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Patient initiation of information: Exploring its role during the mental health intake visit

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Abstract

Objective—Describe the role of patients' initiation of information in patient-provider communication during mental health intake visits.

Methods—One hundred and twenty-nine mental health intake visits of diverse racial/ethnic patients were videotaped. Semi-structured interviews were conducted with patients and providers following each intake visit. We qualitatively analyzed the interviews to identify themes related to patients' initiation of information. We quantitatively analyzed the videos of the intake visits utilizing a checklist that identified whether the patient or the provider initiated the information exchanged.

Results—Patient initiation of information affected providers' evaluation of the credence of the information, assessment of rapport and appraisal of the success of the intake visit. Patients' initiation of information varied with patients' race, age and prior treatment experience; and provider's age, discipline and experience. Patients expressed a personal preference either to not be interrupted or to be asked questions by their providers.

Conclusion—Our findings illuminate the role of patient initiation of information in provider decision-making and highlight the importance of tailoring the communication style to patients' preferences.

Practice Implications—Encouraging explicit communication with patients about expectations related to information exchange styles is recommended. Improving provider awareness of assumptions regarding their decision-making is also suggested.

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Keywords

Communication; decision-making; initiation; intake; mental health

1. Introduction

The intake visit is often the first point of contact between patients seeking mental health services and providers. It usually includes a clinical interview which holds multiple aims, including but not limited to: establishing diagnosis, facilitating rapport, providing psycho-educational tools, and planning treatment [1–3]. Despite its importance for determining patient care, the intake visit has been subject to little empirical investigation [4–6]. Furthermore, there is a lack of information as to how clinicians integrate the information gathered as part of the intake visit to guide their decision-making.

Communication between patients and providers has attracted increasing attention, with research documenting its role in establishing rapport, improving information exchange, and facilitating clinical decisions [7]. Recent models of clinical interviewing such as the client centeredness model [8] emphasize an egalitarian approach in the clinical encounter, particularly in terms of how patients' participation and sharing of information is to be encouraged.

The concept of patient participation emerged from studies on patient-provider communication and has been defined in terms of patient communication style, based on the centrality of communication in involving patients in their care [9–12]. Although it received little attention, the importance of who initiates the information exchanged between patients and providers can be regarded as a key element in the concept of patient participation.

Information initiation is of particular interest in mental health encounters, where patients' illnesses can directly affect their capacity to communicate with their providers [13]. This dilemma is of interest given the effect patients' communication can have on providers' decision-making. For example, when communicating with high-participation patients, clinicians volunteered more information relative to communicating with low-participation patients [12]. Similarly, other studies have found that patients who asked more questions received more information from their providers [9,10]. Patient characteristics such as emotional distress were associated with increased initiation of new information by the patients, as well as passive, supportive listening by the provider, which was focused on the patient's emotions [14]. A time analysis of the medical encounter has documented that providers contribute about sixty percent of the clinical dialogue and patients the remaining forty percent [15]. Typically, the contribution of patients to the dialogue consisted largely of information giving in response to providers' questions [15].

The time spent on different topics in the medical encounter is influenced by different dimensions such as the nature and the initiator of the topic. Patients tend to speak longer if they initiate the topic [16]. Whether initiated or offered in response to provider questions, the patients' provision of information regarding the histories of their illness, their needs, and preferences for care affords providers the data that they deem essential in making appropriate clinical decisions [17]. However, some patients report that they have not provided important information to their providers, including histories of their chief complaints [18]. Robinson and Roter [19] have found that the act of patients providing information is greatly influenced by the questions posed by providers. Patients are more likely to provide information about psychological distress to primary care physicians, if the provider asks about it.

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In sum, research on patient-provider communication in the past two decades has been tied to patient care and satisfaction as well as provider decision-making during the medical encounter. However, little is known about the patient-provider communication process in mental health service delivery or the role of the initiation of information in the patient-provider encounter. In the current study we present a mixed methods investigation of the role of patient initiation of information in the patient-provider communication process during the mental health intake visit. We focus on the association between patient's initiation of information and provider's evaluation of the information and assessment of rapport. We also study patients' preferences regarding initiation of information as well as patient and provider characteristics that are related to patient initiation of information.

2. Methods

2.1 Sample

We report on data from the Patient-Provider Encounter Study [20]. Forty seven providers from eight adult outpatient mental health clinics in the Northeastern United States participated in the study. All facilities offered services to a diverse and socioeconomically disadvantaged patient population. Providers participated up to five times in the current study (with 5 different intake visits) in order to increase the diversity of the sample. The providers represented varied disciplinary backgrounds and levels of experience and were predominantly of non-Latino White racial background (see Table1).

One hundred seventy-one adult patients who sought outpatient mental health services were invited to participate in the study. Of these, one hundred twenty-nine participated in the study (42 patients declined to participate and 2 did not pass the capacity to consent screen). Patients presented to the intake visit which was their first contact with the service for a new episode of care. Patients' presenting problems were diverse and included social and interpersonal problems as well as major axis I symptomatology (e.g., depression, anxiety etc.). Intake visits ranged between 20–70 minutes, with average length of visit lasting 59 min (SD=25 min). Patients identified as psychotic or suicidal by clinicians, required an interpreter during their intake visit, or for other reasons lacked capacity to consent to participate were excluded. Patients were of diverse ethnic and racial backgrounds, with a majority having a household annual income of less than $15,000 (see Table 2).

2.2. Procedure

All patient participants completed an assessment of their capacity to consent prior to their participation using a 10-item screening measure [21]. Participation in the study consisted of videotaping of the mental health intake visit, partaking in a semi-structured research interview, and completing demographic and clinical measures. All research interviews were audiotaped and fully transcribed using a professional service. These interviews were designed to assess the experiences of patients and providers during the intake visit and lasted approximately thirty minutes. Provider interviews included questions about their understanding of the patient's presenting problem, their clinical decision-making process, their rapport with the patient, and their views of the role of socio-cultural factors in the patient's presenting problem. Patient interviews included questions about their presenting problem, rapport with providers, and significance of socio-cultural factors in the presenting problem. All interviews were conducted by trained research assistants. Supervision was provided throughout the data collection process by an expert in medical ethnography. Patients and clinicians completed survey measures which included demographic information used in the National Latino and Asian American Study (NLAAS) [22] and patients offered clinical information by answering the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version (AUDADIS-IV) [23].

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2.3. Analyses

2.3.1. Qualitative analysis—Analysis of the patient and provider interviews was conducted using NVivo 7 [24] to identify major themes across interviews in the content and process of patients' initiation of information, and involved a series of steps. Patient and provider interviews were read independently to identify sections of the transcripts where patients' initiation of information was discussed. Each noted the main thematic areas across patient and provider interviews and organized these into nodes and sub-nodes. Each node represented a thematic category under which excerpts from the transcripts were organized. The readers then convened and discussed emerging themes. When disagreement arose, authors attempted to identify the source of the discrepancy, and coded sections were reviewed again to refine and revise emerging thematic categories until consensus was reached [25].

2.3.2 Quantitative analysis: Information checklist—Videotapes of the mental health intake visits were quantitatively analyzed using a measure designed to code information exchanged during the initial intake visit. The measure, named "information checklist", was developed by the authors and included 128 items (and over 200 sub-items) in order to systematically code the information exchanged between patients and providers during the intake visit. Items covered symptoms related to Axis I as well as anti-social personality disorders. All items were derived from the diagnostic criteria in the DSM–IV [26] and the AUDADIS [23]. We also included items that reflected personal and familial risk factors of psychiatric disorders identified in an extensive review of the literature. In addition, the measure included items that describe physical symptoms/illness, conditions of disability and treatment history used in the NLAAS [22]. Each item that was discussed during the intake visit was coded for whether it was initiated by the patient, or elicited by the provider.

Eight mental health clinicians served as coders for the information checklist. Reliability was established using five training tapes (agreement was 86–87% between each coder and master coding).

In order to study patient initiation of information during the intake visit we created an initiation variable which included the number of items initiated by the patient divided by the overall items discussed during the intake visit. We conducted regression analyses to detect whether patient and provider characteristics were associated with patients' initiation of information. These variables included: patient's age, gender, education, race/ethnicity, and prior mental health experience; provider's age, gender, discipline, and length of experience in clinical work.

3. Results

3.1. Qualitative analysis

We present the major themes related to patients' initiation of information generated from the provider interviews (information exchange style, weighing the information, assessment of rapport and the success of the intake process) and patient interviews (patients' personal preference). Supportive text is included to illustrate the main findings.

3.1.1. Provider interviews: Information exchange style—Providers consistently reported that they were using an iterative process of information exchange in which patient initiating and provider eliciting of information emerged as key components of the mental health intake visit. It was usually the information that patients initiated that triggered providers to ask questions in order to elicit more detailed information for clarification as demonstrated in the following example:

> "She would say things that would prompt questions in my head about information that I needed to gather maybe different pieces of the history… She might mention

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> something, but without giving a lot of clarifying detail and so I needed to get a little more…. So, it's just a matter of do I want to ask a question for clarity sake and risk derailing her from where she was going to go in her free-flowing conversation?" (204CN).

3.1.2. Provider interviews: Weighing the information—Patients' initiation of information influenced providers' decision-making regarding the use and weight of the information. Providers repeatedly described giving more credence and valence to information that was initiated by patients in comparison to information that was elicited by providers. This pattern was particularly noticeable with patients presenting for substance abuse treatment. In the following example, the provider described what led her to believe the patient's presentation:

> "In comparison to other people I've sat with… she's providing me with more information. I'm not needing to pull and search, she's offering. I just didn't get a sense that there were ulterior motives that I could notice…. It leads me to believe that she doesn't have a reason to come in here and ask for this kind of help and then withhold or inaccurately report" (300CN).

Providers repeatedly associated 'patient honesty' with information that was initiated by patients, which in turn increased the provider's trust of these reports:

> "With addictions she came out on her own, she took a Percocet, that's something that she didn't have to really tell me. She was able to be honest about that. So I looked at her addiction where she was saying it was out of control, so pretty much her report was pretty good" (312CN).

3.1.3. Provider interviews: Assessment of rapport—Providers' accounts suggested that the level of patient initiation of information helped them gauge the quality of the rapport with their patients. In the following example the provider described how the patient's increasing willingness to initiate information suggested his increased comfort with the provider and the interview process:

> "The rapport, I think fell into place because he felt that he got some important information out about himself, and I noticed that he became more engaged in the interview, less guarded, offering more information unsolicited as opposed to sort of waiting for inquiry from me" (108CN).

In the following example the provider described his belief that allowing patients to talk in an uninterrupted manner not only facilitated rapport building but also improved the quality of the information the patient provided:

> "I think as a young clinician you're frantic that you do everything right and ask all the things… it's almost like you have to think and remember if you've asked everything. As you get comfortable, you know the person can tell you almost everything you need to know without you having to do too much…. In my experience, I can put more of my energy into having a person feel comfortable- and open to talking, and something natural happens when they do that where everything sort of seems to come out" (427CN).

Alternatively, in the following example the provider described how his style of asking questions to elicit information impeded on the development of good rapport with his patient:

> "I got the sense that he wanted to tell his story and that just wasn't in the cards for today, because we needed to fill out the intake visit. So, I could tell that he was unpleased that I would be interrupting him and asking him all these questions. He said

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> at the end that he didn't feel that he could really talk to me, that sometimes he didn't think I was listening" [450CN].

3.1.4. Provider interviews: Assessment of the success of the intake process— Providers often discussed the importance of patients' ability to be good historians and volunteer a coherent narrative of their history and presenting problem. They frequently referred to this ability when assessing the success of the intake visit and the evaluation of their own comfort level during the intake visit:

> "She wasn't volunteering too much information….I think in part, it is her style, she was a little bit guarded…. she had a certain barrier and I just interacted with her and felt totally fine. It's just that I see other patients too, and I realize how some patients, it's really a pleasure, fun, to interview them, and with some others it is more work…. with her, I needed to dig to get information and to keep the interview moving in a direction that will give me that information" (640CN).

The patient's reluctance to initiate information was perceived as a barrier to the communication process and a hindrance to a successful intake process. However, this expectation on the part of providers was rarely explicitly articulated to patients.

Providers often reported a preference for a balance between having patients initiate enough information to allow them to complete the assessment process but not too much information to be inefficient with the use of limited time. The challenge of achieving this balance was particularly evident in the discussion of traumatic events where the clinician was wary that too much disclosure may have negative consequences for the patient:

> "She definitely gave me as much information as I needed when she was providing information about this most recent traumatic insult…. I didn't want her to go into any greater detail with that. I mean I was able to definitely get the flavor of something that had happened to her, which I am sure has had a profound and long term effect" (301CN).

3.1.5. Patient interviews: Personal preference—Patient interviews included significantly less references to the role of information initiation during the intake visit. One important theme which consistently emerged in the interviews related to patient preferences for communication style. Although providers rarely explicitly asked patients about their preferences, patients often specified a preferred communication style. Some patients described a preference toward being asked questions by the provider while others preferred to independently initiate information in an uninterrupted manner ('tell their story'). In the following example the patient discussed his preference to be asked questions in order to articulate his experience:

> "…Just ask me anything. I'll probably give him the answer. Just ask me certain things and try to open me up….like personal questions. I can get them off my chest a little bit so I can feel better" (428PT).

Other patients emphasized their preference to volunteer information without being asked questions which they perceived as interruptions, as evident in the following example:

> "She let me talk, she gave the impression that she wanted to listen to you. You really don't want someone giving you a lot of opinions, and I mean she listened to me a lot…she didn't stop me or stuff like that, she just let me go" (704PT).

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3.2. Quantitative analysis

3.2.1. The association between socio-demographic factors and patient initiation of information using the information checklist—As seen in Table 3, patient's race and age were significantly associated with the initiation of information during the intake visit. Latino patients were less likely to initiate information as compared with Non-Latino White patients (OR=0.91, 95% CI=0.82, 1.00). Patients of the middle to older age range (i.e., 50–64 years old) were more likely to initiate information (OR=1.20, 95% CI=1.07, 1.36) as compared with younger patients (i.e., 18–34 years old). In addition, patients who had prior experience in mental health treatment were significantly more likely to initiate information as compared with patients who had no prior experience in mental health treatment (OR=1.26, 95% CI=1.14, 1.40).

In addition, provider's age, discipline and experience in clinical practice was associated with patient initiation of information. Patients seen by the oldest providers (over 65 years old) were less likely to initiate information as compared with patients seen by younger providers (25–34 years old). Patients who were seen by psychologists were more likely to initiate information as compared with patients who were seen by psychiatrists. (OR=1.23, 95% CI=1.08, 1.42). Patients who were seen by providers with 11–15 years of clinical experience were more likely to initiate information (OR=1.16, 95% CI=1.00, 1.33) as compared with patients who were seen by less experienced providers (1–5 years of experience).

4. Discussion and Conclusion

4.1 Discussion

Our results suggest that providers consistently struggle with the need to balance allowing patients to initiate information and to elicit necessary information to complete their assessment of the patient. Mishler [27] refers to this tension between alternative communication models as the conflict between the 'voice of medicine,' emphasizing a technical, medical frame of reference, and the 'voice of the life-world,' reflecting the patient's personal contextualized story expressed in familiar terms. Mishler [27,28] further suggests that patients are often compelled to follow the provider's medical discourse which tends to dominate the interaction, while making it difficult for patients to 'tell their stories' in a way that makes sense to them. This tension was evident throughout the interviews with patients and providers in the current study.

Our qualitative results further suggest that patients vary in their preference regarding initiation of information. Although providers rarely explicitly asked patients about their expectations with regard to the style of information exchange, patients expressed strong preference for a particular style. Some preferred to be asked questions by providers in order to facilitate information exchange. Others indicated that they felt it was essential that providers allowed them to 'tell their story' in an uninterrupted manner to feel understood and comfortable during the intake visit.

Our quantitative results show that patients' race and age were associated with their likelihood to initiate information. These findings are consistent with other studies which documented that patient characteristics can be associated with patient-provider communication patterns [10] and expand them to show that such associations appear as early as the initial mental health intake visit. Furthermore, our findings show that patient initiation of information varied based on prior experience in treatment which highlights the importance of patient familiarity with the expectations related to communication styles during the intake visit.

Moreover, research in recent years has consistently documented that minorities have less access to mental health care [29]. It is plausible that reduced access to care may be related to reduced

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familiarity with the medical encounter and be associated with different communication processes, particularly with regard to providers' evaluation of patients' initiation of information.

Our results also show that provider's age, discipline and clinical experience can be associated with patient's initiation of information. These provider characteristics may determine the specific context of the intake visit setting such as length and reason for the visit which in turn can be related to different patient communication style [30]. Providers with middle ranged experience were more likely to allow their patients to initiate information compared with less experienced providers who may more rigidly adhere to clinic regulations needed to complete intake visit forms and hence interrupt their patient with more questions; and more experienced providers who may increase efficiency utilizing the expertise they acquired over years of practicing [16]. Interestingly, patients seen by the oldest providers were less likely to initiate information as compared with patients seen by the youngest providers. Oldest providers, particularly in public settings may be less attuned to patients' needs as part of a burnout factor. Future research on the association between provider characteristics and patient communication style may shed more light on this topic.

The present study has several limitations which include the lack of follow up information on the patients that were seen for intake visits. Future research which will explore factors such as the treatment recommended and retention in care can deepen our understanding of the impact of patient initiation of information on important factors related to patient care. A second limitation relates to the makeup of the patient sample in our study which was heterogeneous both in terms of diagnostic impression and racial/ethnic background. This makeup contributes significantly to the generalizability of our findings to the general outpatient population as well as their applicability to 'real-life' mental health intake visits. However, in order to conduct meaningful analyses as well as protect patient confidentiality we needed to collapse patient ethnic and racial subgroups.

4.2. Conclusion

Our results highlight the role of patient initiation of information in the patient-provider communication during the intake visit. They further suggest that initiation of information impacts providers' decision-making. Providers frequently attributed honesty and trustworthiness to patients who initiated information, particularly, what they perceived as sensitive information. Similarly, providers reported using the amount of information volunteered by patients as a barometer for the quality of the rapport and success of the intake visit. It is unclear whether providers were aware of these influences or whether these factors implicitly affected their decision-making. Recent research suggests that providers' decisions concerning intake visit goals, diagnosis, or treatment almost always employ implicit processes that appear to be impacted by the information exchanged [31–33]. In the current study, providers' references to the role of patient initiation of information in their decision-making were not made explicit but rather were embedded in providers' descriptions of their thought processes regarding their evaluation of the interactions with their patients and may suggest that these processes were implicit. However, data from the current study is limited in its ability to determine this hypothesis.

Whether implicit or explicit, our findings suggest that providers are attributing importance to patient initiation of information, a factor which is determined in part by the patient's prior experience in treatment, age and ethnic/racial background. Therefore, novice patients who are not familiar with the expectations of the intake visit may engage in communication patterns that limit their initiation of information. Providers may perceive these patients as less engaged and attribute less value to the information that is exchanged during the intake visit. Such patterns may have important implication in the clinical encounter since they might impact the

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perception of rapport and level of engagement that the provider incorrectly evaluates the patient has during the intake process. In cases were the provider evaluates the patient is disengaged in care, it might influence their investment in “working with” this patient, particularly if they perceive increased likelihood of that the patient may be dropping out of care.

4.3. Clinical implications

Encouraging explicit communication about expectations regarding information exchange style and tensions in goals of the intake visit is recommended. Providers should inform patients that there are contextual restrictions/expectations for the intake visit (e.g., time, forms) and emphasize the dialectic between their need to ask questions and their interest in hearing the patient’s story. Tailoring the information exchange style to patients’ preferences (by explicitly asking them about it) is also imperative in improving patient centered care. In addition, continued effort to help providers be more aware of assumptions in their decision-making through training will increase the transparency of these processes and improve the quality of care [34,35]. Finally, the importance of patient education needs to be emphasized. In particular, communication skills building can facilitate patient engagement in providing and seeking information and improve patient care [9,10].

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Table 1

Provider Participants Characteristics

N= 47	**Percent of total sample**
Age	
25–34yr	34.04
35–49yr	44.68
50–64yr	17.02
≥ 65y	4.26
Gender	
Male	34.04
Female	65.96
Race/Ethnicity	
Non-Latino White	53.19
Latino	36.17
Non-Latino Black	8.51
Asian	2.13
US Born	
US born	61.70
Not US born	38.30
Discipline	
Psychiatrist	27.66
Psychologist	25.53
Social worker	38.30
Nurse	6.38
Mental Health counselor	2.13
Years of Experience (clinical work)	
1–5 years	29.79
6–10 years	25.53
11–15 years	17.02
≥16 years	27.66

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Table 2
Patient Participants Characteristics

N=129	**Percent of total sample**
Age	
18–34yr	39.06
35–49yr	40.63
50–64yr	17.19
≥65y	3.13
Gender	
Male	40.31
Female	59.69
Race/Ethnicity	
Non-Latino White	38.76
Latino	49.61
Non-Latino Black	11.63
Education	
≤11yr	34.65
12yr	23.62
13–15yr	28.35
≥16yr	13.39
Household Annual Income (in US $)	
<15,000	64.29
15–35,000	19.84
35–75,000	11.90
≥75,000	3.97
Employment Status	
Employed	45.31
Unemployed	23.44
Other/Out of the labor force	31.25
Insurance[i]	
No insurance	4.69
Private	13.28
Medicare	14.06
Medicate	50.00

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N=129	**Percent of total sample**
Other	17.97
US born	
US born	47.24
Other than US born	52.76

[i] Private insurance: Health insurance obtained privately or through an employer.

Medicare: The U.S. government’s health insurance program for people age 65 or older.

Medicaid: The U.S. government’s health insurance program for low-income people.

Other insurance: Military health care and/or other special state program.

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Table 3

Effect of Socio-Demographic Factors on Patient Initiation of Information

N patients=121[ii] **N providers=47**	**Odds Ratio**	**95% Confidence Interval**	**P value**
Provider Gender			
Male	1.00		
Female	1.04	(0.95, 1.14)	n.s.
Provider Discipline			
Psychiatrist	1.00		
Psychologist	1.23	(1.08, 1.42)	0.01
Social worker	1.03	(0.93, 1.15)	n.s.
Nurse	0.96	(0.60, 2.32)	n.s.
Provider length of experience of clinical work			
1–5 years	1.00		
6–10 years	1.04	(0.92, 1.16)	n.s.
11–15 years	1.16	(1.00, 1.33)	0.01
16 years or more	0.93	(0.78, 1.11)	n.s.
Provider Age			
25–34yr	1.00		
35–49yr	1.10	(0.98, 1.25)	n.s.
50–64yr	1.05	(0.85, 1.28)	n.s.
≥65yr	0.67	(0.50, 0.90)	0.01
Patient Age			
18–34yr	1.00		
35–49yr	1.04	(0.95, 1.14)	n.s.
50–64yr	1.20	(1.07, 1.36)	0.01
≥65yr	1.09	(0.82, 1.44)	n.s.
Patient Gender			
Male	1.00		
Female	1.04	(0.95, 1.14)	n.s.
Patient Education			
≤11yr	1.00		
12yr	1.03	(0.93, 1.15)	n.s.
13–15yr	1.09	(0.99, 1.20)	n.s.
≥16yr	0.90	(0.79, 1.04)	n.s.

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N patients=121[ii] **N providers=47**	**Odds Ratio**	**95% Confidence Interval**	**P value**
Patient Race			
Non-Latino White	1.00		
Latino	0.91	(0.82, 1.00)	0.05
Non-Latino Black	0.97	(0.85, 1.11)	n.s.
Patient previous experience in treatment			
No	1.00		
Yes	1.26	(1.14, 1.40)	0.01

[ii] We were not able to complete the information checklist on 8 cases due to poor recording quality.