipline extremely likely, their undergraduate preparation has not received much attention in the literature, and no prior study had attempted to document what other credentials, such as professional certifications or other interdisciplinary grounding (such as from undergraduate studies in a field other than psychology) they might bring with them to their prescribing practice. Thus, this first topic was selected out of a curiosity to better document what, if any, educational diversity exists within this small body of New Mexico mental health providers (MHPs).

The second and third foci of the provider survey stem from their interrelatedness to one another, and to patient-centered care overall. The CDC (2016) defines health literacy as “the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions,” and numerous sources (HHS, 2010; Abram et al., 1983; Godolphin, 2009) pinpoint it as the

foundation necessary for *informed* shared decision-making (SDM) in health-care. As key sources of health information, and the reason health decisions generally need to be made in health care, physicians are essential to promoting their patients' health literacy. However, years of research suggests that many healthcare providers overestimate the health literacy of their clients, use ineffective health literacy and information communication strategies, and that most printed health materials are written at a level well-above what most people can comfortably read and understand (HHS, 2010; Hironaka & Paasche-Orlow, 2008).

SDM, in turn, “is a key component of patient-centered health care” in that it is” ...a process in which clinicians and patients work together to make decisions and select tests, treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values” (National Learning Consortium, 2013). Promoting the use of SDM within all healthcare contexts is among the goals of major health initiatives both in the U.S. and abroad (Slade, 2017; Bee et al., 2015). Among the reasons for this is that SDM is not only correlated with client satisfaction (HHS, 2010; National Learning Consortium, 2013) but also with better treatment adherence and thus, outcomes (Slade, 2017; O'Connor et al., 2007, Makoul & Clayman, 2007; Hoffman et al., 2014; Brown & Bussel, 2011). This is a consequence of decision-making that takes into account patient values and priorities as much as those of physicians, and which fosters a sense of mutual respect and alliance between the two parties (Wilder et al., 2010). Yet, in mental health care, wherein medication non-adherence is as high as 50% (Bellack et al., 2009), these client-centered practices for better outcomes are nonetheless still eschewed (Wilder et al., 2010; Slade, 2017). Most MHCSUs report that they were not consulted about their preferences and priorities for psychotropic medications, and that this lack of alliance with their providers and inattention to their concerns subsequently

contributed to poor treatment adherence (Wilder et al., 2010). Meanwhile, psychiatrists concur that they are reluctant to practice SDM with their patients because they do not believe them capable of making “good” choices about their treatment (Sheperd, Shorthouse, & Gask, 2014; Seale, Chaplin, Lelliott, & Quirk, 2006).

However, whereas these issues with health literacy and SDM have been documented among the populace of traditional medical providers (Agoritsas et al., 2015; McCaffery et al., 2013; O’Connor et al., 2007, CDC, 2014a; CDC, 2001; Duncan, Best, & Hager, 2010), as with most aspects of the field, no research has looked at health literacy strategies or knowledge and attitudes about SDM among RxPs. Given that these providers are trained predominantly in psychology, in which treatment typically requires a great deal more verbal interaction and alignment between patient and provider perspectives, it was postulated that RxPs might bring aspects of this training to bear alongside with their psychopharmacological practice.

So for these reasons, the provider survey asked participants questions about their health communication practices, as well as about their familiarity with SDM as a concept, and their preparation and attitudes towards practicing it with the majority of the MHCSUs they treat. Likewise, the client survey portion of the study, which will be discussed in a following section, focused on evaluating MHCSUs’ experiences and satisfaction with care from RxPs, with particular attention to SDM.

Context of the Provider Sample

When this study received IRB approval and commenced in early 2015, New Mexico’s professional organization for RxPs, SPA, estimated its active membership at 45 individuals, which likely included a few individuals nearing the end of their conditional certification

period, since the state's Licensing and Regulations Department (NMLRD) reports only 38 RxPs were fully licensed⁶ as of the beginning of May that year (NMLRD, 2019). However, the NMLRD does not provide public data on where these individuals practice, and some may work in other states for federal service agencies with offices there (e.g. Indian Health or the Veteran's Administration). This possibility factored into the present study when, during the 2016 SPA CEU event where additional recruitment for the provider survey took place, several attendees (exact number unknown) who had otherwise expressed interest in participating declined after it was explained that the inclusion criteria specified RxPs practicing within the state. Though it was not necessary to explain one's reason for opting out of the provider survey, two of these individuals explained that it was because they worked for IHS offices in Midwestern states, but maintained their prescriptive authority credentials in NM due complex federal educational and licensure regulations; they also suggested that at least some of their other colleagues who declined to participate did so because they were in a similar employment situation. Thus, the number of RxPs actually practicing in New Mexico at the time this study began was likely even fewer, perhaps 30-35.

As mentioned above, the NMLRD does not provide public data about where the RxPs (or other psychologists) it licenses practice, but the U.S. Health Research and Services Agency (HRSA) coordinates with other state offices to identify areas with shortages⁷ of certain

⁶ Individuals seeking RxP licensure in NM must first apply for and complete a years-long period of provisional certification, during which time they must practice under the supervision of another prescribing health professional; these individuals were excluded from the present study.

⁷ Based on a population to provider ratio (HRSA, 2019b).

healthcare specialists, with mental health providers (MHPs) being among them. In fact, persistent shortages in prescribing mental health professionals (PHMPs) was a pivotal factor in New Mexico’s decision to become the first state to pass RxP legislation, and continues to be at the forefront of efforts to expand the profession to other jurisdictions (Andrews, 2011). That said, given the small number of RxPs practicing in the state⁸, most areas of the state are still severely underserved. Figure 4 comes from the HRSA (2019a) provider-shortage mapping tool and areas in blue are those with shortages in mental health providers.

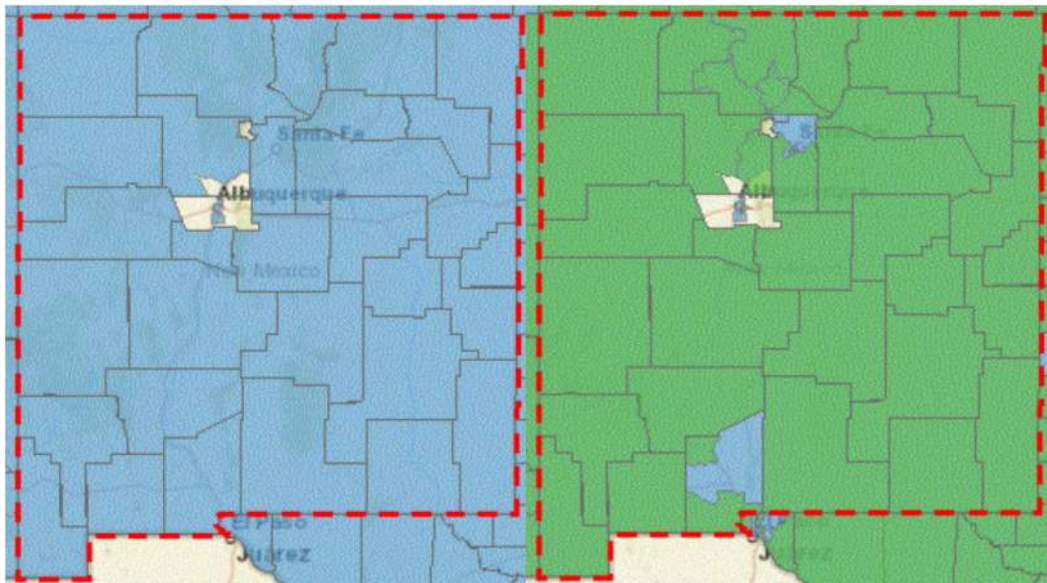


Figure 4: HRSA-Designated Mental Health and Primary Care Provider Shortages Areas

As can be seen from the left image in Figure 4, only two areas (those not in blue) in the state have enough MHPs per capita, and those two areas happen to New Mexico’s largest

⁸ At the start of 2019, there were about 50 active, full RxP licenses registered in the state (NMLRD, 2019).

urban center (Albuquerque) and its largest military installation (Los Alamos); all other areas of the state, including its second (and only other) metropolitan area, Las Cruces, are HRSA-designated MHPs shortage areas. Because general physicians (GPs)/primary care providers (PCP) prescribe most psychotropic medication in the U.S. (Abed Faghri, Boisvert, & Faghri, 2010) due in part to pervasive shortages of MHPs, the right image in Figure 4 is meant to illustrate the gravity of the situation in NM especially: areas in green are areas PCP shortages. As can be seen, shortages of MHPs in the state overlap with PCPs in almost all areas of NMs, with the noted exceptions being the greater Los Alamos-Santa Fe areas and the second urban area, Las Cruces (HRSA, 2019).

Thus, while the exact number of PMHPs working in New Mexico is not available to aid in calculating the portion made up of RxPs, even if there were only 35 such hybrid professionals working in the state at the time this study began, prescribing psychology no doubt comprised a significant part of the MHP network. Moreover, following the abrupt suspension of Medicaid reimbursement and subsequent closure of some of the state's largest MHP venues (explained in the methods chapter), RxPs were left in a position of filling even greater gaps in coverage.

As a consequence, even though the provider sample size obtained in this study was small ($n=12$), it likely represents a third or more of the RxPs working in the state during the time of the study. Moreover, this was a time during which long-standing shortages of MHPs were greatly exacerbated by unforeseen events, and therefore these 12 RxPs may also have represented a major portion of New Mexico's overall PMHP workforce. Thus, although the sample obtained and discussed henceforth remains qualitative in scope and cannot be generalized, it still sheds light on this small, yet vital, workforce.

Provider Participants and Data Preparation

Twelve individuals completed the provider survey. For specific questions, see Appendix A: Survey Instruments, which includes a list of the questions in the provider survey instrument. Any survey that contained answered questions and was returned to the researcher, either online or on paper, was considered in this sample. However, amidst the data collected from the online version of the survey, several “unfinished” attempts were reported. Most of these attempts reportedly lasted for less than one minute, and none of them contained answers to any of the questions. Therefore, these were interpreted as erroneous activations of the survey link and excluded from analysis.

Missing data was limited only to questions about academic history. In some cases, it was possible to extrapolate with certainty the intended answer from the information provided, e.g. where only the distinctive abbreviation for an institution was given; however, in other cases this was not possible. Therefore, sample sizes for data on providers’ academic history vary.

Provider Education and Academic Pathways to Prescriptive Authority

In an effort to answer the research questions, several questions on the provider survey asked participants to provide detailed information on their academic history—major, degree or credential earned, and institution. These questions sought to solicit information on all levels of post-secondary education, including post-doctoral degrees or certifications and non-degree professional credentials, and also to allow for the possibility that someone might have completed more than one degree or major at the same academic level.

Table 1 tabulates the degree information obtained from these questions, organized by credential type. Baccalaureate degrees were considered primary undergraduate degrees, relative to associate degrees; where an individual listed more than one baccalaureate degree or major, the first one was considered the primary degree. This system of organization was not needed for the data graduate or post-graduate degrees, as none of the participants reported holding more than one such credential. Non-degree credentials, post-doctoral or otherwise, were not ranked, but notations indicate where an individual held more than one non-degree credential.

Table 1: Providers’ Academic and Training Backgrounds

Provider Academic Preparation	n (details)
	Sample size: $n = 12$ people
<i>Undergraduate Degrees</i>	Total Undergraduate Degrees: $n=14$ (11 BA; 1 BS; 1 AAS)
<i>Primary Degree & Major</i>	
Psychology	9 (7 BA, 2 BS)
Physiological Psychology	1 (BA)
English	1 (BA)
Unspecified	1 (BA)
<i>Undergraduate Degree & Major, Secondary</i>	
Cultural Anthropology	1 (BA)
Criminal Justice	1 (AAS)

	Sample size: $n = 5$ people
<i>Master's Degree & Major</i>	Total Master's Degrees: $n=5$ (3 MA; 1 MS; 1 MED)
Clinical Psychology	1 (MA)
Psychology	1 (MA)
Counseling	1 (MA)
Guidance & Counseling	1 (MS)
Medical Psychology	1 (MED)
	Sample size: $n = 11$ people
<i>Doctorate Degree</i>	Total Doctorate Degrees: $n=11$ (8 PhD; 3 PsyD)
Clinical Neuropsychology	2 (2 PhD)
Clinical Psychology	6 (3 PhD, 3 PsyD)
Psychology/Neurology	1 (PhD)
Counseling	1 (PhD)
Education Foundations & Social	1 (PhD)
Psychology	1 (PhD)
	Sample size: $n=11$ people
<i>Post-Doctorate Credentials⁹</i>	Total Post-Doctoral Credentials: $n=13$

⁹ In the table, a post-doctoral credential refers to any certification for which prior completion of a doctorate degree was required. Post-doctoral programs may result in an additional degree, or some other type of credential, and are separated accordingly. "Non-degree credentials" result from programs that do not require prior completion of a doctorate degree.

	Degrees: $n=10$ (4 MS; 6 MA); Certificates: $n=3$
Clinical Psychopharmacology (Degree)	4 (MS)
Psychopharmacology ¹⁰ (Degree)	4 (MA)
Neuropsychology (Certificate)	1
Psychopharmacology (Certificate)	2
Psychopharmacology (Credential unspecified)	2
<i>Other Non-Degree Credentials</i>	Sample size: $n=3$ people
	Total Other Non-Degree Credentials: $n = 6$
ASSECT Sex Therapist	1
Board Certified Medical Psychologist	1
Certified Alcohol & Drug Counselor	1
Domestic Violence Counselor	1
Forensic Counselor	1
Microsoft Systems Certified Engineer	1
Rehab Counselor	1

Undergraduate Education

¹⁰ The specific majors listed for this item reflected the fact that the names of such programs have changed over time; the terms used here are based on the most common designation attributed to a particular degree program.

The majority of participants (n=10) held baccalaureate degrees in psychology, of which most (n=8) were a bachelor's of arts (BA); overall, a BA was the most common type of primary undergraduate degree reported (n=10). Of the 11 participants who specified their undergraduate major, only three reported undergraduate degrees in a field other than psychology, and two of these were secondary to degrees in psychology. As shown in Table 1, this means that one person did not report their undergraduate major, one person completed their only baccalaureate degree in English, one person double-majored in psychology and anthropology, and another person completed an associate of arts and sciences (AAS) degree in criminal justice before going to complete a baccalaureate degree in psychology.

Graduate Education

Graduate education included data on master's degrees, doctoral degrees, and post-doctoral programs. Post-doctoral programs were defined as any credentialing trajectory that required prior completion of a doctorate degree, even if the outcome of the program was not an additional degree. Therefore, post-doctoral credentials were subclassified in Table 1 as either degrees or non-degree certifications. One thing that did not come across clearly in the data on graduate degrees is that all RxPs in New Mexico essentially have two master's degrees—the first being whatever they earned prior to, or *en passant* to completing their doctorate in psychology or counseling, and the post-doctoral master's degree needed as part of the prescriptive licensure process. As will be discussed below, many of the provider survey participants did not list two different master's degrees, and/or only specified the field of study for their psychopharmacology degree, suggesting, but not confirming, that many may have earned their first graduate degree along an *en passant* route, in which they completed a master's degree in psychology as part of, rather than as a precursor to entering, a doctoral program in the same field. Furthermore, as some

participants pointed out, when it was first implemented, New Mexico's psychopharmacology training program for psychologists seeking prescriptive authority only granted a certificate, but was eventually converted into a degree-granting program. Therefore, its earliest graduates still hold only a certificate in psychopharmacology, but more recently-licensed RxPs in New Mexico most likely completed the degree program. Thus, the master's level graduate degree information reported in this study, presented in Table 1, and discussed below underrepresents the number of graduate degrees or equivalent credentials held by individuals in the provider sample.

Master's degrees. Data on master's degrees was not reported by all participants.

Although definitions distinguishing graduate from post-doctoral degrees was included in the survey instrument, participants may have accidentally skipped over or been confused by this section, given that later questions inquired about post-doctoral degrees. Alternately, participants may have earned an *en passant* master's degree, through doctorate programs that do not require a prior graduate degree but rather, grant one along the way. However, a recent survey of U.S. graduate programs in psychology undermines this assumption, instead indicating that prior preparation in the field of psychology plays a notably less significant role in admissions decisions than most other criteria, including undergraduate GPA, recommendation letters, candidate interview and statement of goals, research and clinical experience, and GRE score (Michaliski, Cope, & Fowler, 2016). Taken together with the homogeneity of undergraduate majors, this may portend a pattern of concentrated training in psychology that is specific to RxP trajectories; however, due to the small sample size of the present study, additional research is needed to transition this from speculation to the realm of a more definite finding.

In terms of degree type at the master's level, only one individual reported a master's of science (MS) in psychology; more common (n=4) was a master's of arts (MA), although one

person also reported a master's of education (MED). However, the MED is not atypical, since the second most common location for psychology programs is within a university college of education (Michaliski, Cope, & Fowler, 2016). As such, it is possible that if the sample size had been larger or more complete, the MED would have emerged as a more common stop along the trajectory to prescriptive authority.

Doctoral education. All participants who provided information on their doctorate programs (n=11) reported that their degree was in psychology, with more than half of participants (n=6) specifying that their doctorate was in clinical psychology; second most common (n=3) was a degree in a neuroscience subfield. This uniformity is unsurprising given that a doctorate in psychology is a requirement for the post-doctoral training in psychopharmacology that underlies the RxP profession.

Another observation pertains to the types of doctorate degrees reported by the sample. Although there are many subdisciplines in psychology, there are only two types of doctorate degrees: the PsyD and the PhD. Clinical psychology is among the most common track among both for practice-oriented professionals, but the PsyD is specifically designed for this trajectory, as an alternative to the research-oriented PhD. Nonetheless, both are considered pathways to licensure, and the most frequently awarded doctoral degree in psychology is the PhD (Michaliski & Fowler, 2016). In the present sample, only three of the 11 participants who reported information about their doctorate degrees indicated they held PsyDs. All of the PsyDs reported in this study were in the subdiscipline of clinical psychology, which is one of three fields approved for those seeking licensure to practice in New Mexico, whether or not as a prerequisite to becoming an RxP (New Mexico Regulations and Licensing Department, 2018). Given these statistics, even though prescribing psychology is a practice-oriented field, this breakdown of

doctoral degrees may not be remarkable. However, further investigation into the relationships between these different doctoral tracks in connection to practical skills might be worthwhile in future studies of patient-centered practices in psychology and prescribing psychology.

Post-doctoral credentials. Since post-doctoral degrees are an academic option somewhat unique to the prescribing psychology field, with doctoral degrees being the terminal degree in most fields, it was expected that answers to the question of post-doctoral degrees would fall along a very narrow spectrum. Substantively speaking, this was the result; however, specific answers to this question pointed to the many ways in which psychopharmacology programs for psychologist prescriptive authority have changed over the years, and to the difficulties of capturing the details of this information within a simple survey instrument. For example, at least one of the post-doctoral non-degree certificates in psychopharmacology was earned at NMSU before the program was redesigned to confer a full MA; this was revealed by a participant's notation for why they were listing a non-degree certification and the granting institution in a spot designed for post-doctoral degrees; institutional information was not solicited for other types of non-degree credentials, so it is not known where the other certificates in psychopharmacology were earned. In addition, even those participants with post-doctoral degrees from the same institution listed a variety of different things for "major," reflecting the evolving and interdisciplinary nature of these programs. Thus, future attempts to survey RxPs as to their academic credentials should take into account the historically changing nature of such programs, in order to solicit more complete and comparable data.

Other findings from the data on providers' post-doctoral training pertain to the types of post-doctoral degrees and the awarding institutions. Only a small number of institutions were represented in the data, and furthermore, the data seem to indicate that at least one of these

institutions has changed the credential they offer pursuant to prescriptive authority preparation. Half (n=4) of the post-doctoral degrees for which complete information was provided were MAs; of these, three were earned at NMSU and the fourth was earned at an institution in Arizona. The remaining four post-doctoral degrees in psychopharmacology were MS degrees awarded by Fairleigh Dickinson, a distance education institution. What is interesting about this information is in relationship to the APA list of designated programs for psychologist preparation for prescriptive authority and other trends and traditions in psychology credentialing.

Firstly, although all of the NMSU post-doctoral degrees reported in this study were MAs, NMSU currently identifies their psychopharmacology program as a master's of science (MS) (NMSU CEP, 2018), as does the APA list of designated post-doctoral training programs for obtaining prescriptive authority (APA, 2018). Although the criteria employed by the APA do not specify the type of credential that approved programs must offer (APA, 2009), all four of the programs on this list lead to an MS, not an MA. Indeed, all four of the post-doctoral MS degrees reported in this study came from another APA-designated program, Fairleigh Dickinson, while the fourth MA degree in psychopharmacology reported in this study was earned at an institution that does not appear on the APA's list of currently designated prescriptive authority programs. Since New Mexico RxP law pre-dates the APA criteria, which were developed in 2009, completion of an APA-designated program is not necessarily a requirement to practice in the state where this study was conducted. However, the sum of this data suggests that the full range of pathways to prescriptive authority may not be represented in the sample.

In addition, both Fairleigh Dickinson's and NMSU's programs have been APA-designated since 2010, and it is not clear if the type of degree offered by NMSU changed from an MA to an MS before or after becoming an APA designated program. Although it does not

provide a complete picture, the institutional information gathered in this study indicates that some changes within these degree programs may not be reflected in the current provider sample.

Furthermore, both the timing and motivation for the NMSU change from an MA to an MS could be of interest and should be investigated in future research. One possibility is that the transition in program designation from a master's of "arts" to a master's of "science" may be related to assuaging concerns that RxPs will be "deficient" in the scientific grounding needed for competent psychotropic prescribing.

As discussed in the introduction chapter, a staple argument of opponents to prescribing privileges for psychologists is that psychologists lack training in scientific disciplines related to psychopharmacology—such as biology and chemistry—comparable (usually on the basis of course hours) to that of medical specialists like general physicians, psychiatrists, and nurses (Merrick, 2007; Lavoie & Fleet, 2002; Lavoie & 2006; Robiner, Tumlin, & Tompkins, 2013; Stuart & Heiby, 2007). Of course, the special education requirements put in place for psychologists seeking prescriptive authority are designed to ensure they receive sufficient training in these very disciplines, specific to psychotropic prescribing (Muse & McGrath, 2010; APA, 2013a, 2013b). Thus, it may be that classifying post-doctoral degrees in psychopharmacology as MS degrees is a semantic choice meant to convey a "science-centric" focus, more akin to biomedical parlance and the field of psychiatry. While it is beyond the scope of this study to investigate the outward and underlying reasons, or effects of this change and the overall trend to classify post-doctoral degrees in psychopharmacology as MS degrees, this would seem to break with other extant trends and traditions and should be investigated along these lines in future research. That is to say, this change should be looked at in consideration of degree trends in the field of psychology. While all of the APA-designated programs for prescriptive

authority result in an MS, this is typically considered a research-oriented degree; the MA-PsyD pathway is the more specifically practice-oriented trajectory in this field (Michaliski, Cope, & Fowler, 2016; BLS, 2018; Michaliski & Fowler, 2016). Also pertinent may be the fact that most master's degrees granted in the field are practice-oriented (Christidis, Stamm, & Luona, 2016). These factors frame the post-doctoral MS degree in psychopharmacology as an outlier among practice-oriented master's level degrees in this field.

Other Non-Degree Credentials

While six different non-degree, non-post-doctoral credentials reported in this study, four of these were reported by a single individual. It is not known whether other discipline-specific credentials, such as those related to counseling, were unreported, or if the data is an accurate representation of non-degree credentialing among RxPs in New Mexico.

Summary of Data and Analysis on Providers' Academic Backgrounds

Provider education was predominantly in the field of psychology, even at the undergraduate level, where diversity would not have been unexpected. This homogeneity in educational pathways may be a reflection of constraints to qualify as a prescribing psychologist; that is to say that licensure typically emphasizes extensive training in biological disciplines as well as psychology, such that individuals with more diverse educational trajectories may be precluded from the field. This may also be represented in the small number of PsyD (practice-oriented) degrees represented in the sample.

However, another possibility is that given the extremely small sample size, the present study may not be generalizable to the field of prescribing psychology at large. For this reason, future research should further investigate the characteristics and trends within the academic

pathways undertaken from undergraduate to post-doctoral and professional training by RxPs, both as a subcategory and relative to the overall field of practicing psychologists. If a similar survey instrument is to be used, care should be taken to design an instrument that can capture data on RxPs' academic backgrounds even in light of oft-changing nature of their specialized credentialing programs.

Relatedly, research should also investigate the classification or reclassification of post-doctoral degrees in psychopharmacology aimed at RxPs, to determine to what extent, if any, these decisions may be influenced by pressures to align with biomedical sentiments. While certainly, such programs are designed specifically to provide training in biomedicine to psychologists, further investigation of these nuances could be of use to programs and policy in development, which will likely be subject to the same degree of scrutiny and resistance from traditional prescribers as were their predecessors.

Health Literacy and Shared Decision-Making: Provider Knowledge, Attitudes, and Practices

Additional survey questions asked about RxPs' knowledge, attitudes, and practices regarding health literacy and SDM. Except where instructed to skip a question based on a prior response, all participants fully completed this section of the provider survey. However, because some questions allowed for more than one answer, the total number of responses received sometimes exceeds 12.

Health Literacy: Information Communication Strategies

The first health literacy question in the provider survey asked providers how they usually provided information about treatment options to their clients, while the second asked providers how they provided clients with information about the treatments they were going to receive. Response options for both questions were the same, except for first choice, which was phrased specific to treatments options vs. treatment to be received. Thus, the response options were:

1. I do not usually provide clients with information about [their treatment options] / [the treatments they are to receive].
2. I provide clients with information verbally
3. I provide clients with printed, primarily text-based information (e.g. pamphlets, medication warning sheets, books, etc.)
4. I provide clients with information through other media (e.g. showing videos, playing audio recordings, or websites that use these approaches; printed materials in which information is conveyed using pictures, such as graphic novels, cartoons, or comics)
5. I provide clients with decision aids designed specifically to help people make health decisions
6. I direct patients to read certain printed resources, but I do not provide these resources to patients
7. I direct patients to read certain online texts, but I do not provide access to these sources
8. I direct patients to view certain multimedia sources, but I do not provide access to these sources
9. I provide or direct patients to informational resources I know are available in the language the patient prefers for communication (e.g. Spanish, English, Tagalog, Urdu, etc.)

10. Other (please specify): _____

These response options were designed to cover as many communication modalities as possible, including strategies that are recommended as well as those that are considered suboptimal for promoting health literacy.

Responses by frequency. The frequency of responses by question are presented in Figure 5; because the only option that was not selected by any participants was the “other, please specify” response, it is not included in this graphic.

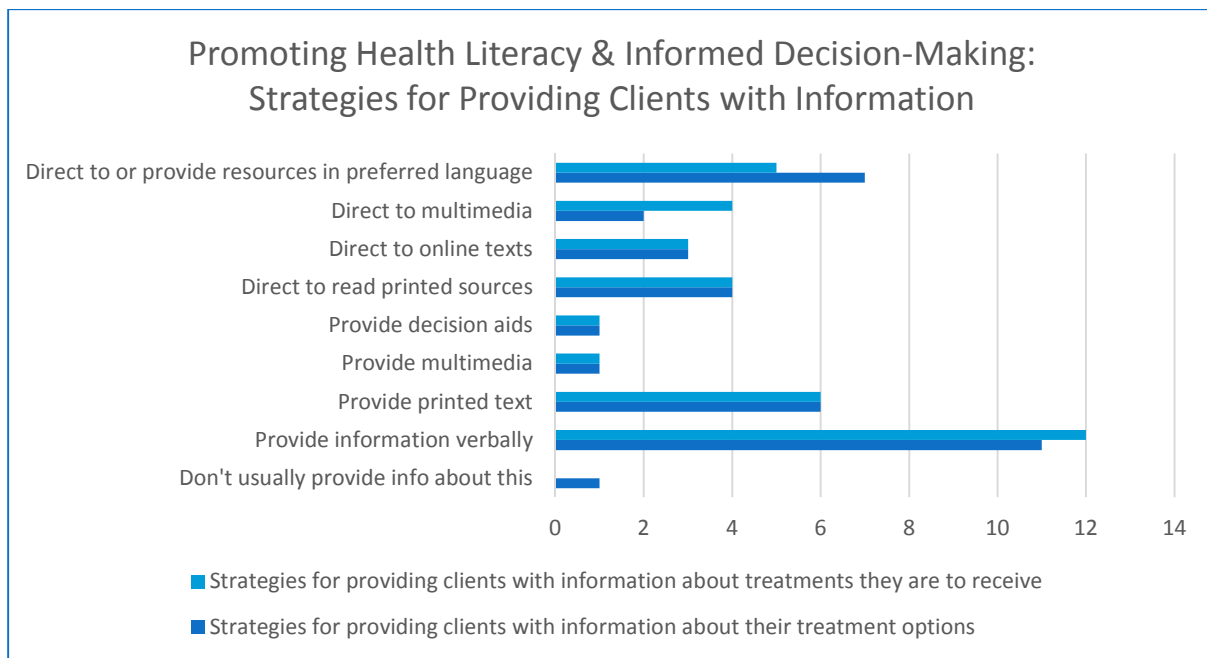


Figure 5: Provider-Reported Strategies for Providing Clients with Treatment Information

As shown in Figure 5, the most common response to both questions (n=11; n=12) was that information was verbally communicated to patients, though in most cases providers reported using multiple strategies. Only two providers, both in response to the treatment options question, indicated using only a single approach. One individual indicated they

provided treatment option information only verbally, while the other indicated they only directed clients to read certain printed resources available elsewhere. Only one provider indicated that they did not typically provide information to their clients, and only selected this option for the question about treatment options. At the same time, however, the same provider also selected the verbal communication option for that question, perhaps indicating that while they did not normally provide information about treatment options but might do so verbally. No provider selected the “other, please specify” option.

Most providers (n=10) indicated the same responses to the question about treatments to be received as they did for the treatment options question. The two providers who indicated different procedures for providing this information about treatments to be received, compared to treatment options, specified particular changes. In one case, the provider who indicated they did not normally provide information about treatment options responded that with regard to treatments the patient would receive from them, they provided such information verbally. In the other case, the provider who had indicated they normally provided information about treatment options only by suggesting printed reading material they did not provide, indicated that with regards to treatments to be received, they also provided such information verbally to the patient.

Responses by strategy type. A key component to successfully promoting health literacy is the active role of health care staff in providing accurate and accessible information to their patients (Batterham, Hawkins, Collins, Buchbinder, & Osborne, 2016). Conversely, strategies that are predominantly passive on the part of the provider, such as suggesting clients search for or secure information resources on their own, have demonstrated little to no efficacy in promoting health literacy and are therefore not recommended (Schwartzberg, Cowett, VanGeest, & Wolf, 2007). Thus, strategies for cultivating and supporting health literacy can be divided into

a basic dichotomy of desirable and suboptimal categories on the basis of whether the communication approach is active or passive on the part of the provider. In general, text-dense materials are also considered suboptimal for health literacy because even those designed for the general public tend to be written well above most people's preferred reading level (Hironaka & Paasche-Orlow, 2008), and while not an entirely passive strategy if the provider gives them directly to a client, providing written materials still relies on the patient to read them on their own, which not all clients can or will do (Schwartzberg, Cowett, VanGeest, & Wolf, 2007; Safer & Keenan, 2005). Likewise, studies show that health professionals have difficulty communicating health information verbally in a manner that is comprehensible and thorough enough to help clients comprehend instructions and make informed decisions about their care (Schwartzberg, Cowett, VanGeest, & Wolf, 2007; Coleman, 2011).

However, in a purely active vs. passive dichotomy, giving a health care client objective information verbally or in a written textual format would still be more conducive to improving health literacy than not doing so at all, or to simply suggesting the layperson seek out materials or information on their own (Schwartzberg, Cowett, VanGeest, & Wolf, 2007; Sudore & Schillinger, 2009). Therefore, in the present study, active strategies would include response options #2-5 in the above list, while passive strategies would include options #6-8. Responses to option #10 could fall into either the passive or active category, but this was not a factor in the present analysis, since none of the providers in this study selected option #10.

The remaining two choices—options #1 and #9—are not included in the analysis of active vs. passive provider strategies for the following reasons. First, option #9 cannot be included in this type of categorization because it is worded to include either passive or active referral to resources in a preferred language. This was a design error that should be corrected

for in future research regarding provider strategies or promoting health literacy. On the other hand, option #1 indicates no attempt to convey health information on a topic, and therefore does not fall along a communication spectrum, passive or active. Based on these criteria, responses were categorized as either active or passive on the part of the provider. This analysis thus divides the reported strategies in terms of those that are preferable or suboptimal, respectively, in relation to promoting clients' health literacy and contingent ability to fully participate in informed, SDM. Figure 6 depicts this information.

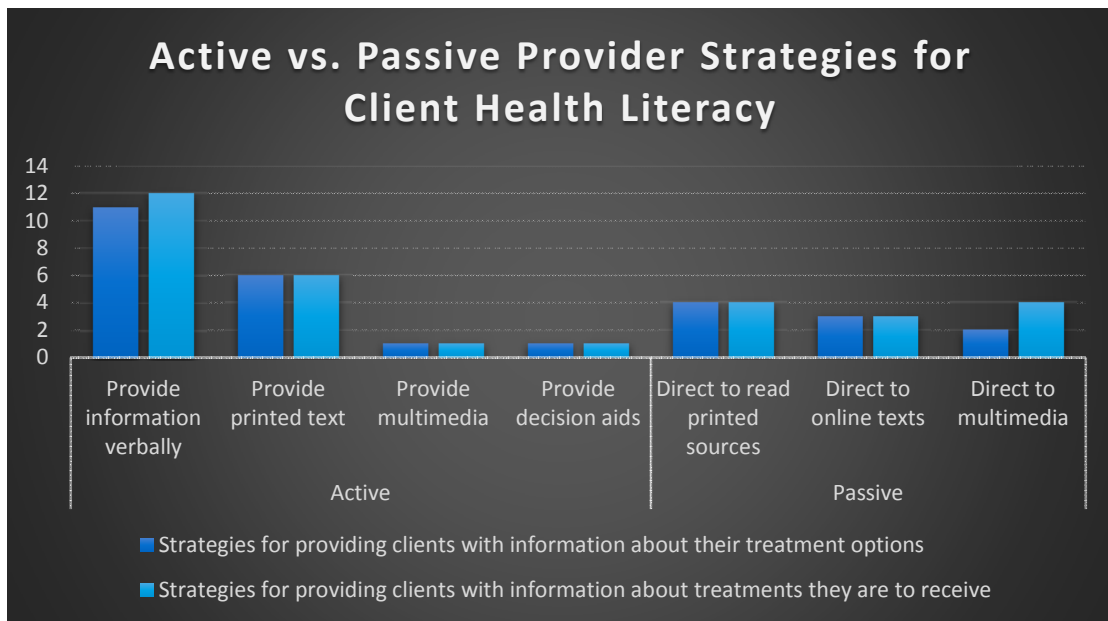


Figure 6: Provider Information-Sharing Strategies by Type

As shown in Figure 6, more providers reported using active strategies than passive ones, although the most frequently reported active strategies were those that are least preferable from within this category, i.e. providing information verbally or through predominantly textual printed materials. Of note is that although Figure 6 indicates that one person reported providing decision aids and one person reported providing information through multimedia, both responses came from the same individual, meaning these particular active strategies are particularly uncommon

among the providers in this study. More frequently reported was passive referral to multimedia for information about treatments the client would receive (n=4), which was selected by three participants in addition to the same individual who reported actively providing media of this type. In sum, about one-third of strategies for providing clients information were passive (11 of 31 for treatments to be received, and 9 of 28 for treatment options).

While implications and interpretations of these data relative to answering the research questions will be discussed further in the next chapter, it is worthwhile to summarize a few factors that may have affected the choice of strategies reported by providers in this study. For instance, providers reported client literacy issues as a barrier to their completion of the client survey in written form. Accordingly, the perception that these issues are common amidst their clientele might lead providers to prefer verbal communication over, or at least in addition to, other modes for communicating health information. Another factor might simply be provider preference or specialized training towards verbal communication.

A limitation to the current dataset and analysis is that the survey did not ask providers to rank the strategies in any way. Thus, it is not known in what order they might be employed and why, e.g. whether verbal information is usually paired with other approaches for a single client; if different strategies are used for different clients; if passive strategies are employed secondary to active ones, and so forth. In addition, due to the small sample size and conflated wording of the question about preferred language resources, examination of responses by combination was not deemed appropriate to this study, but looking at health literacy strategies from these angles might yield meaningful insights in future research and could supplement what is reported here.

Shared Decision-Making: Provider Knowledge and Attitudes

The remaining questions on the provider survey asked about SDM. A brief definition of SDM was provided, after which providers were asked if they felt they were familiar with the concept of SDM in health care; whether they felt they had received training that enabled them to practice it with most of their clients, and if so, where they remembered receiving such training; and whether they thought their clients were able to fully participate with them in decision-making about their care. Responses to this first question are depicted in Figure 7, while responses to the second question are represented in Figure 8. The intent of these questions was to gather information on the knowledge and attitudes of providers towards SDM, to eventually be compared with data on SDM experiences gathered from the client phases of the study.

Knowledge and attitudes towards shared decision-making. Responses to the questions about the concept of SDM and about clients' ability to participate were unanimous. All of the providers (n=12) reported being familiar with the concept of SDM. Likewise, all (n=12) felt that their clients are able to share as much they would like in decision-making about the treatment they will receive from the provider.

However, differences providers' responses began to vary when it came to formal training to prepare them to practice SDM with their clients, as shown in Figure 7 below.



Figure 7: Providers Who Feel Trained to Practice Shared Decision-Making

Training to practice shared decision-making. Although all providers reported familiarity with the concept, two providers reported that they did not feel they had received training that prepared them to practice SDM with their clients; this breakdown is depicted in Figure 8. A follow-up question asked providers who reported having received training in SDM where this training had occurred (i.e., during undergraduate, master’s, doctoral, or post-doctoral education, or professional development). Figure 8, below, shows these responses.

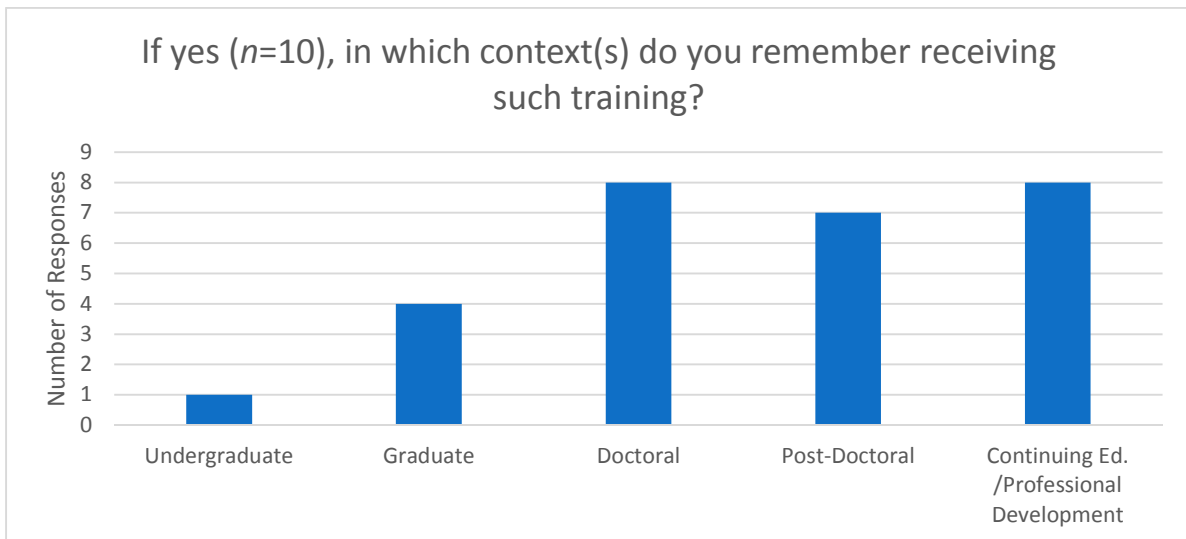


Figure 8: Sources of Provider Training to Practice Shared Decision-Making

As shown in Figure 8, among the providers who felt formally prepared to practice SDM with their clients (n=10), most (n=8) reported receiving training to do so at multiple educational levels. The most commonly reported contexts to have received training to practice SDM with clients were during doctoral education and continuing education/professional development (n=8 each); second most common was during post-doctoral studies (n=7). The two individuals who reported only having received preparatory training in one context reported that this was either during their graduate or doctoral studies.

Summary of Health Literacy and SDM Data and Analysis

Some of the data from the provider survey seems to be in conflict; for instance, although all providers reportedly felt that most of their clients were able to fully participate in decision-making about their care, not all felt that they had received training in SDM. Likewise, some of the data on strategies for communicating information about treatments (options and/or those to be received), belie issues with promoting health literacy as a prerequisite to SDM.

Most providers reported using a variety of strategies to provide information to their clients regarding treatment options and plans, and more active than passive strategies were reported. Most predominant among the active strategies providers reported using were to communicate information verbally or through primarily textual printed materials. Though preferable to passive strategies that require clients to obtain information on their own, these are nonetheless not typically the best methods of promoting client health literacy. The high reported frequency of verbal communication might be a reflection of a discipline-specific emphasis on oral communication, or a response to the providers' perceptions that they are

serving clients with low reading skills, although the high reported frequency of also using printed text materials complicates this potential interpretation. Though many providers selected the “preferred language” option for providing information, it is not clear if they meant this as a passive or active strategy, nor the medium of the materials they referred to.

In sum, while most of the providers in this small sample feel that their clients are able to partake in decision-making with them as much as they would like to, this is not a complete answer to the question of whether or not SDM takes place, and if so, to what extent and whether clients are adequately prepared from a health literacy standpoint to fully participate in this process. Further research is needed to determine details of the health literacy strategies RxPs (and other mental health care providers) use with their clients, to ensure that clients are being adequately availed of the information and opportunities necessary to engage in decision-making about their health care. Additional research or application could be done to emphasize the role and best methods of facilitating health literacy in order to enable SDM, as providers in this study indicated many educational contexts where training in the latter occurs.

Results Part II: Client Survey

A total of 30 completed client surveys were obtained in this study. Due to missing values and more frequently, the structure of the survey—which instructed clients to skip certain questions based on their answers to previous ones—the sample size for some questions is smaller. Two statistical software packages, SPSS 25 and JASP 0.9.2.0, were used for the statistical analyses performed on the data.

Data Preparation and Procedures

All close-ended data and some data captured within the open-ended questions was coded into SPSS for analysis. For some questions, this included the creation of additional categories that were not part of the original survey; these questions and categorical revisions are discussed in situ below and in some cases, as part of the implementation findings from this study. While this process accounted for most of the open-ended data, that which was not converted for quantitative analysis in SPSS was analyzed qualitatively for content and themes (Saldaña, 2016).

Results from the client survey are presented as descriptive statistics, limited analyses of construct reliability, and qualitative themes from open-ended responses. Given limitations to the survey sample and emerging statistical research on comparative reliability measures, three were used in the present study rather than the more standard practice of only Cronbach's alpha. The decision to present results in this manner is further explained henceforth, and then the results themselves follow. Lastly, after these quantitative results, qualitative data from the open-ended questions at the end of the client survey is presented according to the themes into which this data divides.

Descriptive statistics

Preliminary analysis of the client survey data included the calculation of responses by and across questions. This revealed a high degree of homogeneity in responses to most questions (generally, only one or two dissenting responses were recorded for each question). As a result of this homogeneity, outlier responses had a pronounced impact on the skewedness and kurtosis for most questions; yet, due to the small overall sample size, eliminating outlier

responses from analysis was not a viable option. Thus, the client survey results are discussed below by construct, with most findings presented as frequencies and proportions, although some cross-tabulations are included. However, these patterns are not discussed with reference to statistical power, as calculating this would be fundamentally limited due to the non-normal distribution of the data. Consequently, all such results must be verified through additional research conducted in the future.

Reliability analyses

The above said, the only inferential analysis performed on the data was concerning construct reliability. Because of the known limitations to the dataset, construct reliability was calculated via three different statistics: Cronbach's alpha (α), Guttman's lambda (λ_6), and McDonald's total omega (ω). Although Cronbach's alpha is the most widely used and known measure of scale reliability and has historically been used with non-normal datasets (Trizano-Hermosilla & Alvarado, 2016; Reville, 2018; Sheng & Sheng, 2012), more recent critiques suggest that it may be more adversely affected by leptokurtic skew, particularly in small samples, than previously acknowledged (Sheng & Sheng, 2012). McDonald's omega (both ω and the hierarchical coefficient, ω_h) and Guttman's lambda have been proposed as potentially more robust measures of reliability in datasets with non-normal distributions (Trizano-Hermosilla & Alvarado, 2016; Reville, 2018). As Reville (2018) explains, this is due to the varying propensity of each tests to over- or under-correct depending on the dimensionality involved in the prediction of the criterion of interest, as well as the homogeneity of the set. Based on a discussion of these limitations, Reville concludes that although λ_6 underestimates reliability for a completely homogenous set it is preferable to α as the test becomes more multifaceted. Nonetheless, in multidimensional tests, Reville suggests that ω is ultimately the

more preferable choice. Specifically, ω_t will lead to a more accurate correction in tests wherein several dimensions contribute to the prediction of the criterion, and ω_h will lead to a more accurate correction when “only the test’s general factor contributes to the prediction of the criterion of interest” (p. 230).

All three tests perform best with datasets that are much larger than that collected in the present study (Sheng & Sheng, 2012; Trizano-Hermosilla & Alvarado, 2016; Reville, 2018). Given this and the myriad other limitations to the present dataset, which include both homogeneity within responses but multifaceted scale items, all three measures were calculated and are presented for each construct discussed below. Constructs 1-8 are those identified by subheadings in the original survey; Construct 9 pertains to an additional concept embedded within the survey and reflected via questions found throughout the original sections. See below for details. To reference the exact survey questions and response options, see Appendix A: Survey Instruments.

Characterizing reliability. For reliability measures, including those calculated in this study, the closer the value to one, the greater the reliability, or likelihood that the survey questions are measuring the intended construct (Reville, 2018). However, there are no universally-accepted cut-off points for characterizing reliability based on numerical values. Nonetheless, as Cronbach’s alpha is by far the most common reliability statistic reported today (Sheng & Sheng, 2012), certain “rule of thumb” cut-off points for interpreting scale reliability statistics have been popularized based on this measure. As summarized by Stephanie (2014) for the blog Statistics How To, these points are as shown in Table 2.

Table 2: Values for Characterizing Internal Reliability

Cronbach's alpha	Internal Consistency
$\alpha \geq 0.9$	Excellent
$0.9 > \alpha \geq 0.8$	Good
$0.8 > \alpha \geq 0.7$	Acceptable
$0.7 > \alpha \geq 0.6$	Questionable
$0.6 > \alpha \geq 0.5$	Poor
$0.5 > \alpha$	Unacceptable

In the results that follow, construct reliability has been calculated where possible, first according to the pre-identified constructs in the survey, and then for two additional constructs identified by the researcher based on a combination of questions from across different sections of the instrument. For each construct reliability analysis, this above scale is used to characterize the results of all three measures (α , λ_6 , and ω) calculated.

Client Participant Demographics

Missing values were excluded in the following calculations of client demographics. The client survey sample was comprised predominantly (n=21; 70%) of women and persons who identified as White or Caucasian (n=18, 60%). Nearly half (n=13; 44.8%) of respondents identified their ethnicity as Hispanic, and 13.3% (n=4) also chose to write this in as their

race.¹¹ Only two clients identified solely as Native American; however, all but one of those who identified as being of multiple races indicated Native American heritage as part of this background, bringing the total Native American portion of respondents to 20% (n=6) of the sample. The sample was distributed relatively evenly across different age brackets, albeit with fewer participants falling within the lower- and uppermost categories. These demographic data can be found in **Error! Reference source not found.**

Table 3: Client Survey Sample Demographics

Characteristic	n	Percent (%)
<i>Gender</i>		
Male	8	26.7%
Female	21	70.0%
Other	1	3.3%
<i>Age</i>		
Under 20	3	10.0%
20-29	7	23.3%

¹¹ Since 2010, the U.S. federal government has sought to distinguish “race” from “ethnicity” through separate questions about each factor, and the statement that “Hispanic persons...may be of any race.” However, until more recently, the state of New Mexico continued to employ data collection instruments and reporting mechanisms that included “Hispanic” within the options for race, perhaps explaining this result.

30-39	7	23.3%
40-49	6	20.0%
50-59	5	16.7%
60 and above	2	6.7%
<i>Ethnicity</i>		
Hispanic	13	44.8%
Non-Hispanic	16	55.2%
<i>Race</i>		
White	18	60.0%
Native	2	6.7%
Mixed/Multi	5 ^a	16.7%
Other	5 ^b	16.7%

^a Four of these people specified their heritage as Native American in combination with one or more known or unknown other races.

^b Four of these people specified their race as “Hispanic or Spanish.”

Another demographic variable that was calculated was distance traveled to see provider. It was postulated that since the availability and location of a mental health service provider with prescriptive authority could influence a client’s choice of practice, convenience

of location might factor into client satisfaction with their provider. Thus, in cases with sufficient data (n=23), the distance a service user traveled from home to their provider was calculated. A disproportionate number (n=16) of these calculations came from the clients of a particular provider whose practice was located in a rural area, while the rest came from the clients of a provider located within a metropolitan area¹². Each of these providers had clients that traveled significant distances (30 or more miles) for appointments; however, a majority (n=15; 93.8%) of the rural provider's clients lived less than 10 miles from where their appointments took place while to the contrary, most (n=5; 71.4%) of the metropolitan provider's clients hailed from further away. While this finding is fascinating in that it belies the common assumption that rural clients have to travel farther for specialty care, it warrants additional research and verification before implications can be generalized. Additionally, in the present study, distance as a variable (whether ordinal or scale) did not bear significance within calculations of client satisfaction. It is therefore represented as a demographic variable in

¹² These urbanization levels are based on federal definitions and population density estimates; citations to these sources and datasets are not provided in order to maintain the anonymity of the locations and participants.

Table 4.

Table 4: Client Distance from Provider’s Office

		Distance Traveled to See Provider				Total <i>n</i> (%)
		Less than 10 miles <i>n</i> (%)	10-19 miles <i>n</i> (%)	20-29 miles <i>n</i> (%)	30 miles or more <i>n</i> (%)	
Provider	Metro	2 (28.6%)	1 (14.3%)	3 (42.9%)	1 (14.3%)	7 (30.4%)
Location	Rural	15 (93.8%)	0	0	1 (6.2%)	16 (69.6%)
Total (<i>n</i> =23)		17 (73.9%)	1 (4.3%)	3 (13.0%)	2 (8.7%)	-

Survey Construct Results

The following results are organized by constructs found within the client survey, of which the first eight follow according to the section titles within the original instrument. After discussion of the descriptive and reliability results for each of these constructs, an additional construct not explicated in the headings of the original instrument is analytically explored.

Construct 1: Your Care and Treatment

This section was comprised of Questions #1-3. There were no missing values for these questions. Because clients obtained the survey at their providers’ offices, all (*n*=30) had seen their provider within the last month. Slightly more than half (53.3%; *n*=16) had been in contact with their RxP for 1-5 years; 40.0% (*n*=12) for less than a year, and 6.7% (*n*=2) for 6-10 years. Though taken from the original survey, all of these categories pertaining to length of association were theoretical possibilities in the present context, given that New Mexico was the first state to legislate prescribing psychology, in 2002 (Murray, 2003).

Asked if they felt they had been able to see their provider often enough over the past year, the vast majority (93.3%; n=28) responded “yes, definitely,” while one person (3.3%) responded “yes, to some extent” and one (3.3%) responded “no.” No one in the sample indicated they had seen their provider “too often.” The type and limited number of questions in this section precluded construct reliability analysis.

Construct 2: Your Mental Health Services Provider

This section was comprised of Questions #4-7. The vast majority of clients responded that it had been easy (80%; n=24) or somewhat easy (16.7%; n=5) for them to get to their last appointment, although one person (3.3%) indicated they had found it hard to do so. Asked whether their provider listened carefully to them and if they were given enough time to discuss their needs and treatments, answers were the same: for each question, the vast majority (96.7%; n=29) of clients responded “yes, definitely,” while one individual (3.3%) responded “yes, to some extent.” There was one missing value for the last question in this section, which asked clients whether their provider understood how mental health needs affect other areas of their life. Of the 29 obtained answers to this question, all but one (96.6%) person responded “yes, definitely,” while one (3.4%) selected “yes, to some extent.”

In the present survey, it was unclear whether the question about journeying to the appointment was capturing the intended type of information. Most clients seemed to answer based on difficulty of commute; for instance, the one individual who responded that it was “hard” to get to the appointment wrote in a notation with their response that this was because they lived in a rural location. Other participants who completed the survey orally also indicated that travel time and distance were factors in their response choices. However, based on the

response options and development documentation for the original NHS survey, Question #4, may have been included in order to capture the specific experiences of patients with agoraphobia, who find it difficult to leave their homes for initial mental health care services; based on the materials available for the original NHS survey, agoraphobia seemed to be a topic of some focus during the client-centered development of the instrument (CQC, 2014b; IAPT Programme, 2014). Given this ambiguity, the researcher recommends that this question be clarified if the survey is to be used again.

Reliability analysis. In addition to the ambiguity of Question #7 in terms of descriptive analysis, it seemed to undermine reliability analysis of this construct as well. Specifically, when the question regarding the physical difficulty of journeying to the appointment is included, reliability for Construct 2 is at best poor to questionable, with $\alpha = 0.249$ being unacceptably low by standard cut-off values, while $\omega = 0.671$ and $\lambda_6 = 0.698$. However, when Question #4 is dropped from the equation, construct reliability increases across all three measures, with $\lambda_6 = 0.794$ and $\omega = 0.793$ thusly falling into the range of moderate reliability. Cronbach's α still remains poor at 0.574, but this is not unexpected given the limitations of this measure in the context of the study sample.

Construct 3: Planning Your Care

This section was comprised of Questions #8-10; there were no missing values these questions. Asked whether they had agreed with their provider on the care they would receive, responses (n=30) were unanimously “yes, definitely.” Follow-up questions indicated that most (93.3%; n=28) clients had “definitely” been involved as much as they wanted to be in reaching this agreement and likewise, the same proportion indicated that the agreement “definitely” took

their personal circumstances into account. Dissenting responses to these two questions were as follows: one person (3.3%) indicated that they had been involved as much as they wanted to be only “to some extent,” while another person (3.3%) responded “no, but I did not want to be.” Two individuals (6.6%) responded that the agreement about care only took their personal circumstances into account “to some extent.”

Reliability analysis. Because there was no variability in response to Question #8, it could not be included in reliability calculations for this construct. Reliability based on the remaining two questions in this section was acceptable to excellent, depending on the measure: $\omega = 0.941$; $\alpha = 0.794$; $\lambda_6 = 0.888$.

Construct 4: Reviewing Your Care

This section was comprised of Questions #11-13, for which there were no missing values. Asked whether in the last year, they had had a direct conversation with their provider about how their care was going, answers (n=30) were unanimously in the affirmative. Subsequent questions about the nature of this conversation indicated that most clients felt they had definitely (86.7%; n=26) or to some extent (13.3%; n=4) been involved as much as they wanted to be in discussing how their care was going. Likewise, a majority felt that decisions had definitely (96.7%; n=29) or to some extent (3.3%; n=1) been made together between them and the provider during this discussion.

Reliability analysis. As with Construct 3, the reliability of Construct 4 could not be assessed inclusive of Question #11, due to the complete homogeneity of responses thereto. Based only on the two remaining questions in the section, the reliability of Construct 4 per the current sample was questionable to poor across all three measures ($\omega = 0.643$; $\alpha = 0.562$; $\lambda_6 = 0.473$). It is

recommended that the reliability of this construct be reevaluated with a larger and more heterogeneous sample such that Question #11 might be included.

Construct 5: Changes in Who You See

This section was comprised of Questions #14-19. Question #16 asked whether a client had a prior mental health care provider, and if not, instructed them to skip to the next section of the survey. Of the 30 total participants, 27 (90%) indicated that they had previously seen someone else for mental health care services, and thus, this is the baseline sample size for Questions 17-19. None of the questions in this section of the survey were of the appropriate type for construct reliability analysis, and thus no such analysis was performed.

However, responses to questions throughout this section revealed the need to make adjustments to the instrument. Many clients felt that the extant options were insufficient to convey their experiences of finding and/or switching to their current, RxP-provider. This was evident by a high number of “other, please specify” responses in surveys completed without assistance from the researcher, and several narrative responses to those that were done orally. The researcher took notes on these narrative explanations and together with details clients wrote into the “other, please specify” option for these questions, assessed them thematically during data entry and preliminary analysis. This process resulted in the creation of the following new response categories for Questions #14 and #18, respectively.

Question #14. For the question of “how did you find your current provider?” a new category entitled “Referral type, other” was added. This category is premised on two distinctions. First, it includes responses that do not fit within the specific options provided on the survey, some of which included other types of referrals such as those made by general physicians (GPs)

or primary care providers (PCPs). Second, and more importantly, it draws upon a line between informal or neutral *suggestions* or references provided by friends, family, or health coverage companies, to include only *referrals* in the stronger sense that they were made by arguably more credentialed or authoritative bodies or figures. To better illustrate this distinction, some of the specific pathways encapsulated within this category include the following: referral by court authorities, hospitals, rehabilitation and transitional living facilities, and semi-formal peer-led support groups such as Alcoholics Anonymous, Narcotics Anonymous, those for specific life experiences or medical conditions, etc. It is worth emphasizing that all of these responses came up in the survey sample, despite how small it was. Thus, it is likely that with a larger sample, it might be better and possible to subdivide this category into these specific pathways. In addition, although no one in the present sample indicated that they had been referred in such a manner, this category could also conceivably represent prison-system referrals, those made by religious authorities, and other types of referrals from outside of health-related fields. In sum, this is currently a very broad category, but represents a specific, albeit nuanced, theme in terms of referrals. The implications of this are further discussed in the next chapter of this dissertation.

Question #18. This question allowed for more than one answer; thus, the *n* is greater than 27. Of all the questions in the survey, this one elicited some of the most detailed responses from clients during oral administration of the instrument, which in part highlighted the need for additional response categories. The question itself asked why clients had switched to their current provider, and the two additional categories that were added to it during analysis were “to simply care” and “old provider closed.” With the addition of these new categories, all but one of the “other, please specify” responses to this question could be encoded in a meaningful way for analysis. The following two paragraphs explain each of these new categories for question #18.

To simplify care. A number of clients indicated that they had switched to their current RxP in order to simplify or streamline their care, whether of their own motivation or at the suggestion of another provider. As one client put it, a social worker suggested they switch to an RxP in order to have a “one-stop provider” for all her mental health care needs, which included both prescription and psychotherapy. Thus, this category was created to capture such scenarios.

Prior mental health provider closed. This was perhaps the most unforeseen finding in the study. A number of clients reported that they switched to their current RxP provider in part or in whole due to the abrupt and complete closure of their prior provider’s practice. As explained in the Methods chapter of this dissertation, the present study coincided with the abrupt and unprecedented closure of many of New Mexico’s largest mental health care practices, and this is how the event manifested within the client data, necessitating the creation of this category. The need for this category, and more specifically, the fact that it revealed an implicit bias towards an assumption of client agency of choice within the language of questions in this section of the survey, is discussed in some depth in the next chapter of this dissertation.

Results for Construct 5 questions. A slight majority (n=18; 60%) of clients indicated that they had been seeing their current provider for more than a year, and 36.7% (n=11) indicated that they had not, with one person leaving the question blank. As stated previously, 27 of the 30 client participants (90%) had seen a previous mental health provider (MHP). None of these individuals indicated that they had switched from one RxP to another. Rather, their previous providers represent a variety of occupations associated with mental health care, of whom some have prescriptive authority and some that do not. These data are detailed in Table 5.

Table 5: Prior Provider Type

Before your current (RxP) provider, who did you see last for mental health services?

	n	%
Psychiatrist only	7	25.9
Psychologist only	7	25.9
Social worker only	5	18.5
PCP or GP only	4	14.8
Psychologist & Psychiatrist Concurrently	2	7.4
Nurse Practitioner?	1	3.7
Don't know/Can't remember	1	3.7
Total	27	100.0

As shown in Table 5, the most frequent immediately prior MHPs were either a psychologist or a psychiatrist (n=7; 25.9%, each). Also common was having previously received mental health care services solely from a social worker (n=5; 18.5%), although some clients reported having switched to their current RxP from a PCP or GP, nurse, or multiple concurrent MHPs.

Table 6 depicts different informational means by which clients found out about their current RxP.

Table 6: Routes to Seeing an RxP

How did you find out about your current provider?	n	%
A friend or family member	10	33.3
The internet	3	10.0
GP or PCP	5	16.7
Phone book	1	3.3
Prior MHP closed	3	10.0
Referral by another MHP, not due to immediate closure	4	13.3
Referral, type other	4	13.3

As shown in Table 6, informal recommendations from friends and family (n=10; 33.3%) comprise the predominant manner by which individuals learned about the existence of the RxP they were now seeing, although more formal referral types were also common. Of note is that the individuals who indicated they learned about their RxP only because their prior MHP provider shut down and attempted to refer them for continuity of care, could also be categorized as being referred by another MHP. If they were added to the number of individuals who chose “referral by another MHP” as their sole reason, this would make this mechanism the second most common (n=7; 23.3%).

Answers in response to the question of why a client switched to their current provider demonstrated some overlap with the question of how they learned about that provider. However, answers to this latter question indicated that while clients may have heard about their RxP from a previous provider, this was usually not the sole reason behind their action to actual change over. For this reason, the data shown in Table 7 is shown by response frequency and a

percentage calculated out of the total number of individuals in the responding subsample (n=27). Accordingly, the percentages total more than 100.

Table 7: Reasons for Switching Providers

Why did you change to your current [RxP] provider?	Frequency	Percent (of n=27 respondents)
Old provider didn't offer all the MH services I wanted	10	37.0%
Didn't like old provider	7	25.9%
Old provider too far away	5	18.5%
I moved	4	14.8%
Heard this provider was better	4	14.8%
Referred by different MHP (not GP/PCP)	3	11.1%
To simplify care	3	11.1%
Took too long to get an appointment	3	11.1%
Old provider left	3	11.1%
Don't know/Can't remember	2	7.4%
Referred by PCP or GP	1	3.7%
Still seeing both	1	3.7%

The most frequently cited reason for changing providers (n=10; 37% of the subsample) was that the prior provider had not provided all the mental health (MH) services the client wanted; narratively it was explained that many clients decided to seek out someone who could provide medication, something their prior providers were unable to do. This was especially common amongst the clients who had only been to non-prescribers previously. However, at

least some responses in this category came from clients whose prior provider had been someone with prescriptive authority who nonetheless “did not feel comfortable treating mental health issues” (client quote) and suggested the individual see a specialist. About a quarter (n=7; 25.9%) of the participants indicated that dislike of their previous provider was a motivating reason behind their change.

The final question of the section asked about the impact that switching providers had had on the client’s care. Responses to this question were less uniform than to some other satisfaction measures in the survey, though mostly positive. A majority of clients (81.5%; n=22) felt that their care had improved since switching to their RxP, though two individuals felt it had stayed the same and two were unsure of the impact of switching (7.4%, each). One individual (3.7%) felt their care had worsened. Because this was the only scale question in the section, the reliability of this construct could not be assessed.

Construct 6: Treatments

This section consisted of Questions #20-27. The results of the questions in this section do not conform to the survey instructions for this portion. While this somewhat complicates the results from this implementation of the survey, it also suggests some possibilities and avenues for improving the instrument in the future. These complications and suggestions are discussed below.

Question #20 indicated that the majority of participants (n=26; 86.7%) had been receiving “medications for their mental health needs” during the last year. Those who were not receiving medications were instructed to skip to Question #26. Thus, the total number of respondents to the intervening questions should have been equal to or lesser than 26, as in the

case of Questions #23 and #25, which were premised on further screens. Likewise, Question #26 serves as a screening question for Question #27. However, more people than should have answered each of these questions. Presumably, the incongruous *n* values can be attributed either to individuals answering Question #20 incorrectly, or to interpreting the subsequent questions differently than intended. One factor complicating interpretation of this data is that superfluous answers to post-screening questions in this section do not follow a consistent pattern whereby specific surveys could be adjusted for the error. In other words, the issue is not that one or two clients completed entire sections that they were not supposed to, but that several clients each completed a variety of extra questions incongruous with prior responses intended to preclude them from answering. In some cases, clients explained their reasoning for doing so, but in other instances they did not.

For example, Question #26, instructed clients who answered anything other than “yes” to skip the last question in this section and move on to the start of the next (Question #28). Many clients felt this was unfair and problematic. Question #26 asks clients whether they have received any non-medication treatments for their mental health needs during the last year, and solicits responses in terms of “yes,” “no but I would have liked this,” “no but I did not mind,” “this was not appropriate for me,” or “don’t know/can’t remember.” The follow-up question to this, which people who select any of the latter four answers are instructed to skip, inquires about whether clients were as involved as they would have liked in decision-making about what alternative treatment or therapies to use. Considering that this is a question about client satisfaction with the SDM process, it does not seem wholly logical to exclude those patients who did not receive alternative therapies from evaluating whether they would have liked to discuss this option with their MHP, and indeed, this is exactly what many clients pointed out.

Thus, the researcher accepted all answers provided to Question #27 and included them in Table 8, even when the survey instructions were to preclude these data based on a prior answer.

While this line of thinking does not explain all the inconsistent *n* values in this section, it might explain some in addition to Question #27. For example, question #21 allows for the same response categories as Question #26 in answer to whether a client was as involved as they wanted to be in decision-making about what medications they would receive. There is no question in the survey that explicates whether a client was involved in decision-making about whether or not they would receive medications at all, so it is possible that clients who had not been prescribed medicines interpreted this question as nonetheless relevant to them. Another possibility is that clients who answered this question despite a disqualifying prior response had discontinued a medication sometime during the last year, while another is that they answered subsequent questions in the context of medications they had received more than a year ago. This is the case for Question #23 at least, in which the two responses in excess of the 16 that would be anticipated based on the screening question came from individuals who completed the instrument verbally and insisted they remembered the context in which they had last been prescribed a medication for their mental health, even though it was more than a year ago. These clients were adamant that they be allowed to provide their opinion in response to this question, and out of respect for the client participatory role in the process, the researcher agreed. Moreover, since this question solicited entirely homogenous results, the inclusion or exclusion of these two responses does not affect the results, and as such, they are included in Table 8, which thus details all responses received for questions within the “Treatments” section of the client survey.

Table 8: Questions and Responses Regarding “Treatments”

Question	n	%*
<hr/>		
Q20. Have you been receiving any MH medications in the last year? (n=30)		
Yes	26	86.7%
No	4	13.3%
Q21. Were you involved as much as you wanted to be in decisions about which medications you would receive? (n=28)		
Yes, definitely	25	89.3%
Yes, to some extent	3	10.7%
Q22. In the last year, have you had any new MH medications prescribed? (n=28)		
Yes	16	57.1%
No	12	42.9%
Q23. The last time you had a MH medication prescribed, were you given information about it in a way you were able to understand? (n=18)		
Yes, definitely	18	100%
Q24. Have you been receiving any medications for more than a year? (n=28)		
Yes	21	75%
No	7	25%
Q25. In the last year, has your RxP checked with you about how you are doing with your medications? (n=25)		
Yes	24	96%

No	1	4%
Q26. In the last year, have you received any treatments or therapies for your mental health needs that do not involve medication?		
Yes	18	62.1%
No, but I would have liked this	7	24.1%
No but I did not mind	2	6.9%
This was not appropriate for me	2	6.9%
Q27. Were you involved as much as you wanted to be in deciding what treatment or therapies to use?		
Yes, definitely	21	87.5%
No but I wanted to be	1	4.2%
No, but I didn't want to be	2	8.3%

* Calculated exclusive of missing values.

Reliability analysis. Of the eight questions in this section, five (Questions #21, 23, 36, 27, and 28) were structurally applicable to analysis as non-binary scale questions. However, due the homogeneity of responses to Question #23, it could not be included in the reliability analysis of this construct. Overall, the reliability of this construct calculated based on the present sample is relatively poor according to all three scales employed ($\omega=0.677$; $\alpha=0.575$; and $\lambda_6=0.578$), with further calculations indicating no one item that could be eliminated in order to dramatically enhance it. Likely, these calculations are undermined by inconsistent client interpretations and responses to questions in this section. Thus, based on these values

and the aforementioned feedback during implementation of the instrument, it is recommended that this section be revised and further piloted to improve future renditions of the survey.

Construct 7: Other Areas of Life

This construct consisted of Questions #28-37. Questions #28-31 dealt with securing support services beyond mental health care and had a somewhat unique set of response options, relative to other questions in the survey. With the exception of Question #31, which was designed relative to the uniquely stateside provisions of the Americans with Disabilities Act (ADAA), these questions were in keeping with the original survey but nonetheless paralleled services provided across a constellation of separate U.S. systems. These systems are complex, multi-level, separately operated but nonetheless related, and cover an array of services ancillary to medical care and public, and individual health and well-being. For instance, examples of U.S. government-regulated assistance include the following, but are administered at various structural levels by one or more of the agencies denoted parenthetically: Social Security and disability payments (social security administration), food assistance programs, e.g. WIC and SNAP (U.S. Department of Agriculture; state-specific income support agencies; local income-support offices); health coverage programs (federal seven-part Center for Medicaid and CHIP Services; Centers for Medicaid and Medicare Services; state insurance exchanges; federal and state legislative bodies); issues related to disability services in the workplace (Equal Employment Opportunity Commission) or in education (Department of Education, local school boards).

This is all to say that while social support services for many of the same things exist in both England and the U.S., such that clients in the present study felt these questions were

applicable to them, the systems implied are quite different, and more complex stateside. Moreover, given their complexity, these systems of welfare jurisprudence are not well understood by the U.S. public, and most people, even recipients, refer simply to the benefits or immediate program eligibility sought, rather than the agency(ies) responsible. Thus, in the context of administering the survey in the U.S., clients understood questions #28-31 to be asking about specific programs, social services, and types of welfare, as follows:

- Question #28: treatment or support for physical health issues (such as medical care or home health care services for non-psychiatric issues)
- Question #29: social security or supplemental security disability income (SSI/SSDI), food voucher programs (e.g. SNAP, WIC), or other forms of public financial assistance (e.g., TANF, utility riders, low-income housing programs, etc.)
- Question #30: securing employment
- Question #31: workplace or school accommodations for disability (such as IEPs or provisions mandated under Section 504 of the Americans with Disabilities Act, as amended (ADAA))

Assistance with non-medical needs. Through these and other questions in this section, clients indicated that their RxP had helped them in a number of ways beyond their immediate mental health needs. As shown in

Table 9, 50% (n=15) of all participants who answered the question indicated their RxP had assisted them in securing support for physical health needs; 43.4% (n=13) indicated they had received help securing financial support; 27.6% (n=8) had received help finding or keeping work; 43.3% (n=13) with academic or workplace accommodations, and 36.7% (n=11) with participating in a social activity locally.

Table 9: Mental Health Provider Assistance with Clients' Other Needs

Question	Responses (n; %*)					
			No but I would have liked help with this	I have support and didn't need help finding it	I do not need/want support for this	I do not have [these] needs
Q28. Services for physical health needs	15(50%)	1(3.3%)	3(10%)	4(13.3%)	5(16.7%)	2(6.7%)
Q29. Financial support	13(43.4%)	2(6.7%)	3(10%)	4(13.3%)	8(26.7%)	-
Q30. Finding or keeping work	8(27.6%)	4(13.8%)	1(3.4%)	1(3.4%)	11(37.9%)	4(13.8%)
Q31. Work or school accommodations	13(43.3%)	1(3.3%)	1(3.3%)	5(16.7%)	10(33.3%)	-
Q32. Engaging in social activities locally	11(36.7%)	3(10%)	1(3.3%)	7(23.3%)	8(26.7%)	

* Calculated exclusive of missing values; last answer option was not available for all questions, as indicated.

Table 10 reconfigures these results, excluding individuals who indicated that help with each need was not relevant to them, in order to show the percentage of interested persons who were assisted in each of these ways. Hence, Table 10 better conveys how well client needs in these areas are being met by their RxPs.

Table 10: Assistance from MHPs Regarding Other Needs (Interested Clients Only)

Question	% of applicable respondents		
Has your provider helped you find or obtain...	Yes, definitely	Yes, to some extent	No, but I would have liked help with this
Q28. Services for physical health needs	78.9%	5.3%	15.8%
Q29. Financial support	72.2%	11.1%	16.7%
Q30. Finding or keeping work	61.5%	30.8%	7.7%
Q31. Work or school accommodations	86.7%	6.7%	6.7%
Q32. Engaging in social activities locally	73.3%	20.0%	6.7%

These results are significant because they indicate that the RxP providers reflected via the client survey are assisting clients more holistically than through psychotropic prescribing alone. Of particular interest are the findings regarding help securing financial support, employment, services for physical health needs, and engaging in social activities locally. While petitioning for workplace or school-based accommodations typically only requires a single statement from one’s physician stating such need, these other types of assistance involve more complicated processes from both a physician and client perspective, yet have extreme implications for quality of life and treatment outcomes. Within the next chapter these findings

are further discussed in the context of extant literature and practices in the broader domain of U.S. mental health care.

Understanding and helping with what is important to the client. The last three questions in this section, Questions #35-37, asked, respectively, whether the provider understands what is important to the client, whether the provider helps the client with what is important to the latter, and whether the provider makes the client feel hopeful about such things. While “no” was a response option for each of these questions, no one selected it. Instead, responses to both Question #35 and #36 were the same: 93.3% (n=28) answered that their provider ‘always’ understands and helps them with what is important, while 6.7% (n=2) responded that their provider did so “sometimes.” Asked with their provider helped them “feel hopeful” about the things that are important to them, 86.7% (n=26) of clients responded “yes, always,” while 13.3% (n=4) responded “yes, sometimes.”

Reliability analysis. Reliability analysis for this construct was calculated using Questions #28-34, 36, and 37. Based thereon, reliability for the “Other Areas of Life” construct was good to excellent across all three measures: $\omega = 0.926$; $\alpha = 0.855$; and $\lambda_6 = 0.973$.

Construct 8: Overall

This construct from the original survey consisted of Questions #38 and #39. Question #38 asked clients to rate their overall experience with their provider on a whole-number scale from lowest to highest of 1-10. Question #39 asked clients whether they felt their provider treated them with respect. Two people did not answer Question #38, but there were no missing values for Question #39. There were not enough scale questions in this section to assess construct reliability; thus, only descriptive analysis is described below.

The responses coded to the options for Question #38 ranged from 6-10, although some respondents specified fractions not included on the scale and others attempted to write in numbers beyond 10. Thus, out of those who rated their overall provider experience on a scale, the majority (67.9%; n=19) were completely satisfied, as indicated by selected “10” or attempting to write in a higher number. An additional 21.5% of participants (n=6) rated their provider experience as highly satisfactory at least a 9 but less than 10. One response (3.6%) was received for a rating of 6, 7, and 8, respectively, making for 10.7% within what can be characterized as a range of moderate satisfaction. A substantial majority (93.3%; n=28) of clients felt their provider “always” treated them with respect, with the remaining 6.7% (n=2) selecting “yes, sometimes” in response to Question #39.

Construct 9: Shared Decision-Making

In addition to the above constructs, which were determined in accordance with those specified in the original survey, it was hypothesized that a combination of questions from across different sections of the survey might reliably assess experiences of SDM as a construct. This hypothesis was supported by nature of certain questions, in tandem with materials describing the goals and theoretical premises that informed the development of the questionnaire.

Thus, it was postulated that a “Shared Decision-Making (SDM)” Construct might be reflected in the amalgamation of Questions #8, 9, 10-13, 23, 21, 27, and 33 or some combination thereof, as each of these questions dealt with client involvement in conversations and decision-making about their care. However, because of the lack of variance in responses to Questions #8, 11, and 23, these could not be included for analysis of the SDM Construct using

the present sample. Thus, calculations proceeded based only on Questions #9, 10, 12, 13, 21, 27, and 33. Results from these calculations indicated good to excellent reliability for this construct, specifically: $\omega=0.982$; $\alpha=0.865$; and $\lambda_6=1.00$. Further analysis indicated that if Question #27 were excluded, all three reliability measures would fall within the excellent range ($\alpha=0.901$; $\omega=0.945$; $\lambda_6=0.980$). However, given the previous discussion regarding Question #27, as well as and other general limitations to the study, the researcher recommends that this question not be eliminated from the model until the survey can be revised and assessed based on a larger sample. At such a time, additional construct analyses to measure validity are also recommended, as the small study sample precluded these measures for all constructs discussed above.

Open-Ended Qualitative Responses and Data

In addition to the close-ended questions discussed above, the survey concluded with three open-ended question for “other comments” that did not align with any particular construct, but offered participants the opportunity to share other information they felt was relevant. These three questions were “is there anything particularly good about your care?,” “is there anything that could be improved?” “any other comments?” For verbally-administered surveys, answers to these questions could be quite lengthy, and were thus recorded in the researcher’s shorthand before being written out in full. During administration of the instrument, these questions were not only read to clients and their responses taken down in this manner, but these their answers were read back to them as they would be fully written out in order to check for accuracy.

As with other detailed responses received in addition to what the instrument was initially designed to capture, information obtained through these open-ended questions was initially screened and coded into earlier survey questions where appropriate. However, not all answers to these open-ended questions were integrated in this way, nor could coding the information into close-ended responses represent the full-breadth of detail clients provided. Therefore, for data that was not applied to close-ended questions, this section provides a thematic (Saldaña, 2015) analysis of these open-ended responses. After cyclical coding, data were arranged into hierarchical categories and subcategories.

Qualitative Data Overview

In this survey of just 30 MHCSUs, only 11 individuals passed on the opportunity to provide open-ended comments about their care from RxPs, meaning that at least one statement was made by each of the remaining 19 client participants.

There were three, unnumbered questions at the very end of the client survey designed to elicit and capture open-ended commentary; these asked:

- “Is there anything particularly good about your care?”
- “Is there anything that could be improved?”
- “Any other comments?”

In addition, some clients wrote or instructed the researcher to write (depending on how they completed the instrument), extra comments in the margins and white space surrounding various close-ended questions within the survey, providing details in addition to what the pre-printed responses allowed or seemed to indicate to them, or to ensure their answers were contextualized. At data entry, these comments were collected along with those clients had

written in answer to the above questions and typed into an Excel spreadsheet. Similarly, comments dictated the open-ended questions by clients completing the survey orally were taken down in the researcher's shorthand, but read back to clients as they would be written out in full to check for accuracy and later added in their explicated form to the same spreadsheet.

Changes were made to correct for spelling and to remove references to providers' names and genders; bracketed text was added where necessary for an answer to make sense outside of a specific question's context. However, anything substantive¹³ a client wrote or indicated was retained. Likewise, a decision was made at data entry to retain any expressive punctuation, such as exclamation points, as it signaled the writer's intentions for the tone of a statement. In practice, the this only came to apply to Participant 20's use of the punctuation to indicate a smiley face emoticon (i.e., a colon and the parenthesis). Following this typing protocol, the complete spreadsheet of open-ended responses was coded and analyzed as described next.

Coding-Analytical Process and Schematic

The open-ended data from the client surveys was analyzed according to methods described by Saldaña (2016). The exact process involved coding and analyzing the data in two cycles, which led to the categorical arrangement of comments into four broad themes:

¹³ This excluded only two comments: a non sequitur about a client's unrelated treatment for sleep apnea by a different doctor, and a reply to the question of "is there anything that could be improved?" that, in its entirety, consisted of "my life." No other open-ended commentary was provided in the survey containing this latter response, and so it could not be well-interpreted and was thusly omitted from this analysis.

”Medically Skilled,” “Empathically Skilled,” “Accessibility Through Accommodation,” and “Generic Praise or Endorsements.”

In addition to offering insight into client experiences with their RxP, and in some cases, other MHPs, the themes within this data speak to client views on what makes for a “good” prescribing mental health professional (PMHP). So, while the dataset is not large enough to support postulating predictive, generalizable theory, each theme will be discussed in turn, followed by a discussion of the assertions that can be drawn from this analysis (Saldaña, 2016).

Theme 1: Medically Skilled Care

In looking at clients’ open-ended comments, it became clear that many pertained to diagnosis and medication management, and more specifically, to a provider’s aptitude in these regards. Since the definition of “clinical” skills can vary from physical dexterity to interpersonal communication, depending on one’s profession (Michels, Evans, & Blok, 2012), and prescribing psychology is a hybrid field, the term “medical” skills was used in naming this category, and will be used in order to juxtapose these aptitudes with other types of “skills” clients mentioned (discussed in later sections). Client comments also distinguished between a provider’s various skills, and their ability to offer different types service functions simultaneously, and so remarks about an RxP’s ability to offer integrated care are also discussed separately.

With these distinctions explained,

Table 11 presents only those comments made regarding medical skills. All were made in the context of stating things that were “particularly good” about the care a client was receiving from their current, RxP provider, and so ostensibly.

Table 11: Comments About Medical Skills

MEDICAL SKILLS	
Medication Management	Diagnosis
<p>This provider dealt with the side effects of the medication I had wrongly (due to incorrect diagnosis) been prescribed by someone else. (Participant 13)</p> <p>This provider knows their medications and is good at cross-managing treatment for different conditions. (Participant 11)</p> <p>I switched to this provider because my prior prescriber for mental health meds [a GP or PCP] set my pills too high. This new person fixed the dosage right away. (Participant 19)</p> <p>[What is particularly good about my care is that] this provider tends to my medication needs. (Participant 24)</p>	<p>This provider helped me get the correct diagnosis, when I had been misdiagnosed previously. They are very good at diagnosis. (Participant 13)</p>

As can be seen from

Table 11, only one client commented specifically on diagnosis, but they do so in a way that shows they appreciated their RxP not only for their ability to identify the mental health issue, but to adjust the client's medicine accordingly. Specifically, Participant 13 stated:

This provider helped me get the correct diagnosis, when I had been misdiagnosed previously. They figured it out and treated it quickly. They are very good at diagnosis.

This provider dealt with the side effects of the medication I had wrongly (due to incorrect diagnosis) been prescribed by someone else.

Within this one quote, the Participant 13 is making several points about the skills they value in their RxP, all of which are medical. The client praises their RxP's competence with psychiatric diagnosis and medication management, but also draws a comparison between this provider's aptitudes and those of past healthcare providers, to emphasize the RxP's superior competence at these medical tasks. Though it is not evident from the open-ended comments, information provided by the client in answer to the close-ended questions explain this situation underlying these comments in more detail. The misdiagnosis and mis-medication Participant 13 refers to above came from a PCP, but the client's social worker had been in agreeance with both; it was a separate counselor provided through a free staff service who suggested that Participant 13 might not be receiving treatment for the correct diagnosis. However, as per the nature of this service, the counselor had to refer the client to another PMHP for actual diagnosis and follow-up. The client then told their PCP about the alternate diagnosis the counselor had suggested, but this led the PCP to say they felt unable to treat the issue any longer. The social work practice where the client had been seen then closed down, and so the client ended up with their RxP, who promptly assessed them, decided the prior diagnosis and medication was indeed wrong, and corrected both. Thus, in this case, when Participant 13 praises the RxP's diagnostic and prescribing

aptitudes comparatively, it is intended to reference a whole host of other professionals involved in the provision and management of mental health care.

This view that one's RxP was not just qualified, but competent enough to correct another MHP's diagnosis and treatment was expressed in the commentary of another client, Participant 19. Earlier in the survey, in response to Question #18, Participant 19 chose a pre-printed option answer as their reason for switching from their old MHP to the RxP they were seeing now, stating it was because "I didn't like my old provider." However, they also explained to the researcher that the reason they did not like their old provider was that this "previous provider set my pills too high" and that upon changing to their RxP, this issue concern had been addressed. For this reason, Participant 19 much preferred their RxP, credited them with improving their mental health care, and also described them as "awesome, patient, and compassionate" in comment written elsewhere (see Table 15).

Interestingly, the provider whom Participant 19 felt had over-medicated them had, like Participant 13's prescriber, also been a PCP. This is a fascinating commonality, between a client prizing an RxP's skill with medication management in specific comparison to a PCP's, since the vast majority of mental health prescribing in the U.S. are written by the latter provider type (Abed Faghri, Boisvert, & Faghri, 2010; Lavoie & Fleet, 2002). On the one hand, due to critical shortages of psychiatrists, and the fact that as the acronym "PCP" suggests, the family doctor is often the front line for treating mental health issues, that primary care providers (PCPs) are often put in the position of serving as a prescribing mental health professional (PMHP). However, on the other hand, most programs in general, family, and primary care medicine involve very few hours of training specific to psychotropic prescribing (Merrick, 2007; Lavoie & Fleet, 2002), meaning they are not really specialized in mental health care.

The two other comments in

Table 11 (those from Participants 11 and 24) serve to further show the value clients place on a MHP's medication management skills. Participant 24 succinctly but forthrightly points to the importance they place on medication management as a provider skill, given that the statement in

Table 11 represents the entirety of Participant 24's their answer to the question of "is there anything particularly good about your care?" While much that would be needed to further contextualize and interpret this statement is left unsaid, it could refer to a prior provider who was not so good at meeting the client's medication needs, or it might refer to the RXP's aptitude at helping the patient only with psychiatric medication. However, in care from psychiatrists, a tendency towards assigning and poorly explaining complex psychotropic medication regimens has been fingered as a cause for low medication adherence among clients with SMI (Wilder et al., 2010), so the client here may have also been referencing appreciation for a simplified cocktail, or a well-explained one, or any combination between these scenarios. In any case, this individual thought it worth the effort to write in for this comment, which at least attests that recognition of this medical skill was important to the MHCSU.

Contrary to Participant 24, there is some context for the short statement from Participant 11 as shown in

Table 11. Though not part of a *comparison* between the medical skills of past and present providers, Participant 11 commented on their RxP’s medication management and prescribing aptitude within a broader pitch for the *convenience* of seeing a single professional with hybrid skills (italics added to denote the statement specific to medication skills):

It is good to see someone who can prescribe, and not three separate people as I was before (a social worker, counselor, and psychiatrist). *This provider knows their medications and is good at cross-managing treatment for different conditions.* I would recommend a hybrid professional like this and that for people looking for a mental health provider, ask questions regarding continuity of care. It’s just better to get everything you need from one person, without the need to repeat your story over and over. It makes it less frustrating.

As shown, though Participant 11’s statement about their RxP’s medication management skills is not meant to compare their skill to the three providers this individual saw previously for the same scope of care, it still serves to highlight the importance of this medical skill to the client’s definition of a “good” mental health provider.

In sum, this comment adds to the conclusions that can be drawn regarding medical skills: firstly, that clients value MHPs who are competent at selecting, dosing, and adjusting psychotropic medications, and secondly, that they consider their RxPs to possess this medical skill. To a lesser extent, this set of comments also suggests that diagnosis may be part of the medical skillset clients value in their RxPs, but more detailed information would be needed to confirm this before it can be definitively included in a definition of “medical skills” derived from this data.

However, in referencing that an RxP can supplant the need to see several different types of mental health professionals, Participant 24’s comment also points to another interpretation of the data, which is that many—if not most—clients’ comments focused on a provider’s non-

medical skills. An array of other client commentary suggests that MHCSUs, at least those who have received care from RxPs, highly value a PMHP's empathic repertoire—i.e., their ability to foster an emotional environment that the client perceives to be critically related to their mental health care treatment and outcomes. Comments related to a provider's non-medical skills are discussed next.

Theme 2: Empathically Skilled Care

Of relevance to transitioning from a discussion of MHCSU comments about “medical skills” to that of “empathic skills” and the making of a “good mental health professional” is to note that in this study, most (n=26) clients were indeed receiving medication for their mental health needs. Moreover, only one participant who was not receiving psychotropic medication from their RxP—Participant 6—provided open-ended comments, and this comment was a non-specific endorsement of their care, and thus it is included only under the theme “Generic Praise or Endorsements” (below).

This means that in the following analysis of comments on “empathic skills,” most clients were that follows, even though most clients do not reference medical and empathic skills simultaneously, the medical skills were relevant to their care, but they nonetheless chose to focus their comments on a different category of provider abilities. The relevance of this service user distinction between skillsets will become clearer and the details of the “empathic skillset” are expounded.

Whereas the medical skillset, from the perspective of MHCSUs, included diagnosis and medication management (drug selection, prescribing ability, and dosing), clients also commented on a wide range of attributes that can best be categorized as emotional aptitudes. Specifically, participants remarked on being made to feel cared for, listened to, safe, and hopeful, while not

feeling judged by their RxPs, and in several cases, tied these conditions to their treatment outcomes.

This emphasis on empathic skills, and especially these particular aptitudes, is highly significant in the context of comments about care from RxPs. This is because the empathic skills that clients specified in their comments (shown in Table 12 and Table 13) are not merely interpersonal skills desirable in a healthcare provider, but rather, clearly linked to interdisciplinary training. These two findings—(1) that an empathic skillset is apparent to and seen by the clients of RxPs as a significant asset to their practice, and (2) that these empathic skills are clearly derived from RxPs’ training in psychology—are more important at this incipient stage of research into prescribing psychology than which particular schools of psychotherapy these skills appear to reflect. Nonetheless, those in Table 12 are closely aligned with the core tenets of Rogerian psychology, a school of counseling practice also known as person-centered therapy (Noel, 2018).

Table 12: Comments About Rogerian Empathic Skills

Non-Judgment & Listening				
Dr.-- is very understanding and I do not feel judgement from them. (Participant 11)	My provider takes time to listen without me feeling that I’m being judged. (Participant 23)	Dr.--- listens before prescribing medication; most doctors that I’ve seen don’t listen and just want to push medication. (Participant 4)	Dr.-- listens and goes from there. They are very thorough. They listen, ask questions, and put things in perspective to help you rationalize it. (Participant 10)	I feel like Dr.-- takes their time to get to know their patients individually. This provider uses no overall “blanket” statements. (Participant 17)
Caring, Understanding, Compassion, & Patience				

Dr.-- is very caring. (Participant 18)	I'm very grateful to have a kind and understanding psychiatrist to help me cope with my mental health. (Participant 25)	[Dr. – is] amazing, patient, compassionate. (Participant 21)	Sometimes because Dr.- - is so caring, they go over into other patients' appointment times. This is something that could be improved a little bit. (Participant 17)	Dr.-- has always been a very caring and high-quality provider. (Participant 22)
Openness		Comfort & Safety		Respect
This is the first time I've ever seen anybody for mental health and Dr.- - has made it unbelievably easy to open up to them, because I have trouble with that. (Participant 14)		I feel safe and that helps me to progress with my care. (Participant 7)		I really enjoy Dr.-- because they let me make the decisions and they have my back on those decisions, as long as they're healthy decisions. (Participant 14)
I can open up to this provider more than anyone. (Participant 19)		Dr.-- is very helpful (I cry less when I see them than with prior providers) and makes me feel very comfortable. (Participant 11)		

Since its introduction in the 1940s, Rogerian psychology has had a tremendous influence on the practice of psychotherapy (Noel, 2018). When introduced, Rogers' ideas differed from prevailing approaches and theories in its premise that, rather than being "inherently flawed, with problematic behaviors and thoughts that require treatment, person-centered therapy identifies that each person has the capacity and desire for personal growth and change" (Noel, 2018, no page number). As a result, many of its key principles have remained salient to psychotherapy practice, even as these fields have continued to evolve. Rogers' suggested three core tenets to person-centered therapy have received the most recognition and application: therapist congruence (genuineness); unconditional positive regard and acceptance; and accurate empathic understanding (Pierce, 2016). It is these latter two tenets, accurate

empathic understanding and unconditional positive regard, that are most evident in client statements about their care from RxPs.

For instance, the many comments in Table 12 about feeling “listened to” and “not judged” correlate with Rogers’ concept of unconditional positive regard (UPR).

Operationalized definitions of UPR vary (Farber & Doolin, 2011), and colloquially, UPR is often misunderstood to mean that a therapist must be nice to, like, or condone the actions and feelings of a patient (Joseph, 2012). However, at its most basic, UPR refers simply to the stipulation that a therapist must accept a client—and convey this to them—“as they are,” without condition, based on the underlying principle that only when this happens will the client be able to develop self-regard and work towards positive personal growth (Iberg, 2001; McLeod, 2014; Joseph, 2012). Thus, the client statements about judgement and listening suggest they are perceiving a provider’s effort to convey UPR.

Moreover, UPR regard has always been closely linked with respecting a client’s autonomy and right to self-determination (Bozarth, 2013, Joseph, 2012). Therefore, when Participant 14 states “I really enjoy Dr.-- because they let me make the decisions and they have my back on those decisions, as long as they’re healthy decisions” this is also suggestive of person-centered psychotherapeutic techniques.

Creating a sense of UPR and this environment in which to develop self-regard is closely tied to a therapist’s ability to convey a caring, safe environment, and empathic understanding—that they understand a patient’s subjective experience (Pierce, 2016). Accordingly, then, it is clear how the other comments in Table 13—those in which a client

describes feeling “understood,” “cared for,” “safe,” “comfortable,” and abled to be “open” with their RxP also relate to and seem indicative of a skillset drawn from training in psychotherapy.

As with the comments about medical aptitudes, not only do clients acknowledge these empathic skills within their statements, but they do so while ascribing them to their RxPs and linking them to “positive” aspects of their care. This is true even of one comment offered as constructive criticism. Participant 17 was the only person to offer an answer in response to the question of whether there was anything about their care that could be improved, and it too framed the provider’s sense of “caring” as something “positive,” even if it led to another issue. Participant 17 noted that, “Sometimes because Dr.-- is so caring, they go over into other patients' appointment times. This is something that could be improved a little bit.” This is a constructive comment, written in the client’s own words, so it is interesting that the MHCSU attributes the RxP’s tendency to run beyond a scheduled appointment time to their sense of “caring.”

A final set of comments, not included in Table 12, also fit with a person-centered, non-deterministic approach to mental health care, but may not stem so directly from Rogers’ work. Three other comments, shown in Table 13, implicitly (Participant 25) or overtly (Participants 20 and 22) credit the client’s RxP with saving their life. In doing so, the three comments point to another empathic skill, which is the ability to instill hopefulness regarding a prognosis, even if the specifics of how this happened are not exactly clear from the comments.

Table 13: Conveying Hopefulness and Recovery as Empathic Skills

Conveying Hopefulness

<p>Dr.-- has changed my life so positively. They mean the world to me. I came for their services without a prayer or willingness to live any longer. Because of Dr.-- tomorrow's my goal, today is my focus, and my past is a stepping stone. (Participant 20)</p>	<p>Dr.--- saved my life. I have no doubt that if I had not come into their care, I would have eventually ended my life. (Participant 22)</p>	<p>I'm humble and grateful for programs that help us cope with our health. I'm fortunate to have a doctor like --- to care for my mental health. Thanks to programs like this one, many of us are still alive. Thank you for this opportunity to talk about my provider. (Participant 25)</p>	<p>[Is there anything that could be improved?] Just me, and we're working on it :) (Participant 20)</p>
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Though Rogers' theory does imply hopefulness because it assumes an inherent capacity and desire for growth and change (Piece, 2016), and in fact this non-deterministic view of behavior is what make it unique in its day (Iberg, 2001), hopefulness has been more explicitly incorporated as a core tenet of "recovery" oriented models of illness (Frost et al., 2017). Recovery models have recently started to garner significant attention in mental health care, in part because like Rogers' theory at its introduction, they upend many of the negative and inhibitive implications of older models of psychiatric illness and treatment, in favor of a more person-centered approach (Jacobs, 2017; Frost et al., 2017).

To explain in brief, the “recovery” model offers a counternarrative of sorts to other models of illness and treatment prevalent in healthcare, and this counternarrative is particularly salient to mental illness. On the one hand, traditional models of medicine have been focused on the cause-effect-cure cycle (Deacon, 2013; Wade & Hallington, 2004), which does not fit with the lived experiences of people—or the families of people—who have illnesses requiring chronic treatment (Jacobs, 2017; Deacon, 2013).

These older models convey the expectation that one should be able to take medicine for a while and then stop once symptoms---and presumably the illness causing them---abate (Deacon, 2013; Wade & Hallington, 2004). Certain SMI, such as bipolar or schizophrenia, do not fall into this “curable” category, and to think otherwise can be very problematic. However, erroneous patient beliefs that their condition is cured is in fact widely cited by psychiatrists for why medication treatment adherence for these conditions is so low (Bellack et al., 2009; Wilder et al., 2010). The inability to “cure” various mental illnesses, or rather, the idea that these conditions are “persistent,” has also been associated with stigma about MHCSUs (Sickel, Seacat, & Nabors, 2014; Barnes, 2004). On the other hand, the “chronic illness” metaphor can be problematic, because patients in the throes of a mental illness may not find the idea that it is “manageable” with diligence but ultimately intractable to be a very inspiring idea, or conducive to accepting a treatment that comes with severe negative side effects, and this imbalanced payoff is another widely cited reason for psychiatric treatment non-adherence (Wilder et al., 2010).

The recovery model ultimately takes a more middle ground, hope-centered approach to mental illness (or addiction), that positively reframes many of the demotivating aspects of the chronic illness management model into a narrative around meeting changing needs and

adjusting to underlying processes (Frost et al., 2017). As a result of being more hopeful and client-centered, rather than medical-instructional in its emphases, the model has been shown to help psychiatric patients achieve better long-term clinical outcomes (Frost et al., 2017). However, because it is also more structurally holistic than medical models, focusing on meeting client needs through more outlets than just the doctor's office (Frost et al., 2017). Thus it has mainly been promoted for integrated care settings and public health projects that target many levels of care simultaneously (SAMSHA, 2010; Frost et al., 2017), and has not received much attention in terms of doctor-patient interactions as yet.

Therefore, this study may provide preliminary evidence of a provider type well-suited to drawing on the recovery model in one-on-one client-provider mental health care interactions, particularly when the open-ended comments above are considered alongside the data on the impressive scope of other areas of life with which RxPs assist their clients. If creating a sense of hope leads to greater client satisfaction with their mental health care, and it seems from the present analysis of open-ended comments that it does, this may be another reason for its association with better treatment outcomes. Regardless of the reason, however, these three comments are further evidence that clients perceive their RxPs to use of a range of empathic skills, and that these empathic skills are key to how MHCSUs qualify the “quality” of PMHPS.

Summary of the Empathic Skills Theme

Though this analysis uses the recovery model and Rogers' principles of UPR and empathic understanding to discuss the comments shown in Table 12 and Table 13, it should be reiterated that the theme these data support is not intended to be specific to any particular

psychotherapeutic modality or treatment model. Rather, the theme that emerged from the data was simply that clients conveyed appreciation for a wide range of empathic skills their RxPs displayed within their practice. These skills clearly differ from the medical skills emphasized in the prior theme, and in most clinical training for psychiatry (Merrick, 2007). Moreover, the empathic skills mentioned—and lauded—by clients in their comments are inherently person-centered in a way that sets them far apart from psychiatric practice as typified in the literature. On the one hand literature investigating provider resistance to SDM in mental health care has documented psychiatrists' concerns that their patients are not competent enough to make wise decisions for themselves about their treatment (Wilder et al., 2010; Shepherd, Shorthouse, & Gaske, 2014), and some studies have even documented psychiatrists articulating the stance that it is their professional duty to manipulate patient's into the provider's treatment choice (Seale et al., 2006). In contrast, the empathic skills mentioned here suggest the primacy given to a patient-centered, self-determinist approach to psychiatric treatment, as delivered by the RxPs these clients were seeing. As the comments indicate, clients were attuned to these dynamics and very appreciative of them, linking them to their own definitions of skills that make for a good prescribing mental health professional.

A third theme, “accessibility through accommodation,” also draws from provider behaviors on which clients positively remarked. However, these behaviors are not skills in the same way as the aforementioned “medical” and “empathic” themes, and thus this topic is discussed below.

Theme 3: Accessibility Through Accommodation

Several clients noted their appreciation for their provider’s willingness to accommodate scheduling changes, preferred modes of contact (text or calls), and their availability for unscheduled emergencies. This data is presented in Table 14. While no one specifically compared the availability of their current RxP-type provider to issues they had encountered with previous MHPs, the knowledge that they could contact their provider as needed and that they were free to change their appointment schedule when necessary was clearly important to clients.

Table 14: Responses Regarding Scheduling Needs

Comments about Scheduling Flexibility
[My provider is] available in urgent situations. (Participant 24)
I can all day or night if something important comes up. I can call any time as needed for my kids. (Participant 15)
I like the scheduling verification and accommodation this provider offers. This provider is very available and approachable as needed. (Participant 13)
This provider is accommodating with cancellations or rescheduling appointments and you can text or call to do so. (Participant 10)
If a lot of people need a psychiatrist, call this provider, it is worth the wait list. (Participant 11)

These comments comprise a theme entitled “creating accessible care through accommodation.” This theme draws its name from a public health conceptualization of scheduling flexibility as accommodation that facilitates access to care. This will be explained henceforth.

In public health, which grounds health and related interventions in a socio-environmental context that does not isolate encounters with medical providers from the steps

necessary to get to that point of care (nor those that must take place afterwards for the encounter to effect health outcomes) (UNICEF, 2018; Poux, 2018), “access” to care is a simultaneously fundamental and broad concept with far-reaching significance. Access to healthcare can be operationally defined succinctly, as the ability to realize care that one seeks; however, the implications are endless, since this definition implies a host of factors, from self-motivation, to the built environment, to social stigma, to a lack of desirable services, to the cost of care, and countless more, that moderate access (Levesque, Harris, & Russell, 2013). Levesque, Harris, and Russell (2013) have arranged these innumerable contingencies into five “dimensions” of accessibility and five concordant abilities that interact on a population basis to generate (or create barriers to) access. These dimensions are 1) Approachability; 2) Acceptability; 3) Availability and accommodation; 4) Affordability; 5) Appropriateness.

While “access” is such a broad and multidimensional concept that many of the comments reviewed in this section could be mapped to this model, the above comments match to one particular dimension that may often be misconstrued as a matter of convenience rather than one of access, and that is: the dimension of “availability and accommodation.” In the Levesque, Harris, and Russell (2013) model, care that is “available and accommodating” is accessible to clients both physically and temporally; i.e., available and accommodating refers to the fact that health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner. Physical shortages of PMHPs and the tendency of such services to be congregated only in select locations within NM (HRSA, 2019) have been discussed at length elsewhere in this paper, but a less emphasized issue that is addressed in client comments representing this theme is temporal accessibility. Given these shortages, one might expect extant providers to have relatively inflexible scheduling policies,

due to imbalances in supply and demand. In other words, even if the healthcare services one desires are available nearby, wait times and scheduling flexibility can pose a temporal barrier to access. For instance, any number of personal circumstances may necessitate rescheduling a doctor's appointment, but if this is not possible due to provider inflexibility or wait times, clients may simply not return to care, often with negative outcomes (Filippidou, Lingwood, & Mirza, 2014; Miller & Ambrose, 2019). On the other hand, urgent situations may lead a client to desire an immediate appointment, and if this is not possible, they may be forced into a tertiary treatment venue, such as an emergency room, or forgo care, with potentially dire consequences. These things are as true in mental as in physical health and in both contexts, emergency room care is associated with a significantly higher financial burden and lower likelihood of coordinated post-discharge care, which can lead to poor health outcomes and a cycle of seeking care only at a crisis point (NAMI, 2016).

Thus, it was perhaps not surprising that several clients in this study made comments about the temporal accessibility of mental health care services, but it was a bit unexpected that these comments were generally in consensus that their respective RxPs were accommodating in this regard. In other words, this theme is supported by client comments illustrating that their respective RxPs were flexible in terms of needs for changes to regularly-scheduled and unexpected urgent care. Although one client, Participant 11, alludes to a waitlist, it was not clear whether this was meant theoretically in the context of the rest of their statement, which is a general endorsement of RxPs made separate from, but intended by the client to reference other comments they had made (previously discussed) about the convenience of seeing one MHP who could meet all their needs. Thus, it is included in Table 14, but does not seem to

undermine the consensus of other participants' comments that their provider is accessible in part because they are accommodating with scheduling.

As a theme, this one also suggests qualities clients appreciate in their RxPs, though being accommodating of scheduling needs is not inherently related to practitioner skills, as were the first two themes. However, these comments are further indications of patient satisfaction with their RxP care experiences, and the last theme, "Generic Praise or Endorsements of a Specific RxP" conveys this sentiment literally.

Theme 4: Generic Praise or Endorsements

In keeping with a sematic approach to coding and analysis, in which the goal is to provide an overview of the complete dataset taken at face value (Saldaña, 2016), some comments have not yet been discussed. These happen to share a theme in that they all represent positive, very general client "assessments" of a particular provider. These statements were initially coded as "sentiments," but since they were unanimously positive, the theme was entitled using the terms "endorsements" and "praise." Table 15 lists these statements in their entirety (none were abbreviated or separated from context that might have provided additional understanding).

Table 15: Comments Indicating Generic Praise

Comments Indicating Generic Praise or Endorsements of a Specific RxP
I highly recommend this provider, especially when it comes to kids. (Participant 15)
Dr.-- is really awesome. (Participant 19)

I would recommend this provider to others. (Participant 10)

Dr.--- is great. (Participant 4)

This provider should get an award for [their] great care. (Participant 11)

As can be seen in Table 14, many of these endorsements were very brief, or, while containing palpable enthusiasm, very generic as to the reasons why; since most come from clients who did not make more specific comments, it is difficult to go much farther in interpreting this subset of the qualitative data, other than to say it indicates that clients are very happy with their RxPs.

Qualitative Conclusions, Connections, and Assertions

To summarize and quantify what has been presented above, from a sample of 30 clients, 19 participants made comments falling across four themes. In their respective thematic contexts, these comments were all geared towards positively noting something about the aptitudes of the client's RxP, and were distributed across the following broad categories: four different individuals made comments about "medical skills"; 15 different individuals remarked on their RxP's "empathic skills"; five different individuals made comments regarding their provider's scheduling flexibility; and five different individuals made comments praising their provider that could not be further classified due to their non-descript nature. This breakdown is important for highlighting that the bulk of participants who offered comments did so with regards to their providers' empathic competencies.

The present dataset is insufficient to support the development of theory; however, it does lend itself to some assertions. One thing that is evident from this qualitative analysis of

clients' comments is that the MHCSUs in this study qualify the care they receive from their RxPs as "high" quality, but do so on the basis of a holistic skillset, and moreover, one that is heavily grounded in the emotional setting the provider creates. As explained by the above discussion of literature, the skills--and likely, inclination—for attending to these dynamics of mental health care derive from RxPs' training in psychology rather than biomedicine. This is clear evidence that RxPs' hybrid skillset influences the care they deliver—for the positive, in the minds of their clients. This dual skillset, being neither purely medical nor purely psychological, seems to appeal to some patients by making them feel their care is being individualized (e.g. Participant 17's comment that "this provider uses no 'blanket' statements"). For many others, the most significant effect seems to be their RxP's ability to create an environment in which the client feels truly able, and inclined, to pursue self-improvement in alliance with their MHP. There were a range of factors involved in conveying this kind of environment to different clients, including non-judgement and openness; respect for autonomy; listening; safety; and a sense of hopeful prognosis. Since only four different clients spoke specifically about medical skills, and Participants 11 and 19 were the only two who made comments about both medical skills and empathic skills, this leaves 13 people (out of the 19 total who made open-ended comments) that fall into this category of qualifying their PMHP as laudable on the basis of their empathic skillset alone, though it should be remembered that all of these people were also receiving psychotropic medication from them. The weaving of these threads together—all comments about empathic skills being positive (i.e., none discussing RxP deficits in this regard, but some discussing comparative deficits in other MHPs); all being from clients receiving psychotropic medication; most being from clients whose only mention of skills was in reference to empathic ones—strong strongly

suggests that clients are amenable to mental health care, even that which involves treatment with psychotropic medication, when it is fostered through a psychotherapeutic relationship with a single provider wielding both medical and empathic skillsets. If further qualitative research were to more thoroughly substantiate this assertion, the implications for prescribing psychology, and public health more generally, could be profound.

This preliminary evidence suggests that clients view their RxPs as competent, while also suggesting some underlying reasons for why these patient perceptions might translate into positive long-term mental health treatment outcomes. At the same time, these reasons—hybrid skills—suggest that it may not be a matter of whether RxPs are as qualified to achieve these desirable outcomes as other mental health care providers, but whether *other* providers, who lack training in psychology, are as qualified as RxPs to do so. Certainly, it is feasible enough to get PMHPs to be more accommodating with their scheduling policies, and align with that theme reported herein; it is not so feasible to ensure that other PMHPs have enough training in psychology that it grounds their patient interactions. Thus, to the extent that this qualitative analysis points to new strategies for achieving positive treatment outcomes in an area of medicine that reports patient adherence rates as low as 50% (Bellack et al., 2009), these results are significant and deserve follow-up in future research.

RESULTS PART III: A BRIEF IMPLEMENTATION ASSESSMENT

Process Evaluation

Implementation assessment—also referred to as process evaluation—is a form of review normally undertaken in the context of health programs, although it can also be adapted and useful in the context of research projects (Eldredge et al., 2016; Issel & Wells, 2017). While implementation assessment can look at the extent to which various stages of a project reached their intended audience, maintained their timelines, engaged or were supported by target stakeholders, and so on, it can also represent more qualitative and experiential evaluations of the process by which various project goals were pursued, the hurdles encountered, and what might be done differently upon reflection. Implementation assessment is therefore useful even in research projects and regardless of when it occurs, because it is intended to improve future outcomes (Eldredge et al., 2016; Issel & Wells, 2017). Although when it is conducted *ex post facto*, there is no opportunity to apply the evaluation results to improving the current study and so some implementation findings may overlap with study limitations, they retain value to the extent they are directed towards improving future projects.

Indeed, given that this is one of very few studies to evaluate mental health service users' satisfaction with their care, and likewise, to investigate the care provided by RxPs, it is hoped that future research will build on its foci as well as its strategies. Therefore, as a final section of “results,” it is worth discussing the process of implementing the study and what can be learned from the experience in order to potentially improve future research. Many of the limitations highlighted throughout the previous results sections nonetheless point to implementation considerations that will be useful to similar research.

Implementation Analysis

Lessons learned from implementation of each phase of the research project—the provider survey, client survey, and client interview—are presented below.

Provider survey implementation. Undoubtedly, a more streamlined and active approach to recruiting for the provider survey would likely elicit better results. This includes a better participation and completion rate, as well as higher caliber data. Administering the survey at an event exclusively for the target audience shortens and simplifies the data collection process for researchers and participants alike. At the same time, administering the survey at a single point in time may help reduce the likelihood of duplicate responses, although this is not suspected to have been issue in the current study. Administering the provider survey in-person allowed the researcher to answer any questions the participants had, and thereby also elicited more complete responses (fewer missed or skipped questions), resulting in higher quality data.

This is almost certainly also tied to the instrument itself, which as discussed in earlier sections should be somewhat redesigned if utilized again. However, as indicated by the two different recruitment methods employed during the provider survey phase of this study, contextual factors can make delimited active methods more advantageous than passive recruitment approaches deployed over a longer period of time. There are related takeaways to be had from analyzing the implementation of the client survey and client interview phases.

Client survey implementation. Chief among the findings from implementing the client survey is the impact of different strategies for recruitment and completion on overall response rates and detail. Initially, the client survey phase was implemented reliant on passive recruitment measures delegated to 15 different providers. At the event where providers were

recruited in-person for the first phase of the project, those who were interested in assisting with the second phase were provided with advertising posters, paper client surveys with pre-addressed and postage paid return envelopes, and cards with the link to the online version. It was explained that these materials should be availed to clients for them to take if they were interested. However, the response rate to this form of recruitment was extremely low and also, from a limited geographic scope. This phase of the project also coincided with the escalating client and provider impact of the statewide closure of mental health care practices. Thus, when inquiries directed to the full list of providers who had signed up to distribute the client survey went unanswered by most, this second phase of the project was redesigned around the participation and anecdotal feedback of just those few who did respond. This resulted in the revised recruitment plan in which the researcher administered the client survey verbally and on-site at only two practices within the state.

Implemented in this way, clients were extremely eager to participate in this survey phase; of approximately 25 clients approached to participate in this format, only about two declined and approximately 20 requested the researcher read them the survey. This supports the providers' suggestions, based on anecdotal evidence, that insufficient reading skills may have been a barrier to participation in the survey as originally (passively) designed. However, low rates of home internet access throughout New Mexico (Ryan, 2018) may also have undermined the utility of offering the survey digitally. In other words, offering the survey online was probably a waste of time in the present study, not only because literacy issues likely precluded this alternate form of self-administration in the same way it did completion of the paper survey, but because this is not a widely accessible modality within the region where the study took place. Although the survey could be completed through a cellular phone with

internet access, which is more common within the region, it was not designed specifically for this format and would not be ideal for it, either. Thus, another implementation finding is that although internet access is something assumed to be available to most people in the United States, this is not always the case, and as such it is worth considering if and how digitizing a survey is truly the best way of increasing access to it within a specific context. In the present study, the best way to increase access to it happened to be through verbal, in-person administration.

In addition, in-person administration of the survey yielded some additional boons. Once engaged in the survey process, clients shared great detail in response to the questions, providing far more data than likely would have been captured had the survey been wholly self-administered. Furthermore, clients from both the self-administered and researcher-administered survey designs seemed to appreciate being asked to discuss their experience with mental health care service providers. This was evident in both the detail and thoroughness of responses provided to open-ended questions, and the fact that some of them implicitly or explicitly stated as much. In addition to specific comments recorded as survey responses, several clients who completed the instrument with the researcher's assistance thanked the researcher profusely for the opportunity to discuss their provider. In sum, in-person administration of the instrument may have given the activity an added sense of sincerity regarding what clients had to say, and simultaneously allowed for the possibility of collecting additional data not considered in the original survey design.

This implementation experience, combined with the data that was obtained from the survey, supports the assertion that mental health care clients are capable of and very interested in providing meaningful insights about their care—as much so as any other type of service

user. Consequently, more opportunities for clients to rate their satisfaction and experiences with mental health care should be made available. However, future endeavors of this kind should strive to pre-emptively plan around the possibility of literacy issues as a barrier to recruitment. Furthermore, in-person administration of the instrument is recommended, not only as a means of accommodating literacy issues as a potential barrier to participation, but also for its possible recruitment and data collection benefits.

Client interview implementation. Lastly, the failed implementation of the client interview phase suggests some broad lessons to be learned. The client interview phase was designed to take place after the conclusion of the survey phase, as clients indicated their interest in participating in the interview through the last page of the survey, and because preliminary results from survey would be used to further develop interview questions. Interviews were also anticipated to take place by phone, though eventually an in-person option was also offered. Only one interview, conducted by phone, was ultimately obtained, compared to a goal of three, minimum. Retrospectively, then, implementation might have been more successful had both these strategies been revised to some extent.

Firstly, recruitment for the client interviews would likely have been more successful had it happened very shortly after the survey was completed. This would have improved retention of interest in participating in the third phase of the project. Secondly, due to a variety of factors, it would likely have worked better to initially offer in-person interviews instead of by phone. For instance, although most people have cellular phones, geography and financial strains alike can lead to service interruptions and number changes, causing some prospective participants to be lost at follow-up. Also, shifts in how we use phones to communicate make them less desirable for spoken conversations and mainly tools for text-based communication;

as one client indicated, getting a phone call from an unrecognized number—or at all—can trigger anxiety in some people, and thus text messaging is the preferred use for cell phones. However, text message is not an ideal format for semi-structured interviews, and thus face-to-face would have been preferable. Furthermore, in-person interviews could build on the rapport and face recognition developed between clients and the researcher during the course of verbally administered surveys, which may have improved recruitment. Though face-to-face interviews conducted via online software such as Zoom and Skype are also theoretical options, they would not have worked for the present context, given the aforementioned limitations to internet access.

Thus, although it would preclude refinement of the interview questions or necessitate a prior pilot study to do so, offering more immediate post-survey interviews that take place face-to-face would likely elicit a much higher response rate than was obtained in the present study. Future studies with similar designs for client surveys should keep in mind these needs to implement and coordinate subsequent phases of research in order to capitalize on client interest in a manner that is copasetic to their communication preferences and to thereby improve what is essentially retention. In deciding which strategies are best, future research should therefore consider approaches used in research retention, as well as contextual factors that affect communication preference and feasibility.

CHAPTER 5: ANSWERING THE RESEARCH QUESTIONS

Introduction

The research questions that guided this study were as follows:

1. What are some details of New Mexico prescribing psychologists' educational backgrounds and self-perceived communication skills and behaviors?
2. What are the varied experiences of clients of prescribing psychologists in New Mexico?
 - a. What are the experiences of clients of prescribing psychologists in New Mexico with regard to provider-mediated health literacy and shared decision-making practices?
3. How do clients of prescribing psychologists feel about the care they received from these professionals?
4. How might the experiences of New Mexico prescribing psychologists' clients reflect the training undertaken, skills, and/or behaviors espoused by these providers?
5. What is the utility of using the NHS survey to measure client satisfaction among the clients of New Mexico prescribing psychologists?

Based on the results of the study, presented in the previous chapter, each of these questions is addressed in turn in the following subsections. In discussing the data obtained relative to answering these questions, it is worthwhile to keep in mind that this study focuses on an area of study wherein multiple lacunae persist. As established in Chapter 1, very little research has sought to gauge service users' satisfaction and perspectives on mental health care they receive; meanwhile, with the exception of a military evaluation report conducted on an

RxP training project in the 1980s (VECTOR, 1996), there has been no actual research done on the field of prescribing psychology. Thus, although the data gathered in the course of this project was ultimately less than hoped for, it is, a starting place in regards to both of these gaps in extant knowledge. Therefore, even where the conclusion below must be that the data is insufficient for answering all or part of a research question, it is nonetheless beneficial to discuss the results as the most nascent of findings.

Research Question 1: What are some details of New Mexico prescribing psychologists' educational backgrounds and self-perceived communication skills and behaviors?

The provider survey portion of the study was designed to answer research question #1. The first part of the provider survey focused on the academic and training backgrounds of RxPs working in New Mexico. Another portion asked providers about their information-sharing practices as a means of assessing what strategies they might use with clients that promote health literacy. The final section asked providers whether they were familiar with the concept of SDM and if so, where they remembered learning about it and if they felt prepared to implement it with their clientele. In total, 12 RxPs working in New Mexico completed the instrument. Results according to these three sections are discussed henceforth in answer to research question #1.

Educational Backgrounds

Across all the undergraduate, graduate, and doctoral levels of formal education, degrees earned by providers in this study were predominantly in the field of psychology. While this result was anticipated at the uppermost academic level, given that a doctorate in a psychology

or counseling is needed to pursue additional master's degree and testing for prescriptive authority in New Mexico, there was surprisingly little variation in undergraduate majors. Only three providers reported holding a specific undergraduate degree in a discipline other than psychology or counseling, and in two cases, they also held (4-year) baccalaureate degrees in psychology. There was only one individual in the sample completely without an undergraduate (baccalaureate or associate) degree in psychology. All but one licensure reported by the provider participants also pertained to psychology or counseling.

An undergraduate degree in the field is not necessarily required for admittance into graduate programs in psychology (Michaliski, Cope, & Fowler, 2016; Michaliski & Fowler, 2016), so this concentration of rather homogenous academic trajectories could be related to any number of factors that the provider survey was not designed to capture. It could also be the result of design issues with the provider survey. There is some evidence that these issues indeed undermined the level of detail gathered in the present study as to RxPs' academic backgrounds. Given that many people did not report holding a master's degree, or if they did, neglected to specify what subject it was in, any future research on the academic backgrounds RxPs should seek to do so via an instrument that better accounts for a broader range of academic possibilities, such as *en passant* graduate degrees, shifts in program designations and accreditation (such as the conversion of a certificate program into a degree, or the shift of a program from one university college to another).

It is also possible that the sample of providers reported in this study is not representative of RxPs, either in New Mexico or in the field overall. The sample obtained was very small (n=12), when it was estimated that at the time the provider portion of the study

commenced, 45 RxPs were actively licensed within the state. Likewise, this study excluded RxPs who did not work in New Mexico, thus leaving out those practicing in the federal services or Louisiana at the time. This may actually explain the low participation rate, as it was explained by some participants at the event where live provider recruitment took place that many of the individuals who maintain RxP licensure in New Mexico actually do so in order to practice with federal services in other states; for example, several RxPs were excluded from this study because they were licensed in New Mexico but reported working for Indian Health Services (IHS) in the Dakotas. Additional research should not only employ more advanced data collection tools for gathering details on the academic history of RxPs, but expand this inquiry to include more of these providers, especially as other states (i.e., Iowa, Illinois, and Idaho) have passed RxP legislation since this study commenced.

Practices to Promote Health Literacy

To assess perceived communication skills, this study asked RxPs in New Mexico to identify strategies they used with their mental health care service users (MHCSU) to communicate (a) information about the client's treatment *options*, and (b) information about the treatments the client would be provided. The premise for doing so was also twofold: firstly, because health literacy is a necessary precursor for truly shared decision-making (Mayo Clinic, 2015); secondly, because while any strategy that communicates health information can conceivably be classified as one meant to foster health literacy, research suggests that some are more effective than others, but that providers often do not use these best practices when attempting to provide medical information to their clients (Schwartzberg, Cowett, VanGeest, & Wolf, 2007). There is also the fact that little research has been done to assess literacy skills, or

provider-mediated health literacy practices specifically among MHCSUs, but what is available suggests that MHPs are prone to the same set of interrelated mistakes as providers in other fields of medicine. These include; (1) provider overestimation of their own knowledge of effective health literacy techniques and tools; (2) inconsistent or rare application of evidence-based best practices for accommodating low health literacy; (3) provider overestimation of clients' literacy skills and prior knowledge on relevant topics; (4) provider misalignment of the information they provide, and the modes by which it is offered, with client needs and skills (Lincoln, Arford, Doran, Guyer, & Hopper, 2015; Mackert, Ball, & Lopez, 2011; Safeer & Keenan, 2005; Schwartzberg, Cowett, VanGeest, & Wolf, 2007). As a result, MHCSUs are unlikely to be provided with the information they need, in a manner that is accessible, for them to be able to make *informed* decisions about their health care (Slade, 2017).

Results from the present study suggest that most of these realities about medical providers and health literacy are also true for RxPs. Most providers in the sample reported using multiple strategies to communicate information to their clients about treatment options *and* treatment plans. The two most commonly reported strategies to do so were verbally and by providing service users with printed, primarily textual materials in English. Most (83.3%, n=10) providers reported using the same strategies for communicating information about treatment options as for communicating about treatment plans. Only one provider indicated that they did not normally offer clients information about their treatment options; all 12 RxPs in the sample, including this individual, indicated that they typically provide clients information on the treatments the MHCSU is to receive from the provider. For providing clients with information about their treatment options as well as treatments to be provided, the

most common strategy that RxPs reported using was to communicate verbally. Second most common in both circumstances was to “direct clients to, or provide them with,” resources in the MHCSUs preferred language. This option was included among the possible answers to this provider survey question because 35% of people in New Mexico speak a language other than English at home (U.S. Census, 2018) and it is likely that many providers do not speak all the same languages as their clients prefer. However, phrasing this option to include either *referrals* to materials *or provision* of materials in a preferred language was a design mistake that made it impossible to determine what exactly providers meant when they selected it. Thus, this popular option had to be excluded from further analyses of provider communication strategies, as this analysis divided the strategies according to whether they were passive, and relied on clients to figure out how to access recommended information, or were active, with RxPs providing clients access to the information via a specific communication modality.

Health communication strategies for client health literacy fall along this active vs. passive continuum, with more active strategies usually showing more efficacy than passive ones (Hironaka & Paasche-Orlow, 2008; Meppelink, van Weert, Haven, & Smit, 2015; Perrenoud, Velonaki, Bodenmann, & Ramelet, 2015). This is due in part because provider-initiated (i.e., active) communication can avoid many problems associated with leaving clients to their own devices: clients do not need to remember or be motivated enough to look for information outside the healthcare setting; the factual reliability of their source is not much of a concern, when information is coming from the healthcare provider; and concerns or unknowns regarding a client’s reading abilities can be circumvented by using simple language, professionally developed decision aids, audiovisual materials, and other established strategies

for health literacy (Roter, 2011). Unfortunately, numerous studies have documented that in practice, verbal communication of health information is not usually effective, due to issues with health care providers' abilities to convey information orally in a manner that is intelligible to laypeople (Roter, 2011; McCarthy et al., 2012; Dawson, Taylor, Williams, Taylor, & Brown, 2014; Richard, Glaser, & Lussier, 2017). Likewise, although providing clients with printed, textual information would technically be an active strategy, it is still susceptible to many of the issues involved in passive methods, since it requires clients to have the ability and inclination to read the materials on their own. Given these various issues, mounting evidence actually points to decision aids—among the least reported strategies in the present study—as a best practice for both health literacy and SDM (Agoritsas et al., 2015; McCaffery et al., 2013; O'Connor et al., 2007; Sudore & Schillinger, 2009).

Decision aids vary in design, but in their most effective forms (O'Connor et al., 2007) are essentially pre-made, but personalizable tools to help doctors walk patients through decision-making about treatment options for a specific health condition or situation, thereby ensuring clients receive the information they need while removing the onus from the doctor to communicate technical information at a level the patient can understand. At the time this study commenced, decision aids had been developed for a variety of contexts, including mental healthcare, but as with many patient-centered practices, adoption into clinical practice, particularly mental health care, was moving slowly (O'Connor et al., 2007).

Indeed, only one RxP in this study reported using decision aids to provide clients with information about their treatment options, and treatments they would receive from the provider. However, the two most commonly reported strategies that could be categorized via

the above-described active-passive dichotomy were in keeping with the literature on provider health literacy practices, but were not ideal. This included providing clients with information verbally (treatment options: n=11; treatment plans: n=12), and providing them with information in printed, primarily textual formats (n=6, for both options and plans). Given that this study indeed found indications that below-average reading and writing skills may pose issues for clients seeing RxPs in New Mexico, this points to avenues for further research. Specifically, future studies should focus on New Mexico and its MHCSU and MHP populations, to more widely promote the use of evidence-based strategies for communicating health information to clients with low literacy, whether through decision aids or other means.

Since this study commenced in 2015, more attention has focused on making decision aids that are practical to implement in clinical practice; emphasizing decision-aids as part of patient-centered healthcare; and emphasizing patient-centered practices as essential to recovery in mental health (Slade, 2017; Agoritsas et al., 2015). However, research on the attitudes of psychiatrists regarding SDM in mental health care remains limited, although at least one recent study suggests they remain adverse to decision aids specifically because they do not feel their patients are competent enough to warrant prioritizing their concerns in decision-making about their treatments (Slade, 2017).

However, this is not to imply that that RxPs in this study are eschewing decision aids, or other health literacy best practices for the same reasons; in fact, since decision aids are products that must be marketed to healthcare providers who will have contexts to use them, low adoption rates of these tools may be due to a lack of awareness on the part of RxPs, or marketer awareness due to their relative obscurity as a profession, rather than anything else.

It is also possible that the health communication strategies reported here may have already changed to include different health literacy techniques; likewise, there is always the possibility that because the sample size obtained in this pilot study was so small, it is not representative of the practices of RxPs in general. Finally, it must be emphasized this data on health RxPs' literacy practices does not function to suggest they are any more or less competent than other healthcare providers in this regard. Promoting health literacy continues to be a challenge for health care providers in all disciplines, meaning that the findings reported here regarding RxPs do not represent a shortcoming specific to their field; in fact, because so few studies have evaluated health literacy or other patient-centered practices in U.S. psychiatric care, there really is nothing to which this dataset can be compared.

Finally, it must be stated that it was the RxPs in this study, albeit only a few from among the 12 who participated in the provider survey, who suggested that client literacy might be inhibiting the success of the second phase of this research project; as will be discussed more in answer to research question #4, this seems to have been an accurate observation, insofar as it was indirectly verified by a major uptick in the client survey response rate following study amendments to ensure reading was not a requirement to participate. This suggests that at least some providers in the present study were aware that a heavy reliance on textual materials would not be the best communication strategy for their clients, and this may be eclipsed within the provider survey data on health literacy practices due to the option to pick multiple response options. However, this information about clients' perceived literacy issues was communicated to the researcher as informal feedback from only a few providers about what might be causing a poor survey response rate, and as such does not represent all RxPs' understanding of their

client base. Thus, while the present study presents some insight into the self-perceived communication practices of New Mexico RxPs, further research will be needed in order to develop a detailed and comprehensive understanding of what these communication behaviors actually entail.

Knowledge, Training, and Attitudes about Shared Decision-Making

When offered a basic definition of SDM, all 12 of the RxPs who completed the provider survey indicated they were familiar with the concept, and all felt that the majority of their clients were able to share as much as they would like in decision-making about their mental healthcare. However, only 10 (83.3%) reported they felt prepared to practice SDM with their clients, and of this subset, only eight (80%) remembered receiving formal training to do so. In terms of where they remembered receiving training to practice SDM with their clients, six of these eight RxPs (75%) reported having done so at multiple educational levels, most commonly during doctoral education and/or professional development training (n=8 for each context; multiple responses allowed per person). Thus, the results of the provider survey show that even if RxPs are not reporting best practices for health literacy, they are familiar with and amenable to using SDM in delivering their mental health care services.

Research Question 2: What are the varied experiences of clients of prescribing psychologists in New Mexico? What are the experiences of clients of prescribing psychologists in New Mexico with regard to provider-mediated health literacy and shared decision-making practices?

While this study chose to focus on SDM in mental health care for a variety of reasons explicated in previous chapters, it also sought to investigate the specific combination of provider-mediated health literacy practices and SDM because of the premise that the two are fundamentally interrelated. In other words, even if the opportunity is provided, clients may not be able to legitimately engage in SDM if they lack the knowledge or literacy skills necessary to obtain information needed to make reasoned choices about their care (Lincoln et al., 2015; Shohet & Renaud, 2006). In one of only a small number of studies assessing literacy skills specifically in MHCSUs, Lincoln et al. (2015) go even further in linking literacy with the ability to fully participate and partake of treatment options in mental health care. In their study, they point out that reading and writing factors into a client's ability to adhere to certain treatment options, whether psychopharmaceutical or psychotherapeutic, as medication regimens and various psychotherapeutic practices require reading skills.

However, the limitations that emerged within this study constrain its contribution to examining provider-mediated health literacy practices. In particular, because the interview phase of the project was revised, along with being unsuccessful at achieving its anticipated scope, data collected from the study is insufficient to provide detailed information on the experience of clients directly related to provider-mediated health literacy. In sum, the data that was gathered on client experiences regarding provider-mediated health literacy practices draws from only one survey question and from one client interview; although responses to the open-ended questions, and additional details offered in answer to close-ended questions provided additional information on a variety of topics, none addressed health information needs or practices. Nevertheless, with these limitations to generalization in mind, the data collected is

henceforth discussed in the context of answering the portion of this research question specific to client experiences of provider-mediated health literacy practices, after which, client experiences with SDM are discussed in order to answer the other part of this research question.

Client Experiences with Provider-Mediated Health Literacy Practices

The client survey contained only one question explicitly regarding the comprehensibility of treatment-related information provided to service users by their RxP (Question #23), which asked service users, “The last time you had a new medication prescribed for your mental health needs, were you given information about it in a way you were able to understand?”. Responses to this question were supposed to be delimited to individuals who had received a new prescription within the prior year, and although more individuals than should have answered it, responses were unanimous. The consentaneous response to this question was “yes, definitely.” This would seem to indicate that clients felt they received sufficiently intelligible information about medication treatments they were to receive. However, within the context of the present study, several factors undermine the utility of this question in attempting to more broadly discuss client experiences with provider-mediated health literacy practices. These factors are the combined force of: (a) the homogeneity of responses to this question; (b) sampling issues specific to this section of the client survey as described in the results chapter; and (c) the small overall size of the client survey sample. Together, these factors preclude a meaningful multifactorial or inferential analysis of responses to this question in relation to other SDM-related elements. That correlations between this one question regarding health literacy and other questions in the client survey cannot be gauged in the present sample is problematic because the wording of the question does not address client application of the

information to SDM. Indeed, an earlier question in the same section of the survey as this health literacy question asks whether clients were involved as much as they'd like to be in decisions about psychotropic medications they were to receive; however, a screening question in between that and the health literacy question skews their relatedness and is further complicated by the fact that more people answered the health literacy question than should have. In sum, this question alone, given the present sample, is insufficient to provide much insight into the overall experiences of clients regarding provider-mediated health literacy.

Client interview. Because only one client interview was obtained, its contribution is also insufficient to facilitate a meaningful answer to this portion of the research question, although it did suggest at least one novel take on client experiences of provider-mediated health literacy practices. As explained previously, based on the results of the client survey, the client interview protocol was adapted to focus more on SDM than on precursor health literacy practices. Nonetheless, as discussed in the context of client survey results regarding peer support, the one interview obtained touched on health literacy practices in a unique way. Specifically, in response to being asked about mechanisms their provider employed to provide clients with information about their treatment options, the interviewee explained a kind of social referral practice in which the provider connected prospective recipients of particular treatments with other patients who had received the same, in order for them to discuss with each other various client perspectives on the particular course of action. It is important to note also that the client did not hesitate in offering this response (which might have suggested she was unsure of how to answer), but immediately saw it as very much connected to the research question about health literacy. From this interview, it seemed that the client's provider might

use this approach for pharmaceutical, psychotherapeutic, and combined treatment recommendations. However, because only one interview was obtained, it is unclear how often the provider used this strategy, and whether it was employed primarily for specific conditions or more generally.

This was an unexpected finding in multiple ways. Firstly, as discussed in the results, it is a form of connecting individuals who share a particular mental health condition with one another, albeit not in the way anticipated by questions in the client survey regarding peer support groups. Additionally, it was an unforeseen client interpretation of provider-mediated practices to promote health literacy, and perhaps, of “health literacy” itself.

Health literacy research continues to evolve, with recent efforts focused on definitions of health literacy that are not only closely linked to decision-making, but that can be operationalized and measured, to facilitate better intervention-related studies (Pleasant & McKinney, 2011). Also, more recently, there has been movement towards specifying that health literacy ought to be “critical,” in the sense that the consumer is discerning as to the reliability and validity of their information sources (Chinn, 2011). While this shift in terminology from “health literacy” to “critical health literacy” does potentially help clarify that the focus is on connecting individuals with objective, scientific, information, even older definitions imply the assumption that the knowledge clients *need* in order to make *informed* decisions is objective, scientific, information.

Yet, there does not appear to a great deal of attention paid as-yet to critically examining definitions of critical health literacy, such as from patient-centered perspectives, or particularly in the context of decision-making in mental health care. Indeed, it had not occurred even to the

researcher to question the assumption that the information involved ought to be scientific, from a scholarly source, until the aforementioned client interview. However, the interviewee's comment suggests patients in this context might differ in opinion from most health experts as to what kind of information is meaningful and what sources are credible to them as they make decisions about their mental health treatments. The researcher now realizes that there may be other ways to look at definitions of "meaningful" health information, which may not yet be articulated in the extant literature, and which were not anticipated in the present study.

However, due to insufficient scope and sample size, the extent to which the answers to either the client survey question or interview can be interpreted to answer the research questions about the experiences of clients of prescribing psychologists in New Mexico with regard to provider-mediated health literacy practices is severely constrained. While the homogeneity of responses to the survey suggest that clients perceive their providers to offer intelligible information about their medications, the single question asking about this is insufficient to draw broader conclusions about health literacy practices. Moreover, while the interview response is an extremely fascinating finding, it is one that demands follow-up research before it can be used to answer this dissertation's research question regarding provider-mediated health literacy practices. This research should gather more detail about how client define, and experience, provider information-sharing practices in the context of their mental health care, and what, if any relationship they perceive between this and SDM in the same context.

Client Experiences Regarding Shared Decision Making with Prescribing Psychologists

Contrary to health literacy, the client survey included several questions related to service user experiences with SDM, and as such, can offer more in the way of answering this research question. Table 16 below is a composite of SDM-related questions and answers from the client survey. If an answer option was not selected by anyone in the current study, it is not included in the table.

Table 16: SDM-Related Client Survey Questions and Their Answers

Question	Yes, definitely	Yes, to some extent
Q5. Did your provider listen carefully to you?	96.7%	3.3%
Q8. Have you agreed with your provider as to what care you will receive?	100.0%	0.0%
Q9. Were you as involved as you wanted to be in discussing what care you would receive?	93.3%	3.3% ¹
Q10. Does this care agreement take your personal circumstances into account?	93.3%	6.7%
Q11. In the last year, have you had a direct conversation with your provider about how your care is working?	100.0%	0.0%
Q12. Were you involved as much as you wanted to be in this conversation [about how your care is going]?	86.7%	13.3%
Q13. Do you feel that decisions about your care are made together by you and your provider?	96.7%	3.3%

Q21. [If you've had medicine prescribed for your mental health needs], were you as involved as you wanted to be in decisions about which medications you would receive?	89.3%	10.7%
Q35. Does your provider understand what is important to you in life?	96.7%	3.7%
Q36. Does your provider help you with what is important to you in life?	96.7%	3.7%

¹ The remaining portion of respondents (3.3%) answered “no but I did not want to be.”

As can be seen from the table, an overwhelming majority of clients ($\geq 86.7\%$) answered in the extreme affirmative for each measure assessing whether they perceived decision-making with their provider to be shared and cooperative to their degree of interest. This is an extremely important finding, as most studies have reported a discrepancy between provider perceptions that they practice SDM, and patients' perceptions that time constraints and a lack of information mean their actual ability to participate in decision-making about their care is far more limited (O'Connor, 2007; Agoritsas et al., 2015). Providers in this study reported a high level of confidence regarding their familiarity with SDM, preparation, and willingness to implement it with their clients, and to the extent that service user responses to the client survey questions in Table 16 speak to the practices of New Mexico RxPs, this assessment seems to be accurate.

However, it is important to note that there are other questions in the client survey that could be construed as related to SDM, such as Questions #21, #26, and #27, all of which relate to treatments. While both these questions are discussed at length in answer to research questions #4 and #5, it must be noted here that 25.9% of respondents stated that they would have liked to have been asked about their interest in non-medication treatments (Question

#26), and were thus not as involved in decision-making about this aspect of care as they would have liked. As noted in later discussion, this suggests that while clients generally feel they are involved in SDM about their mental health care from RxPs, RxPs might focus more on ensuring clients feel availed of the chance to discuss both medication and non-medication therapy options with them, before decisions about a course of treatment are made by the two parties together. Overall, however, the data supports the conclusion that broadly speaking, clients perceive their care from RxPs to be grounded in SDM.

Research Question 3: How do clients of prescribing psychologists feel about the care they received from these professionals?

No doubt due partly to their perception that their care is decided through SDM (as discussed in answer to research question #3), clients seem very satisfied with the care they receive from their RxPs. For each of the many questions within the client survey that can be interpreted as satisfaction measures, the proportion of applicable responses¹⁴ indicating the highest possible degree of satisfaction (phrasing varied by question) was in excess of 60% (the lowest rate of highest satisfaction, 61.5%, was reported for Question #30, which asks about provider help finding or keeping employment); however excepting Question #26, which is discussed above and in more detail in answer to later research questions, and likewise for questions in the “other areas of life” section, utmost client satisfaction is near 90% or more for

¹⁴ Excludes answers indicating a question was not relevant to a client’s situation, or that the client was content not to be offered or involved in the process.

most measures. By exempting Question #26 and Questions #28-32 in order to draw this conclusion, the researcher is not suggesting there is not room to improve client satisfaction in the domains being measured; in fact the opposite is true, as will be discussed in subsequent sections. Nonetheless, when it is looked at overall, the data from the client survey strongly supports the interpretation that the clients in the sample feel very positively about the care they receive from RxPs. This is further supported by the many positive remarks made in answer to the open-ended client survey questions. Most of these commented directly about clients' positive feelings about their providers and the care they delivered, some exuberantly so.

Research Question 4: How might the experiences of New Mexico prescribing psychologists' clients reflect the training undertaken, skills, and/or behaviors espoused by these providers?

Results from two particular sections of the client survey, the "Other Areas of Life" and the "Treatments" sections, serve to illustrate ways in which RxPs' hybrid training in both psychology and psychopharmacology appear to translate into patients' positive care experiences. While it was anticipated that the second of these sections ("Treatments") would provide insight towards answering this research question, given that questions therein ask about psychological vs. psychopharmaceutical treatment modalities, the research did not expect the results of the "Other Areas of Life" section to also so clearly point to a hybridized approach to mental healthcare practice, nor to do so in the ways that they do. Thinking retrospectively, perhaps this should also have been anticipated, or at least foreseen, given the researcher's own background in public health, but as it was not, it is necessary to briefly discuss some competing models of health in order to ground the discussion thereafter regarding

the “Other Areas of Life” results. Next, the single client interview will also be discussed in brief, as in some ways it also touched on provider assistance with domains covered in the survey questions about other areas of life. Lastly, to substantiate a well-developed answer to research question #4, results from the “Treatments” section of the client survey will also be discussed.

Western Biomedical Models of Care

In the present study, client responses to questions in this section indicate that most clients who were interested received assistance from their RxP towards addressing life issues that fall outside of strictly medical models of health, which have traditionally dominated Western medicine. In such models, medical conditions and their treatments are approached in isolation from non-somatic factors (Deacon, 2013). In other words, purely medical models of disease focus only on training physicians to identify and target factors with a physical basis in individual patients, relegating the study and modification of other, less clearly bio-individual health determinants to more social science-oriented domains such as public health (Deacon, 2013). This has resulted in greater emphasis being placed on pharmaceutical interventions for mental illness (Harvey & Gumport, 2015; Deacon, 2013), since even where diagnostic biomarkers are lacking, this approach suggests a physical, “medical” basis for the condition. As such, although psychiatry differs from other fields of medicine in that its diagnostic criteria are still primarily observational rather than somatic, in virtually all other respects it has kept with the approaches to treatment facilitated by these biomedical models of illness and care (Deacon, 2013).

Biopsychosocial Models and Social Determinants of Health

To the contrary, while some areas of psychology—such as research design—have changed in response to pressure from the preeminence of the biomedical model, it is still generally classified as a social science, rather than a medical field (Michaliski, Cope, & Fowler, 2016; Michaliski & Fowler, 2016; Deacon, 2013), and remains attentive to human health and behavior from a vantage point more open to biopsychosocial modeling. Building from Engel’s 1977 model offered in critique of a mind-body dualism and reductionist approach in medicine, public health and related clinical practice has come to distinguish itself from more traditional models of biomedicine and healthcare through models that emphasize individual health as the product of complex interactions between biology and numerous outside factors operating across multiple structural and environmental levels (Borrell-Carrió, Suchman, & Epstein, 2004). These indirect factors from our lived environments—social and physical—are now known as “social determinants of health (SDOH)” (CDC, 2014b). Because SDOH include such a broad array of factors, there is no finite list, but SDOH are typically categorized according to five groups: economic stability; education; social and community context; health and health care access; neighborhood and built environment (CDC, 2014b). In many ways, determinants of one group can overlap with another, and it should be noted here that in public health parlance, “access” covers a very broad range of things, including but not limited to cost; insurance coverage; cultural appropriateness of services; physical and temporal availability; and anything that might be interpreted as prohibitive to someone seeking care or adopting a desirable health behavior can be construed as a barrier to access (McGibbon, Etowa, & McPherson, 2008). So, for instance, “stigma” might fall into the “social and community context” category, but also work to limit “health care access;” likewise, health literacy might

seem directly related to “education,” but is actually is specified by the CDC (2014b) as an example within “health and health access.” For example, one way that health literacy can function to limit access to care is in terms of knowledge about recommended screenings; another way is in terms of being able to find out information about the availability of healthcare providers. In both cases, if someone lacks the skills necessary to obtain the information they need—say, to know when or where to get screened—their access to care is diminished. Likewise, if there are no materials available that they can access at their reading level, health literacy has also influenced access.

Presently, although the significance of SDOH to clinical care are becoming more widely acknowledged within medical practice thanks to emphasis placed on them in national initiatives like Healthy People 2020 (CDC, 2014b), medical care in the U.S. is still comprised mainly of physicians treating an individual for only specific somatic or psychiatric ailments that fall within their medical domain, while assistance meeting needs more related to SDOH than to traditional Western biomedical practice remain are seen as outside of the doctor’s scope of practice, leaving clients to navigate the completely different government systems that handle social benefits and services on their own. In other words, though they are very related, medical services in the United States remain almost completely divorced from social (welfare) operations, and treatment itself continues via a delivery model in which care from multiple providers tends to proceed with little to no coordination between them. While this lack of integrated medical care, and lack of attention to social needs, has negative ramifications for all clients, as will be discussed more below, these issues are particularly salient for individuals with mental health needs, resulting in a number of persistent, cyclically related health and social disparities for them as a population.

Prescribing Psychology at the Crossroads of Health Models

This review of health and health care models is a relevant prelude to discussing the study results in answer to research question #3, because it helps ground fundamental differences between the scope of practice as it is perceived by practitioners whose training is primarily in biological representations of health (e.g., psychiatry), from those whose training in health rests on conceptualizations from within the social sciences (e.g., psychology). As emphasized repeatedly in earlier chapters, RxPs operate on the cusp of this socio-medical divide, but have training predominantly from within the social sciences, and thus may offer a hybrid skillset within the domain of medicine. As will now be discussed, this indeed seems to be the case, with an unexpectedly high proportion of clients in the study reporting that their RxP assisted them in ways not typical in biomedical care, i.e., with finding or keeping services related to holistic conceptualizations of health and its promotion.

Helping with Other Areas of Life

As stated earlier, results from the “Other Areas of Life” (Construct 7) section of the client survey point to unique ways in which providers’ hybrid training might be manifesting in their practice and clients’ experiences thereof. Specifically, answers to questions in this section suggest that the RxPs reflected via the client sample often times provide their service users care that is more holistic—medically and in terms of other needs—than is typical in American psychiatry. The evidence for this conclusion is discussed below, followed by a review of relevant information from the single client interview obtained for this project, as it may shed some light on survey findings related to help with social support.

Healthcare and Health Access

Question #28 of the client survey asked about provider assistance with meeting or obtaining services to meet physical health needs. Most literature on the comparative health outcomes of individuals with mental illness versus the general population have focused on the subset of psychiatric conditions known as severe mental illnesses (SMI), which include bipolar disorder, major depressive disorder, schizophrenia, and schizoaffective disorder (Chesney, Goodwin, & Fazel, 2014; de Hert et al., 2011). From this literature, it is well established that morbidity and mortality from physical illnesses is significantly higher among individuals with SMI than among the general population (de Hert et al., 2011). While much of this disparity can be attributed to modifiable behavioral risk factors associated with lifestyle choices like smoking, drinking, exercise, etc., they do not fully account for such differences. Rather, it would appear that disparities in health care access, utilization, and provision contribute to disparate physical health outcomes among individuals with SMI (de Hert et al., 2011; Correll, Detraux, Lepeleire, & de Hert, 2015). As stated by de Hert et al. (2011), there is clear evidence that,

...the somatic well-being of people with a (severe) mental illness has been neglected for decades and still is today...A confluence of patient, provider, and system factors has created a situation in which access to and quality of health care is problematic for individuals with SMI. (p. 52)

Beyond difficulties accessing and coordinating quality comprehensive healthcare, clients with SMI face challenges posed by mental health treatment itself. Many medication groups used in treatment of SMI are associated with increased risk for obesity, metabolic

syndrome, diabetes, and other physical ailments (de Hert et al., 2011), further repositioning some responsibility for monitoring and securing the physical health of clients with SMI onto mental health or coordinated care practitioners.

However, despite the evidence that clients with SMI are at elevated risk for poor physical health outcomes as a result of psychotropic medications and other factors, health professionals in the position to monitor their health and implement early screening and interventions for such issues have not historically done so (de Hert et al., 2011; Mitchell, Delaffon, Vancampfort, Correll, & De Hert, 2012). This includes even relatively easy tests and the MHP who prescribe psychotropic medications as well as clients' general physicians (de Hert et al., 2011). Although guidelines for monitoring biomarkers of physical health, such as cholesterol, obesity, and blood pressure are in place, these are not always matched with practice review protocols, and oftentimes as few as 50% of clients with SMI receive these recommended screenings (Mitchell, Delaffon, Vancampfort, Correll, & De Hert, 2012). In fact, in one recent study, no patients could recall ever even having a conversation with their providers about physical health needs in the context of mental health care planning (Small et al., 2017). In sum, then, most clients with SMI receive somatic health care that is subpar and insufficient for their needs and special risk factors.

Given this context, the finding that 50% of all clients and 79.8% of those who identified as having previously unmet physical health needs reported that their RxP had helped them secure related services is impressive. While it is not known whether these individuals were diagnosed with a severe or other type of mental illness, it nonetheless indicates an ethic of care for the whole person beyond what is normally demonstrated by attention to the physical health and needs of individuals seeking mental health care.

Economic Stability

Questions #29-#31 essentially addressed different aspects of attaining financial security. As detailed previously, clients interpreted Question #29 to pertain to any of the many different government-related public assistance programs available in the U.S.; Question #30 pertained to finding or maintaining employment; and Question #31 asked about assistance obtaining school or workplace accommodations for health conditions covered under the ADAA. From specifics provided during the verbally administered instrument, some examples SNAP, WIC, SSI/SSDI, and income-based housing programs—essentially, a host of programs that saved clients money, served as income, or alleviated basic life expenses. As pointed out in the prior chapter, applying for these services often requires complex processes across multiple levels of bureaucracy, and in the case of SSI/SSDI, medical providers must engage as well as a fundamental part of a client’s application process. This makes the entire process of seeking public assistance a daunting endeavor, not even considering other factors that may further complicate the situation, such as shame, low literacy levels, and whatever circumstances lead someone to seek assistance with basic necessities in the first place. It should be stated at this point, that many supplemental income programs are only available to individuals with a demonstrated inability to retain self-supporting employment due to disability (e.g. SSI/SSDI) (Daly & Burkhauser, 2003; Duggan, Kearney, & Rennane, 2016). Consequently, many individuals who reported provider assistance with pursuing government aid in Question #29 wanted to make it clear that it was this application process, and not provider disinterest, that precluded them from reporting help seeking similar assistance with employment, in Question #30, and that this regulatory requirement that they not work therefore influenced their answer to Question #31, since they were not employed or looking for work and most clients were not

currently in school. As this explanation insinuates, decision-making surrounding means of pursuing economic security are complex and weighty, yet they are especially salient in the context of mental illness, and a discussion of this serves to ground the significance of the remaining discussion, which will focus mainly on Questions #29 and #30.

SMI and economic disparities. To begin this discussion, in addition to increased morbidity and mortality of physical ailments, mental illness is associated with increased risk of joblessness or underemployment, homelessness, and/or unstable living situations (National Alliance to End Homelessness, 2019; National Coalition for the Homeless, 2009; Cook, 2006). On one hand, these outcomes can be understood in large part as a consequence of discrimination and stigma against individuals with disability and to lesser extent, poor social functioning that may improve with treatment (Kay, Jans, & Jones, 2011; Sickel, Seacat, & Nabors, 2014; Mojtabai et al., 2015; Druss et al., 2009). At the same time, however, housing and income are fundamental social determinants of mental and overall health (Forchuk & Corring, 2016; Sederer, 2016). Therefore, as both stressors and manifest realities, housing and financial insecurity may not only exacerbate pre-existing mental health issues but also contribute to their initial development, while also undermining an individual's ability to obtain and adhere to treatment (Johnson & Chamberlain, 2016; Hunter et al., 2015). Accordingly, helping mental health care clients maintain or obtain employment, whether as a means to support themselves or as an identity-building and social recovery strategy, is associated with improved long-term well-being and outcomes and viewed by many service users, ethicists, and health care professionals as vital (Dunn, Wewiorski, & Rogers, 2008; Crowther, Marshall, Bond, & Huxley, 2001). Thus, addressing client financial and housing security is a necessary part of holistic, sustainable, and person-centered recovery-oriented approaches to mental health

care (Henwood, Stanhope, & Padgett, 2011; Bitter, Roeg, van Nieuwenhuizen, & van Weeghel, 2015).

Moreover, for individuals who are unable to work due to their mental health issues, physician assistance is essential to the process of documenting this disability in order to secure public financial assistance, such as Social Security Insurance (SSI) or supplemental security disability income (SSDI). Securing SSI, particularly for mental disabilities, is a lengthy and arduous process that requires significant documentation and input from one's treating physician and is nonetheless often accompanied by multiple application rejections. Furthermore, even though as a federal benefit the SSDI application process is ostensibly standardized, research consistently shows that final approval and acceptance of medical documentation is a subjective process, particularly with regards to applications premised on mental disability (Daly & Burkhauser, 2003; Duggan, Kearney, & Rennane, 2016). As such, many health care providers are reluctant to engage in the process of helping clients petition for such benefits, or refer patients to physicians and/or attorneys who specialize in the application process (Iezzoni, Ngo, & Kinkel, 2007). Moreover, despite the well-established evidence for housing and income as social determinants of health, research into the views and practices of medical providers (psychiatrists, nurses, physicians, etc.) have found that these types of professionals generally do not perceive their roles to include helping patients obtain employment, financial assistance, or housing (Cleary, Horsfall, O'Hara, Aarons, & Hunt, 2013; Peck & Norman, 1999; Hall, 2005). Rather, prescribing professionals such as these report that assisting with psychosocial needs falls within the purview of other allied, but less "diagnostic" occupations, such as social workers or psychologists (Herrman, Trauer, Warnock,

& Team, 2002; Hutschemaekers, Tiemens, & Kaasenbrood, 2005). This delineation of roles is problematic for several reasons.

This delineation of roles is not only problematic from the standpoint of biopsychosocial models of health, which hold that psychosocial factors should be dealt with as eminently relevant to, rather than separate from, biomedical care (Barnes, 2004). It is also problematic given that while interdisciplinary, interprofessional coordinated care in which is *ideal*, it is not always a reality or an option, particularly in the United States (Sundararaman, 2009). Rather, due to provider shortages, systems design, and barriers to access, many mental health service users in America do not have access to a mental health care specialist, let alone a coordinated interprofessional team (Sundararaman, 2009) to account for practitioners who feel their role does not include helping patients address financial, social, or other needs that may appear outside the scope of traditional biomedicine. This leaves many clients in the position of seeing only a single prescribing practitioner for their mental health needs, who in many cases may not be involved in addressing these needs holistically for optimum outcomes.

Thus, it is a rather exceptional finding in this study a majority of clients reported that their RxP had been instrumental in helping them secure financial support (Question #29), whether through public assistance or by obtaining or maintaining employment. This includes the 27.6% of all clients who reported receiving help securing employment, as well as the additional 43.4% who reported receiving help from their RxPs in securing financial benefits. While this option did not specify what type of financial assistance was sought, qualitative data suggest that in most cases, it was in fact SSDI. Clients who completed the survey verbally took this question as an opportunity to extoll what they perceived as monumental assistance from their MHPs in obtaining SSDI. Because individuals seeking SSDI must prove their inability to work, the sample

subsets for the question regarding employment precluded these individuals to some extent. Thus, if the percentage of clients who responded “yes, definitely to whether their RxP had provided them help securing financial benefits such as SSDI is calculated exclusive of those who indicated they did not need such benefits then this includes nearly three-quarters of participants (72.2%). Likewise, 61.5% of individuals interested in assistance obtaining or maintaining employment (Question #30) indicated their RxP had definitely assisted them in doing so.

In sum, beyond monetary remuneration, employment confers many social and psychological benefits, while SSI and other forms of public assistance can be a lifeline for individuals who cannot secure adequate employment due to disability. Yet navigating the bureaucracy behind the application and approval systems for these benefits can be confusing and require advocacy and assistance. Indeed, many clients who elaborated on their response to this question extolled their gratitude that a provider had helped them with this complicated process. As evidenced by these results, RxPs reflected through the client sample are serving as vital mediators of pathways to public assistance for underserved and vulnerable populations.

Social and Community Context

For much the same reasons that employment is associated with self-esteem, social connectedness, and by proxy, positive health outcomes, participation in social events can be an integral component to mental wellness. Research has thoroughly established the progressive, debilitating impact social isolation can wreak on individuals with stigmatizing mental illnesses (Sickel, Seacat, & Nabors, 2014; Barnes, 2004). Thus, Question #32, the last question in this subset of Construct 7, asked whether the RxP helped the client to take part in a social activity locally and to the extent clients respond in the affirmative, measures the provider’s attention to

the interpersonal element of mental well-being. As with other aspects of life that extend beyond the individual, specific complaint, and/or provider's office, responsibility for translating mental health care to include social integration has not historically been seen by providers as relevant to biomedical outcomes (Astin, Soeken, Sierpina, & Clarridge, 2006; Astin, Sierpina, Forys, & Clarridge, 2008) or within the purview of prescribing MHPs working in non-residential care settings (Cleary, Horsfall, O'Hara & Aarons, & Hunt, 2013; Peck & Norman, 1999; Hall, 2005). Rather, responsibility for developing and maintaining social ties has typically been seen as a psychosocial aspect of health distinct from the biomedical, and thus the responsibility of the individual, psychologists, or other non-prescribing specialists, such as case workers (Peck & Norman, 1999; Herrman, Trauer, Warnock, & Team, 2002; Hutschemaekers, Taiemans, & Kaasenbrood, 2005). However, responses to this question indicated that, while half the clients (n=15) wanted or felt they needed their RxP's help to take part in social activities within the community, 73.3% of those who did (n=11) reported definite provider assistance doing so. Those who did not want assistance (23.3% (n=7) of the total sample), said it was because they already had social support and did not need help finding it, while another 26.7% (n=8) of the sample simply indicated they were not interested in assistance in this area. Interestingly, though, two individuals within this latter group explained that while they were not interested in assistance with social activities, it was because they were seeking treatment for related mental health conditions (e.g., social anxiety, anti-social behavioral problems), and that they were confident that as their treatment progressed, their provider would offer them assistance doing so and they would eventually accept. This not only shows confidence in the provider, but an understanding that one's medical care for mental health issues that manifest in interpersonal issues *should* eventually progress to include

assistance overcoming these social problems. This reinforces the conclusion that the MHCSUs in this study anticipated their care should be biopsychosocial, rather than purely medical, and the survey results suggest that in most cases it was.

The remaining questions in the “Other Areas of Life” section (Questions #33-37) further investigated care experiences related to other areas of life, but followed slightly different formats than those discussed above. There were no missing values for this subset of questions; however, analysis of Question #33 in the context of satisfaction is a bit complicated, but nonetheless can be pared down to show RxPs at least gave consideration, when desired by patients, to involving family members in their care.

Analysis for Question #33 indicated that half the clients felt their provider had “definitely” (43.3%; n=13) or “to some extent” (6.7%; n=2) involved their friends and family in their treatment as much as they would like, although a total of 40% indicated that they either did not want their friends and family involved (23.3%; n=7) or that this did not apply to them (16.7%; n=5), while 6.7% (n=2) indicated that their friends and family were not interested in such involvement. Only one individual (3.3%) felt their provider had not involved their friends or family as much as the client would have liked. Assessment of this question in terms of client satisfaction is somewhat limited by the fact that one person’s healthcare provider has little ability to engage the patient’s loved ones if they do not want to be involved, but when only the first three choices are analyzed, this data shows that 81.3% of clients were very satisfied with the degree to which their provider had engaged their loved ones in the patient’s care.

Question #34 asked clients if their provider had helped as them much as they would have liked to connect with individuals who shared their mental health condition or experience.

Analysis indicated that 46.7% (n=14) of clients felt their provider had “definitely” assisted in this regard, 26.7% (n=8) responded that their provider had not but they would have liked this, while an equal portion (26.7%; n=8) answered that they did not want this. Thus, of those who were interested in connecting with peer support for their mental health condition, 63.6% felt their provider had definitely assisted them in doing so, while 36.4% felt they had not.

While Question #34 also reflects on fostering social connectedness and support for individuals with mental health issues, there are several factors of possible note to interpreting these results. The first is that provider-facilitated patient groups for mental health conditions (whether for psychotherapy or peer support) might not be as standard a practice in the United States as in England. Unlike in the United States, where one-on-one interactions between health care providers and patients typifies the model of care across most areas of medicine, in England, whence this question was designed, group therapy is among the most widely practiced methods of mental health care (Schlapobersky, 2015). In contexts in which peer support groups are common in the United States, these groups are typically peer-facilitated by individuals who share the same experience or condition that unites the group, but do not necessarily have any formal health-related training (e.g. Alcoholics Anonymous or survivor support groups of various kinds). While these groups can provide individuals with a sense of social support and for this and other reasons have been associated with improved medical outcomes across different conditions—including mental illnesses—due to concerns regarding efficacy; patient confidentiality; program sustainability; and the non-medical, non-expert, and often faith-based nature of peer-led groups, medical professionals may be reluctant to refer patients to such activities (Repper & Carter, 2011; Fisher et al., 2017; Fisher et al., 2014). Moreover, for these same reasons, as compounded by stigma regarding the abilities of mental health service users to provide competent peer support

(Horsfall, Cleary, & Hunt, 2010; Schulze, 2007; Thornicroft, Rose, & Kassam, 2007), some medical providers may be particularly reluctant to suggest group strategies for their mental health care clients, peer-led or otherwise (Chinman et al., 2014; Mahlke, Krämer, Becker, & Bock, 2014; Repper & Carter, 2011).

However, due to advocacy from service users, its inherently patient-centered approach, and evidence that peer support enhances a recovery-orientation in mental health care, some health care systems outside the United States have actually begun implementing policies that mandate peer support opportunities as a measure of health care quality (Mahlke, Krämer, Becker, & Bock, 2014; Repper & Carter, 2011).

In the present study, the finding from the client survey that over one-third of clients would be interested in meeting with individuals who share their mental health experiences indeed supports the inclusion of questions about referrals to peer support within questionnaires on client satisfaction with psychiatric services. Even if such questions were not extrapolated to measures of quality before evidence of the efficacy of peer support in mental illness is further established, client desire for such services is sufficient to justify their use as measures of satisfaction. Taken as such, the results of this study would indicate that interest in peer support is an unmet need among U.S. mental health care clients, though there is no indication that this is a shortcoming specific to care provided by RxPs. In fact, it would seem to be a shortcoming of U.S. MHPs in general, given that a recent report concludes that in the United States, “services run for and by people and their families with serious mental health problems now number more than double the traditional, professionally run, mental health organisations” (Repper & Carter, 2011, p. 392).

Additionally, responses to Question #34 on the client survey do not shed light on why the providers represented are not meeting client interests in peer support, nor do they provide the whole picture of how peer support is mediated by the providers represented in this study. For instance, another factor of note to interpreting responses to Question #34, is that much of the data collected for this study came from a rural locale, in which there might not be enough overall demand to host a support group for a particular condition, and wherein it would also be difficult to coordinate support groups that could stand up to HIPAA or other desirable patient privacy stipulations. Mediating the overall responses to this question, however, is that there is some indication of an alternative provider-mediated approach to facilitating peer support, one that was not anticipated in the design of the question.

Client Interview and Peer Support

The single client interview obtained in pursuit of the original study design came from the same rural locale mentioned above. It hinted that there might be more a slightly different dynamic underlying referrals for peer support in this area. Specifically, in perhaps the most salient piece of information gleaned from the interview, the client indicated their provider maintained a list of patients who had given permission for their names to be shared with other service users at the discretion of the RxP. The RxP referred clients on a case-by-case basis to speak with other patients on this list if they had questions about a particular course of treatment the provider recommended, or if the provider thought a client could benefit from speaking to someone demonstrative of successful outcomes for a particular condition the two individuals might share. Therefore, rather than run a support group, the interview participant described their provider as running a one-to-one referral service. As a participant in this service (someone who first received a referral and now offers their name for others to contact), the

interviewee suggested that the provider facilitates peer-to-peer contacts in this manner in order to better protect all patients involved, by essentially vetting both parties prior to introducing them. However, the client explained that the purpose of these introductions was not necessarily the same as a support group, in that it was not intended to foster ongoing interactions among clients; rather, the goal was to simply allow patients considering treatment to see evidence that their condition could be successfully addressed, or in some cases, to get a peer perspective on a particular course of therapy that the provider offered and suggested. Thus, while this system does involve referrals to a peer support network, it nonetheless differs somewhat from a traditional support group.

This fascinating and unforeseen piece of information obtained from the client interviews is therefore clearly adjacent to understanding the results of Question #34. However, since the results of Question #34 pool answers from all sites involved in the study, while this finding pertains to only one provider in a specific location, and because only one interview was obtained in the study, the data is insufficient to draw conclusions. However, further research might more deliberately look into alternative ways in which U.S. MHPs foster peer support, while simultaneously investigating client interest in such services.

Treatments: Offering and Sharing Decision-Making About Options

Whereas the above findings rather unexpectedly emerged from questions within the “Other Areas of Life” section as indications of the ways in which RxPs’ uniquely interdisciplinary training may emerge to impact the care experiences of their clients, another section of the survey—“Treatments”—were anticipated to yield data on the extent to which the clients of RxPs received mental health treatments that seemed to reflect their providers’ hybrid

skillset. Together, questions in this section sought to determine whether clients had received monotherapies (either medication or non-medication) or a mix of different therapies from their MHP and their level of involvement in deciding on their course of treatment. Indeed, answers to questions in this section of the survey indicate that a majority of the RxP clients in this study received both medication and non-medication treatments from their RxP for their mental health needs. Likewise, most clients were satisfied with their level of involvement in deciding about which treatments (and whether they would be pharmaceutical or non-pharmaceutical) they would receive for their mental health. Results from this section thus also lend credence to the conclusion that the hybrid training RxPs undertake translates into multimodal care experiences for their clients.

However, this is not the whole story to be told with data from questions in this section; rather, answers to questions in the “Treatments” section of the client survey seemed to indicate that more clients would have liked to have discussed non-medication treatment options with their provider than were offered the chance. This suggests that providers may be acting somewhat selectively in terms of whom they avail of their hybrid skillset, or at least, with whom they discuss non-medication treatments. While there may certainly be good reasons for this selectivity, a number of clients responded to questions in this section that since it was not a matter of their provider only being trained to provide one type of service (such as medication), they would have at least liked to hear from their RxP why non-medication options were not appropriate for them. Though most clients were still very satisfied with their engagement in SDM about treatments, this level of satisfaction varied depending on the treatment modality. Given that in this section covers the crux of seeking mental health care (i.e., getting treatment for a mental health issue), and that SDM represents a potential pivot point in how clients experience

care from MHPs of different types, it is worth further examining the results in detail. A more detailed examination will not undermine the claim that the hybrid skillset of RxPs seems to translate into patients’ treatment experiences in a positive way, but may point to ways in which doing this can be emphasized to further improve and positively differentiate the quality of their practice. In addition, questions, clients provided a valuable critique of the logistics structured into questions in this section (which were carried over from the original instrument), so that will be after a discussion of the client experiences with treatment options and satisfaction with SDM regarding them.

Treatment options. To provide context for discussing the “Treatments” section results in more detail, Table 17 below recaps data presented in the prior chapter for these questions, but is delimited to those specifically related to which therapies clients reported receiving for their mental health needs (medication, or non-medication), and how involved they felt they were in deciding about these therapies.

Table 17: Treatment Options and Decision-Making About Them

Question	n	%*
Q20. Have you been receiving any mental health medications in the last year?		
Yes	26	86.7%
No	4	13.3%
Q21. Were you involved as much as you wanted to be in decisions about which medications you would receive?		
Yes, definitely	25	89.3%
Yes, to some extent	3	10.7%

Q22. In the last year, have you had any new mental health medications prescribed?		
Yes	16	57.1%
No	12	42.9%
Q26. In the last year, have you received any treatments or therapies for your mental health needs that do not involve medication?		
Yes	18	62.1%
No, but I would have liked this	7	24.1%
No but I did not mind	2	6.9%
This was not appropriate for me	2	6.9%
Q27. Were you involved as much as you wanted to be in deciding what treatment or therapies to use?		
Yes, definitely	21	87.5%
No but I wanted to be	1	4.2%
No, but I didn't want to be	2	8.3%

* Calculated exclusive of missing values.

As shown in Table 17, the vast majority (n=26; 86.7%) of the RxP clients surveyed reported receiving psychotropic medications, and nearly two-thirds (n=25; 62.1%) reported having received non-medication therapies for their mental health needs during the prior year. Moreover, cross-tabulation of clients who reporting receiving medications with those who reported receiving non-medication therapies for their mental health needs shows that nearly

three-quarters (n=17; 73.9%¹⁵) received both approaches to treatment. This indicates that many of the clients of RxPs in this study benefitted directly from their MHPs' hybrid educational backgrounds, training, and skillsets.

However, it is also worth noting that the vast majority of respondents (89.3%) were highly satisfied with their level of involvement in decision-making about the medications they would receive (Question #21), the case is not as definitive regarding non-medication therapies. That is to say, answers to the questions regarding non-medication therapies (Questions #26, and 27) reflect relatively lower client satisfaction with SDM about these options than do answers to most other questions in the survey.

Client critiques about filter questions regarding treatments. Questions #26 and #27 also elicited meaningful client feedback towards improving the survey instrument in future iterations. In brief, clients provided feedback regarding the structure of Questions #26 and #27, suggesting that the former be revised so as not to preclude clients from answering the latter. This is a compelling argument, given that Question #27 asks about client satisfaction with their level of involvement regarding how the decision reported in Question #26 was made, and thus a participant's answer to Question #27 remains relevant even if they were not provided with non-medication treatments (as gauged per Question #26). Thus, in the present sample, several people who would have been screened out by the instructions nonetheless answered Question #27, after expressing these ideas. As such, nearly a quarter of individuals who answered

¹⁵ Calculated based on 23 valid responses to both questions (three people who indicated they were prescribed medications did not answer the question regarding other treatments).

Question #26 (n=7, 24.1%) reported they had not been offered non-medication therapies but would have like to have been; this includes four people who previously indicated they were involved as much as they preferred in deciding which medications they would receive. This means that nearly one-fifth (18.2%) of individuals who were satisfied with the level of SDM involved regarding their prescription mental health medications were unhappy with the level of SDM involved in decisions regarding non-medications treatment options offered to them.

Summary. These additional analyses of data from the “Treatments” section of the survey suggest that while clients are generally satisfied with the care they receive from RxPs, and that this care often avails them of the different treatment strategies that their providers are qualified to deliver, i.e. medication *and* psychotherapy, clients do not feel they are being offered the latter course of treatment as often as they would like. While psychotherapy (i.e., non-medication therapy) may not be appropriate as a stand-alone treatment for all mental health conditions, in some cases it is, while at the same time research also suggests that psychotherapy concurrent with psychopharmaceutical treatment generally enhances patient outcomes for most psychiatric conditions (Harvey & Gumpert, 2015). In addition, it is possible, particularly given critical shortages in prescribing mental health professionals (HRSA, 2018), that certain RxPs prefer to focus their practice mainly on meeting the medication needs of clients, rather than also providing psychotherapy, which can be more time-intensive (Harvey & Gumpert, 2012; APA Division 12, 2016) or a required priority of the agencies and capacities within which they work. In other words, if employed to serve mainly prescribing needs, this may be the role RxPs choose to fill, regardless of their hybrid skillset. However, since many clients expressed interest in the possibility of non-medication treatments, but indicated that their provider had not discussed this option with them, this suggests a

provider-centric approach to offering information about non-medication therapies. Such an approach obviously precludes informed, SDM. Thus, clients might be more satisfied with the care they receive from RxPs if they were more often at least availed of the provider's hybrid knowledge regarding different treatment modalities, even if that discussion included a statement of limitations to what treatments the provider would recommend or be willing to personally provide to the client in terms of treatment options.

In sum, although the bulk of RxPs report feeling trained and prepared to practice SDM with the majority of their clients, a sizable portion of clients in this study do not feel their respective providers adequately engaged them in SDM regarding non-medication treatments for their mental health needs. Thus, this is one area in which providers' may be under-utilizing their hybrid training, and in which clients could stand to further benefit from this unique skillset. It would also help to strengthen the data collected from the client survey if Questions #26 & 27 were revised to attend to the client feedback.

Qualitative Data from Open-Ended Responses

As discussed at length in the results chapter, the qualitative analysis of the open-ended survey questions also strongly supports the conclusion that clients are not only experiencing, but perceive themselves to be benefitting from their RxPs' hybrid skillsets. Specifically, two of the themes that emerged from this qualitative analysis—Empathically Skilled and Medically Skilled—highlight client experiences and satisfaction with care on the basis of RxPs' training psychology and psychopharmacology, respectively. Together, however, they point to client understandings of what constitutes a “good prescribing mental health professional,” and this definition involves both skillsets.

As was discussed in the results chapter, the majority of client comments emphasized an RxP's empathic repertoire, which would be those skills derived from their training in psychology and used to create an emotional environment of care. At the same time, however, the clients who focused on these skills when describing their care and the positive attributes of it were clients who were receiving medication from their RxP. This suggests that while these clients experienced both the psychology- and psychopharmacology-related training of their providers, what stood out, and mattered to them most, was the former. Though not all clients expressed this appreciation of a dual skillset explicitly, Participant 4 comes close when stating: "Dr.--- listens before prescribing medication; most doctors that I've seen don't listen and just want to push medication." Keeping in mind that this statement came from someone who was, in fact, receiving medication, this shows the impact of these empathic skills on clients' perception of the treatment negotiation process. Similarly, when stating, "I really enjoy Dr.-- because they let me make the decisions and they have my back on those decisions, as long as they're healthy decisions," Participant 14 highlights this experience of being treated with respect for their choice-making autonomy, something that the literature documents is too often lacking in mental healthcare (Wilde et al., 2010; Sheperd, Shorthouse, & Gask, 2014; Seale, Chaplin, Lelliott, & Quirk, 2006). Furthermore, though this study was limited into its investigation into client experiences provider-mediated health literacy practices pursuant to SDM, together with the other survey data, comments such as these support the conclusion that clients, at least, perceive themselves to be engaged in less paternalistic, autocratic provider-centric decision-making about their care. However, while these findings about SDM do not conflict with the results of the survey questions related to measuring and evaluating client perceptions of this process within their mental health care, the ways in which these findings

emerged in response to open-ended questions suggest there might be other ways to ask clients about this. For example, asking clients about their care environment, open-endedly, might elicit more information as to how clients of RxPs define and experience their providers' various skillsets, and in so doing, might also point to ways in which clients might understand SDM and provider-mediated health literacy that are not accounted for in the survey's original design. Any additional open-ended questions, regardless of their topic, would need to be piloted before being added to the survey; however, given the wealth of information that was captured from allowing open-ended responses to the survey instrument, not just to these questions but to others designed to be close-ended, they are clearly a valuable tool for capturing extra information about client experiences and understandings.

In sum, then, the qualitative analysis, along with the other analyses performed on the client survey data, strongly support the conclusion that RxPs' hybrid training translates into their clients' experiences of care. Moreover, these same analyses suggest that clients appreciate the hybrid skillsets their providers employ, in particular, those empathic skills they bring from psychology to their psychopharmacological practice. More research should further explore these client experiences and perceptions of RxPs dual skillsets in practice.

Research Question 5: What is the utility of using the NHS survey to measure client satisfaction among the clients of New Mexico prescribing psychologists?

Overall, this pilot of a modified NHS survey shows tremendous potential for the instrument's use in specific, client-centered assessment contexts for which there is otherwise a gap in both available instruments and research attention. These contexts include assessing, *within the United States*, (a) client satisfaction with integrated prescriptive and psychological

mental health services; (b) service user experiences with practices related to SDM in mental health care; and (c) client experiences of care provided by prescribing psychologists (RxPs). These conclusions regarding the utility of the instrument are substantiated by the construct, descriptive, and qualitative analyses detailed in the previous chapter. To support and outline an answer to the research question regarding the utility of the client survey piloted in this study, these results are further discussed henceforth. However, as will be further explained below, these conclusions about the utility of the client survey are inextricably related to its implementation as a verbal instrument, or at least made available to clients with a verbal completion option. In other words, the present study offers evidence for the multifaceted utility of the client survey instrument, but only insofar as future implementation follows the revised protocols for administering it described herein. The reasons for this are explained throughout the following discussion. In addition, although evidence in the present study supports the assertion that the revised NHS instrument has many potential applications, it also highlighted several ways in which it might be further improved, or at least, suggested alterations that should be piloted before the study is used in future and/or broader enterprises. These avenues for improvement are also discussed in context below.

Reliability of Client Survey Constructs

As discussed previously, the client survey used in this study was only slightly modified from the original, and these modifications pertained primarily to vernacular and spelling changes made to align it with the conventions of American English. Thus, the instrument employed in this study retained eight sections and respective headings found in the original, and analysis of the client survey data treated each as a distinct construct, before also analyzing an additional construct proposed by the researcher, “Shared Decision-Making.” Based on this procedure, there

were a total of six pre-determined constructs for which the data and questions were sufficiently appropriate for construct reliability analysis. As summarized in Table 18, based on these calculations, all but two of these constructs (those marked with asterisks) demonstrated acceptable to excellent internal reliability (≥ 0.70) according to one or more of three reliability measures: Cronbach’s alpha, Guttman’s lambda, and McDonald’s omega. As is explained earlier, each of these measures has unique limitations based on sample size and distribution (Reville, 2018); hence reporting all three in this study and emphasizing those constructs for which two or more of these measures indicated acceptable or better internal validity.

Table 18: Summary of Highest Internal Reliability Calculated for Applicable Constructs

Construct (Questions)	Reliability		
	α	λ	Ω
Your Mental Health Services Provider (Questions #5-7)	0.574	0.794	0.793
Planning Your Care (Questions #9-10)	0.794	0.888	0.941
Reviewing Your Care (Questions #12-13)*	0.562	0.473	0.643
Treatments (Questions #21, 36, 27-28)*	0.575	0.578	0.677
Other Areas of Life (Questions #28-34, 36-37)	0.855	0.973	0.926
Shared Decision-Making (Questions #9, 10, 12-13, 21, 33)	0.901	0.980	0.945

*Statistical measures are indicative of questionable to poor internal reliability (< 0.70)

As is detailed in the previous chapter, the two constructs with poor to questionable reliability—“Reviewing Your Care” and “Treatments”—represent sections of the survey for which the data gathered in the present study was particularly limited or unreliable. As such, it

is worth discussing these limitations and what might be done in order to further develop and test these two sections before determining their ultimate value to the survey.

In both cases, one additional scale question contained within the given section had to be omitted from the construct reliability analysis due to a lack of variation in responses to it (i.e., answers were unanimous to Question #11 in the “Reviewing Your Care” section, and to Question #23 in the “Treatments” section). In addition, as is also discussed at greater length in the results chapter, data inconsistencies and client feedback regarding some of the questions in the “Treatments” section suggests that further revisions should be made to the instrument before this section can be analyzed for construct reliability. Specifically, clients suggested changes be made to Questions #22 and #26, which each included (in the present survey version, as per the original instrument), instructions directing clients to skip subsequent questions depending on their answers. Client arguments for doing so regarding Question #26 seemed particularly valid to the researcher. Question #26 is itself a scale question, one that asks about satisfaction with whether non-medication treatment options were made available to them. However, as was pointed out by client participants in this study, it is among the only in the survey that directs clients to skip a related question based on their level of satisfaction. In other words, according Question #26, for which the original instructions were retained, if a client did not receive non-medication treatments in the prior 12 months for their mental health needs, they were directed to skip the next question regarding how involved they were in deciding this course of treatment, even if their answer to Question #26 suggested they were unhappy about this; other questions in the client survey only instruct a client to skip subsequent related questions like this if they indicate they cannot remember the circumstances or that the question is wholly irrelevant to them. Indeed, as was pointed out by clients in the

present sample, the language of Question #26 seems to contradict the intent of Question #27 to measure client satisfaction with the extent to which a provider may have availed them of non-medication treatment options. In some cases, clients therefore insisted on answering Question #27 even when their answer to Question #26 resulted in instructions to skip Question #27, further complicating an analysis of the reliability of the construct into which these questions fall. Therefore, for these reasons, while statistical evidence for the internal reliability of the “Treatments” and “Reviewing Your Care” sections is poor in the present sample, it is the researcher’s conclusion that the instrument must be retested with a larger sample size and with attention to these suggested revisions, before the merits of these two constructs can truly be evaluated.

However, for the pre-determined client survey sections on “Planning Your Care,” “Your Mental Health Services Provider,” “Other Areas of Life,” as well as the cross-sectional construct “Shared Decision-Making, this study offers preliminary statistical support for the ability of the instrument to reliably assess specific concepts related to satisfaction with care among the clients of New Mexico prescribing psychologists.

Other Support for the Utility of the Client Survey Instrument

Further support for the practicality and utility of the client survey for assessing client satisfaction can be drawn from a less statistical examination of client answers to various survey questions. There a very low rate of skipped or missed questions, suggesting that the instrument was generally intelligible and amenable to clients. Likewise, other analyses and critiques specific to the client survey are also supportive of its utility for assessing the satisfaction of service users seeing RxPs in New Mexico. This includes components of the survey

implementation process evaluation, as well as the qualitative data gathered from the open-ended, construct non-specific questions at the end of the client survey. As discussed in the previous chapter, the response rate, sheer volume of detail collected through the open-ended questions, and general enthusiasm of clients to share this detailed information once the survey protocol was modified to include verbal administration of the instrument, supports the utility of the instrument for assessing client satisfaction among the specified population. However, this mention of the modification to allow for verbal administration of the instrument is important, as it provides good context to reiterate that this assessment of the client survey's utility is predicated on its administration with an oral completion option, and several other alterations and considerations have been suggested to improve it further. This admonition for the client survey as a verbal tool, and several of these recommendations, are discussed henceforth.

Refinements to Ground or Enhance Utility in U.S. Contexts

In addition to instrument revisions hitherto discussed, the implementation experience and analysis indicated a number of ways in which the client survey instrument might be further developed prior to future use in contexts similar to those in this study. Addressing these may further improve its utility for use with the clients of prescribing psychologists, and more generally, the utility of this survey for assessing the client satisfaction among the users of *U.S.-based* mental health care services.

This brings up an important point, relevant to answering Research Question #5: given that the prescribing psychology profession is as-yet unique to the United States, this study essentially tested the instrument for its utility across two modifications to the context for which it was originally designed: the first being care delivered by psychologists with prescriptive

authority, i.e. individual hybrid professionals, as a new take on the meaning of “integrated care;” the second being the utility of the instrument within the United States. Therefore, keeping in mind that the instrument was only slightly revised from its original forms, and predominantly just for stateside spelling and vernacular, an underlying assumption within the present study was that original survey design and implementation protocols should be maintained as much as possible during use in the United States.

As such, a focus on the utility of the instrument within U.S. contexts was not an explicit part of the original research questions guiding this study; however, given that this shift in geographical and policy context underpins the context of prescribing psychology, attention to the utility of the instrument in the United States cannot be separated from investigation of its utility with the clients of New Mexico prescribing psychologists. Indeed, though indications for future revisions are to be expected during the pilot of any survey instrument, those that emerged in this study appear to be predominantly related to adaptations necessitated for geographical relevance and potentialities unique to the United States, but not necessarily to clients of prescribing psychologists (as opposed to other types of medical health care delivery settings or professionals).

To this end, although the totality of evidence gathered within this exploratory study supports the utility of the modified instrument for use assessing client satisfaction among the clients of New Mexico prescribing psychologists, it also suggests several ways in which the instrument should be further revised and developed prior to additional implementation, and most of these avenues for improvement stem from its use within the United States, rather than specifically with the clientele of prescribing psychologists therein. These include the best method of administering the instrument, plus necessary and suggested changes to the choice

options for some questions. These alterations are important to any discussion of the quality and practicality of the instrument, and when addressed, will strengthen its utility in future research projects.

Verbal administration option. One important conclusion from the present study that is highly relevant to answering Research Question #5 is that the client survey demonstrated the greatest utility when administered verbally. A number of reasons for this can be postulated and are discussed henceforth, but it should be noted that this study did not seek to comparatively assess different methods of administering the survey and therefore cannot be conclusive in regards to why verbal administration seems to work better. At the same time, however, the researcher suggests that not definitely understanding why verbal administration of the survey is more effective need not be considered a detriment to its utility for assessing the satisfaction of mental health care clients in the United States.

As discussed in chapters 3 and 4, it was necessary to administer the client survey verbally, instead of having service users complete it on their own. These changes were made because RxPs involved in the study postulated that low textual literacy in English among their clients might be preventing many from completing the survey on their own. While the evidence that this was the underlying problem was anecdotal, the limited research on the relationship between mental health and literacy indicates that as a group, mental health service users may have read at lower levels than the average population (Berkman et al., 2004; Bonito, 2004; Currier, Sitzman, & Trenton, 2001; Christensen & Grace, 1999; Lincoln et al., 2008; Sentell & Shumway, 2003). As described in earlier chapters, when the client survey was promoted only as something clients needed to fill out themselves, thus requiring them to read it on their own, the response rate was very low. However, the client survey protocol was then

revised to allow the researcher to offer to administer the instrument verbally while face-to-face with clients in a pre- or -post-appointment office setting, thus circumventing the need for clients to read it themselves or ask for assistance from someone else. Following these revisions, the response rate increased significantly, and ultimately only about three of clients approached after these alterations were implemented chose to complete the survey without substantial researcher mediation.

However, whether this is indicative of low literacy among mental health care service users, those service users in New Mexico, the state population in general, or the United States vs. England, is unknown. New Mexico as a state has a particularly low high school-graduation rate (NCES, 2018), which may result in an overall lower-than-average adult reading ability in English, although the most recent national study of adult literacy with accessible state-level data is now dated compared to these graduation statistics, making comparisons difficult (NCES, n.d.). Thus, to the extent that the research question specifically asks about the utility of the survey among RxP clients within the state, the recommendation holds that it has utility primarily as a verbally-administered instrument. Relatedly, since it is unknown whether literacy issues were at fault and if so, the extent to which they are specific to either the service user population and/or the state of New Mexico, a recommendation is made for maximizing the utility of the client survey is to make a verbal administration option available no matter where it is offered, at least until further evaluations of it can be performed. Moreover, there are several other justifications for doing so.

Firstly, no part of the protocol asked clients *why* they preferred to have the researcher administer the instrument, nor is this recommended in case low literacy is a barrier clients experience. The perception that one's reading and writing skills are insufficient is often

associated with intense embarrassment and shame (Parikh, Parker, Nurss, Baker, & Williams, 1996) and thus it would not be conducive to participant recruitment for a survey to ask about this directly before simply offering a solution to it, via oral options to take the survey (Maybank & Dickson, 2008).

Secondly, though, this recommendation that the instrument demonstrates the greatest utility as a verbally administered survey attends to the exceptional and additional data that was captured through this revised administration mechanism. As discussed earlier, some aspects of client trajectories into the care of the RxP may not have been recorded if the instrument were not being administered by a researcher capable of noting details beyond those allowed for by pre-existing close-ended response options, as would have been the case if the instrument were solely self-completed. Likewise, the researcher would not have had the opportunity to hear clients' reasoning for revisions such as those discussed earlier regarding questions in the "Treatments" section. Even though some clients who completed the survey without researcher assistance chose to complete questions they were instructed to skip, such as those in this particular section, such close-ended data would not have spoken for itself as clearly as did literal explanations for why clients wanted to answer certain questions despite instructions not to. This level of client feedback is important to the refinement of any survey instrument, but is particularly relevant to one designed to target an underserved population and to assess such participative concepts as SDM. Indeed, verbal administration of the client survey not only allowed for this capture of constructive feedback on the instrument itself, but seemed to encourage client participation simply by demonstrating the sincerity of the researcher's interest in what clients had to say about their experiences. This in itself represents a third justification

for concluding that the utility of the client survey is at least enhanced by, if not definitively dependent upon, offering it with a verbal completion option.

That is to say that clients seemed quite happy to be asked—literally (verbally)—to personally share their thoughts and experiences regarding their mental health care providers, past and present. However, mental health care clients are not asked for this kind of feedback as often as other users of other kinds of health care services, particularly in terms of their satisfaction with SDM, although there is no good justification for this exclusion, and quite a few for why satisfaction and SDM are both intimately related to mental health care quality and outcomes (Slade, 2017; CDC, 2014a). Indeed, the enthusiasm with which clients began responding to survey questions during verbal administration of the instrument seemed to increase as they came to understand the client-centered and satisfaction-related nature of the questions, and as they saw the researcher actually take note of what they had to say; in other words, while verbally administering the survey, the researcher observed that the level of detail clients provided seemed to increase as the survey continued. One might assume that as the survey went on, clients would become tired of the questions and less talkative in order to finish it faster, but the opposite seemed true. This might be a consequence of increasing rapport with the researcher, increasing interest in the study, the result of face-to-face administration providing a respite from the well-documented social isolation many mental health care service users report (Sickel, Seacat, & Nabors, 2014; Barnes, 2004), not having been asked for their opinion on their mental health care previously, other factors, or any combination thereof. However, in all probability, verbal administration of the instrument likely drew together a combination of these factors. This is supported by the fact that even in surveys that clients completed by themselves, many participants provided a great deal of information to the open-

ended questions at the end, and a common thread within this qualitative data was excitement for the opportunity to simply provide feedback about their providers. This ultimately supports the simple conclusion that creating accessible ways for clients to provide feedback on their satisfaction and experiences with mental health care services is, in fact, a viable, worthwhile, and appreciated endeavor, and one that should be offered more frequently than is currently the case.

Thus, there are many advantages to verbal administration of the instrument that may have inadvertently enhanced its utility, including but not limited to overcoming literacy-related hurdles with New Mexico clients. Consequently, even if the survey were to be administered in a population known to have greater textual literacy, the recommendation would still be to make the survey available with a verbal or at least researcher-assisted completion option. Moreover, the aforementioned supports for verbally administering the instrument coincide with other suggestions regarding the instrument and directed towards assessing and improving its utility within U.S., and prescribing psychology, mental health care contexts. These findings are discussed henceforth.

Accommodating U.S. pathways to care with extra answer options. During the data analysis stage of this project, several additional codes were necessitated, beyond those contained in the original survey. Specifically, additional answers were needed for Questions #14 & #18 on the client survey, which both allowed for, and received a sizeable number of responses to, an “other, please specify” option. These alterations were needed in order to capture additional client pathways to receiving prescriptive mental health care services. These pathways are often related, and Questions #14 and #18 were designed to synchronistically gather information about how clients ended up seeing an RxP as their current provider; given

the general obscurity of the profession, it was anticipated that clients might have specific reasons for seeking out a hybrid MHP. Accordingly, Question #14 asked all clients how they had come to *learn about* their current provider—whether it be word-of-mouth, from an internet search or list of insurance-covered providers, phonebook, etc.—while Question #18 asked clients who had previously seen someone else for their mental health needs *why* they had switched to currently seeing an RxP. Pre-printed response options for Question #18 included various reasons a client might choose to switch providers, including things like distance, appointment waitlist time, insurance coverage, and personal preference factors; though some alluded to changes in insurance coverage or moving, most assumed the client was relatively self-motivated to seek out a different provider.

Specific issues with the extant options for both questions are described below, as are the new response options that were created and those that are recommended for future uses of the client survey instrument. Because the questions themselves were related, there is some overlap in this reasoning. Upon a close reading of these responses, one thing that became clear was that these were necessary additions to thinking about pathways to mental health care, and they were not adequately accounted for within the pre-printed options. In some cases, the new categories represent differences between U.S. and English health care systems, while in others, they stemmed from implicit assumptions imbedded within the survey options regarding relatively straightforward pathways to care, and client agency and choice in selecting their provider, that are not always typical in America. Thus, the researcher maintains that the additional category options are not only essential in the present sample, but that it is important to understand the reasoning behind them, as this line of thinking may point to additional categories that might be warranted even pre-emptively if the survey were to be used with a

larger U.S. population. Accordingly, some specifics of these additional response options and their implications for the utility of the instrument are discussed in more detail henceforth.

Most additional answer options are indicated for Question #14. Question #14 asked, “How did you find out about this provider?” many people initially selected the “other, please specify” option and wrote in or dictated a scenario that led them to discover their current RxP. In all but one case, this pathway did not actually fit with the extant (pre-printed) survey options for the question. Upon examination of these explanations, three additional categories were created and coded for at analysis to account for the entirety of “other” responses to Question #14. These were entitled, respectively, “My previous provider closed/moved”; “referred by another mental health professional,” and “referral, otherwise unspecified.” This lattermost category included only one response, in which a client selected other and simply wrote “referral” but did not provide any other detail; all remaining “other” answers included specifications that fit within the two new categories. The first category was applied to those responses where the client indicated that the primary impetus for switching to an RxP was the closure of their prior mental health provider’s practice; in some cases, this recoded “other” explanation was also paired with the code for “referred by another mental health provider, if factors besides closure had been indicated as a motivating factor.

While these categories worked for analysis in the present study, it was mainly because the sample size was quite small, and further disaggregation was thus impractical. In actuality, though, the categories used herein somewhat obscure a number of very specific pathways to care that would likely come up often enough in a larger study done in America to warrant their own categories. Thus, the researcher maintains that the utility of the instrument for use in the U.S. would best be accomplished by adding pre-printed answer options to the survey that

explicitly address for the specific scenarios encapsulated in the more general referral categories created for this study.

Referral by hospital. The first of these would be an option to account for hospital referrals to see an RxP as an outpatient, and it would probably be best if this option allowed for differentiation between referrals stemming from in-patient psychiatric care, emergency room care, and in-patient care for somatic issues. While referral of hospital patients to community-based mental health services is related in a sense to continuity of care (another answer option that will be discussed shortly), because hospital care is considered a “crisis-level” tertiary service context and therefore when a client is first seen there for mental health issues, it suggests gaps in the healthcare system at earlier care levels (NAMI, 2011). Moreover, due to a host of issues, not all clients seeking emergency room care for mental health issues are admitted and stabilized before being referred to outpatient services (Pettersen, Miller, Payne-Murphy, & Phillips, 2014; NAMI, 2011). However, in the United States, hospitals have historically been one of the only ways for low-income, uninsured, and underinsured patients to get connected with mental health services (NAMI, 2011), and therefore gathering information about hospital referrals to community-based MHPs is vital to the survey’s utility in America. More recently, as correlations between somatic illnesses and mental health conditions have received attention in biomedicine—such as between myocardial infarction, depression, and physical recovery outcomes—screening for mental illness following admission for unrelated health problems has also become more routine (Bush et al., 2005). Thus, it also cannot be assumed that “hospital referral” means the patient was seen there *for* mental health issues, and answer options should allow for this possibility as well.

Referrals from “health-adjacent” contexts. Next, several options are warranted to capture different kinds of “referrals” that come from a variety of sources perhaps best categorized as “health-adjacent”: i.e. the court system (judges, supervisory services, prisons, jails, etc.); transitional living facilities (because these can be unaffiliated with the court system, they should be a separate option); substance abuse (rehabilitation) facilities; and members of community-based support groups, such those for addiction or shared traumatic experience. Finally, an option needs to be created for individuals who learn about a new provider simply because their old one leaves, as this scenario most clearly belies assumptions about client agency in seeking out healthcare.

Of note is that patients understood “learning about” a provider as distinct from whatever drove them to actually seek them out. Thus, except for a few clients who were casualties of a provider closure and would not otherwise have sought to switch MHPs, at least at that time, most of the MHCSUs surveyed found the pre-printed answer options for Question #18 to be comprehensive and applicable to their experiences. These distinctions between learning about their RxP as a provider option for psychological and/or psychiatric services, and deciding to actually seek services from them, are in keeping with many theories and models of health behavior, in which “gathering information,” “preparing to act” and “acting” represent different steps with different inputs (Glanz, Rimer, & Viswanath, 2008). They point to the potential utility of the instrument for future health research on pathways to care, particularly if these suggestions for expanded Question #14 answer options are adopted. In sum, then, this means that although the two questions are related, the only additional response options suggested by this study’s data for Question #14 that may also be applicable to answers offered for Question #18 were with regards to “continuity of care” and “simplifying care

Referrals and provider changes to streamline complicated care. Next would be an option for recommendations from extant MHPs to see an RxP in order to “simplify” the coordination of care that would otherwise necessitate seeing multiple health professionals. Though a widely touted ideal, integrated care, particularly in the form of co-located specialists (also known as “medical homes”), is still not the norm, so clients with multiple health needs often have to see different providers in different locations to get comprehensive care (SAMSHA, n.d.). None of the pre-printed options for Question #14 addressed a scenario in which someone with awareness of RxPs’ hybrid skillset recommended a client seek out this type of healthcare specialist for the specific purpose of simplifying complex mental healthcare that would otherwise require seeing multiple specialists concurrently. Yet, several clients reported this exact scenario as their explanation for finding out about their current RxP. Oftentimes, this was tied with other circumstances they credited with actually causing them to make the switch (reported via Question #18), such as needing prescriptive services their old provider did not offer, or because their prior MHP closed soon after suggesting they see an RxP. However, instigating factors aside, given that their hybrid skillset is what makes RxPs unique among MHPs, it seems quite reasonable to include an option specifically related to within Question #14.

Outward referrals for continuity of care. Though the “streamlining” care option covers some aspects of continuity, it does not account directly for another common scenario reported by participants as answer to both Question #14 and Question #18: referral to another MHP due to a current provider’s complete exit from the market. As discussed elsewhere in this dissertation, many clients reported learning about their current RxP only as their prior provider announced their abrupt closure, due to statewide reimbursement issues. Some client

participants who had experienced this scenario said that the closing MHP tried to offer additional justifications for referring them outward—or as one person put it, “the social worker tried convince me it would be better for me, to make me feel better about the fact they *had* to pass me off.” However, most said their former providers been upfront in explaining that clients were being given the name of the RxP due to a limited number of MHPs in the vicinity, and a desperate attempt to “ensure” their continuity of care pending the old provider’s imminent closure.

Summary. To reiterate, each of the suggestions in this subsection is based on actual responses obtained in the present pilot study, from a sample size of only (n=30). With the exception of a provider closure, all were offered in response to Question #14, but those related to provider closures and coordination of care also have obvious overlap with answering Question #18 and were therefore sometimes reiterated there as well. These answers were not addressed in those form the original survey instrument, and seem related to an American mental healthcare context.

That is to say that while perhaps referrals to outpatient mental health care services by court judges, drug detoxification programs, peer-led support group members, or from “crisis point” care such as emergency rooms are uncommon in England, this is not the case in America. In fact, due to fractured care networks and barriers to access, the majority of individuals with any mental illness, including more than one-half of those with an SMI, have not received treatment for their condition during the prior year, and so these rather indirect and happenstance pathways to care often represent key routes to specialist treatment within the U.S. (Pettersen et al., 2014; Kaba et al., 2015; National Alliance on Mental Illness, 2011).

Thus, adding the aforementioned answer options to those already suggested on the instrument will increase the client survey's utility for use in U.S. contexts.

CHAPTER 6: LIMITATIONS, IMPLICATIONS, AND CONCLUSION

Limitations

Clearly, the study is limited by small provider survey, client survey, and client interview sample sizes and is coupled with limited diversity in the providers represented by proxy of the client survey sample. So few client interviews were obtained that this element of analysis could not be included as planned in this final report. Likewise, although descriptive and construct reliability statistics were calculated for the client survey data, plans to conduct other inferential analyses had to be abandoned, and the measures presented herein must be understood as limited and in need of verification before they are generalized to any degree. The data collected on RxPs in New Mexico is similarly limited, and thus cannot be construed as a comprehensive profile of the providers in the state. Because of these small sample sizes, the generalizability of the results should be treated as preliminary.

Effective recruitment for this study was no doubt undermined by the abrupt closure of several major mental health care practices within the state, which displaced and disconcerted providers and patients alike. While these implementation challenges were recognized during the course of the study, adaptations in response were limited by time constraints on the overall project and ultimately led to only partial successful in meeting recruitment goals for each phase of the project and resulted in the other limitations described above.

Implications

Despite its limitations, this study is the first of its kind in several ways, and involved the successful use of a survey instrument novel in U.S. contexts, and therefore holds many

implications and suggests many avenues future research. To center these implications, let us review the context of the study and recent history of prescribing psychology.

Though prescribing psychology as a profession has been allowed in certain parts of the United States for more than 20 years (Murray, 2003), this project commenced as one of the first *research* studies directed at the field. The majority of literature published about prescribing psychology has been speculative in nature, debating whether, even with strict post-doctoral education and practicum requirements, psychologists can be trained to competently provide psychopharmaceutical services (Walker, 2002; Merrick, 2007; Lavoie & Barone, 2006; Lavoie & Fleet, 2002). Much of the literature has been generated in response to proposed legislation to allow prescribing psychology, and in some cases the concerns expressed about the competence of RxPs combined with a lack of data to inform such conversations, has kept such policies from passing or being implemented (Murray, 2003; Munsey, 2006).

Thus, in 2015, when this project began, RxPs could only practice in the U.S. federal services, Guam, New Mexico, and Louisiana (APA, 2017). However, legislation to allow psychologists to obtain prescriptive authority is often a response to critical, persistent, nationwide shortages of prescribing mental health professionals (McGuinness, 2012; Caccavale, Reeves, & Wiggins, 2012; Ax et al., 2008; McDowell et al., 2010; Thomas & Hozler, 2006), and indeed, during the time this study was taking place, Idaho, Illinois, and Iowa passed laws to allow psychologists with advanced and specialized training to prescribe psychopharmaceutical medications (APA, 2017), bringing the total number of states where RxPs can practice to five. Therefore, since there not only is continued interest in expanding the field of prescribing psychology to additional jurisdictions, but new territories in which to study

it in practice, future research should endeavor to replicate the client-centered aspects of this study on a larger scale.

The patient-centered client survey used in the present study is, in fact, among its most significant contributions, not only in terms of the results it generated but the instrument itself. Though patient-centered care is emphatically promoted and researched in most fields of healthcare due to its association with client satisfaction, health literacy, self-determination, goal alignment, and thus treatment outcomes (Agoritsas et al., 2015; McCaffery et al., 2013; O'Connor et al., 2007, CDC, 2014a; CDC, 2001; Duncan, Best, & Hager, 2010; Slade, 2017), there is a disturbing lack of attention to SDM and patient-satisfaction in psychiatric care (Slade, 2017). In general there is silence from the field about why this is so, but evidence from at least one study done among psychiatrists supports the conclusion that that it is their attitudes towards client competency and shared authority that hinders the wider adoption of these practices in mental health care (Shepherd, Shorthouse, & Gask, 2014). The few studies that have been done on the use of SDM and satisfaction surveys in mental health care—mostly conducted abroad—have found that both are feasible, ethical, that it is not harmful to let patients share in decision-making about their psychiatric treatments (Slade, 2017). Moreover, the NHS Community Mental Health survey that was adapted and used in the present study, remains among the only instruments designed specifically for measuring client experiences and satisfaction with SDM in mental healthcare (Slade, 2017). These factors serve to frame the use of the survey in US contexts, as well as what the data collected reveal about prescribing psychology in practice, valuable to expanding the mental health research literature, in particular that regarding U.S. contexts. In the same way, even the revisions to the survey

administration protocol and instrument are valuable, because they lay the groundwork for its successful use in larger, U.S. based studies.

Because of the small sample sizes obtained at each phase of this study, one implication is that more studies will be needed to draw conclusions about the generalizability of the data reported here. Though this data would suggest that the academic pathways RxPs take in their journeys to prescriptive authority are relative homogenous, future research should further investigate the characteristics and trends within the academic trajectories undertaken from undergraduate to post-doctoral and professional training by RxPs, both as a subcategory and relative to the overall field of practicing psychologists. If a similar survey instrument is to be used, care should be taken in its design to ensure that it can capture data on RxPs' academic backgrounds even in light of oft-changing nature of their specialized credentialing programs.

Relatedly, research should also investigate the classification or reclassification of post-doctoral degrees in psychopharmacology aimed at RxPs, to determine to what extent, if any, these decisions may be influenced by pressures to align with biomedical sentiments. While certainly, such programs are designed specifically to provide training in biomedicine to psychologists, further investigation of these nuances could be of use to the development of new programs and policy. Investigation into the reasons for adopting certain program designations may help inform objective responses to concerns about the quality of care RxP are prepared to delivery, as many of these concerns center on the biomedical training, or lack thereof, attributed to psychologists (Walker, 2002; Merrick, 2007; Lavoie & Barone, 2006; Lavoie & Fleet, 2002).

Nonetheless, one of the most promising findings from this study is that when healthcare practice is considered from an interdisciplinary model, in which biomedical concerns are not looked at in isolation from psychological and social factors and environmental conditions, RxPs in New Mexico are providing very competent care indeed. That is, they are meeting patient needs with regards to many SDOH, and moreover, clients are very satisfied in most respects with the care they receive from these hybrid professionals.

The results of the provider study also suggest starting points for efforts to further promote patient-centered practices in mental healthcare: while most of the RxPs felt they were familiar with the concept of SDM, they did not preface it with best practices for health literacy, and instead reported practices that would not be helpful if the client population has low textual literacy, which may be the case in New Mexico.

This brings up one final implication, which is that the client survey seems best used in accordance with a verbal administration protocol. This was not how it was designed for use in England, but using it in this way in the U.S. resulted in a better completion rate, high quality answers, and detailed feedback. Offering the survey with a verbal completion option confirmed that MHCSUs have much to share about their treatment experiences, but supports the hypothesis that they may face additional barriers to health literacy and participating in their care beyond simply not being offered the opportunity to do so by their psychiatric providers. Therefore, future research that expands the use of the adapted instrument in the U.S. should not only be done for the sake of the data it will yield, but to provide MHCSUs the opportunities they desire and deserve to share this information about their care experiences.

Conclusion

In sum, this dissertation offers new insight into a little-studied discipline, and highlights a number of ways in which patient-centered care and research can move forward in mental health care. It introduces and supports a novel survey tool for assessing client experiences of SDM and satisfaction in their mental health care, and adds to existing evidence that these service users are as eager and capable as those in other health care domains to engage in these endeavors.

REFERENCES

- Abed Faghri, N. M., Boisvert, C. M., & Faghri, S. (2010). Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): enhancing the assessment and treatment of psychiatric conditions. *Mental Health in Family Medicine, 7*(1), 17–25.
- Adams, J. R., & Drake, R. E. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal, 42*(1), 87-105.
- Adams, J., Drake, R., & Wolford, G. (2007). Shared decision-making preferences of people with severe mental illness. *Psychiatric Services, 58*(9), 1219-1221.
- Agency for Health Care Research and Quality [AHRQ]. (2014). Patients' satisfaction with care: patients' overall rating of their physician. Retrieved from <http://www.qualitymeasures.ahrq.gov/content.aspx?id=26774>
- Al-Abri, R., & Al-Balushi, A. (2014). Patient satisfaction survey as a tool towards quality improvement. *Oman Medical Journal, 29*(1), 3.
- American College of Neuropsychopharmacology [ACNP]. (1998). *DoD prescribing psychologists: External analysis, monitoring, and evaluation of the program and its participants*. [Government document]. Available at http://www.dod.mil/pubs/foi/Personnel_and_Personnel_Readiness/Personnel/966.pdf.
- American Medical Association [AMA]. (2009). Comparison of prescribing statutes: New Mexico and Louisiana. *American Medical Association Advocacy Resource Center*.

American Medical Association Advocacy Research Center. (2009). Comparison of Prescribing Statutes 1 : New Mexico and Louisiana. American Medical Association, (December), 1–6.

American Psychological Association [APA] Division 12. (2016). Psychological treatments. Retrieved March 3, 2019 from <https://www.div12.org/psychological-treatments/>.

American Psychological Association [APA]. (2009). Designation criteria for education and training programs in preparation for prescriptive authority. Retrieved December 17, 2018 from <https://www.apa.org/education/grad/rxp-designation-criteria.pdf>.

American Psychological Association [APA]. (2011). Practice guidelines regarding psychologists' involvement in pharmacological issues. *American Psychologists*, 66(9): 835-849.

American Psychological Association [APA]. (2013a). APA Guidelines for the Undergraduate Psychology Major. Retrieved October 30, 2014 from <http://www.apa.org/ed/precollege/about/psymajor-guidelines.pdf>.

American Psychological Association [APA]. (2013b). Guidelines and Principles for Accreditation of Programs in Professional Psychology. Retrieved October 30, 2014 from <http://www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf>.

American Psychological Association [APA]. (2014). Understanding psychotherapy and how it works. Available at <http://www.apa.org/helpcenter/understanding-psychotherapy.aspx>.

American Psychological Association [APA]. (2018). Prescriptive authority program designation.

Retrieved December 17, 2018 from

<https://www.apa.org/education/grad/designation.aspx>.

Andrews, M. (2011). Why some states want psychologists to prescribe antidepressants. *NPR*.

Retrieved March 3, 2019 from [https://www.npr.org/sections/health-](https://www.npr.org/sections/health-shots/2011/03/24/134759654/why-some-states-want-psychologists-to-prescribe-antidepressants)

[shots/2011/03/24/134759654/why-some-states-want-psychologists-to-prescribe-antidepressants](https://www.npr.org/sections/health-shots/2011/03/24/134759654/why-some-states-want-psychologists-to-prescribe-antidepressants).

Antonuccio, D. O., Danton, W. G., & DeNelsky, G. Y. (1995). Psychotherapy versus medication

for depression: Challenging the conventional wisdom with data. *Professional*

Psychology: Research and Practice, 26(6), 574.

Arcury, T. A., Quandt, S. A., & Russell, G. B. (2002). Pesticide safety among farmworkers:

Perceived risk and perceived control as factors reflecting environmental justice.

Environmental Health Perspectives, 110(Supplement 2), 233.

Astin, J. A., Soeken, K., Sierpina, V. S., & Clarridge, B. R. (2006). Barriers to the integration of

psychosocial factors in medicine: Results of a national survey of physicians. *The Journal*

of the American Board of Family Medicine, 19(6), 557–565.

<https://doi.org/10.3122/jabfm.19.6.557>

Astin, John A., Sierpina, V. S., Forys, K., & Clarridge, B. (2008). Integration of the

biopsychosocial model: Perspectives of medical students and residents. *Academic*

Medicine: Journal of the Association of American Medical Colleges, 83(1), 20–27.

<https://doi.org/10.1097/ACM.0b013e31815c61b0>

- Ax, R. K., Bigelow, B. J., Harowski, K., Meredith, J. M., Nussbaum, D., & Taylor, R. R. (2008). Prescriptive authority for psychologists and the public sector: Serving underserved health care consumers. *Psychological Services, 5*(2), 184-197.
- Baker, D. (2016, December 23). Fourth Arizona mental health provider leaving NM. [News article]. Retrieved November 27, 2018 from <https://www.abqjournal.com/914722/fourth-arizona-mental-health-provider-leaving.html>.
- Balderas, H. (2015). 2013 behavioral health audit and investigative reports. [Government reports]. Retrieved November 27, 2018 from <https://www.nmag.gov/2013-behavioral-health-audit.aspx>.
- Barnes, H. (2004). Social exclusion and psychosis. *Social Work in Mental Health, 2*(2-3), 207-233. https://doi.org/10.1300/J200v02n02_13
- Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*(2), 247-273.
- Barton, D. (2007). *Literacy: An introduction to the ecology of written language* (No. 2nd). Wiley-Blackwell.
- Batterham, R. W., Hawkins, M., Collins, P. A., Buchbinder, R., & Osborne, R. H. (2016). Health literacy: Applying current concepts to improve health services and reduce health inequalities. *Public Health, 132*, 3-12. <https://doi.org/10.1016/j.puhe.2016.01.001>
- Bee, P., Brooks, H., Fraser, C., & Lovell, K. (2015). Professional perspectives on service user and carer involvement in mental health care planning: A qualitative study. *International*

Journal of Nursing Studies, 52(12), 1834–1845.

<https://doi.org/10.1016/j.ijnurstu.2015.07.008>

- Bell, P. F., Digman, R. H., Jr., & McKenna, J. P. (1995). Should psychologists obtain prescription privileges? A survey of family physicians. *Professional Psychology: Research and Practice*, 26: 371–376.
- Bellack, A. S., Bowden, C. L., Bowie, C. R., Byerly, M. J., Carpenter, W. T., Copeland, L. A., ... Diaz, E. (2009). The expert consensus guideline series: Adherence problems in patients with serious and persistent mental illness. *Journal of Clinical Psychiatry*, 70(SUPPL. 4), 1–48.
- Berkman, N. D., DeWalt, D. A., Pignone, M. P., Sheridan, S. L., Lohr, K. N., Lux, L., ... Bonito, A. J. (2004). Literacy and health outcomes [Evidence Report/Technology Assessment No. 87]. Rockville, MD: Agency for Healthcare Research and Quality.
- Berkman, N. D., DeWalt, D. A., Pignone, M. P., Sheridan, S. L., Lohr, K. N., Lux, L., ... Bonito, A. J. (2004). Literacy and health outcomes [Evidence Report/Technology Assessment No. 87]. Rockville, MD: Agency for Healthcare Research and Quality.
- Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011a). Low health literacy and health outcomes: An updated systematic review. *Annals of internal medicine*, 155(2), 97-107.
- Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., Viera, A., Crotty, K., ... Viswanathan, M. (2011b). Health literacy interventions and outcomes: An updated systematic review. *Evidence Report/Technology Assessment*, (199), 1–941.

- Berkman, N.D., DeWalt, D.A., Pignone M.P., Sheridan, K.N., Lohr, L., Lux, S.F., Sutton, T., Swinson, & A.J. Bonito. (2004). Literacy and health outcomes: Report summaries. Rockville, MD: Agency for Healthcare Research and Quality. (AHRQ publication; no. 04-E007-1); (Evidence report/technology assessment; no. 87). Available from: <http://www.ahrq.gov/clinic/epcsums/litsum.htm>
- Bitter, N. A., Roeg, D. P. K., van Nieuwenhuizen, C., & van Weeghel, J. (2015). Effectiveness of the Comprehensive Approach to Rehabilitation (CARE) methodology: Design of a cluster randomized controlled trial. *BMC Psychiatry, 15*, 165. <https://doi.org/10.1186/s12888-015-0564-0>
- Bonfils, K. A., Fukui, S., Adams, E. L., Hedrick, H. M., & Salyers, M. P. (2014). Why are you here again? Concordance between consumers and providers about the primary concern in recurring psychiatric visits. *Psychiatry Research, 220*(1–2), 541–548. <https://doi.org/10.1016/j.psychres.2014.07.049>
- Bowskill, R., Clathworthy, J., Parham, R., Rank, T., & Horne, R. (2007). Patients' perceptions of information received about medication prescribed for bipolar disorder: Implications for informed choice. *Journal of Affective Disorders, 100*(1-3): 253-257.
- Bozarth, J. (2013). Unconditional positive regard. In M. Cooper, M. O'Hara, P. F. Schmid, & A. Bohart (Eds.), *The Handbook of Person-Centred Psychotherapy and Counselling* (pp. 180–192). Macmillan International Higher Education.
- Brannen, J. (2008). The practice of a mixed methods research strategy: Personal, professional and project considerations. In M. M. Bergman (Ed.), *Advances in mixed methods research*, (pp. 53-65). Thousand Oaks, CA: Sage Publications.

- Bray, J., Tilus, Vento, C., & Greenspan, M., Wilson, G., Sammons, M. (2014). Prescriptive authority for psychologists: Current status and future directions. *The Behavior Therapist, September*, 137-144.
- Brentar, J., & McNamara, J. R. (1991). The right to prescribe medication: Considerations for professional psychology. *Professional Psychology: Research and Practice, 22*(3), 179.
- Brown, M. T., & Bussell, J. K. (2011). Medication adherence: WHO cares? In *Mayo clinic proceedings* (Vol. 86, pp. 304–314). Elsevier.
- Brown, P., Mayer, B., Zavestoski, S., Luebke, T., Mandelbaum, J., & McCormick, S. (2003). The health politics of asthma: Environmental justice and collective illness experience in the United States. *Social Science & Medicine, 57*(3), 453-464.
- Brulle, R. J., & Pellow, D. N. (2006). Environmental justice: human health and environmental inequalities. *Annual Reviews in Public Health, 27*, 103-124.
- Bureau of Labor Statistics [BLS]. (2018). Psychologists. *Occupational outlook handbook*. Retrieved December 17, 2018 from <https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm#tab-4>.
- Bush, D. E., Ziegelstein, R. C., Patel, U. V., Thombs, B. D., Ford, D. E., Fauerbach, J. A., ... Bass, E. B. (2005). *Post-Myocardial Infarction Depression: Summary*. Agency for Healthcare Research and Quality (US). Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK11913/>
- Caccavale, J., Reeves, J. L., Wiggins, J. (2012). *The Impact of Psychiatric Shortage on Patient Care and Mental Health Policy: The Silent Shortage that Can No Longer Be Ignored*.

- [Agency document]. American Board of Behavioral Healthcare Practice. Retrieved June 17, 2014 from <http://abbhp.org/survey.pdf>.
- Cameron, R. (2011). Mixed methods research: The Five Ps framework. *The Electronic Journal of Business Research Methods*, 9(2), 96-108.
- Care Quality Commission [CQC]. (2014a). Community Mental Health Survey 2014. *National Health Service*. Available at <http://www.nhssurveys.org/surveys/675>.
- Care Quality Commission [CQC]. (2014b). Technical details: Patient survey information, 2014 Community Mental Health Survey. Available at <http://www.cqc.org.uk/sites/default/files/MH14%20technical%20document%20v1.pdf>.
- Care Quality Commission [CQC]. (2019). Surveys. Retrieved March 2, 2019 from <https://www.cqc.org.uk/publications/surveys/surveys>.
- Carlson, M. J., & Gabriel, R. M. (2001). Patient satisfaction, use of services, and one-year outcomes in publicly funded substance abuse treatment. *Psychiatric Services*, 52(9), 1230-1236.
- Catford, J., & Nutbeam, D. (1984). Towards a definition of health education and health promotion. *Health education journal*, 43(2-3), 38-38.
- Center for Disease Control [CDC]. (2016). Health literacy. Retrieved March 6, 2019 from ¹ <https://www.cdc.gov/healthliteracy/learn/index.html>.
- Center for Disease Control and Prevention [CDC]. (2014a). Healthy People 2020. Available at < <http://www.healthypeople.gov/>>

- Center for Disease Control and Prevention [CDC]. (2014b). Social determinants of health. Retrieved March 2, 2019 from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.
- Center for Medicare and Medicaid Services [CMS]. (2014). HCAHPS: Patient's perspective of care survey. Retrieved from <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html>
- Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry, 13*(2), 153–160.
<https://doi.org/10.1002/wps.20128>
- Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services, 65*(4), 429–441.
<https://doi.org/10.1176/appi.ps.201300244>
- Chinn, D. (2011). Critical health literacy: A review and critical analysis. *Social Science & Medicine, 73*(1), 60–67.
- Christensen, R. C., & Grace, G. D. (1999). The prevalence of low literacy in an indigent psychiatric population. *Psychiatric Services, 50*(2), 262–263.
- Christidis, P., Stamm, K., & Luona, L. (2016, December). Psychology master's and doctoral degrees awarded by broad field, subfield, institution type and state (2004-2013). APA Center for Workforce Studies. Retrieved December 17, 2018 from <https://www.apa.org/workforce/publications/2016-postsecondary-data/index.aspx>.

- Chue, P. (2006). The relationship between patient satisfaction and treatment outcomes in schizophrenia. *Journal of Psychopharmacology*, 20(6 suppl), 38-56.
- Cleary, M., Horsfall, J., O'Hara-Aarons, M., & Hunt, G. E. (2013). Mental health nurses' views of recovery within an acute setting. *International Journal of Mental Health Nursing*, 22(3), 205–212. <https://doi.org/10.1111/j.1447-0349.2012.00867.x>
- Coleman, C. (2011). Teaching health care professionals about health literacy: A review of the literature. *Nursing Outlook*, 59(2), 70–78. <https://doi.org/10.1016/j.outlook.2010.12.004>
- Colombo, M., Guaita, A., Cottino, M., Cairati, M., Ferrari, D., Previderè, G., ... & Mercanti, A. (2009). Customer satisfaction as a quality factor in geriatric rehabilitation. *Open Geriatric Medicine Journal*, 2, 1-4.
- Cook, J. A. (2006). Employment barriers for persons with psychiatric disabilities: Update of a report for the president's commission. *Psychiatric Services*, 57(10), 1391–1405. <https://doi.org/10.1176/ps.2006.57.10.1391>
- Cooper, R.A. (2002). There's a shortage of specialists: Is anyone listening? *Academic Medicine*, 77(8): 761-766.
- Correll, C. U., Detraux, J., De Lepeleire, J., & De Hert, M. (2015). Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder. *World Psychiatry*, 14(2), 119–136.
- Crowther, R. E., Marshall, M., Bond, G. R., & Huxley, P. (2001). Helping people with severe mental illness to obtain work: Systematic review. *BMJ: British Medical Journal*, 322(7280), 204–208.

- Cruz, M., Roter, D. L., Cruz, R. F., Wieland, M., Larson, S., Cooper, L. A., & Pincus, H. A. (2013). Appointment length, psychiatrists' communication behaviors, and medication management appointment adherence. *Psychiatric Services, 64*(9), 886-892.
- Csordas, T.J. & Kleinman, A. (1996). The therapeutic process. In C. Sargent and T. Johnson (Eds.), *Medical Anthropology: Contemporary Theory and Method* (pp. 3-21). New York, NY: Praeger.
- Currier, G. W., Sitzman, R., & Trenton, A. (2001). Literacy in the psychiatric emergency service. *Journal of Nervous and Mental Disease, 189*(1), 56–58.
- Daly, M. C., & Burkhauser, R. V. (2003). The Supplemental Security Income (SSI) program. In R. Moffitt (Ed.), *Means-tested transfer programs in the United States* (pp. 79–139). Chicago, Ill.: University of Chicago Press.
- Das, A. K., Malik, A., & Haddad, P. M. (2014). A qualitative study of the attitudes of patients in an early intervention service towards antipsychotic long-acting injections. *Therapeutic advances in psychopharmacology, 2045125314542098*.
- Davis, T.C. & Wolf, M.S. (2004). Health literacy: Implications for family medicine. *Family Medicine, 36*(8): 595–8.
- Dawson, A. M., Taylor, R. W., Williams, S. M., Taylor, B. J., & Brown, D. A. (2014). Do parents recall and understand children's weight status information after BMI screening? A randomised controlled trial. *BMJ Open, 4*(7), e004481–e004481.
<https://doi.org/10.1136/bmjopen-2013-004481>

- De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D. A. N., Asai, I., ... Ndeti, D. M. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52–77.
- De las Cuevas, C., Peñate, W., & de Rivera, L. (2014). To what extent is treatment adherence of psychiatric patients influenced by their participation in shared decision making?. *Patient Preference and Adherence, 8*, 1547.
- Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846–861. <https://doi.org/10.1016/j.cpr.2012.09.007>
- Deegan, P. E. (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatric Rehabilitation Journal, 31*(1), 62.
- DeNelsky, G. Y. (1991). Prescription privileges for psychologists: The case against. *Professional Psychology: Research and Practice, 22*(3), 188.
- Drake, R. E., Deegan, P. E., & Rapp, C. (2010). The promise of shared decision making in mental health. *Psychiatric Rehabilitation Journal, 34*(1), 7-13.
- Drake, R., & Deegan, P. (2009). Shared decision making is an ethical imperative. *Psychiatric Services, 60*(8), 1007-1007.
- Druss, B. G., Hwang, I., Petukhova, M., Sampson, N. A., Wang, P. S., & Kessler, R. C. (2009). Impairment in role functioning in mental and chronic medical disorders in the United

- States: Results from the National Comorbidity Survey replication. *Molecular Psychiatry*, 14(7), 728–737. <https://doi.org/10.1038/mp.2008.13>
- Duggan, M., Kearney, M. S., & Rennane, S. (2016). The Supplemental Security Income (SSI) program. In R. Moffitt (Ed.), *Means-tested transfer programs in the United States* (pp. 1–58). Chicago, Ill.: University of Chicago Press.
- Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatric Rehabilitation Journal*, 32(1), 59–62. <https://doi.org/10.2975/32.1.2008.59.62>
- Eldredge, L. K. B., Markham, C. M., Ruiter, R. A., Kok, G., Fernandez, M. E., & Parcel, G. S. (2016). *Planning health promotion programs: An intervention mapping approach*. New York, NY: John Wiley & Sons.
- Fagan, T.J., Ax, R.K., Liss, M., Resnick, R.J. & Moody, S. (2007). Prescriptive authority and preferences for training. *Professional Psychology: Research and Practice*, 38(1): 104-111.
- Farber, B. A., & Doolin, E. M. (2011). Positive regard. *Psychotherapy*, 48(1), 58–64. <https://doi.org/10.1037/a0022141>
- Feder, M. A., Shouse, A. W., Lewenstein, B., & Bell, P. (Eds.). (2009). *Learning science in informal environments: People, places, and pursuits*. National Academies Press.

- Filippidou, M., Lingwood, S., & Mirza, I. (2014). Reducing non-attendance rates in a community mental health team. *BMJ Quality Improvement Reports*, 3(1).
<https://doi.org/10.1136/bmjquality.u202228.w1114>
- Firestone, M. & Sanbar, S.S. (2007). Chapter 41: Psychiatric malpractice. In ACLM (Ed.), *The Medical Malpractice Survival Handbook*, (pp. 469-478). Philadelphia, PA: Mosby Elsevier.
- Fisher, E. B., Boothroyd, R. I., Elstad, E. A., Hays, L., Henes, A., Maslow, G. R., & Velicer, C. (2017). Peer support of complex health behaviors in prevention and disease management with special reference to diabetes: Systematic reviews. *Clinical Diabetes and Endocrinology*, 3(1), 4. <https://doi.org/10.1186/s40842-017-0042-3>
- Fisher, E. B., Coufal, M. M., Parada, H., Robinette, J. B., Tang, P. Y., Urlaub, D. M., ... Xu, C. (2014). Peer support in health care and prevention: Cultural, organizational, and dissemination Issues. *Annual Review of Public Health*, 35(1), 363–383.
<https://doi.org/10.1146/annurev-publhealth-032013-182450>
- Fletcher Thompson, B. (2007). *The impact of false complaints in ethics and licensing board actions on the clinical practice of psychology*. (Doctoral dissertation). Retrieved from Proquest and Google Books. (UMI Number 3297710).
- Forchuk, C., & Corring, K. D. and D. J. (2016). Social determinants of health: Housing and income. *Healthcare Quarterly*, 18(Special Issue), 27–31.
<https://doi.org/doi:10.12927/hcq.2016.24479>

- Fox, R. E., DeLeon, P. H., Newman, R., Sammons, M. T., Dunivin, D. L., & Baker, D. C. (2009). Prescriptive authority and psychology: A status report. *The American Psychologist, 64*(4), 257–268. doi:10.1037/a0015938.
- French, J., & Adams, L. (1986). From analysis to synthesis Theories of health education. *Health Education Journal, 45*(2), 71-74.
- Friedman, A. (2008). Framework for evaluating impacts of informal science education projects. *National Science Foundation*.
- Frost, B. G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T. J., Sly, K. A., & Conrad, A. M. (2017). An Integrated Recovery-oriented Model (IRM) for mental health services: Evolution and challenges. *BMC Psychiatry, 17*(1), 22. <https://doi.org/10.1186/s12888-016-1164-3>
- Fukui, S., Salyers, M. P., Matthias, M. S., Collins, L., Thompson, J., Coffman, M., & Torrey, W. C. (2014). Predictors of shared decision making and level of agreement between consumers and providers in psychiatric care. *Community mental health journal, 50*(4), 375-382.
- Gallant, M. D., & Coutts, L. M. (2003). Evaluation of an oncology outpatient orientation program: Patient satisfaction and outcomes. *Supportive care in Cancer, 11*(12), 800-805.
- Garland, A. F., Haine, R. A., & Lewczyk Boxmeyer, C. (2007). Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning, 30*(1), 45-54.
- Gee, J. P. (1999). *An introduction to discourse analysis: Theory and method*. Routledge.

- General Accounting Office [GAO]. (1997). *Need for More Prescribing Psychologists Is Not Adequately Justified*. [Government document]. Document number: HEHS-97-83.
- General Accounting Office [GAO]. (1999). *Prescribing Psychologists*. [Government document]. Document number: HEHS-99-98.
- Gerber, B. S., Brodsky, I. G., Lawless, K. A., Smolin, L. I., Arozullah, A. M., Smith, E. V., ... & Eiser, A. R. (2005). Implementation and evaluation of a low-literacy diabetes education computer multimedia application. *Diabetes care*, 28(7), 1574-1580.
- Gharabawi, G. M., Greenspan, A., Rupnow, M. F., Kosik-Gonzalez, C., Bossie, C. A., Zhu, Y... & Awad, A. G. (2006). Reduction in psychotic symptoms as a predictor of patient satisfaction with antipsychotic medication in schizophrenia: Data from a randomized double-blind trial. *BMC psychiatry*, 6(1), 45.
- Gideon, N., Hancock, E., & Nelstrop, L. (2009). Talking Treatment—Developing a service user satisfaction questionnaire for a national audit. [Government report]. *Royal College of Psychiatrists*. Available at <
<http://www.rcpsych.ac.uk/pdf/report%20on%20development%20of%20Talking%20Treatment.final.pdf>>.
- Glanz, K., Rimer, B., & Lewis, F. (2002). *Health behavior and health education: Theory, research, and practice*. 3rd edition. New York, NY: Jossey-Bass.
- Glanz, K., Rimer, B., & Viswanath, K. (2008). *Health behavior and health education: Theory, research, and practice*. 4th edition. New York, NY: Jossey-Bass.
- Godolphin, W. (2009). Shared decision-making. *Healthcare Quarterly*, 12: e186–e190.

- Good, B.J. (1994). *Medicine, Rationality, and Experience*. New York, NY: Cambridge University Press.
- Gotham, K. F. (2007). Critical theory and Katrina: Disaster, spectacle and immanent critique. *City, 11*(1), 81-99.
- Gourdji, I., McVey, L., & Loiselle, C. (2003). Patients' satisfaction and importance ratings of quality in an outpatient oncology center. *Journal of nursing care quality, 18*(1), 43-55.
- Gravel, K., Légaré, F., & Graham, I. D. (2006). Barriers and facilitators to implementing shared decision-making in clinical practice: A systematic review of health professionals' perceptions. *Implementing Science, 1*(1), 16.
- Gray, R., Rofail, D., Allen, J., & Newey, T. (2005). A survey of patient satisfaction with and subjective experiences of treatment with antipsychotic medication. *Journal of Advanced Nursing, 52*(1), 31-37.
- Green L. W. & C. L. Anderson. (1986). *Community Health*. St. Louis, MO: Times Mirror/Mosby College Publishing.
- Green, L. W., & Krueter, M. W. (1991). *Health promotion planning: An educational and environmental approach*. 2nd Edition. Mountain View, CA: Mayfield.
- Green, L., Krueter, M., Deeds, S., & Partridge, P. (1980). *Health education planning: A diagnostic approach*. Mountain View, CA: Mayfield.
- Green, L.W. & Krueter, M.W. (1999). *Health promotion planning: An educational and ecological approach*. 3rd Edition. Mountain View, CA: Mayfield.

- Grol, R. (2001). Improving the quality of medical care: Building bridges among professional pride, payer profit, and patient satisfaction. *JAMA*, *286*(20), 2578-2585.
- Gulbrandsen, P., Dalby, A. M. L., Ofstad, E. H., & Gerwing, J. (2014). Confusion in and about shared decision making in hospital outpatient encounters. *Patient Education and Counseling*, *96*(3), 287-294.
- Hall, C. J., Smith, P. H., & Wicaksono, R. (2013). *Mapping applied linguistics: A guide for students and practitioners*. Routledge.
- Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, *19*(sup1), 188–196. <https://doi.org/10.1080/13561820500081745>
- Harvey, A. G., & Gumport, N. B. (2015). Evidence-based psychological treatments for mental disorders: Modifiable barriers to access and possible solutions. *Behaviour Research and Therapy*, *68*, 1–12. <https://doi.org/10.1016/j.brat.2015.02.004>.
- Hasler, G., Moergeli, H., Bachmann, R., Lambreva, E., Buddeberg, C., & Schnyder, U. (2004). Patient satisfaction with outpatient psychiatric treatment: The role of diagnosis, pharmacotherapy, and perceived therapeutic change. *Canadian Journal of Psychiatry*, *49*(5), 315-321.
- Haussaman, H. (2016, February 8). AG clears health providers; Martinez Admin. defends Medicaid freeze. [News article]. *NMPolitics.net*. Retrieved November 27, 2018 from <https://nmpolitics.net/index/2016/02/ag-clears-health-providers-martinez-admin-defends-medicaid-freeze/>.

- Hayes, S. C., & Heiby, E. M. (Eds.). (1998). *Prescription privileges for psychologists: A critical appraisal*. Reno, NV: Context Press.
- Health Resources and Services Administration [HRSA]. (2014a). Health professional shortage areas. Accessed July 11, 2014 at <http://hrsa.gov/shortage/index.html>.
- Health Resources and Services Administration [HRSA]. (2014b). Health center patient satisfaction survey. Available at <http://bphc.hrsa.gov/policiesregulations/performanceasures/patientsurvey/satisfactionsurvey.html>.
- Health Resources and Services Administration [HRSA]. (2018). Health Professional Shortage Areas. [Dataset]. Retrieved November 27, 2018 from <https://data.hrsa.gov/tools/shortage-area/hpsa-find>.
- Health Resources and Services Administration [HRSA]. (2019a). Map tool and dataset. Retrieved March 6, 2019 from <https://data.hrsa.gov/hdw/tools/MapTool.aspx>.
- Health Resources and Services Administration [HRSA]. (2019b). Shortage designation application and scoring process. Retrieved March 6, 2019 from <https://bhw.hrsa.gov/shortage-designation/hpsa-process>.
- Healthwise. (2014). What is shared decision making? Retrieved November 10, 2014 from <http://www.informedmedicaldecisions.org/what-is-shared-decision-making/>
- Heiby, E. (1998). The case against prescription privileges for psychologists: An overview. In S. C. Hayes & E. M. Heiby (Eds.), *Prescription Privileges for Psychologists: A Critical Appraisal*. Reno, NV: Context Press.

- Henwood, B. F., Derejko, K.-S., Couture, J., & Padgett, D. K. (2015). Maslow and mental health recovery: A comparative study of homeless programs for adults with serious mental illness. *Administration and Policy in Mental Health, 42*(2), 220–228.
<https://doi.org/10.1007/s10488-014-0542-8>
- Herrman, H., Trauer, T., Warnock, J., & Team, P. L. C. (Australia) P. (2002). The roles and relationships of psychiatrists and other service providers in mental health services. *Australian and New Zealand Journal of Psychiatry, 36*(1), 75–80.
<https://doi.org/10.1046/j.1440-1614.2002.00982.x>
- Hironaka, L. K., & Paasche-Orlow, M. K. (2008). The implications of health literacy on patient–provider communication. *Archives of Disease in Childhood, 93*(5), 428–432.
- Hoffmann, T. C., Légaré, F., Simmons, M. B., McNamara, K., McCaffery, K., Trevena, L. J., ... & Del Mar, C. B. (2014). Shared decision making: What do clinicians need to know and why should they bother?. *The Medical journal of Australia, 201*(1), 35-39.
- Holstein, R., & Paul III, D. P. (2012). ‘Phantom Networks’ of managed behavioral health providers: An empirical study of their existence and effect on patients in two New Jersey counties. *Hospital Topics, 90*(3), 65-73.
- Hoover, M., & Andazola, J. (2012). Integrated behavioral care training in family practice residency: Opportunities and challenges. *Journal of Clinical Psychology in Medical Settings, 19*(4), 446-450.
- Hughes, C.C. (1996). Ethnopsychiatry. In C. Sargent and T. Johnson (Eds.), *Medical Anthropology: Contemporary Theory and Method* (pp. 132-148). New York, NY: Praeger.

- Hunt, S. D. (1991). Positivism and paradigm dominance in consumer research: Toward critical pluralism and rapprochement. *Journal of Consumer Research*, 32-44.
- Hunter, C. E., Palepu, A., Farrell, S., Gogosis, E., O'Brien, K., & Hwang, S. W. (2015). Barriers to prescription medication adherence among homeless and vulnerably housed adults in three Canadian cities. *Journal of Primary Care & Community Health*, 6(3), 154–161. <https://doi.org/10.1177/2150131914560610>
- Hutschemaekers, G., Tiemens, B., & Kaasenbrood, A. (2005). Roles of psychiatrists and other professionals in mental healthcare: Results of a formal group judgement method among mental health professionals. *The British Journal of Psychiatry: The Journal of Mental Science*, 187, 173–179. <https://doi.org/10.1192/bjp.187.2.173>
- IAPT Programme. (2014). Improving Access to Psychological Therapies. (2014). *National Health Service*. Retrieved from <http://www.iapt.nhs.uk/>.
- Iberg, J. R. (2001). “Unconditional positive regard: Constituent activities,” in *Rogers' Therapeutic Conditions: Evolution, Theory and Practice, Volume 3: Unconditional Positive Regard*, eds J. Bozarth and P. Wilkins (Ross-on-Wye, Herefordshire HR9: PCCS Books), 155–171.
- Iezzoni, L. I., Ngo, L., & Kinkel, R. P. (2007). Social security disability application experiences of people with multiple sclerosis in the United States. *International Journal of MS Care*, 9(4), 131–138.
- Ingram, B. L., & Chung, R. S. (1997). Client satisfaction data and quality improvement planning in managed mental health care organizations. *Health care management review*, 22(3), 40-52.

- Institute of Medicine [IOM]. (2013). The IOM Health Care Quality Initiative. Available at <http://www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx>
- Issel, L. M., & Wells, R. (2017). *Health program planning and evaluation*. New York, NY: Jones & Bartlett Learning.
- jazintellect.wordpress.com. (2013). The final rant, part 2: Dispelling the myth. Retrieved November 1, 2014 from <http://jazintellect.wordpress.com/2013/03/29/the-final-rant-part-two-dispelling-the-myth/>.
- Jena, A.B., Seabury, S., Lakdawalla, D., Chandra, A. (2011). Malpractice risk according to physician specialty. *New England Journal of Medicine*, 365(7): 629–636.
- Jenkins, J. (1996). Culture, emotion, and psychiatric disorder. In C. Sargent and T. Johnson (Eds.), *Medical Anthropology: Contemporary Theory and Method* (pp. 71-87). New York, NY: Praeger.
- Johnson, G., & Chamberlain, C. (2011). Are the homeless mentally ill? *Australian Journal of Social Issues*, 46(1), 29–48. <https://doi.org/10.1002/j.1839-4655.2011.tb00204.x>
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of mixed methods research*, 1(2), 112-133.
- Joseph, S. (2012). Unconditional positive regard. *Psychology Today*. Retrieved March 11, 2019 from <https://www.psychologytoday.com/us/blog/what-doesnt-kill-us/201210/unconditional-positive-regard>.

- Kaba, F., Solimo, A., Graves, J., Glowa-Kollisch, S., Vise, A., MacDonald, R., ... Angell, S. (2015). Disparities in mental health referral and diagnosis in the New York City jail mental health service. *American Journal of Public Health, 105*(9), 1911–1916.
- Karnieli-Miller, O., Zisman-Ilani, Y., Meitar, D., & Mekori, Y. (2014). The role of medical schools in promoting social accountability through shared decision-making. *Israel journal of health policy research, 3*(1), 26.
- Katschnig, H. (2010). Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. *World Psychiatry, 9*(1), 21-28.
- Kaye, H. S., Jans, L. H., & Jones, E. C. (2011). Why don't employers hire and retain workers with disabilities? *Journal of Occupational Rehabilitation, 21*(4), 526–536.
<https://doi.org/10.1007/s10926-011-9302-8>
- Kennicott, M. (2015, November 10). New report shows significant improvement for mental health in New Mexico. [Press release]. *New Mexico Human Services Department*. Retrieved November 27, 2018 from http://www.hsd.state.nm.us/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/FINAL___MHA_Numbers_Release.pdf.
- Kicheloe, J. & McLaren, P. (2002). Rethinking critical theory and qualitative research. In Y. Zou & E. Trueba (Eds.), *Ethnography and Schools: Qualitative Approaches to the Study of Education* (pp. 87-138). New York, NY: Rowman & Littlefield.
- Kinash, S. (2006). Paradigms, Methodology & Methods. *Bond University, Australia*. Available at < http://bond.edu.au/prod_ext/groups/public/@pub-tls-gen/documents/genericwebdocument/bd3_012336.pdf>

- Kleinman, A. (1995). *Writing at the Margins: Discourse Between Anthropology and Medicine*. Berkeley, CA: University of California Press.
- Klumpp, E. (2009). What puts a psychiatrist at risk for a malpractice lawsuit? *Psychiatry*, 6(8):38–39.
- Knobel, M. (1999). *Everyday Literacies: Students, Discourse, and Social Practice*, New York: Lang.
- Køppe, S. (2012). A moderate eclecticism: Ontological and epistemological issues. *Integrative Psychological and Behavioral Science*, 46(1), 1-19.
- Kotze, T. G., & Du Plessis, P. J. (2003). Students as “co-producers” of education: A proposed model of student socialisation and participation at tertiary institutions. *Quality Assurance in Education*, 11(4), 186-201.
- Kratochwill, T.R., Johnston, H.F., & Fruehling, J.J. (2009). Limited prescription privileges for psychologists: Review and implications for the practice of psychology in the schools. *Psychology in the Schools*, 46(9): 836-845.
- Kravitz, R. (1998). Patient satisfaction with health care. *Journal of general internal medicine*, 13(4), 280-282.
- Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). The health literacy of America’s adults: Results from the 2003 National Assessment of Adult Literacy (NCES 2006–483). U.S. Department of Education. Washington, DC: National Center for Education Statistics.

- Lavoie, K. L., & Barone, S. (2006). Prescription privileges for psychologists. *CNS drugs*, 20(1), 51-66.
- Lavoie, K. L., & Fleet, R. P. (2002). Should psychologists be granted prescription privileges? A review of the prescription privilege debate for psychiatrists. *Canadian Journal of Psychiatry*, 47(5), 443-449.
- Leech, N. L., & Onwuegbuzie, A. J. (2009). A typology of mixed methods research designs. *Quality & Quantity*, 43(2), 265-275
- Lerner, E.B., Jehle, D.V.K., Janicke, D.M., & Moscati, R.M. (2000). Medical communication: Do our patients understand? *American Journal of Emergency Medicine*, 18(7):764–6.
- Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, 12, 18. <https://doi.org/10.1186/1475-9276-12-18>
- Lincoln, A. K., Arford, T., Doran, M. V., Guyer, M., & Hopper, K. (2015). A preliminary examination of the meaning and effect of limited literacy in the lives of people with serious mental illness: Limited literacy and serious mental illness. *Journal of Community Psychology*, 43(3), 315–320. <https://doi.org/10.1002/jcop.21680>
- Lincoln, A., Espejo, D., Johnson, P., Paasche-Orlow, M., Speckman, J. L., Webber, T. L., & White, R. F. (2008). Limited literacy and psychiatric disorders among users of an urban safety net hospital's mental health outpatient clinic. *The Journal of Nervous and Mental Disease*, 196 (9), 687–693.

- Lock, M. & Nguyen, V-K. (2010). *An Anthropology of Medicine*. Malden, MA: Wiley-Blackwell.
- MacDowell, M., Glasser, M., Fitts, M., Nielsen, K., & Hunsaker, M. (2010). A national view of rural health workforce issues in the USA. *Rural Remote Health, 10*(3): 1531-1546.
- Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in educational research, 16*(2), 193-205.
- Mahlke, C. I., Krämer, U. M., Becker, T., & Bock, T. (2014). Peer support in mental health services: *Current Opinion in Psychiatry, 27*(4), 276–281.
<https://doi.org/10.1097/YCO.0000000000000074>
- Makoul, G., & Clayman, M. L. (2006). An integrative model of shared decision making in medical encounters. *Patient education and counseling, 60*(3), 301-312.
- Martin, L. R., Williams, S. L., Haskard, K. B., & DiMatteo, M. R. (2005). The challenge of patient adherence. *Therapeutics and clinical risk management, 1*(3), 189.
- Martínez, J. A., & Martínez, L. (2010). Some insights on conceptualizing and measuring service quality. *Journal of Retailing and Consumer Services, 17*(1), 29-42.
- May, R. J. (1991). Effects of waiting for clinical services on attrition, problem resolution, satisfaction, attitudes toward psychotherapy, and treatment outcome: A review of the literature. *Professional Psychology: Research and Practice, 22*(3), 209-214
- Maybank, K. A., & Dickson, T. (2008). Breaking down health literacy barriers. *DOs against Diabetes, 4*.

- Mayo Clinic Shared Decision Making National Resource Center. (2014). Shared decision making philosophy. Retrieved from < <http://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/>>
- Mayo Clinic. (2014). Mayo Clinic Shared Decision Making National Resource Center. Retrieved November 10, 2014 from <http://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/>.
- Mayo Clinic. (2014). Psychotherapy. Available at <http://www.mayoclinic.org/tests-procedures/psychotherapy/basics/what-you-can-expect/prc-20013335>.
- McCarthy, D. M., Waite, K. R., Curtis, L. M., Engel, K. G., Baker, D. W., & Wolf, M. S. (2012). What did the doctor say? Health literacy and recall of medical instructions. *Medical Care, 50*(4), 277–282. <https://doi.org/10.1097/MLR.0b013e318241e8e1>
- McGrath, R. E., Wiggins, J. G., Sammons, M. T., Levant, R. F., Brown, A., & Stock, W. (2004). Professional issues in pharmacotherapy for psychologists. *Professional Psychology: Research and Practice, 35*(2), 158-163.
- McGrath, R.E. & Sammons, M. (2011). Prescribing and primary care psychology: Complementary paths for professional psychology. *Professional Psychology: Research and Practice, 42*(2): 113-120.
- McGrath, R.E. (2012). Prescribing in integrated primary care: A path forward. *Journal of Clinical Psychology in Medical Settings, 19*: 451-454.

- McGuiness, K.M. (2012). The prescribing clinical health psychologist: A hybrid skill set in the new era of integrated healthcare. *Journal of Clinical Psychology in Medical Settings*, 19:434-440.
- McLeod, J. (2014). Carl Rogers. Retrieved March 11, 2019 from <https://www.simplypsychology.org/carl-rogers.html>.
- Mental Health America. (2004). Position statement 36. In support of self-determination initiatives. Retrieved August, 2007, from <http://www.mentalhealthamerica.net/go/position-statements/36>
- Meppelink, C. S., van Weert, J. C. M., Haven, C. J., & Smit, E. G. (2015). The effectiveness of health animations in audiences with different health literacy levels: An experimental study. *Journal of Medical Internet Research*, 17(1), e11.
<https://doi.org/10.2196/jmir.3979>
- Merrick, L. (2007). *Prescriptive authority for psychologists: Issues and considerations*. Hawaii Legislative Reference Bureau. Available at <http://lrbhawaii.info/lrbrpts/06/rxauth.pdf>.
- Merwin, E., Hinton, I., Dembling, B., & Stern, S. (2003). Shortages of rural mental health professionals. *Archives of Psychiatric Nursing*, 17(1): 42-51.
- Michaliski, D. & Fowler, G. (2016, January). Doctoral degrees in psychology: How are they different, or not so different? *American Psychology Association Psychology Student Network*. Retrieved December 17, 2018 from <https://www.apa.org/ed/precollege/psn/2016/01/doctoral-degrees.aspx>

- Michaliski, D., Cope, C., & Fowler, G. (2016). Summary report: Admissions, applications, and acceptances. *American Psychological Association Education Directorate, Office of Graduate and Post-Graduate Education & Training*. Retrieved December 17, 2018 from <https://www.apa.org/education/grad/survey-data/2017-admissions-applications.aspx>.
- Michels, M. E. J., Evans, D. E., & Blok, G. A. (2012). What is a clinical skill? Searching for order in chaos through a modified Delphi process. *Medical Teacher, 34*(8), e573-581. <https://doi.org/10.3109/0142159X.2012.669218>
- Miller, M. J., & Ambrose, D. M. (2019). The problem of missed mental healthcare appointments. *Clinical Schizophrenia & Related Psychoses, 12*(4), 177–184. <https://doi.org/10.3371/CSRP.MIAM.112316>
- Minkler, M. (2000). Using participatory action research to build healthy communities. *Public Health Reports, 115*(2-3), 191.
- Minkler, M., Vásquez, V. B., Tajik, M., & Petersen, D. (2008). Promoting environmental justice through community-based participatory research: The role of community and partnership capacity. *Health Education & Behavior, 35*(1), 119-137.
- Mitchell, A. J., Delaffon, V., Vancampfort, D., Correll, C. U., & De Hert, M. (2012). Guideline concordant monitoring of metabolic risk in people treated with antipsychotic medication: Systematic review and meta-analysis of screening practices. *Psychological Medicine, 42*(01), 125–147. <https://doi.org/10.1017/S003329171100105X>
- Moffitt, R., & National Bureau of Economic Research (Eds.). (2016). The Supplemental Security Income (SSI) program. In *Means-tested transfer programs in the United States* (pp. 1–58). Chicago, Ill.: University of Chicago Press.

- Mojtabai, R., Stuart, E. A., Hwang, I., Susukida, R., Eaton, W. W., Sampson, N., & Kessler, R. C. (2015). long-term effects of mental disorders on employment in the National Comorbidity Survey ten-year follow-up. *Social Psychiatry and Psychiatric Epidemiology*, 50(11), 1657–1668. <https://doi.org/10.1007/s00127-015-1097-z>
- Moody, C.E., Smith, M.T., & Maedgen, B.J. (1993). Litigation of psychiatric malpractice claims. *Medical Malpractice Conference, 1993*.
- Moore, B. & McGrath, R.E. (2007). How prescriptive authority for psychologists would help service members in Iraq. *Professional Psychiatry: Research and Practice*, 2: 191-195.
- Morris, B. J., Jahangir, A. A., & Sethi, M. K. (2013). Patient satisfaction: An emerging health policy issue. *AAOS Now*.
- Morrissey, J. P., Thomas, K. C., Ellis, A. R., & Konrad, T. R. (2007). Geographic disparities in the mental health workforce. HSH-230200532038C.
- Moyer, D. M. (1995). An opposing view on prescription privileges for psychologists. *Professional Psychology: Research and Practice*, 26(6), 586.
- Munsey, C. (2006). RxP legislation made historic progress in Hawaii. *Monitor on Psychology*, 37(7): 42.
- Murry, B. (2003). A brief history of prescribing psychology. *Monitor*, 34(9): 66. Retrieved March 3, 2019 from <https://www.apa.org/monitor/oct03/rxp>.
- Muse, M. & McGrath, R.E. (2010). Training comparison among three professions prescribing psychoactive medications: Psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. *Journal of Clinical Psychology*, 66(1): 96-103.

Myles, P. S., Williams, D. L., Hendrata, M., Anderson, H., & Weeks, A. M. (2000). Patient satisfaction after anaesthesia and surgery: Results of a prospective survey of 10,811 patients. *British Journal of Anaesthesia*, 84(1), 6-10.

National Alliance for the Mentally Ill [NAMI]. (2014). About NAMI. Retrieved from http://www.nami.org/template.cfm?section=About_NAMI.

National Alliance for the Mentally Ill. (2006). NAMI policy platform: 3. treatment. Retrieved from http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=45980

National Alliance on Mental Illness [NAMI]. (2011). *State Mental Health Cuts: A National Crisis*. Retrieved from <https://www.nami.org/getattachment/About-NAMI/Publications/Reports/NAMISStateBudgetCrisis2011.pdf>

National Alliance on Mental Illness. (2011). *State Mental Health Cuts: A National Crisis*. Retrieved from <https://www.nami.org/getattachment/About-NAMI/Publications/Reports/NAMISStateBudgetCrisis2011.pdf>

National Alliance to End Homelessness. (2019). Homelessness in America: What causes homelessness? Retrieved January 19, 2019, from <https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/health/>

National Archives. (n.d.) Open government licence. Retrieved March 2, 2019 from <http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/>

National Association of Social Workers. (1999). Code of ethics of the National Association of Social Workers. Retrieved from [http:// www.socialworkers.org/ pubs/ code/code.asp](http://www.socialworkers.org/pubs/code/code.asp)

National Center for Education Statistics [NCES]. (2018). Public high school graduation rates. Retrieved March 3, 2019 from https://nces.ed.gov/programs/coe/indicator_coi.asp.

National Center for Education Statistics [NCES]. (n.d.). National Assessment of Adult Literacy: State and county estimates of low literacy. Retrieved March 3, 2019 from <https://nces.ed.gov/naal/estimates/overview.aspx>.

National Coalition for the Homeless. (2009). *Mental illness and homelessness*. [Agency fact sheet]. Retrieved January 15, 2019 from https://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

National Council of State Boards of Nursing. (2014). National Council of State Boards of Nursing (NCSBN). Retrieved from <https://www.ncsbn.org/nclex.htm>.

National Health Services (NHS). (2014). Community Mental Health Survey 2014. [Questionnaire]. Available at: <http://www.nhssurveys.org/survey/1370>.

National Institute of Mental Health. (2014). About NIMH. Document number NIH 12-7730.

National Learning Consortium. (2013). Shared decision making. Retrieved March 6, 2019 from https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf.

National Network of Libraries of Medicine. (2014). "Health literacy." Retrieved from <http://nnlm.gov/outreach/consumer/hlthlit.html>.

New London Group. (1996). A pedagogy of multiliteracies: Designing social futures. *Harvard Law Review*, 66:1. Available at

http://wwwstatic.kern.org/filer/blogWrite44ManilaWebsite/paul/articles/A_Pedagogy_of_Multiliteracies_Designing_Social_Futures.htm.

New Mexico Board of Nursing. (2014). Laws and rules Retrieved from

<http://nmbon.sks.com/ruleiso.aspx>.

New Mexico Human Services Department. (2012). Core Service Agency: Basic information.

[Public information document]. Retrieved November 26, 2018 from

http://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/1_CSA_Basic_Information_July_2012.pdf.

New Mexico Medical Board. (2014). New Mexico Medical Board. Retrieved from

<http://www.nmmb.state.nm.us/>.

New Mexico Nursing Education Consortium . (2014). Curriculum. Available at

<http://www.nmnec.org/curriculum.aspx>.

New Mexico Regulations and Licensing Department [NMRLD]. (2018). New Mexico State

Board Of Psychologist Examiners: Professional Psychologists Act. Retrieved January 28, 2019 from

[http://www.rld.state.nm.us/uploads/files/Psychologist%20Examiners%20Rules%20and%20Statutes%20-%20Effective%20July%201%2C%202018%20\(Printable%20%20Sided\).pdf](http://www.rld.state.nm.us/uploads/files/Psychologist%20Examiners%20Rules%20and%20Statutes%20-%20Effective%20July%201%2C%202018%20(Printable%20%20Sided).pdf).

New Mexico State University Department of Counseling and Educational Psychology [NMSU

CEP]. (2018). Postdoctoral M.S. in clinical psychopharmacology (MSCP) degree.

Retrieved December 17, 2018 from <https://cep.nmsu.edu/academic-programs/clinical-psychopharmacology/>.

- New Mexico State University. (2014). Psychopharmacology Training for Practicing Psychologists. Available at <http://cep.education.nmsu.edu/academic-programs/clinical-psychopharmacology/>.
- Newman, R., Phelps, R., Sammons, M.T., Dunivin, D.L., & Cullen, E.A. (2000). Evaluation of the Psychopharmacology Demonstration Project: A retrospective analysis. *Professional Psychology: Research and Practice, 31*(6): 598-603.
- Noel, S. (2018). Person-centered therapy (Rogerian therapy). Retrieved March 11, 2019 from <https://www.goodtherapy.org/learn-about-therapy/types/person-centered>.
- O'Hare, A. M., Armistead, N., Schrag, W. L. F., Diamond, L., & Moss, A. H. (2014). Patient-Centered Care: An Opportunity to Accomplish the “Three Aims” of the National Quality Strategy in the Medicare ESRD Program. *Clinical Journal of the American Society of Nephrology, CJN-01930214*.
- Onwuegbuzie, A. J., Johnson, R. B., & Collins, K. M. (2009). Call for mixed analysis: A philosophical framework for combining qualitative and quantitative approaches. *International Journal of Multiple Research Approaches, 3*(2), 114-139.
- O'Shaughnessy, J., & O'Shaughnessy, N. (2002). Ways of knowing and their applicability. *Marketing Theory, 2*(2), 147-164.
- Ozanne, J. L., & Murray, J. B. (1995). Uniting critical theory and public policy to create the reflexively defiant consumer. *American Behavioural Scientist, 38*, 516-516.
- Paasche-Orlow, M. K., & Wolf, M. S. (2007). The causal pathways linking health literacy to health outcomes. *American Journal of Health Behavior, 31*(Supplement 1), S19-S26.

Parikh, N. S., Parker, R. M., Nurss, J. R., Baker, D. W., & Williams, M. V. (1996). Shame and health literacy: The unspoken connection. *Patient Education and Counseling*, 27(1), 33–39.

Peck, E., & Norman, I. (1999). Working together in adult community mental health services: Exploring inter-professional role relations. *Journal of Mental Health*, 8(3), 231–243.
<https://doi.org/10.1080/09638239917391>

Perrenoud, B., Velonaki, V.-S., Bodenmann, P., & Ramelet, A.-S. (2015). The effectiveness of health literacy interventions on the informed consent process of health care users: A systematic review protocol. *JBIC Database of Systematic Reviews and Implementation Reports*, 13(10), 82–94. <https://doi.org/10.11124/jbisrir-2015-2304>

Perrenoud, B., Velonaki, V.-S., Bodenmann, P., & Ramelet, A.-S. (2015). The effectiveness of health literacy interventions on the informed consent process of health care users: A systematic review protocol. *JBIC Database of Systematic Reviews and Implementation Reports*, 13(10): 82-94.

Petterson, S., Miller, B. F., Payne-Murphy, J. C., & Phillips, R. L. (2014). Mental health treatment in the primary care setting: Patterns and pathways. *Families, Systems, & Health*, 32(2), 157–166. <https://doi.org/10.1037/fsh0000036>

Picker Institute of Europe [PIE]. (2014). Redevelopment of the community mental health service users survey. Available at
<http://www.cqc.org.uk/sites/default/files/MH14%20technical%20document%20v1.pdf>

Pierce, M. (2016). 3 core conditions for therapeutic change. Retrieved March 11, 2019 from
<https://trueselfcounseling.com/2016/02/20/3-core-conditions-for-therapeutic-change/>

- Pies, R. W. (1991). The " deep structure" of clinical medicine and prescribing privileges for psychologists. *Journal of Clinical Psychiatry*, 52(1): 4-8.
- Pleasant, A., & McKinney, J. (2011). Coming to consensus on health literacy measurement: An online discussion and consensus-gauging process. *Nursing Outlook*, 59(2), 95-106.e1. <https://doi.org/10.1016/j.outlook.2010.12.006>
- Poux, S. (2017). Social Ecological Model Offers new approach to public health. Retrieved March 11, 2019 from <https://borgenproject.org/social-ecological-model/>.
- Rae, W.A., Jensen-Doss, A., Bowden, R., Mendoza, M., & Banda, T. (2008). Prescription privileges for psychologists: Opinions of pediatric psychologists and pediatricians. *Journal of Pediatric Psychology*, 33(2): 176-184.
- Researchgate.net. (2014). What is the difference between research paradigm and research approach. [Researcher generated content]. Available at http://www.researchgate.net/post/What_is_the_difference_between_research_paradigm_and_research_approach
- Reville, W. (2018). An introduction to psychometric theory with applications in R. [Open-access textbook]. Published online only at www.personality-project.org/
- Rhodes, K. V., Vieth, T. L., Kushner, H., Levy, H., & Asplin, B. R. (2009). Referral without access: For psychiatric services, wait for the beep. *Annals of Emergency Medicine*, 54(2), 272-278.

- Rhodes, L.A. (1996). Studying biomedicine as a cultural system. In C. Sargent and T. Johnson (Eds.), *Medical Anthropology: Contemporary Theory and Method* (pp. 159-173). New York, NY: Praeger.
- Richard, C., Glaser, E., & Lussier, M.-T. (2017). Communication and patient participation influencing patient recall of treatment discussions. *Health Expectations*, 20(4), 760–770. <https://doi.org/10.1111/hex.12515>
- Riley, W.T., Elliott, R.L., Thomas, J.R. (1992). Impact of prescription privileges on psychology training: Training director's survey. *Clinical Psychology*, 45: 63–70.
- Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Mareck, S., & Armstrong, J. (2002). Prescriptive authority for psychologists: A looming health hazard?. *Clinical Psychology: Science and Practice*, 9(3), 231-248.
- Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., ... & Tanenbaum, R. L. (2003). Prescriptive authority for psychologists: Despite deficits in education and knowledge?. *Journal of Clinical Psychology in Medical Settings*, 10(3), 211-221.
- Robiner, W. N., Tumlin, T. R., & Tompkins, T. L. (2013). Psychologists and medications in the era of interprofessional care: Collaboration is less problematic and costly than prescribing. *Clinical Psychology: Science and Practice*, 20(4), 489–507. <https://doi.org/10.1111/cpsp.12054>
- Roter, D. L. (2011). Oral literacy demand of health care communication: Challenges and solutions. *Nursing Outlook*, 59(2), 79–84. <https://doi.org/10.1016/j.outlook.2010.11.005>

- Ryan, C. (2018). *Computer and Internet Use in the United States: 2016* (No. ACS 39) (p. 14).
U.S. Census Bureau.
- Safeer, R. S., & Keenan, J. (2005). Health literacy: The gap between physicians and patients.
Health Literacy, 72(3), 6.
- Saldaña, J. (2016). *The Coding Manual for Qualitative Researchers*. Thousand Oaks, California:
SAGE.
- Schauer, C., Everett, A., del Vecchio, P., & Anderson, L. (2007). Promoting the value and
practice of shared decision-making in mental health care. *Psychiatric Rehabilitation
Journal*, 31(1), 54.
- Schembri, S., & Sandberg, J. (2002). Service quality and the consumer's experience: Towards an
interpretive approach. *Marketing theory*, 2(2), 189-205.
- Schlapobersky, J. R. (2015). Group psychotherapy in the United Kingdom. *International Journal
of Group Psychotherapy*, 65(4), 568–581. <https://doi.org/10.1521/ijgp.2015.65.4.568>
- Schwartzberg, J. G., Cowett, A., VanGeest, J., & Wolf, M. S. (2007). Communication techniques
for patients with low health literacy: A survey of physicians, nurses, and pharmacists.
American Journal of Health Behavior, 31(1), 96–104.
<https://doi.org/10.5993/AJHB.31.s1.12>
- Seale, C., Chaplin, R., Lelliott, P., & Quirk, A. (2006). Sharing decisions in consultations
involving anti-psychotic medication: A qualitative study of psychiatrists' experiences.
Social Science & Medicine, 62(11), 2861–2873.
<https://doi.org/10.1016/j.socscimed.2005.11.002>

- Sederer, L. I. (2016). The social determinants of mental health. *Psychiatric Services* (Washington, D.C.), 67(2), 234–235. <https://doi.org/10.1176/appi.ps.201500232>
- Sentell, T. L., & Shumway, M. A. (2003). Low literacy and mental illness in a nationally representative sample. *Journal of Nervous and Mental Disease*, 191(8), 549–552.
- Sentell, T. L., & Shumway, M. A. (2003). Low literacy and mental illness in a nationally representative sample. *Journal of Nervous and Mental Disease*, 191(8), 549–552.
- Seymour, H. (1984). Health education versus health promotion—a practitioner's view. *Health Education Journal*, 43(2-3), 37-38.
- Shapiro, J. & Hughes, K. (1996). Information literacy as a liberal art. *Educom Review*, 31(2).
- Shearer, D.S., Harmon, S.C., Seavey, B.M., & Tiu, A.Y. (2012). The primary care prescribing psychologist model: Medical provider ratings of the safety, impact and utility of prescribing psychology in a primary care setting. *Journal of Clinical Psychology in Medical Settings*, 19: 420-429.
- Sheng, Y. & Sheng, Z. (2012). Is coefficient alpha robust to non-normal data? *Frontiers of Psychology*, 3(34): 1-13.
- Shepherd, A., Shorthouse, O., & Gask, L. (2014). Consultant psychiatrists' experiences of and attitudes towards shared decision making in antipsychotic prescribing, a qualitative study. *BMC Psychiatry*, 14(1), 127. <https://doi.org/10.1186/1471-244X-14-127>
- Shohet, L., & Renaud, L. (2006). Critical Analysis on Best Practices in Health Literacy, *Canadian Journal of Public Health*, 97(4): S3-10.

- Sickel, A. E., Seacat, J. D., & Nabors, N. A. (2014). Mental health stigma update: A review of consequences. *Advances in Mental Health, 12*(3), 202–215.
<https://doi.org/10.1080/18374905.2014.11081898>
- Simon, R.I. (2003). The law and psychiatry. *Focus: The Journal of Lifelong Learning in Psychiatry, 1*(4): 349-372.
- Small, N., Brooks, H., Grundy, A., Pedley, R., Gibbons, C., Lovell, K., & Bee, P. (2017). Understanding experiences of and preferences for service user and carer involvement in physical health care discussions within mental health care planning. *BMC Psychiatry, 17*.
<https://doi.org/10.1186/s12888-017-1287-1>
- Smith, S. K., Dixon, A., Trevena, L., Nutbeam, D., & McCaffery, K. J. (2009). Exploring patient involvement in healthcare decision making across different education and functional health literacy groups. *Social Science & Medicine, 69*(12), 1805-1812.
- Solomon, K. D., Fernández de Castro, L. E., Sandoval, H. P., Biber, J. M., Groat, B., Neff, K. D., ... & Lindstrom, R. L. (2009). LASIK world literature review: Quality of life and patient satisfaction. *Ophthalmology, 116*(4), 691-701.
- Sowers, W., & Quality Management Committee of the American Association of Community Psychiatrists. (2005). Transforming systems of care: The American Association of Community Psychiatrists Guidelines for Recovery Oriented Services. *Community. Mental Health Journal, 41*(6), 757–774.
- Stephanie. (2014, December 14). Cronbach’s alpha: Simple definition, use and interpretation. Statistics How To [blog]. Retrieved December 18, 2018 from
<https://www.statisticshowto.datasciencecentral.com/cronbachs-alpha-spss/>

- Stossel, L., Segar, N., Gliatto, P., Fallar, R., & Karani, R. (2012). Readability of patient education materials available at the point of care. *Journal of General Internal Medicine*, 27(9):1165–1170.
- Street, B. & Besnier, N. (1994). *Aspects of literacy*. T. Ingold (Ed.), *Companion Encyclopedia of Anthropology* (pp. 527-562). New York, NY: Routledge.
- Street, B. V. (2006). Autonomous and ideological models of literacy: Approaches from New Literacy Studies. *Media Anthropology Network*, 17.
- Stuart, R. B., & Heiby, E. E. (2007). To prescribe or not to prescribe: Eleven exploratory questions. *The Scientific Review of Mental Health*, 5(1), 1-29.
- Substance Abuse and Mental Health Services Administration (SAMSHA). (n.d.). What is integrated care? [Webpage]. Retrieved February 28, 2019 from <https://www.integration.samhsa.gov/resource/what-is-integrated-care>.
- Substance Abuse and Mental Health Services Administration (SAMSHA). (n.d.). What is integrated care? [Webpage]. Retrieved February 28, 2019 from <https://www.integration.samhsa.gov/resource/what-is-integrated-care>.
- Sudore, R. L., & Schillinger, D. (2009). Interventions to improve care for patients with limited health literacy. *Journal of Clinical Outcomes Management: JCOM*, 16(1), 20.
- Sundararaman, R. (2009). *The U.S. Mental Health Delivery System Infrastructure: A Primer* (Congressional Research Service No. R40536). Retrieved from <https://digital.library.unt.edu/ark:/67531/metadc700846/>

- Sutherland, E. & Tulkin, S.R. (2012). Primary care prescribing psychologists in the Indian Health Service. *Journal of Clinical Psychology in Medical Settings, 19*: 441-445.
- Swanson, K. A., Bastani, R., Rubenstein, L. V., Meredith, L. S., & Ford, D. E. (2007). Effect of mental health care and shared decision making on patient satisfaction in a community sample of patients with depression. *Medical Care Research and Review, 64*(4), 416-430.
- Tabachnick, B. G., & Fidell, L. S. (2012). *Using multivariate statistics* (6 edition). Boston, MA: Pearson.
- Tamblyn, R., Eguale, T., Huang, A., Winsdale, N., & Doran, P. The incidence and determinants of primary nonadherence with prescribed medication in primary care. *Annals of Internal Medicine, 160*(7): 441-451.
- Tatman S.M., Peters D.B., Greene A.L., Bongar, B. Graduate students' attitudes toward prescription privilege training. *Professional Psychology Research and Practice, 28*: 515–517.
- Teddle, C., & Yu, F. (2007). Mixed methods sampling a typology with examples. *Journal of Mixed Methods Research, 1*(1), 77-100.
- Terrell, S. (2017, August 25). Providers targeted in 2013 behavioral health shake-up appeal overpayment rulings. *The Santa Fe-New Mexican*. [News article]. Retrieved November 27, 2018 from http://www.santafenewmexican.com/news/health_and_science/providers-targeted-in-behavioral-health-shake-up-appeal-overpayment-rulings/article_47e5f1e2-129f-5591-b96e-a98f43172882.html.

- Thomas, C. R., & Holzer, C. E. (2006). The continuing shortage of child and adolescent psychiatrists. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(9), 1023-1033.
- Thompson, L., & McCabe, R. (2012). The effect of clinician-patient alliance and communication on treatment adherence in mental health care: A systematic review. *BMC psychiatry*, 12(1), 87.
- Trizano-Hermosilla I. & Alvarado, J.M. (2016). Best alternatives to Cronbach's alpha reliability in realistic conditions: Congeneric and asymmetrical measurements. *Frontiers of Psychology*, 7(769): 1-8.
- Tulkin, S.R. (2012). Prescribing psychologists in integrated primary care: Introduction to the special section. *Journal of Clinical Psychology in Medical Settings*, 19: 418-419.
- U.S. Census. (2018). Quickfacts: New Mexico. Retrieved March 3, 2019 from <https://www.census.gov/quickfacts/nm>.
- U.S. Department of Health and Human Services [HHS]. (2001). Healthy People 2010. Available at < <http://www.healthypeople.gov/2010/>>
- U.S. Department of Health and Human Services [HHS]. (2010). The National Action Plan to Improve Health Literacy. Available at < http://www.health.gov/communication/hlactionplan/pdf/Health_Literacy_Action_Plan.pdf >

- UNICEF. (2018). What are the Social Ecological Model (SEM), Communication for Development (C4D)? Retrieved March 11, 2019 from https://www.unicef.org/cbsc/files/Module_1_SEM-C4D.docx.
- United States Government Accountability Office (GAO). (2006). Medicare: Communications to beneficiaries on the prescription drug benefit could be improved. *United States Government Accountability Office Report to Congressional Requesters*. Available at <https://www.gao.gov/new.items/d06654.pdf>. Accessed November 19, 2018.
- United States Psychiatric Rehabilitation Association (USPRA). (2007). USPRA member public policy agenda 2007. Retrieved from http://www.uspra.org/files/public/USPRA_Policy_Priorities.pdf
- University of New Mexico School of Medicine. (2014). Admission FAQs. Retrieved from <http://som.unm.edu/admissions/application/faq.html>.
- Vector Research, Incorporated (VRI). (1996). Cost-effectiveness and feasibility of the DoD Psychopharmacology Demonstration Project: Final Report. Arlington, VA: Author.
- Wade, D. T., & Halligan, P. W. (2004). Do biomedical models of illness make for good healthcare systems? *BMJ: British Medical Journal*, 329(7479), 1398–1401.
- Walker, K. (2002). An ethical dilemma: Clinical psychologists prescribing psychotropic medications. *Issues in Mental Health Nursing*, 23(1), 17-29.
- Walters, G. D. (2001). A meta-analysis of opinion data on the prescription privilege debate. *Canadian Psychology/Psychologie Canadienne*, 42(2), 119-125.

- Wautier, G. & Tolman, A. (2007). Psychology and psychopharmacology: Natural partners in holistic healthcare. *Papeles del Psicólogo*, 28(2): 2-12
- Weaver, K. (2018). The pragmatic paradigm. In B.B. Frey (Ed.). *The SAGE Encyclopedia of Educational Research, Measurement, and Evaluation*. Thousand Oaks, California: SAGE Publications, Inc. <https://doi.org/10.4135/9781506326139>
- Westin, A. M., Barksdale, C. L., & Stephan, S. H. (2014). The effect of waiting time on youth engagement to evidence based treatments. *Community Mental Health Journal*, 50(2), 221-228.
- Wilder, C. M., Elbogen, E. B., Moser, L. L., Swanson, J. W., & Swartz, M. S. (2010). Medication preferences and adherence among individuals with severe mental illness and psychiatric advance directives. *Psychiatric Services*, 61(4), 380–385.
<https://doi.org/10.1176/ps.2010.61.4.380>
- Woltmann, E. M., & Whitley, R. (2010). Shared decision making in public mental health care: Perspectives from consumers living with severe mental illness. *Psychiatric Rehabilitation Journal*, 34(1), 29.
- World Health Organization. (2001). The World health report: 2001: Mental health: New understanding, new hope.
- World Health Organization. (2013). The World health report: 2001: Research for universal Coverage.
- Wyatt-Nichol, H., & Abel, C. F. (2007). A critical analysis of emergency management. *Administrative Theory & Praxis*, 29(4), 567-585.

Zarcadoolas, C., Pleasant, A., & Greer, D. (2006). *Advancing health literacy: A framework for understanding and action*. Jossey-Bass: San Francisco, CA.

APPENDIX A: SURVEY INSTRUMENTS

Provider Survey

This survey will collect information about your educational background and training. It should take approximately 10 minutes to complete.

The purpose of this survey is to collect detailed information related to the education, training, and perceived communication practices of prescribing psychologists.

You have been invited to voluntarily participate in this survey because you are a prescribing psychologist practicing in New Mexico.

The information you provide will be used to develop an understanding of the unique educational pathways undertaken by prescribing psychologists in New Mexico, and how these pathways may pertain to certain communication-related practices and initiatives.

The information you provide will remain confidential; the survey will not ask for your name. You can withdraw from participating in the survey at any time prior to hitting the “submit” button by closing your browser window. If you close your browser window before hitting submit, your information will not be collected for this research. Once you click “submit,” your information will be submitted and cannot be retrieved or withdrawn.

Please fill in the following information about the degrees and certifications you hold.

- A “postdoctoral” degree is any degree that required prior completion of a doctorate degree.
- If prior completion of a doctorate degree was not a requirement for a subsequent degree, please list any degrees earned after completion of a doctorate under either “undergraduate” or “graduate,” degree(s), as appropriate.

1.

Undergraduate

Degree	Degree Abbreviation	Major	Institution
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Graduate

Degree	Degree Abbreviation	Major	Institution
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Doctorate

Degree	Degree Abbreviation	Major	Institution
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Post-Doctorate

Degree	Degree Abbreviation	Major	Institution
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Non-Degree Certifications

2. What strategies do you usually use for providing clients with information about their treatment options regarding the reason for their visit to you?

Check all that apply.

- I do not usually provide clients with information about their treatment options.
- I provide clients with information verbally
- I provide clients with printed, primarily text information (e.g. pamphlets, medication warning sheets, books)
- I provide clients with information through other media (e.g. showing videos, playing audio recordings, or visiting websites that use these approaches; printed materials in

which information is conveyed using pictures, such as graphic novels, cartoons, or comics)

- I provide clients with decision aids designed specifically to help people make health decisions
- I direct patients to read certain printed resources, but I do not provide these resources to patients
- I direct patients to read certain online texts, but I do not provide access to these sources
- I direct patients to view certain multimedia sources, but I do not provide access to these sources
- Other (please specify): _____

3. What strategies do you usually use for providing clients with information about the treatments they are to receive from you?

- I do not usually provide clients with information about the treatments they are to receive.
- I provide clients with information verbally
- I provide clients with printed, primarily text-based information (e.g. pamphlets, medication warning sheets, books, etc.)
- I provide clients with information through other media (e.g. showing videos, playing audio recordings, or websites that use these approaches; printed materials in which information is conveyed using pictures, such as graphic novels, cartoons, or comics)
- I provide clients with decision aids designed specifically to help people make health decisions
- I direct patients to read certain printed resources, but I do not provide these resources to patients

- I direct patients to read certain online texts, but I do not provide access to these sources
- I direct patients to view certain multimedia sources, but I do not provide access to these sources
- Other (please specify): _____

For the purposes of the last few questions, section, here is a general definition of the term “shared decision making.”

“Shared decision making (SDM) is a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences...This process of sharing in the decision-making tasks involves developing a partnership based on empathy, exchanging information about the available options, deliberating while considering the potential consequences of each one, and making a decision by consensus”

Given the above definition...

4. Do you feel that you are familiar with the concept of shared decision making in health care?

- Yes
- No
- Somewhat

5. Do you feel you have received training that prepares you to practice shared decision making with most of your clients?

- Yes
- No

5a.

If yes, in which context(s) do you remember receiving such training? Check all that apply.

- Undergraduate education
- Graduate education
- Doctorate education
- Postdoctorate education
- Continuing education or professional development
- Other (please specify): _____

6. Do you feel that most of your clients are able to share as much as they want to in making decisions about the treatment they will receive from you?

- Yes
- No

Client Survey Instrument

This survey is also available online at: _____ . Please complete this survey online or put it in the mail by XXX.

What is the survey about?

This survey is about your experiences of the health care you receive from the mental health provider who gave or told you about this survey.

I'm interested in your views of that experience, even if your contact has only been limited or has now finished. This survey does not ask about your medical conditions, only about your care experiences.

Why is this survey being conducted?

Often, mental health service users (patients) are not asked how they feel about their care or treatments. This study is different. Your feedback is very important to helping me gain a picture of the care you received.

I am a researcher at the University of Texas-El Paso. This survey is part of a research project I am conducting to find out about mental health care quality. This survey is not being conducted by your mental health care provider.

Who should complete the survey?

If you are 18 years or older, and a current or former patient of the mental health care provider who gave or told you about this survey, then you are eligible to complete this survey.

This survey is not intended for mental health service users who are less than 18 years old or non-patient guardians, and it is only available in English.

This survey is completely voluntary; there is no penalty for not participating.

Compensation

When you turn in this survey, you will have the chance to win one of several \$50 Target gift cards. After the survey ends, a limited number of \$50 Target gift cards will be raffled to randomly selected participants who fill out the raffle form provided at the end of this survey. Not everyone who enters will win; chances of winning depend on the total number of entries received. You do not have to enter the raffle to participate in the survey.

Completing the survey on paper

For each question please cross clearly inside one box. If you prefer not to answer a question, simply leave it blank.

Sometimes you will find the box you have crossed has an instruction to go to another question. By following the instructions carefully you will skip the questions that do not apply to you.

Don't worry if you make a mistake; simply fill in the box and put a cross in the correct box.

When you have finished the survey, please put it in the envelope provided and put the envelope in the mail. **Please complete this survey online or put it in the mail by XXX.**

How will the information I provide be used and protected?

Information from this survey will be used to help me gain a picture of mental health care and may help improve mental health care.

Your individual answers will remain private. Your mental health care provider will **not** have access to your individual answers because you can do this survey online or you can do it on paper and mail it directly to me. Once I receive your survey information, I will be the only person with access to it. I will keep digital survey information password-protected and paper survey information locked up. I will not use your name when I store or report your survey answers so **your provider will not be told whether or not you participated.**

You do not have to provide your name or contact information with this survey; you can submit your responses anonymously and there will be no way to identify you or connect you to your answers.

Providing contact information is completely optional. There are prizes and other opportunities available for participating in this survey. If you would like a chance to win a prize and/or to participate in another research opportunity, you will need to provide your contact information at the end of this survey, where further details will be given.

If you do this survey online, your contact information will be automatically separated from your answers. If you do this survey on paper by mail, your contact information will not be separated from your answers until I receive your survey. When I receive your survey by mail, I will separate your contact information from your survey answers.

If you provide contact information for the chance to win a prize and/or to participate in another research opportunity, I will not use your contact information will to identify your answers.

Withdrawing from participation

This survey is completely voluntary. There is no penalty for not participating. You can decide not to participate in this research at any time until you turn in the survey. If you do not want to participate, simply do not turn in the survey. Once you submit the survey online or mail the paper survey to me, your answers cannot be retrieved or withdrawn.

Questions or concerns?

If you have any questions or concerns about participating in the survey, please email Ashley Bauer at agraboskibauer@miners.utep.edu or call (XXX).

Reminder: When a question asks about "this provider," please think in terms of the mental health services provider who gave or told you about this survey.

YOUR CARE AND TREATMENT

Please think in terms of **the mental health provider who gave or told you about this survey** when answering questions in this section.

1. When was the **last time** you saw **this provider** for **mental health services**?

- 1 In the last month
- 2 1 to 3 months ago
- 3 4 to 6 months ago
- 4 7 to 12 months ago
- 5 More than 12 months ago
- 6 Don't know / Can't remember
- 7 I have never seen anyone for mental health services → Please go to Q44 on Page 7

2. Overall, how long have you been in contact with **this** mental health services provider?

- 1 Less than 1 year
- 2 1 to 5 years
- 3 6 to 10 years
- 4 More than 10 years
- 5 I am no longer in contact with **this** mental health services provider
- 6 Don't know / Can't remember

3. In the last 12 months, do you feel you have seen this provider **often enough** for your needs?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No
- 4 I see them too often
- 5 Don't know

YOUR MENTAL HEALTH SERVICES PROVIDER

Thinking about **the most recent time** you **visit** this provider for your mental health needs...

4. How easy was the actual **journey** to see this person?

- 1 I found it easy to get there
- 2 I found it somewhat easy to get there
- 3 I found it hard to get there
- 4 I did not have to travel
- 5 Don't know / Can't remember

SW thinking about the **most recent time** you saw **this provider** for your mental health needs...

5. Did the person you saw **listen carefully** to you?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No
- 4 Don't know / Can't remember

6. Were you given **enough time** to discuss your needs and treatments?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No
- 4 Don't know / Can't remember

7. Did the person you saw **understand** how your mental health needs affect **other areas of your life**?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No
- 4 Don't know / Can't remember

Reminder: When a question asks about "this provider," please think in terms of the mental health services provider who gave or told you about this survey.

PLANNING YOUR CARE

Please think in terms of the mental health provider who gave or told you about this survey when answering questions in this section.

8. Have you agreed with **this provider** on what care you will receive?

- 1 Yes, definitely → Go to 9
- 2 Yes, to some extent → Go to 9
- 3 No → Go to 11

9. Were you involved as much as you wanted to be in agreeing on what care you will receive?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I wanted to be
- 4 No, but I did not want to be
- 5 Don't know / Can't remember

10. Does this agreement on what care you will receive take your personal circumstances into account?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No
- 4 Don't know / Can't remember

REVIEWING YOUR CARE

Please think in terms of the mental health provider who gave or told you about this survey when answering questions in this section.

11. In the last 12 months, have you had a direct conversation with **this provider** about how your care is going?

- 1 Yes → Go to 12
- 2 No → Go to 14
- 3 Don't know / Can't remember → Go to 14

12. Were you involved as much as you wanted to be in discussing how your care is working?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I wanted to be
- 4 No, but I did not want to be
- 5 Don't know / Can't remember

13. Did you feel that decisions were made **together** by you and **this provider** during this discussion?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No
- 4 No, but I did not want to be involved in making decisions
- 5 Don't know / Can't remember

Reminder: When a question asks about "this provider," please think in terms of the mental health services provider who gave or told you about this survey.

CHANGES IN WHO YOU SEE

14. How did you find out about **this provider**?

- 1 A friend or family member
- 2 The internet
- 3 My general physician / practitioner or primary care provider
- 4 My insurance company, Medicaid, or Medicare
- 5 The phone book
- 6 Other (please specify): _____

15. Having you been seeing **this provider** for 12 months or more?

Please **do not** include breaks when you stopped care completely.

- 1 Yes → Go to 18
- 2 No → Go to 18
- 3 Don't know/Can't remember → Go to 20

16. Besides **this provider**, have you ever seen **someone else** for mental health services?

- 1 Yes → Go to 17
- 2 No → Go to 20
- 3 Don't know/Can't remember → Go to 20

17. Before **this provider**, who did you see last for mental health services?

- 1 A primary care provider (PCP) / general practitioner or physician (GP)
- 2 A nurse
- 3 A psychiatrist
- 4 A psychologist
- 5 A social worker
- 6 A religious worker
- 7 A school counselor
- 8 Other (please specify): _____
- 9 Don't know / Can't remember

18. Why did you change to **this provider**?

(Select all that apply.)

- 1 I was referred to this provider by my primary care provider (PCP) / general practitioner or physician (GP)
- 2 I was referred to this provider by a different mental health services provider (not a PCP or GP)
- 3 My insurance changed or ended
- 4 I did not like my old provider
- 5 I moved
- 6 My old provider was too expensive
- 7 My old provider was too far away
- 8 It took too long to get an appointment with my old provider
- 9 My old provider did not provide all the mental health services I wanted
- 10 I heard or knew this provider was better
- 11 Other (please specify): _____

19. What impact has changing to **this provider** had on the care you receive?

- 1 It got better
- 2 It stayed the same
- 3 It got worse
- 4 Not sure

Reminder: When a question asks about "this provider," please think in terms of the mental health services provider who gave or told you about this survey.

TREATMENT 8

Please **do not** include medications prescribed **only** by your general practitioner / physician (GP) or primary care provider (PCP) in this section.

20. In the last 12 months, have you been receiving any **medications** for your mental health needs?

- 1 Yes → Go to 24
- 2 No → Go to 28

21. Were you **involved** as much as you wanted to be in decisions about which medications you receive?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I wanted to be
- 4 No, but I did not want to be
- 5 Don't know / Can't remember

22. In the last 12 months, have you been prescribed any **new medications** for your mental health needs?

- 1 Yes → Go to 28
- 2 No → Go to 27

23. The last time you had a new medication prescribed for your mental health needs, were you given **information** about it in a way that you were able to understand?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No
- 4 I was not given any information

24. Have you been receiving any medications for your mental health needs for 12 months or longer?

- 1 Yes → Go to 28
- 2 No → Go to 28
- 3 Not sure → Go to 28

25. In the last 12 months has **this provider** checked with you about how you are getting on with your medications? (That is, have your medications been reviewed?)

- 1 Yes
- 2 No
- 3 Don't know / Can't remember

26. In the last 12 months, have you received any **treatments or therapies** for your mental health needs that do not involve medication?

- 1 Yes → Go to 30
- 2 No, but I would have liked this → Go to 31
- 3 No, but I did not mind → Go to 31
- 4 This was not appropriate for me → Go to 31
- 5 Don't know / Can't remember → Go to 31

27. Were you involved **as much as you wanted to be** in deciding what treatment or therapies to use?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I wanted to be
- 4 No, but I did not want to be
- 5 Don't know / Can't remember

Reminder: When a question asks about "this provider," please think in terms of the mental health services provider who gave or told you about this survey.

OTHER AREAS OF LIFE

Please **do not** include help from your general practitioner / physician (GP) or primary care provider (PCP) in this section.

The following are areas of life where some people need help or support. For each area, **this** mental health services **provider** may have helped you to **find** support you needed.

Support might have been provided by your mental health services provider, or it might have been provided by another organization – such as social services, a charity or a community group. If support was provided by someone else, I am interested in whether **this provider helped you to find this support** from them.

28. In the last 12 months, did **this provider** give you **any help or advice** with **finding support for physical health needs** (this might be an injury, disability, or a condition such as diabetes, epilepsy, etc.)?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I would have liked help or advice with finding support
- 4 I have support and did not need help or advice to find it
- 5 I do not need support for this
- 6 I do not have physical health needs

29. In the last 12 months, did **this provider** give you **any help or advice** with **finding support for financial advice or benefits**?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I would have liked help or advice with finding support
- 4 I have support and did not need help or advice to find it
- 5 I do not need support for this

30. In the last 12 months, did **this provider** give you **any help or advice** with **finding support for finding or keeping work**?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I would have liked help or advice with finding support
- 4 I have support and did not need help or advice to find it
- 5 I do not need support for this
- 6 I am not currently in or seeking work

31. In the last 12 months, did **this provider** give you **any help or advice** with **finding support for finding or keeping other types of mental health care services or accommodation** (such as home care or at school)?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I would have liked help or advice with finding support
- 4 I have support and did not need help or advice to find it
- 5 I do not want this / I did not need this

32. Has **this provider** helped you to take part in a social activity locally?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I would have liked this
- 4 I have support and did not need help or advice to find it
- 5 I do not need support for this

Reminder: When a question asks about "this provider," please think in terms of the mental health services provider who gave or told you about this survey.

33. Has **this provider** involved a member of your family or someone else close to you as much as you would like?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, not as much as I would like
- 4 No, they have involved them too much
- 5 My friends or family did not want to be involved
- 6 I did not want my friends or family to be involved
- 7 This does not apply to me

34. Have you been given **information** by **this provider** about getting support from people who have experience of the same mental health needs as you?

- 1 Yes, definitely
- 2 Yes, to some extent
- 3 No, but I would have liked this
- 4 I did not want this

35. Does **this provider** understand what is **important to you** in your life?

- 1 Yes, always
- 2 Yes, sometimes
- 3 No

36. Does **this provider** help you with what is **important to you**?

- 1 Yes, always
- 2 Yes, sometimes
- 3 No

37. Does **this provider** help you **feel hopeful** about the things that are important to you?

- 1 Yes, always
- 2 Yes, sometimes
- 3 No

OVERALL

Please **do not** include contact with your PCP in this section.

38. Overall... (Please circle a number)



39. Overall in the last 12 months, did you feel that you were treated with **respect and dignity** by **this provider**?

- 1 Yes, always
- 2 Yes, sometimes
- 3 No

ABOUT YOU

This information **will not be used to identify you**. It is used to monitor whether different types of people are having different experiences of mental health care.

40. Who was the main person or people that filled out this survey?

- 1 The mental health **service user**
- 2 A **friend or relative** of the service user
- 3 **Both** service user and friend/relative together

Reminder: All the questions should be answered from the point of view of the mental health care service user (patient). This includes the following demographic questions.

41. What is your gender?

- 1 Male
- 2 Female
- 3 Other
- 4 Prefer not to say

42. What is your **age** in years? (Please write in)

43. Do you identify as Hispanic/Latin@?

1 Yes

2 No

44. Do you identify as...

(Select only one.)

1 White/Caucasian/European Diaspora

2 Black/African American/African Diaspora

3 Native/First Nations/Indigenous

4 Pacific Islander

5 Asian

6 Mixed/Multiple Ethnicities

7 Other (please specify): _____

8 Prefer not to say

OTHER COMMENTS

If there is anything else you would like to tell me about your experience of mental health care in the last 12 months, please do so here.

Is there anything particularly good about your care?

Is there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

Please check that you answered all the questions that apply to you.

The **PRIZE ENTRY FORM** and information about an additional research opportunity are on the next page ➡

Please **MAIL** this survey (and any entry forms you want to fill out) back in the **PREPAID** envelope provided.

SURVEY PRIZE ENTRY FORM

If you would like the chance to win a \$50 target gift card, please fill out the form below. **If you do not want to enter this raffle, leave this form blank.**

I will only use the information you provide on this form to enter you into the prize raffle and to contact you if you are a prize winner.

Name

Street Address or P.O. Box

City

State

Zip Code

Phone number

TO ENTER, FILL OUT AND RETURN THIS WITH YOUR SURVEY

ADDITIONAL RESEARCH OPPORTUNITY

As part of my research into mental health care, I am also conducting brief telephone interviews with service users about information practices related to their care. I am interested in how patients learn about their conditions, treatments, and options.

If you are not interested in this interview research, **leave this form blank.** I will only use the information you provide on this form to enter you for a chance to participate in an interview and to contact you if you are selected for the interview research.

If you would like to volunteer for an interview, please fill out the form below. I will randomly select and contact a certain number of people who volunteer for this. Interview participants will have the chance at another prize.

Name

Street Address or P.O. Box

City

State

Zip Code

Phone number

TO VOLUNTEER, FILL OUT AND RETURN THIS WITH YOUR SURVEY

CURRICULA VITA

Ashley Graboski-Bauer earned her Bachelor of Arts degree from the University of Wisconsin Stevens Point. She earned her Master of Public Health and Master of Anthropology degrees from the New Mexico State University. Prior to beginning her doctorate in Teaching, Learning, and Culture, Dr. Graboski-Bauer worked in epidemiology and other areas of public health. While completing her doctorate at the University of Texas at El Paso, she worked as a research and teaching assistant for the institution. Concurrently, Dr. Graboski-Bauer also worked in numerous academic and community instructional capacities for New Mexico State University, and as an independent data analyst and technical writer for various health agencies within the Paso del Norte U.S.-Mexico Border Region. While working towards her doctorate, Dr. Graboski-Bauer received the George A. Krutilek Memorial Graduate Scholarship and her dissertation project was supported in part by a University of Texas at El Paso Dodson Graduate Grant. Dr. Graboski-Bauer has presented her work from across these capacities at a variety of public health and education conferences, and published in related journals.